Contraception and sexuality among the youth in Kisumu, Kenya

Missie L. Oindo
Partnership Department, Tropical Institute of Community Health and Development (TICH) in Africa
P. O. Box 2224 Kisumu, Kenya

ABSTRACT

Background: A significant proportion of youth is infected by HIV and other sexually transmitted infections mainly through sexual intercourse, while the prevalence of unwanted pregnancies is rising.

Objective: To describe knowledge, attitude and practice and factors influencing sexual relationships and contraceptive practice among the youth in Kisumu town in western Kenya.

Methods: A descriptive cross-sectional study using a semi-structured questionnaire, key informant interviews, focus group discussions and informal conversations was carried out. The sample population of 388 youth aged 15 – 24 years was determined by simple random cluster sampling. Quantitative data were analysed using SPSS computer package.

Results: The majority of the youth are sexually experienced (73.5%) with most of the first sexual experiences occurring within the 15-19 years age group. There is a high level of knowledge (99.2%) of contraceptive methods and a positive attitude towards contraception. However, the level of contraceptive use is relatively lower (57.5%) even for the sexually active. Factors influencing this practice are associated with the individual's background as well as health delivery systems and policy.

Conclusion: There is a wide disparity between contraceptive knowledge and practice, which needs to be bridged. There is need to review policies and practices regarding reproductive health, sexuality and family life education.

African Health Sciences 2002; 2(1): 33-40

INTRODUCTION

The youth[1] aged 25 years and below constitute 64% of Africa's population while one in every Kenyan is an adolsecent[2]. Often the youth experience gradual movement towards heterosexual relationships which can lead to sexual activity. Culture fundamentally affects sexuality and fertility by creating values, norms, and expectations about sexual relationships, roles and behaviour[3]. In most traditional cultural set-ups, both pre-marital sex and pregnancy were frowned at and even punished. Despite religiosity featuring as an important determinant of indiscriminate sex in Kenya[4], traditional cultures have been eroded and the concept of abstinence not fully adopted, further compromising sexual behaviour.

A significant number of unmarried youth are becoming sexually active at early ages, prompted by the mass media presentation of sex as exciting and risk-free[5]. Fifty-two percent of the Kenyan youth aged between 15-19 years are sexually active[6] and specifically 39% and 65% of unmarried Kenyan girls and boys respectively, have had sexual intercourse[7].

Worldwide, studies on adolescent sexual behaviour show that young people's premarital sexual encounters are generally unplanned, infrequent and sporadic, a pattern that pre-disposes the youth to unwanted pregnancy and sexually transmitted infections. In sub-Saharan Africa, 7.4% of all 15-24 years aged youth were infected with HIV in 1997, mainly thorough unprotected heterosexual intercourse[8], while 600,000 Kenyan youths are projected to become HIV positive[9] by the year 2005.

Kenya's teenage births to girls aged 15-19 years account for about 12% of Kenya's total fertility, while Kisumu district's adolescent fertility[10] is reported at 27%. Many of documented schoolgirl pregnancies end in abortions, and adolescent abortions account for 16.5% of all abortions[11]. Worse still up to 74% of the women with abortions in Kenyan hospitals are adolescents[12].

The current conflicting messages about youth sexuality, with the promotion of sexual involvement on one extreme and urging of chastity on the other, make the youth feel guilty, uncertain or indecisive about contraception[13]. Recent Kenya Demographic and Health Surveys (KDHS) show that less than 10 percent of sexually active unmarried adolescent women aged 15-19 years were using any modern method of contraception[14]. Consequently,

Correspondence
Missie L. Oindo
Partnership Department, Tropical Institute of Community Health and Development (TICH) in Africa
P. O. Box 2224 Kisumu, Kenya
Tel. 245-035-23972/44853
E-mail: tich@swiftkisumu.com

there is a 52 percent unmet need for family planning among married women aged 15-19 years[15], a figure bound to increase if unmarried, sexually active teenagers were included.

A study of model sex education programmes found that while a variety of programmes were quite effective at increasing teenagers' level of knowledge of conception and contraception, they had little impact on their behaviour[16]. The relationship between what adolescents know and how they behave is perhaps the most salient issue.

The 1989 Kenya Demographic Health Survey showed that 90.1% of all women in the survey knew at least one contraception method, and that never-married women were least likely to know any method as compared to the currently married[17].

Other factors strongly associated with contraceptive use by sexually active unmarried teenagers include age of initiation, having a stable relationship with a sexual partner, knowledge of reproduction and contraception, acceptance of one's own sexuality, academic aspirations and parental support and controls[18]. For example, the older the girl at the time of initiation of sexual activity, the more likely she is to use contraception regularly and use a modern method, primarily the pill[19]. Younger girls, on the other hand, are more likely to be never-users, sporadic and ineffective contraceptors, and more likely to rely on male methods[20].

Presently, many parents are uncomfortable discussing sexuality and contraception with their children, a role that has been left to schools already limited by the current debates on sex education[21].

Until very recently, reproductive health (RH) services in most developing countries have been influenced by political factors rather than by meaningful state or national planning to meet the needs of the masses[14]. The widespread moral and political disagreements about the adolescent pregnancy problem have created confusion and conflict over what to do about it, resulting in absent or unclear guidelines on adolescent RH issues, including contraception. Even where there are no legal barriers, service providers are not always receptive to young clients and there is a minority who believe contraception is foreign to the culture and that it promotes promiscuity[22].

Given the youth's knowledge level on prevention and control of risks of unwanted pregnancies and STIs/HIV infections, there is concern over their continued unsafe sexual practices and the associated morbidity.

Therefore this paper describes the sexual and contraceptive knowledge, attitude and the factors influencing practice among the youths of Kisumu town in western Kenya. It also discusses the social and policy context of youth contraception in urban Kenya.

METHODS

A semi-structured questionnaire was applied to a total of 388 respondents (48.2% males and 51.8% females) aged 15-24 years selected through simple random cluster sampling. The instrument examined respondents' background factors; knowledge of contraceptive services and service sources; contraceptive attitude; contraceptive practice; and aspects of sexuality. Data was analysed using the SPSS computer software package.

Twelve Key Informant Interviews with parents, guardians, policy makers and health service were conducted through interview guides and focused on youth sexual and RH problems; adult attitude and communication on youth sexuality and contraception; and national and institutional policies on youth contraception. Six informal conversational interviews with parents, guardians, local administration and the youth focused on societal attitudes towards youth sexuality and contraception.

RESULTS

Background characteristics

The mean age of the sample population was 19.5 years. Over 83% were single, 10.4% of these reporting a parity of 1-2 children. Mean age at first marriage was 19.9 years, with 65.1% of the ever-married being female and reporting lower ages at first marriage than males. The occupation of the youth and the household heads are shown in figures 1 and 2.

Figure 1 Occupation of the youth in Kisumu town, Kenya

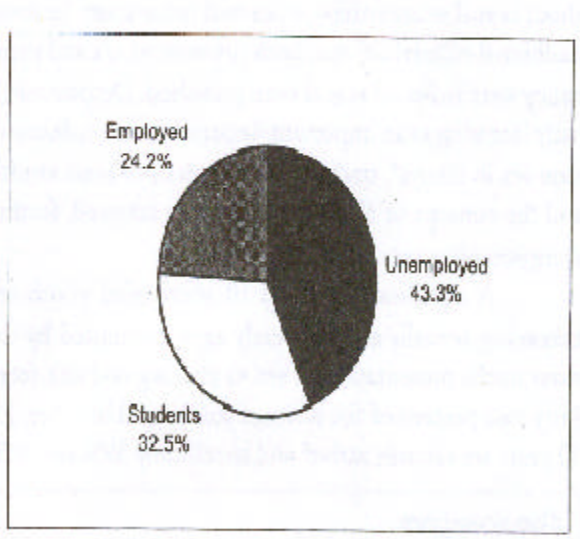
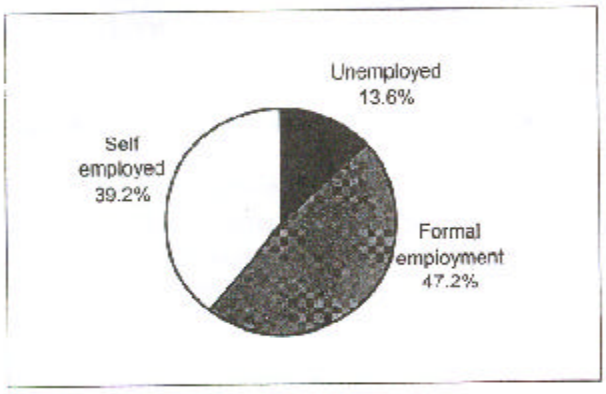


Figure 2 Occupation of household heads in Kisumu town, Kenya



Knowledge of contraceptive services and service sources

There was a 99.2% level of knowledge of at least one contraceptive among the youth (99.5% for males and 99% for females). Main sources of this knowledge were educational institutions, media and peers. Many parents/guardians reported reluctance to discuss sexuality with their 'in-the-family' youth as opposed to other youth within formal educational and health institutions.

The level of knowledge of other contraceptive services, namely information and counselling, was 14.7% and this increased with age. However, there was no significant correlation between age and number of contraceptive service sources known. The most common service source identified was the hospital/dispensary. Others included family planning clinics and pharmacy/shop, with little mention of non-conventional sources such as friends and relatives.

Contraceptive attitude

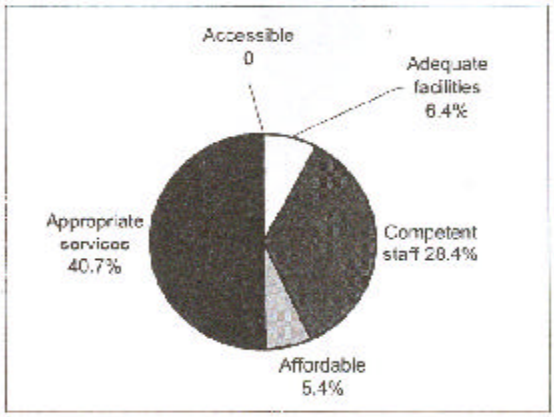
Eighty-five of the youth affirmed present and future need for youth contraceptive services.

The negative attitude towards youth contraception was attributed to the perceived health risks and the notion that the practice promotes promiscuity. Data revealed the basis of this perception as, not definite facts or real life experiences, but rather mere hearsay. Ironically, some opponents were current modern contraceptive users.

Adult opinions on youth contraception also vary from full support of effective youth contraception for service-seekers to total opposition of the issue as inappropriate. There are, also, moderates who advise youth contraception only under very special circumstances, such as pregnancy and STI counselling.

Eighty three percent of the youth favoured health institutions (hospital/dispensary and the family planning clinic) as ideal service points, basing on different reasons as shown in figure 3.

Figure 3: Reasons for choosing health institutions as ideal service points



In terms of adequacy of currently available services, 47.7% believed these were mostly adequate, 26.5% felt they were only sometimes adequate and 25.8% felt they were hardly ever adequate. These varied attitudes were based on issues of current levels of availability (39.7%), accessibility (24.2%), appropriateness (22.4%), affordability (3.1%), and acceptability (2.6%) of the services.

Contraceptive practice

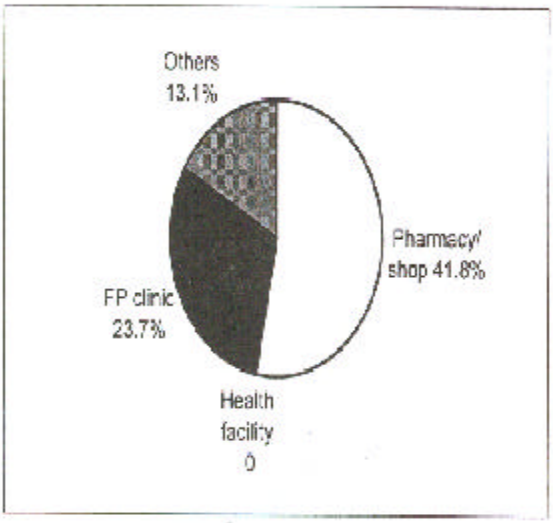
Fifty two percent of the youth had ever-used a contraceptive method, and the trend in the common methods ever-used shows popularity of the male condom, with the pharmacy/shop as the most common service source.

In general 34.6% of the youth had used a contraceptive method during their first sexual experience, a probability that decreased with age.

Only 31.4% of the youth are current users of a contraceptive method. The most common method in use was the male condom, especially among the younger youth. The choice of the currently used method was based on its effectiveness in pregnancy prevention (43.4%), disease prevention (37.7%), affordability (9.8%), ease of use (8.2%) and availability (0.8%).

Common sources for currently used methods are shown in figure 4.

Figure 4: Sources of contraceptives for the youth in Kisumu town, Kenya



The disparity between knowledge and practice of contraception can be analysed at three levels. Across the youth population, there was a 99.2 percent level of knowledge of at least one contraceptive method against a 31.4 percent current contraceptive practice level. Seventy one percent of the sexually experienced youth had ever-used a contraceptive method against 42.8% current use. Most significantly, only 57.5% of the sexually active youth were currently using a contraceptive method.

Aspects of sexuality

Seventy three percent of the youth were sexually experienced, with most of the first sexual experiences occurring within the 15-19 years age group: 74.4% these were sexually active, with 84% engaging in regular sexual encounters and 79.7% maintaining single partner sexual encounters. The major motivational factors for engagement in sex were pleasure (78.4%), obligation (15.6%) and material gain (5%).

About 89.5% of the youth acknowledged the risks in sexual relationships. Of these, 65.3% viewed STI/HIV as the greatest risk and 34.1% considered unwanted pregnancy as the greatest risk. Only 0.6% recognised abortion and psychological problems as main risks. Consequently, about 51.3% of the youth believe that contraceptive use is the main precaution one can take against the identified risks, followed by abstinence (42%) and 6.7% for other practices such as faithfulness between sexual partners.

Significant background factors influencing contraceptive use

Basing on a 95% significance level, the computation of the chi-square test of association for current contraceptive practice against independent background variables identified significant influencing factors of occupation ($p = 0.01$), age ($p = 0.02$) and religion ($p = 0.05$) of the youth. Logistic regression analysis of these factors identified levels of strength of association highest with religion ($\beta = 0.42$), occupation ($\beta = -0.46$) and age ($\beta = -0.66$).

DISCUSSIONS

Knowledge and attitudes towards contraceptive methods

The high 99.2% level of knowledge of at least one contraceptive method among the target population compares relatively well with, and even shows an increase from the national 1989 KDHS figure of 90 percent[17].

Most youth get their contraceptive knowledge from educational institutions and peers with parents and other relatives featuring very little as sources of this knowledge. It emerged that the youth are reluctant to consult informally with adults on contraception issues. Reasons for this include not knowing how to approach the issue and not wanting to alert the disapproving adults of the youth's sexual activities. The 'informed' peer is then viewed as a better source of knowledge and counsel because of assumed confidentiality and non-judgement. Furthermore, few parents/guardians are comfortable discussing matters of sexuality with their youth. They deem issues of contraception and sexuality to be more appropriately discussed in a reactive rather than proactive fashion, especially when the youth is already involved in a sex-related problem such as an unwanted pregnancy or STI. These findings support earlier observations that parents often prefer sex-related issues to be addressed by schools[21]. Yet the formal education system to which the responsibility of sex education has been left is also still limited by the current debate on what aspect of family life education should be taught, to whom, and by whom. In the meantime alternative sources of information are sought in the form of inadequately informed or misinformed peers.

Despite the relatively high level of contraceptive knowledge by the youth, there is still a marked lack of factual information that promotes suspicion and unfounded myths. The mystery around and undue restrictions on youth contraception contribute to negative attitudes towards effective use of the methods.

Religion, though often explicitly not mentioned, greatly influences contraceptive practice among the youth and is indeed the basis of the recurrent morality concerns by the opponents of youth contraception[4]. It does regulate sexual behaviour, including attitude to and practice of contraception. However, the chastity stand has been pointed out as also posing several dilemmas for the sexually active faithful who, being only human, do not know which is the lesser evil. This issue is best captured in the

following statement from one key informant:

"…The church is only right in insisting on chastity from our youth. My concern is on how well this restriction on contraceptive use impacts on efforts to control some life-altering consequences of human sexuality, especially amongst our youth."

The disparity between knowledge of a contraceptive method (99.2%) and other contraceptive services (14.7%) clearly shows lack of comprehensive knowledge of contraceptive services by the youth.

Knowledge and attitudes towards contraceptive service sources and providers

Many youth (87.7%) have a fair idea of conventional sources of contraceptive services. The most favoured choice of ideal setting is the health institution-based settings, a choice based on the appropriateness of the services offered. Here, "appropriate" is synonymous to "requested for" services. Data reveals that the youth often go to service points with their minds already made up on desired service. Competent personnel address this need in an efficient and courteous manner that encourages the client to seek such services even in the future. "Adequacy" of service is equated with the available range of service supply and the accessibility of the same. Many youth believe that there is a wide range of contraceptive services available, especially the methods. However, some service facilities are viewed as hostile and inaccessible. Some health personnel contribute to this as evidenced by the stand held by one 47-year old nurse at a government hospital:

"I wouldn't serve an unmarried teenager with contraceptives. It is only those who come to the clinic for antenatal or post-natal care that I can advice on family planning. But, still I would stress on them not to engage in sex again until they are married".

This attitude limits the desired range of services the youth are finally able to access from more accessible sources like shops, which unfortunately are often not well placed to offer a comprehensive service package.

Suffice it to say that the major determinant of whether service personnel significantly influence clients depends on their level of training, competence, and ability to inspire and motivate the client. Satisfied clients are also effective proponents of contraception and hence the nature of services offered and who offers these services at any point plays a big role in influencing the youth's attitude towards the setting's ability to address expressed needs and consequent health seeking behaviour.

Contraceptive practice

Few youth use a modern contraceptive method during their first sexual experience, a probability that decreases with age. Where a method is used it is more likely to be a male condom whose popularity is attributed to constant media and public campaigns and advertisements, as well as its high accessibility and comparatively low cost[15]. Despite a higher level of knowledge of the pill, fewer females have ever-used it, considering it too cumbersome and too rigorous for irregular sexual contacts.

Abstinence features very little as a method of contraception, mainly because most of the youth view it as the complete withdrawal from sex for reasons not strictly contraception-related. Instead, natural contraception practised in accordance with the ovulation cycle or "safe days period" of the female sexual partner features more.

There is a definite gap between ever-use and current use of contraceptives, attributed to subsequent abstinence, discontinuations and irregularity of use between the first and subsequent sexual relationships. Discontinuations and irregularity of use have been blamed on perceived health risks such as infertility and foetus abnormality in the females, tedious method procedures such as daily pill dosage, influence from partners and societal factors like religion and peers, intimidation by the "assumed" costs, and poor attitude towards service centres and service providers.

Disparity between contraceptive knowledge and practice

There exists a disparity between contraceptive knowledge and practice, indicating that knowledge does not always constitute practice. The concern is the relationship between what the youth know on contraception and what they actually practise[16,21].

Aspects of sexuality

Most youth are sexually experienced, with most of the first sexual experiences occurring within the 15-19 years age group. Many are currently sexually active and engage in regular sexual encounters with regular partners over a given period, showing a relatively stable pattern of relationships.

More importantly, the youth are aware of consequences of sexual relationships such as unwanted pregnancies and STI/HIV infection. They also have knowledge of precautions for these risks as revealed by the analysis of choice of contraceptive method against reason for choice. For example, Norplant, injection and the pill are primarily chosen for their role in pregnancy prevention, while the male condom is primarily chosen for both disease and pregnancy prevention, dual roles that it can serve well if used appropriately. But the recurrent concern, as depicted by the disparity between contraceptive knowledge and practice, especially among the sexually active

youth, is what the youth do given what they know[21].

Factors influencing contraceptive practice

Demographic factors

Age influences contraceptive use at different stages of a youth's life. First, the young youth is less likely to have ever-used or to be currently using a contraceptive method. Secondly, the younger the respondent during the first sexual experience, the less the probability of using a contraceptive method during this first sexual act. Thirdly, the older the youth at first marriage, the greater the probability of contraceptive use. Qualitative data points out that the youth getting married at older ages are more mature and responsible and are thus able to make rational decisions related to their sexuality, including use of contraceptives[12,18].

Sex. Males are more likely to use contraceptive methods, especially so in the current scenario of HIV/AIDS. The role of the male condom in STIs prevention has popularised it as one of the most frequently used contraceptive methods and seen a shift in responsibility for contraception in sexual relationships[20].

Socio-economic factors

Occupation. The out-of-school youth are more likely to use contraceptives than the in-school youth, basing on their age maturity and economic capacity.

Marital status. The single, socio-economically dependent and sexually active youth is more likely to adopt contraceptive practice as a wise precaution against STI and pregnancy and their associated implications than her married counterpart.

Level of education. The higher the level of education one attains the greater the probability of using a contraceptive method. The education system exposes one to more interactions and other sources of information that enables one to make wise decisions such as using a contraceptive when sexually active.

Social activity. The youth interacting in social activities are more likely to acquire varied info+rmation and behaviour regarding contraception from peers and others such as media idols. The right or wrong information they get often consciously or unconsciously influences their attitudes and desire to adopt contraceptive practice.

Cultural factors

Religion. Societal morals and values are often embedded through socio-cultural experiences like religion that promote chastity and mould attitudes towards contraception for the youth and society. These impact on the youth's decision-making process on both sexual behaviour and contraceptive practice and choice[21].

Service factors

Range of services. Availability of a wide range of services gives greater room for choice. Thus the myths and misconceptions on contraceptive effectiveness and effects influence choice and access, a point accentuated by the popularity of the much publicised and easily accessed male condom[2].

Adequacy of service facility. The youth favour friendly settings that provide their desired service readily and at affordable costs. Availability and accessibility of services impacts on the general level of contraceptive practice among the youth. Thus personnel at the service facility can motivate or demoralise the youth from seeking and using services.

Policy factors

The Kenyan policy on youth contraception is not explicit, resulting in different institutional and individual policies ranging from open-door policy for married couples to prohibition of service provision to the more vulnerable unmarried youth[7,9]. This has contributed to the practice of unsafe sex and seen the rise in popularity of the more easily accessible natural contraception and condoms. It can also be sighted for the popularity of the less restrictive commercial service sources over health institution-based facilities that otherwise offer more comprehensive services.

CONCLUSION:

This paper has explored contraceptive knowledge, attitude and factors influencing contraceptive practice among the youth in Kenya's western town of Kisumu. There was a wide disparity between contraceptive knowledge and practice. There is need to review and revise policies and practices regarding reproductive health, sexuality and family life education.

REFERENCES

1. World Health Organisation. The Health of Young People: A challenge and a promise. Geneva: WHO, 1993
2. Ocholla-Ayayo ABC. A Change in Sexual Practices and the Risk of the Spread of HIV/AIDS in Kenya. 1992
3. Hayes CD (ed). Risking the Future – Adolescent Sexuality, Pregnancy, and Childbearing. Vol. 1. Washington, D.C: National Academy Press, 1987
4. Ocholla-Ayayo ABC. Female Migration and Wealth Dissipation among the Exogamous Communities in Southern Kenya. 1981
5. Population Information Programme. Population Reports Nov.-Dec. 1985; Series M (9)
6. United States Aid for International Development. USAID Responds to HIV/AIDS. 1994
7. National Council for Population and Development & John Hopkins Population Communication Services/

Population Information Programme. Preliminary Kenya National information, Education and Communication Situation Survey. 1995
8. United Nations Programme on AIDS. Global Report on AIDS. 1997
9. National AIDS/STDs Control Programme & Ministry of Health. Preliminary Data. 1992
10. Mugwe E. Determinants of Adolescent Fertility: A Case Study of Kirinyaga District. University of Nairobi, 1989
11. Lema V, Kabeberi-Macharia J. A Review of Abortion in Kenya. 1992
12. Mutungi AK, Mango EO, Rogo KO, Kimani VR, Karanja JG. Abortion: behaviour of adolescents in two districts in Kenya. East African Med Journal 1999; 76(10): 541-546
13. Blanc AK, et al. Sexual Behaviour and Contraceptive Knowledge and Use among Adolescents in Developing Countries. *Studies in Family Planning* 1998; 29 (2): 106-116
14. Allan Guttmacher Institute. Hopes and Realities: Closing the Gap between Women's Aspirations and their Reproductive Experiences. New York: Allan Guttmacher Institute, 1995
15. Kirby D. Sexuality Education: An Evaluation of Programmes and their Effect. Santa Cruz, California: Network Publications, 1984
16. National Council for Population and Development & Ministry of Home Affairs and National Heritage. Kenya Demographic and Health Survey. GOK, 1989
17. National Council for Population and Development, Central Bureau of Statistics, Office of the Vice-President, Ministry of Planning and National Development. Kenya Demographic and Health Survey 1989. Calverton, Maryland: Macro International Inc., 1990
18. Zelnik M, Kantner J, Ford K. Sex and Pregnancy in Adolescence. Beverly Hills, California: Sage Publications, 1981
19. Kantner J, Zelnik M. Sexual experience of young unmarried women in the United States. *Family Planning Perspectives* 1972; 4: 9-18
20. Ntozi PM, Kirunga CJ. Family Planning and HIV/AIDS in sub-Saharan Africa: Challenges and Strategies. *African Journal of Reproductive Health* 1998; 2 (2): 47
21. Kamau J. Sexual behaviour in relation to awareness of HIV/AIDS among secondary school girls in Nairobi. Masters thesis University of Nairobi, Kenya, 1996
22. Ladipo OA. "Mobilising Support for Reproductive Health and Activating Change at the National Level". Reproductive Health Education and Technology: Issues and Future Directions, 1998