BARRIERS TO AND FACILITATORS OF CONTRACEPTIVES
UTILIZATION AMONG SECONDARY SCHOOL ADOLESCENT
GIRLS IN KIAMBAA SUB-COUNTY, KIAMBU COUNTY

BY

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Background Information

- An adolescent is a person aged 10-19 years (WHO, 2008)

- 1.2 billion adolescents Worldwide, 16 million give birth/year, Sub Saharan Africa accounts for 50% of these births (WHO, 2014)

- Adolescents face psychological challenges associated with possible sexual relationships with the opposite sex (Imaledo, 2012)

- They can become parents without being ready for parental responsibility (WHO, 2007)
Adults may find the idea disturbing, many adolescents have sexual relations before they are ready for marriage and families (Rose, 2012).

The gap between adult attitudes and adolescent realities is a recipe for early pregnancy. Compounding this, is the low level of contraceptive use amongst adolescents (Kija, 2013).

Without contraceptives, women of any age are unable to realize their own desire to avoid a pregnancy (Cleland, 2006a).

All methods physiologically safe for adults are physiologically safe for adolescents with exception of TL & vasectomy (WHO, 2007).
Problem Statement

- Globally, adolescents face a high unmet need for contraception (Blum, 2007)

- In Kenya though many adolescents wish to avoid pregnancy they are not using contraceptives to make this possible (Khan, 2008)

- Consequently, the age-specific fertility rate among adolescents in Kenya is 103 per 1000 women (KDHS 2008/09)

- Adolescent pregnancy one of the leading causes of school dropout in Kenya, 13,000 girls drop out per year (Hussain, 2012)
Cont. Problem Statement

- Karuri has the majority secondary school in Kiambaa sub-county, over 85% girls enrollment (DEOs, Karuri town council).

- At Karuri sub-county hospital, 90% of deliveries are to adolescents. 60% are secondary school adolescent girls. 65% have had to drop out of school due to pregnancy (ANC records, 2012/13).

- While this is the scenario, the family planning clinic is the least utilized.
Justification

- This study is inline with ICPD “reaching adolescents is critical in improving maternal health & achieving other millennium development goals” (ICPD, 1994) and SGD (5.6: ensure universal access to SRH and RH as agreed in ICPD)

- Little research has been done on adolescent contraception among secondary school girls in Kenya as well as Kiambu-bridging the information gap.

- Investing in contraception is more cost effective than managing unplanned adolescent pregnancy and caring for more children (Sarah, 2008)
ICPD conference (1994) main objective was; “To address adolescent SRH issues and to substantially reduce all adolescent pregnancies,”

The study contributes to future review and revision of policies and practices regarding adolescent’s SRH

This study will serve as a basis for future research on adolescents contraception
Broad Objective

To assess the utilization of contraceptives among secondary school adolescent girls in Kiambaa Sub-County, Kiambu County

specific objectives

To establish the level of contraceptive uptake amongst secondary school adolescent girls in Kiambaa Sub-County, Kiambu County

To establish factors promoting utilization of contraceptives among secondary school adolescents girls in Kiambaa Sub-County, Kiambu County

To establish factors hindering utilization of contraceptives among secondary school adolescent girls in Kiambaa Sub-County, Kiambu County
Methodology

- **Study site:** Karuri Town Council, Kiambu County

- **Study design:** Descriptive cross sectional design

- **Study population:** Secondary School Adolescent Girls from the selected schools in Karuri Town Council, Kiambu county

- **Sampling technique:** All the 9 public schools in Karuri town council, Kiambu county, sample in each school proportionate to the population of adolescent girls in each school, forms 1, 2, 3 & 4 formed the strata. Simple random sampling used to pick participants in the study.
Cont; Methodology

- **Data collection:** Semi-structured questionnaires and FGDs.

- **Data analysis:** Quantitative data managed via SPSS and Qualitative data via thematic content analysis done.

- The study utilized univariate and bivariate analysis
Ethics considered as this sub-group is considered “minors” in the society.
Results

Socio-demographic characteristics

- 421 participants were enrolled in the study
- Age ranged from 13.0 to 19.0 years with a mean age of 16.3 (sd 1.4) years
- Majority were Christians 91.4% and from rural areas 59.1%
- The students selected from Form 1 were (25.7%), form 2 (26.1%), form 3 (24.7%) and form 4 (23.5%).
Knowledge on Contraceptives

- 90.1% of the respondents had knowledge on contraception.

- Majority (79%) knew of condoms. Similar to KDHS 2014.

- Mass media (print and electronic) was the main (59.3%) source of information on contraception, Parents (7.2) and Teachers (4.8) the least.
Type of modern contraceptives

- Condoms: 79.0%
- Pills: 63.8%
- Injections: 5.7%
- Intrauterine devices: 1.8%
- Tubal ligation: 0.9%
- Implants: 0.6%
- Vasectomy: 0.6%
Sexual Activity

- 142 students (33.7%) had ever engaged in sexual intercourse

- The mean age of sex debut for this group was 15.0 years (sd 1.1).

- Being in a mixed secondary school was associated with increased likelihood of having had sex (p=0.038; OR=1.586 (95% CI: 1.024-2.458))
Age at sexual debut among the study participants

% (n=142)

Age in years

- 13: 4.9%
- 14: 26.8%
- 15: 45.8%
- 16: 13.4%
- 17: 6.3%
- 18: 1.4%
- 19: 1.4%
OBJ 1: Level of Contraceptive Utilization

- Of the sexually active, 43.0% reported having ever used a contraceptive.
- Lower than Lawrence 2007 who found that the use of contraceptives among sexually experienced adolescent was 46.9%.
- Emergency Pills were the most commonly used contraceptives 83.6% followed by Condoms 57.4%.
Knowledge on contraceptives: Having knowledge on contraceptives increases by 3 times the likelihood to use contraceptives (OR: 3.200, 95% CI: 1.115-9.183, p=0.025). Similar to Origanje, 2009

Perception: perception was significantly associated with contraceptive utilization (p=0.041; OR: 2.053; (95%CI: 1.024-4.115))

Similar to Jay, Durant, Linda & Litt, 2007 perceived susceptibility and severity of pregnancy outcomes increases adolescent contraceptive utilization
OBJ 3: Factors hindering contraceptive utilization

- **Age:** Adolescent girls aged 18 years and above were more likely to utilize contraceptives as compared to those of a lesser age (\( p<0.001; \) OR: 9.870 (95% CI: 3.781-25.763))

- Similar findings were reported by Moore K, 2008

- **Parental support:** The study depicted a significant association between parental support and the use of contraceptives (\( p=0.445 \)). Similar to Joyce, 2011
OBJ 3: Factors hindering Cont.

Accessibility; of contraceptives increased the likelihood of contraceptive utilization by 2 fold (p=0.034; OR: 2.101; (95% CI: 1.054-4.187)). Similar to Jay, 2007 and Joyce, 2011

Further qualified by qualitative data;

a) Adolescents feel shy to go purchase contraceptives
b) Hospitals don’t have contraceptives and if they do there is clinic and contraceptive fee
c) Long queues
d) Long waiting hours
e) Most adolescents depend on their parents for financial support.

Age at sexual debut and religion were not significantly associated with contraceptive utilization. Similar to Gold, et al., 2010

Peer influence was not significantly associated with contraceptive utilization \( p=0.999 \) \( FET \). Disagrees with Pramod R, 2010 and Regmi, 2010)
<table>
<thead>
<tr>
<th>Attribute</th>
<th>Total</th>
<th>Contraceptive use</th>
<th>OR</th>
<th>95% CI</th>
<th>P-Value</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>Yes</td>
<td>Upper</td>
<td>Lower</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥18</td>
<td>62</td>
<td>22 (35.5%)</td>
<td>40 (64.5%)</td>
<td>9.870</td>
<td>3.781</td>
</tr>
<tr>
<td>17</td>
<td>35</td>
<td>21 (60.0%)</td>
<td>14 (40.0%)</td>
<td>3.619</td>
<td>1.264</td>
</tr>
<tr>
<td>≤16</td>
<td>45</td>
<td>38 (84.4%)</td>
<td>7 (15.6%)</td>
<td></td>
<td>REF</td>
</tr>
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<td><strong>Knowledge on contraceptives</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>119</td>
<td>63 (52.9%)</td>
<td>56 (47.1%)</td>
<td>3.200</td>
<td>1.115</td>
</tr>
<tr>
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<td>23</td>
<td>18 (78.3%)</td>
<td>5 (21.7%)</td>
<td></td>
<td>REF</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81</td>
<td>40 (49.4%)</td>
<td>41 (50.6%)</td>
<td>2.101</td>
<td>1.054</td>
</tr>
<tr>
<td>No</td>
<td>61</td>
<td>41 (67.2%)</td>
<td>20 (32.8%)</td>
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<td>REF</td>
</tr>
<tr>
<td><strong>Parental support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24</td>
<td>12 (50.0%)</td>
<td>12 (50.0%)</td>
<td>1.408</td>
<td>0.584</td>
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<tr>
<td>No</td>
<td>118</td>
<td>69 (58.5%)</td>
<td>49 (41.5%)</td>
<td></td>
<td>REF</td>
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<tr>
<td><strong>Wise to use contraceptives</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>84</td>
<td>42 (50.0%)</td>
<td>42 (50.0%)</td>
<td>2.053</td>
<td>1.024</td>
</tr>
<tr>
<td>No</td>
<td>58</td>
<td>39 (67.2%)</td>
<td>19 (32.8%)</td>
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<td>REF</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>127</td>
<td>73 (57.5%)</td>
<td>54 (42.5%)</td>
<td>0.845</td>
<td>0.289</td>
</tr>
<tr>
<td>Muslim</td>
<td>15</td>
<td>8 (53.3%)</td>
<td>7 (46.7%)</td>
<td></td>
<td>REF</td>
</tr>
<tr>
<td><strong>Age at sexual debut</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤15</td>
<td>110</td>
<td>67 (60.9%)</td>
<td>43 (39.1%)</td>
<td>0.499</td>
<td>0.225</td>
</tr>
<tr>
<td>&gt;16</td>
<td>32</td>
<td>14 (43.8%)</td>
<td>18 (56.3%)</td>
<td></td>
<td>REF</td>
</tr>
</tbody>
</table>
### Others factors identified from Qualitative analysis

<table>
<thead>
<tr>
<th>Factor</th>
<th>Explanation</th>
<th>Contraceptive utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitional sex (sex for financial gain)</td>
<td>Poverty, you need to support your siblings, others in school have good shopping and nice hair hence you have sex to get this things</td>
<td>Adolescents have little or no negotiating power with their partners to insist on use of condoms and experience a higher risk of becoming pregnant and contracting STIs similar to Chatterji M, 2004 &amp; Remes P, 2010</td>
</tr>
<tr>
<td>Culture</td>
<td>In our culture sex is a big word...how do I know I can get pregnant if I do not try...as a girl am not supposed to ask about sex and its consequences... if I have sex the boy expects me not to get pregnant( get contraceptives)... if I have sex as a girl am spoilt but for a boy he is showing manhood</td>
<td>Adolescents girls are socialized to abstain from sexual activity until marriage while boys are regarded as “men” if they engage in sexual activities at an early age. This reduces their ability to refuse unwanted sexual advances, negotiate condom use or safer sexual practices when sexual intercourse is desired similar to Stuart S,2009 &amp; Sibeko, 2012</td>
</tr>
<tr>
<td>Sexual violence/unplanned sexual activity</td>
<td>As a young girl most times its people close to me who force me to have sex... uncles, cousins and boyfriends.</td>
<td>Forced sexual activities and intimate partner violence increase adolescent girls’ vulnerabilities to pregnancy and non likelihood to negotiate contraception similar to Krug L 2002, GOK 2006b</td>
</tr>
</tbody>
</table>
Conclusion

Secondary school adolescents girls are engaging in sexual activities at a young age, by 15 years.

Despite a high level of knowledge on contraceptives 90.1%, the level of contraceptive utilization among secondary school adolescent girls in Kiambu County is low 43%.

Factors influencing contraceptive utilization are age, Knowledge on contraceptives, accessibility, and perception on contraception, parental control and support.

Other factors identified include , transactional sex, cultural factors, and sexual violence/ unplanned sexual activities.
Recommendations

- **MOH:** Tailored age specific information on adolescent SRH to strengthen parent-child communication.

- **Ministry of education:** Develop age specific SRH curriculum.

- **MOH:** Subsidize contraceptive costs and provide adolescent friendly services to improve accessibility.

- More emphasis on duo protection that is condoms; Condoms most known but least utilized.

- **Communities, families, Schools:** Embrace ASRH as a public health issue and not a moral issue, male involvement.
Future Research

- Influence of mixed schools on adolescent’s SRH as opposed to an all girl’s school.

- Replication of similar studies among secondary school adolescent girls in private school.

- Identify ways of closing the gaps between knowledge and practice
Thank you