

KENYATTA UNIVERSITY

SCHOOL OF HUMANITIES AND SOCIAL SCIENCES

DEPARTMENT OF PSYCHOLOGY

**THE RELATIONSHIP BETWEEN CONTRACEPTIVE USE AND RISKY
SEXUAL BEHAVIOUR AMONG SECONDARY SCHOOL STUDENTS IN
NAIROBI CITY COUNTY, KENYA**

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DECLARATION

I Majiwa Benson Okal do hereby declare that this Research project is my original work and that it has not been presented for award of any degree in any university that I am aware of.

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ABSTRACT

The effective use of contraceptives among adolescents remains a challenge for most developing countries. Therefore, adolescents, both unmarried and married, are faced with many risky sexual behaviors. Many teenagers are faced with the risk of sexually transmitted diseases including HIV/AIDS, unplanned pregnancies, and illegal abortions and even dropping out of school. This study evaluates the relationship between contraceptive use and risky sexual behavior among adolescent. This study sought to find out if accessibility of contraceptives contributes to risky sexual behavior and explore various risky sexual behaviors practiced by adolescent as well as their attitude towards contraceptives among secondary school students in Nairobi. Also, evaluate the role of counseling in intervening risky sexual behavior among secondary school students. The theory of reasoned action/theory of planned action is critical in predicting and understanding motivational influences on contraceptive use that is not under the individual's volitional control. This study used mixed methods design; descriptive survey and correlational research designs. The number of students both boys and girls in Nairobi County was used as the study population of 21,231 students. The sample population was 384 participants in twelve secondary schools in the Nairobi County selected through multi-stage sampling approach. Cluster sampling was used to select randomly three sub counties in Nairobi County. Stratified random sampling was used to select both public and private secondary schools, four schools from each sub county with two schools from each category of private and public giving a total of twelve schools. Simple random sampling was used to obtain a sample of 32 students from each school. Further, a quota sampling was used to create one focus group discussion (composing 8 to10 persons per group) in each school. The data was collected by administering questionnaires to participants in twelve secondary schools and interviews conducted on each FGD and 12 counselors. Split- half technique was used to determine reliability. To ensure validity, the instrument was given to experts on the topic of study at Kenyatta University. To ensure reliability of instruments, test re-test was adopted, and the reliability coefficient calculated using Pearson's product moment correlation. Qualitative data was transcribed, classified into various categories and reported according to emerging themes and sub themes for each of the objectives. Quantitative data was analyzed using descriptive statistics. Pearson's r was used to test the hypotheses and all of them were rejected. Qualitative data was analyzed using thematic analysis and presented through narrative, whereas quantitative data was coded and analyzed using SPSS 23.0. The results revealed that the probability of risky sexual behaviour reduces for those students who use contraceptives as compared to those who do not use contraceptives. It was observed that most of the students in Nairobi County had had sexual relationships without a condom or any other contraceptive. The findings revealed that education of the students forms a significant part of the current counseling program related to the use of contraceptives. The findings indicated that the use of contraceptives increases the prevalence of risky sexual behaviour among students. The study concluded that secondary school adolescents in Nairobi County believe that the use contraceptives can prevent risky sexual behaviors among adolescents. In addition, most of the students in Nairobi County engage in risky sexual behaviour at an early age and while still in school. It was further concluded that the school counselor play a vital role in advocating the use of contraceptives and positive behavioural change among the students.

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ABBREVIATIONS/ ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
APHRC:	African Population and Health Research Center
CEDAW:	Convention on the Elimination of All Forms of Discrimination against Women
CRC:	Convention on the Rights of the Child
CSA:	Centre for the Study of Adolescence
CSE:	Comprehensive Sex Education
DHS:	Demographic Health Surveys
EC:	Emergency contraceptive
ESA:	Eastern and Southern Africa
FGDs:	Focus group discussions
HIV/AIDS:	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICPD:	International Conference on Population and Development
IFPP:	International Family Planning Perspective
ITGSE:	International Technical Guidance on Sexuality Education
FHI:	Family Health International

KDHS:	Kenya Demographic and Health Surveys
KHRC:	Kenya Human Rights Commission
MOE:	Ministry of Education
MOH:	Ministry of Health
NCPD:	National Council for Population and Development
NPPSD:	National Population Policy for Sustainable Development
NRHS:	National Reproductive Health Strategy
PAI:	Population Action International
PATH:	Program for Appropriate Technology in Health
SADC:	Southern African Development Community
SRH:	Sexual and Reproductive Health
STI:	Sexually Transmitted Diseases.
WHO:	World Health Organization
UN:	United Nations
UNAIDS:	United States Agency for International Development
UNESCO:	United Nations Education Scientific and Cultural Organization

UNPFA: United Nations Population Fund

UNICEF: United Nations Children's Education Fund

OPERATIONAL OF KEY TERMS

Abortion: the act of bringing a pregnancy to an end thus preventing the birth of a live baby.

Adolescent: people between the ages of 10 to 19 years.

Attitude: It is the degree to which the person has a favorable or unfavorable evaluation of the behavior in question.

Birth control: method used to prevent pregnancy.

Contraceptive: artificial or other techniques used to prevent pregnancy and/ or STI as a consequence of sexual intercourse other than abstinence.

Contraceptive use: the deliberate use of artificial or other techniques to prevent pregnancy and/ or STI as a consequence of sexual intercourse that the respondent was using at the time of study.

Comprehensive sex education: a program with curriculum design that integrates abstinence till marriage and use of contraceptives during sexual intercourse.

Risky sexual behavior: unprotected sexual intercourse or engaging in any sexual behavior that can later be regretted due to negative consequences.

Sexually active student: students who have engaged in any form of sexual intercourse.

Sex education: education on abstinence and birth control methods.

Sexual and reproductive health: a state of physical, mental and social well-being in all matters relating to sexuality.

Volitional Control: The actual willful control over behavior.

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

The World Health Organization (WHO 2013) defines adolescence as the period in human growth and development that occurs after childhood right before adulthood between the ages of 10 to 19 years. It is a critical transitional stage in life that is characterized by a tremendous pace in growth, change and potential that requires guidance and support to successfully navigate the stage. Since the society looks forward to pass the button of leadership to this group in a couple of years to come, failure to bring them in a healthier manner is not an option.

According to a report by the United Nations Children Education Fund (UNICEF 2012), about 1.2 billion adolescents aged between 10-19 years make up 18 percent of the world's population today and the number is expected to increase by the year 2050 although with a decreased share of the total population. More than half of the world's adolescents' population lives in Asia. In Sub-Saharan Africa adolescent make up the greatest population with 23% of those aged between 10 to 19 years. Kenya's population is estimated at 47.5 million (Kenya 2019 Population and Housing Census Highlights) and is projected to reach 56.5 million by the year 2025. Young people aged 15–24 years comprise almost 21 percent of the total population, out of which 51 and 49 percent are female and male respectively (Kenya National Bureau of Statistics, 2010.)

The 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt stressed that adolescent sexual and reproductive health needs are basic human rights. This marked a paradigm shift by recognizing that adolescents have unique needs and vulnerabilities. It emphasized the need to offer sexual health services and information to adolescents and to address

reproductive health challenges across the lifespan. For adolescents to effectively transit into adulthood, they need to be provided with factual, affordable, accessible, confidential, non-judgmental and friendly sexual health information and services. Thirty-eight of the participating countries from sub-Saharan Africa, Kenya included, committed themselves to a Program of Action aimed at providing adolescents with sexual and reproductive health education, information and services. This, it was hoped, would help adolescents to understand their sexuality and protect themselves from sexual health risks (United Nations, 1995).

In the last decade, many countries in Africa, Asia, Europe, Middle East, the Caribbean and the Americas have attempted to implement reproductive health programs in schools to address the sexual needs of adolescent. In almost every country the provision of comprehensive sex education that advocates for contraceptive use has faced legal, financial, cultural and religious barriers as well as opposition from school leaders, teachers, parents and students themselves. Moreover, decision makers and educators are often unsure about what works to improve sexual behavior among school going adolescents.

The sociocultural context has changed in the past few generations. In Kenya, much like around the continent, the adolescents are experiencing changes that are coming along with modernization and industrialization. According to Saroya (2001), the context of rapid change create a disjunction between generations within the family and society, with the youth often accessing the trappings of modern culture while the adults close to them do not. The exposure to global norms seems to lead the adolescent to rebel against family guidance and authority. Therefore, the adolescents will gladly take up contraceptives not to be left out of sexual revolution. Their peers will greatly

influence the manner in which they behave sexually and the contraception methods they would preferably use.

In 2003, the ARHD was developed to respond to concerns about youth issues that were noted in the National Population Policy for Sustainable Development (NPPSD) (2000), the National Reproductive Health Strategy (NRHS) (1997-2010), the Children's Act (2001), and the government's commitment to integrate youth into the national development process. In 2007, the Reproductive Health Policy was developed, and the adolescent reproductive health component is the key pillar of this policy. ARHD's Policy Implementation Assessment Report that was prepared by the National Council for Population and Development (NCPD) stipulates that, among the objectives of the policy was to provide guidelines and strategies to address adolescent health concerns which included comprehensive sex education. Equally the policy targeted to double the contraceptive use rate among adolescents (ages 15-19 years) from 4 percent in 1998 to 8 percent in 2015.

Ministry of Education (MOE), seeking to capitalize on the wide reach of primary and secondary schooling in the country, worked with Family Health International (FHI 360) and UNESCO to use the International Technical Guidance on Sexuality Education (ITGSE) to strengthen sexuality education in their national curriculum (USAID, 2012). Comprehensive sex education (CSE) teaches that abstinence is the best method for avoiding sexually transmitted diseases and unintended pregnancy. However, it also teaches the use of condoms and contraceptives to reduce the risk of unwanted pregnancy and of infection with STIs including HIV/AIDS (Sex Education Programs: Definition and point by comparison, Advocates for Youth, 2008).

Contraceptive must compliment abstinence to effectively address the sexual needs of adolescents. A study of contraceptive use in married and unmarried adolescents in Latin American, European and Asian countries showed rates ranging between 42 percent and 68 percent. African countries have the lowest rates, ranging from 3 percent to 49 percent. The low rate of contraceptive use in Africa was attributed to lack of knowledge about sex and family planning and the lack of skills to put that knowledge into practice (WHO, 2012).

Indeed, in Kenya there has been also a substantial increase in the use of contraceptive among the teenagers over the years. According to Kenya Demographic and Health Survey (KDHS) findings of 2008-2009 states that among younger women (age 20-24), 22 percent used contraception before having any children and 25 percent started using contraception when they had one child. It may be argued that there is an increase in the use of contraceptives after delivering a child.

In adolescence, reasonable risk-taking is considered normal as it leads to confidence in forming new relationships, sports and social institutions. However, high risk behaviors are associated with serious negative consequences which include drugs and alcohol use, unsafe sexual practices, self-injurious behavior and reckless driving (Sadock, 2007).

Many adolescents still choose to initiate sexual intercourse and engage in risky sexual behavior despite knowledge of the consequences. Their decision is influenced by various factors like family, peers, media, religion and drugs as seen in many studies globally. Parents' marital status, family structure and stability all influence the adolescents' sexual behavior, (Hogan, Sun & Cornwell, 2000). Luscombe, (2008) also showed that adolescents whose media diet was rich in sexual content were more than twice as likely as others to have had sex by the time they were sixteen. Young

people often face enormous pressure especially from peers to engage in sex, unlicensed erotic video films and the desire for economic gain (Taffa *et al.*, 2002).

Targeted studies among teenage cohorts report younger ages for sexual coitarche. Among youth age 15-19 years in Brazil, Gabon, Haiti, Hungary, Latvia, Malawi, Mozambique, and Nicaragua, 25 percent of boys and 15 percent of girls had sex below age 15 years. In some countries, sexual debut among a small minority of youth occurs as early as 10yrs (UNFPA/PRB, 2012). Equally, according to an Implementation Assessment Report in 2013 on Kenya Adolescent Reproductive Health and Development Policy (ARDHD), sexual activities among Kenyan young people begin early. Thirteen percent of women and eighteen percent of men had had sex by the age of 15. Women and men start sexual activity at about the same age (median age of 18.2 years for women and 17.7 years for men). It is moreover characterized by what might be called serial monogamy, - one partner after another. The report noted that adolescents' liaisons are usually brief and easily replaced, so by the time a person is ready to consider settling in marriage they have already experienced many partners. Despite this multiplicity of partners, sexual activity is usually unprotected, giving rise to early pregnancy, unsafe abortion, school drop- out, sexually transmitted diseases and economic hardship (Republic of Kenya, 2005). The above figures show that half of the adolescent in Kenya experience and express their sexual desire by engaging in sexual activity.

According to a study by the Centre for the Study of Adolescence, a non-governmental organization that works on issues related to teenage reproductive health, an estimated 13,000 Kenyan school going girls drop out of school annually as a result of pregnancy, and about 17 per cent of girls have had sex before the age of 15. The drop-outs occur in spite of a 'Return to School' policy put in place by the Ministry of Education that allows girls to stay in school until delivery, and resume

their studies as soon as they are strong enough to do so. African Population and Health Research Center (APHRC) have shown that young people in the urban slums of Nairobi initiate sex very early (Republic of Kenya, 2003).

The KDHS findings of 2008-2009 that the proportion of teenagers who have begun childbearing increased dramatically from 2 percent at age 15 to 36 percent at age 19. Early pregnancy can lead to serious health complications with long-term consequences (UNFP, 1997). Accidental pregnancy is a leading cause of abortion (Izugbara, 2011). The KDHS (2008-2009) estimates the national incidence of unsafe abortion to be 44.7 per cent.

Research findings have also shown that young people – both boys and girls – are disproportionately affected by HIV. Studies on sexually transmitted infections (STIs) among young people in Kenya are limited but current data shows that 12.6 percent of girls and 5.5 percent of boys aged 15–19 years are infected with HSV-2, while 0.6 percent of young people aged 14–24 years are infected with syphilis (Kenya National AIDS and STI Control Programme, 2009).

According to Eyo, Joshua and Esuong (2010) guidance and counselling programmes for secondary school students are designed to address the physical, emotional, social, vocational and academic difficulties of adolescent students. Lack of an organizational structure detailing how school counselling should be conducted in schools has led to inconsistencies and variations in how guidance and counselling is conducted in different schools (Wambu & Fisher, 2012).

The question still remains on whether the use of contraceptives has had any association in promoting vulnerability to risky sexual behaviors. This study aims to explore risky sexual behavior, as well as attitude of secondary school students towards contraceptive use and their

sexual behavior and involvement of counselors in sexuality issues. The purpose is to provide information that can be used to increase the knowledge to evaluate the relationship between contraceptive use and risky sexual behaviors among secondary school students in Nairobi City County in Kenya.

1.2 Statement of the Problem

Globally, the average age at which young people begin to have sex has steadily decreased. It has also been noted in Africa, that the age of initiation of sexual intercourse has equally dropped, predisposing the adolescents to the consequences of risky sexual behavior at an early age (Imaledo et al., 2012). Adolescents in Kenya are sexually active, yet many do not take appropriate precautions to prevent pregnancy or the spread of sexually transmitted infections despite the information on sex education availed to them (Oindo, 2002).

There are a number of common reasons for non-contraceptive use among adolescents with most common side effects expressed by the respondents were weight changes, bleeding, and lack of sexual desire. Headaches and blood pressure issues were also cited by a few (Ochako *et al*, 2015). Young girls would give in to the demands of their boyfriends for fear of losing them to more willing girls and thus they lack the power to negotiate the terms of sexual relations where they end up into unprotected intercourse (Wango, 2006).

Many studies in the past have documented that adolescents are more likely to engage in unplanned sex (Kaihura, 1997). Thus, comprehensive sex education teaches the use of condoms and contraceptives to reduce the risk of unwanted pregnancy and of infection with STIs including HIV/AIDS (Sex Education Programs: Definition and point by comparison, Advocates for Youth,

2008). However, the contraceptive experienced adolescent ‘move from focusing on sex for reproduction to sex for pleasure’ and they have a higher tendency of being sexually active for long. Therefore, that prolonged period of being sexually active may increase the chances of inconsistency and or termination in contraceptive use leading to unsafe sexual practices (Nyawande, 2003).

Despite continued investments in adolescent sexual and reproductive health, challenges still exist in meeting the reproductive health needs of adolescents. There is concern over their continued unsafe sexual practices and the associated morbidity. The gap remains whether there is a relationship between contraceptive use and unsafe sexual practices, indicating that use of contraceptives constitutes to exposure to risky sexual behavior.

If the issue is not taken seriously then the rise to early pregnancy, unsafe abortion, school drop-out, sexually transmitted diseases and economic hardship among teenagers may still persist. These has had psychological consequences to the adolescent, such as regret and guilt, loss of self-respect and low self-esteem, stunting personal development, shaken trust, major depression, suicidal tendencies, post-traumatic stress disorder (PTSD) and fear of commitment in future relationships among others.

1.3 Purpose of the Study

The purpose of the study is to evaluate the relationship between contraceptive use and risky sexual behaviors among secondary school students in Nairobi City County with the aim of providing information to intervene the risky sexual behaviors among the secondary school students.

1.4 Objectives of the Study

- i. To determine relationship between accessibility of contraceptives and risky sexual behavior among secondary students in Nairobi City County.
- ii. To explore various risky sexual behaviors practiced by adolescents among secondary school students in Nairobi City County.
- iii. To determine the attitude towards contraceptives use among secondary school students in Nairobi City County.
- iv. To evaluate the role of counseling in intervening risky sexual behavior among secondary school students in Nairobi City County.

1.5 Hypotheses

H₀₁: There is no relationship between accessibility to contraceptives and risky sexual behavior among secondary school students in Nairobi City County.

H₀₂: There is no relationship between risky sexual behaviors practiced by adolescents and use of contraceptives among secondary school students in Nairobi City County.

H₀₃: There is no relationship between the attitudes of students towards contraceptives and risky sexual behavior among secondary school students in Nairobi City County.

H₀₄: There is no relationship between the role of counseling and intervening risky sexual behavior among secondary school students in Nairobi City County.

1.6 Justification and Significance

Adolescent sexual needs remain a challenge in many societies across the globe. Majority of adolescents are sexually active early in their teen years and this has an impact on their social and emotional well-being. The use of contraceptives by adolescents in a country like Kenya with very strong religious and divergent cultural beliefs remains a sensitive issue. However, campaigns and studies have been done to promote the awareness of contraceptive with the intention of reducing unsafe sexual practices among adolescents. Comprehensive sex education as well as counseling has been enshrined in schools. Unfortunately, many adolescents are still affected both physically and psychological. These include teenage pregnancy, sexually transmitted infections and diseases, abortion, major depression, suicidal tendencies, post-traumatic stress disorder (PTSD) among others. These psychosexual factors also come into play, as they affect personality, growth, development and functioning of the adolescent. These include sexual identity, gender identity, sexual orientation and sexual behavior (Sadock, 2007). Majority especially parents are still in denial that teenagers are should actually use contraceptives and any statement that allows adolescent to use contraceptives has brought a wave of protest by many stakeholders.

Despite the uproar and existence of facilities like counseling in schools, there exists a gap between the use of contraceptives and unsafe sexual practices among adolescent which the study aims to determine if there is any relationship. The findings of this study may benefit scholars in understanding motivational influences on human behavior. The findings may also help the policy makers in formulating non-judgmental and adolescent friendly sexuality education and reproductive health services as well as the parents and the teenagers on contemporary approach to empower young people to protect their health, well-being and dignity.

1.7 Scope and Limitation

The study population focused only on teenagers in secondary schools in Nairobi City County despite the fact that some teenagers are in primary schools or even not attending school at all. Cluster sampling was used to widen representation of the target population.

Given the area of study is somewhat ‘taboo’; participants may be unwilling to give honest opinions on their sexual behaviors and contraceptive use due to their cultural or religious beliefs. Trustworthiness of the data collected in this study was met through triangulation of three aspects of data collection: i) having different respondents from different cultures or religious beliefs, ii) using different methods of data collection such as FGDs and questionnaires, iii) using different researchers to moderate group discussions.

The use of questionnaire as an instrument of data collection does have inherent weaknesses such as lack of guarantee of absolute objectivity of the respondents. Certain constructs such as attitude cannot be concretely measured through responses given by participants. The researcher tried to verify and compare responses given on ‘main reason for using contraceptives’ and ‘comment about adolescents being encouraged to use contraceptives’

The study was anchored on the theory of reasoned action; however, other related theories may be used as reference.

1.8 Assumptions of the Study

The assumption of the study is that:

1. There are sexually active secondary school students in Nairobi City County, Kenya.

2. Also among the sexually active participants, there are those who use different methods of contraceptives.
3. The participants have knowledge and willing to reveal their true personal experiences on their risky sexual behavior.
4. There are established counseling department in each school with qualified counselor.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This study evaluated the relationship between the use of contraceptive and risky sexual behavior among secondary school students in Nairobi County, Kenya. The chapter begins by giving a theoretical framework of the study then the review of related studies. It ends with a summary of the literature review and a conceptual framework.

2.2 Theoretical Framework

Icek Ajzen and Martin Fishbein formulated in 1980 the theory of reasoned action (TRA). Later, a few additions were added and it was renamed theory of planned behaviour (TPB). The development of the TBP/TRA originated in the field of social psychology. This theory was developed to show how attitude impacted behavior. Having their emphasis on attitude and behavior, it can be postulated that this theory grew out of the 19th century when the field of psychology began to look at the term "attitude". Those theories suggested that "attitudes could explain human actions" (Ajzen & Fishbein, 1980, p. 13). Therefore, attitude is viewed as individual mental processes that determine a person's actual and potential responses.

The theory has two major assumptions: human beings are rational and make systematic use of information available to them; and people consider the implications of their actions before they decide to engage or not engage in certain behaviors. There has been a concerted effort through programs and policies that has provided the teenagers with information on contraceptives use and risky sexual behavior. Hence they take into account the implications of their actions before they decide either to use or not use contraceptives and equally consider the implications of risky sexual behaviors so as to decide whether to engage or not.

The TRA/TPB began with looking at behavioral intentions as being the immediate antecedents to behavior. It is believed that the stronger a person's intention to perform a particular behavior, the more successful they are expected to be. Intentions are a function of salient beliefs and/or information about the likelihood that performing a particular behavior will lead to a specific outcome. This study will focus on the intentions of the teenagers using contraceptives and whether this intentions change over time. If they do change, then what are the probable events or challenges

that produce changes in intentions? Do such events and/or challenges impact on their attitude towards contraceptive use?

Ajzen and Fishbein were not only interested in predicting behavior but understanding it, they began trying to identify the determinants of behavioral intentions. They theorized that intentions are a function of two basic determinants: a) attitude toward behavior and b) subjective norms of behavior.

Attitude is postulated to be the first antecedent of behavioral intention. It is an individual's positive or negative belief about performing a specific behavior. These beliefs are called behavioral beliefs. An individual will intend to perform a certain behavior when he or she evaluates it positively. Attitudes are determined by the individual's beliefs about the consequences of performing the behavior (behavioral beliefs), weighted by his or her evaluation of those consequences (outcome evaluations). The study intends to establish the attitude of teenagers towards their sexual behavior and how those attitudes have made either direct or indirect effect on behavioral beliefs of contraceptive use.

Attitude is linked with subjective norm and perceived behavioral control. Subjective norms are also assumed to be a function of beliefs that specific individuals approve or disapprove of performing the behavior. Beliefs that underlie subjective norms are termed normative beliefs. An individual will intend to perform a certain behavior when he/she perceives that important or significant others think he/she should. Significant others among teenagers might be a person's, partner, close friends, parents, counselors and teachers. The study will evaluate how likely it is that most people who are significant to them would approve or disapprove of their contraceptive

use as well as their sexual behaviors in a bid to assess the involvement of guidance and counseling on contraceptive use and risky sexual behaviors practiced by adolescents.

Perceived behavioral control refers to the degree to which an individual feels that performance or nonperformance of the behavior in question is under his or her volitional control. People are not likely to form a strong intention to perform a behavior if they believe that they do not have any resources or opportunities to do so even if they hold positive attitudes toward the behavior and believe that important others would approve of the behavior (subjective norm). The study intends to establish perceived behavioral control of teenagers by determining the extent to which (a) participants can use contraceptives if they want to do so, (b) using contraceptives is up to them, and/or (c) using contraceptives is easy or difficult. This is fundamental in describing the association between contraceptive use and risky sexual behavior.

In conclusion, the theory of reasoned action/theory of planned is critical in predicting and understanding motivational influences on contraceptive use that is not under the individual's volitional control. Further it can be used to identify how and where to target strategies for changing risky sexual behaviors. Lastly, explain virtually any human behavior, in this case, why teenagers use and/or misuse contraceptives.

2.3 Review of Related Studies

2.3.1 Relationship between Accessibility of Contraceptive and Risky Sexual Behavior

In recent decades the society has experienced great changes in social norms, especially when it relates to sexuality. Over the post-marketing years of hormonal contraceptives, dating from the 60s, the paradigms for sex have expanded beyond reproduction (Sigusch, V. (1998). The social

permissiveness for playful sex, premarital sex, sexual initiation increasingly early are accompanied by a sexual behavior without adequate preventive care, from which its effects on sexual and reproductive health are even more serious when it comes to teens.(Hugo *et al.*, 2011)

Adolescents having sex at young ages are generally exposed to risk for a longer time, are less likely to use contraception, generally have more sexual partners, and tend to engage in higher risk sexual behaviors such as alcohol or drug use prior to sexual intercourse and having multiple concurrent sexual partners (Moore *et al.*, 2008).

Researches indicate that at the onset of relationships, when partners do not know each other very well, they will insist on using condoms to prevent unwanted pregnancies and STIs. However, with time condom use is relegated on grounds that the young couples know and trust one another very well; suggestion by one partner to continue condom use is to suggest mistrust or unfaithfulness by the other. Hence, the adolescent girls have to rely on the use of 'safe days' within menstrual cycle and practice of 'withdrawal method' by the partner during intercourse (Johnson, 2000b)

Statistics from developed world show discrepancy between contraceptive use and its intended outcome. Britain, despite being one of the world`s biggest users of contraceptives, has a sky-high level of pregnancies, with 2.9 of every 100 girls aged between 15 and 19 years giving birth every year. France with less use of contraceptives stands at 0.9 per every 100 girls while Germany has 1.1 per every 100 girls giving birth (WHO, 2010).

However, in Africa studies conducted in Malawi by (Chipeta, 2012) revealed that by age 18, most teenagers have had sex with prevalence rates at 60% for the girls and 53% for boys. The condom is the most preferred contraceptive although its use is as low as 3% among the female and 13%

among the male teenagers. In Rwanda the situation is not different since 41% of the teenagers have their sexual onset before age 15. (Madkour, 2010). Similar studies by (Tessema *et al*; 2013) on perceptions of teenagers on sexual debut and contraceptive use in Uganda indicated the median age for girls is 17.1 and for boys 18.3, with 76% female and 57% male (15-19) being sexually active. The prevalence of sexual debut, median age and contraceptive use by teenagers seem to differ by gender and country which are bound to have a subsequent effect on the sexual behavior.

Given the importance of sexual behavior in adolescent health and recognizing the use of contraceptive methods as the main ally in the prevention of the personal and social impact of unplanned pregnancy and other associated morbidity, research has underscored the importance sexual behaviour and contraceptive use. Ochieng, in 2013 on Risky Sexual Behaviour among Adolescents Attending Public Secondary Schools in Nairobi indicated that sixty nine percent of the males and seventy two percent of the females used contraceptives during their first sexual encounter. However, in the most recent sexual encounter, which was one week prior to the interview, the overall contraceptive use was reportedly lower, at fifty two percent. This could be explained by the fact that most of the students had one partner each, and the familiarity that arose from a relatively stable pattern of relationships. The trend on contraceptive use in this study was similar to that of Couric's study (2005), which found that "while nearly all young teens (ninety percent) know they can get an STD from having sexual intercourse, they're not always acting on that knowledge. Only two in three (sixty seven percent) say they use protection such as condoms every time they have sex."

A study by Ndungu,(2015) on Factors Associated with Early Sexual Debut among High School Adolescents Boys and Girls in Dagoretti Sub-County, more than half of the respondents

interviewed reported that family planning should be available in schools. Approximately 49 percent of respondents perceived that only condoms should be available in schools as a form of family planning. Of concern, 22 percent of respondents thought that knowledge of family planning encouraged promiscuity. However, of note, 76 percent of respondents reported that use of family planning was very important to avoid pregnancy.

Unintended pregnancies result from non-use or ineffective contraceptive use, method failure and lack of pregnancy planning. It is estimated that of these 20 million unsafe abortions, 2.5 million were attributed to adolescents aged 15-19 years and that almost 60% of unsafe abortions on the African continent were among young women. Shah I, & Ahman E. (2010). The risk of death from unsafe abortion is highest in Africa, with an estimated 590 deaths per 100,000 unsafe abortion procedures compared to 14 deaths per 100,000 procedures in the developed world. (WHO, 2011).

Every day 2500 young people are infected and an estimated of 1.8 million to 2.4 million within the age group 10-19 were living with HIV and AIDs in 2009. Most of them live within Sub Saharan Africa (UNICEF, 2011). Statistics indicate that in Kenya 260,000 teenagers are living with HIV against a population of 1.6 million people living with the condition (Oduor, 2015). From this statistics, the non-use of contraceptives is disastrous hence its use is crucial in addressing sexual needs of adolescents.

The above review of studies indicates that there is a connection between access to contraceptive and risky sexual behavior. This is evident with those who access end up using contraceptive at the initial stage but either stop or inconsistently use it due to the familiarity that arose from a relatively stable pattern of relationships cementing trust. Also, the use of contraceptive has been linked with promiscuity since it encourages having more sexual partners on the basis that they will engage in

safe sex. This study seeks to go further to investigate whether accessibility of contraceptives is a determinant for sexual debut and its impact on frequency of sexual activities.

2.3.2 Exploring various Risky Sexual Behaviors Practiced by Adolescents

Sexual activities among the adolescents have been reported to be increasing worldwide. According to a report tabled on the sixty-fifth World Health Assembly in 2012 stated that most people initiate sexual activities between 15 and 19 years of age, boys earlier than girls, and that there is no universal trend towards earlier sexual debut. The report further notes that the frequency of sexual activity is higher in adolescents who are in stable relationships – marriage or union – than those who are not, hence the greater likelihood of pregnancy in the absence of contraception (WHO, 2012).

Many adolescents still choose to initiate sexual intercourse and engage in risky sexual behavior despite knowledge of the consequences. Their decision is influenced by various factors like family, peers, media, religion and drugs as seen in many studies globally. Research suggests that parents and/or family can strongly influence their teenager's sexual behavior. Parents' marital status, their disapproval of and discussion with teenagers about the standards of behavior and the social and moral consequence of teenage sexual activity as well as parental monitoring all appear to impact teenagers' decisions to engage in sexual activity. Parental involvement in their teenagers' lives, to the extent of even watching television with them and limiting their television viewing, reduced the adolescents' likelihood of being sexually active (Bersamin *et al.*, 2008).

Parents' marital status, family structure and stability all influence the adolescents' sexual behaviour. According to Hogan, Sun & Cornwell (2000), teenage girls in United States were less

likely to be sexually active if their parents were married at the time of their birth. Adolescent females aged 15 to 19 years whose parents were married at the time of the adolescent's birth were 42% less likely to report having engaged in sexual activity when compared to similar adolescents whose parents were cohabiting at the time of the adolescent's birth and 26% less likely to report having engaged in sexual activity when compared to similar adolescents whose parents were not living together at the time of the adolescent's birth.

Other aspects of family that influence risky sexual behaviour include living in a step- parent household, living in a poor household, having siblings who are sexually active, feeling unloved, unwanted or not respected by parents. Community factors such as having few positive experiences at school, living in a neighbourhood with poor neighbourhood monitoring also play an important role in influencing risky sexual behavior. (Morgan & Huebner, 2002).

However, good parent –child relationships, academic aspirations and sports participation was also found to promote healthy sexual decisions by adolescents. A study by Dittus & Jaccard (2000) showed that teenagers who reported being highly satisfied with their relationship with parents were 2.7 times less likely to engage in sex than teenagers who had little satisfaction with their parental relationships. Relationship satisfaction was associated with a lower probability of engaging in sex, higher probability of using birth control if sex occurred, and lower probability of pregnancy during the ensuing twelve months.

Young people often face enormous pressure especially from peers to engage in sex, unlicensed erotic video films and the desire for economic gain. As a result of this, significant number of adolescents is involved in sexual activities at an early age (Alexander and Hickner, 1997; Taffa *et al.*, 2002). Adolescents whose friendship network included mostly low-risk friends were half as

likely to experience first intercourse as were adolescents whose close friend network was composed mostly of high-risk friends (Bearman & Brückner, 1999).

Adolescents find a variety of means to express themselves sexually through media. Various studies have shown that the American media is the most sexually suggestive in the world and that “the media far outranked parents or schools as the source of information about birth control” (Strasburger, 2005). Research also found a direct relationship between the amount of sexual content children see and their level of sexual activity or their intentions to have sex in the future (Brown, 2004; Jones, 2006). Luscombe, (2008) also showed that adolescents whose media diet was rich in sexual content were more than twice as likely as others to have had sex by the time they were sixteen. The use of pornographic materials as well as knowledge and use of contraceptives, especially the condom that has been excessively advertised, has contributed immensely to the involvement of adolescents in sexual practices (Onuzulike, 2002). On the other hand, promotion of condom use in protection of risky sexual behaviours among young people is also promoted through mass media (Ankomah *et al.*, 2011). In Philippine, exposure to newspapers and movies serve as preventive factors for female youth's early sexual behaviour (Onipede 2008).

Religious values and practices have been shown to shape sexual values and behaviours among youth. It guides behaviour, provides standards and a social control function or social norms that religious person will always conform to. Catholics and Protestant females initiate sexual intercourse later than their counterparts. This is confirmed by a study done in Brazil indicating that female youth affiliated with Catholicism, other Protestant faiths, or Pentecostalism have significantly lower odds of early sexual debut when compared to their non-affiliated counterparts (Odimegwu 2005).

Understanding how religion affects sexual attitudes is particularly salient in the sub-Saharan African context where religion permeates social life (Pew Research Centre 2010). To a certain extent, being religious and observant of church obligations serve as a protective factor against early sexual initiation. Religious norms and beliefs affect one's orientation towards sexuality among other things; thus, religion is bound to affect a woman's age at first sex (Ikamari & Towett 2007). However, specific doctrines and policies of the religious institutions to a large extent influence individual attitudes and behaviour towards sexual activity.

In Africa social cultural context is determined the sexual behavior of the adolescents. Increasing urbanization, modernization and education, together with exposure to western media, appear to have led to a decline in traditional values and, in particular, to have increased sexual activity among the youth. Traditional systems of preparing, training and initiating young people into adulthood has disintegrated, and traditional values that once regulated sexual behaviour among youth have broken (Gueye *et al.*, 2001). Studies suggest that adverse economic conditions, no education, coercion, peer pressure to obtain luxury items are reasons for sexual activity among youth. Where some form of payment is received for sex, young women are unable to negotiate condom or contraceptive use, leaving them at a greater risk of HIV /AIDS and unwanted pregnancies. Further studies reveal that poor women initiate sexual activity two years earlier than those who are wealthy and young people in rural areas are likely to have earlier sexual debut than those in urban areas (NCAPD & CSA 2004).

A study in Nigeria on effects of mass media on sexual health behaviour of youth found out that mass media has both negative and positive effects. Negative sexual permissiveness among young

people is promoted by more frequent exposure to print, home video and the internet. On the other hand, promotion of condom use in protection of risky sexual behaviours among young people is also promoted through mass media (Ankomah *et al.*, 2011).

In Kenya, a study conducted by Ochieng, in 2013 on Risky Sexual Behaviour among Adolescents Attending Public Secondary Schools in Nairobi, Kenya found out that more of the male students (thirty six percent) reported that they had ever had sex compared to the female students (ten percent) despite the ratio of male to females who participated in the study being approximately 1:1. Twenty five percent of the students who had ever had sex had been sexually active within the one week prior to the interview. Out of these, ninety one percent of the females and sixty percent of the males had one sexual partner each. Sixty nine percent of the males and seventy two percent of the females used contraceptives during their first sexual encounter. However, 6.3 percent admitted ever being pregnant; 75 percent of them got pregnant once and 25 percent got pregnant twice. Most (50%) got pregnant at 14 years. Most (37.5%) of the girls were shocked at the discovery of being pregnant, and 50 percent of their boyfriends denied and abandoned them. Alcohol and other substance use are significantly associated with risky sexual behaviour, especially during their first sexual intercourse.

Another study by Ndungu, in 2015 on Factors Associated with Early Sexual Debut among High School Adolescents Boys and Girls in Dagoretti District concluded that most of the sexual encounters were with a friend. Of note, students whose sources of information on sex were friends, internet and media had significantly increased odds of early sexual debut and majority of the respondents (68%) reported continued sexual activity after first encounter. The reason for the first sexual encounter was reported as personal choice by 43%; need to feel rebellious by 14%, Peer

influence by 13% and relationship promise by 7% of the respondents. However, nine reported that the sex was forced and four said it was rape. During the first sexual encounter 57% reported contraceptive use. After the first encounter 29% said they regretted while four reported they became pregnant and four acquired a sexually transmitted disease.

The literature above shows that the adolescent faces psychological challenges associated with peer relationships, their self-identity, family, media, religion and exploration of possible sexual relationships with the opposite sex. However, does the availability of contraceptive complicate the already volatile situation? The studies fail to point out even imply if contraceptives is one of the causes of risky sexual behavior. This study seeks to investigate whether contraceptives has had any role in promoting risky sexual behavior.

2.3.3 The Attitude towards Contraceptives Use among Adolescents.

Several researches are starting to reveal how social and cultural forces shape young people's sexual needs despite campaigns targeting young people being encouraged to have safer sex, either through condom use or avoiding penetration. A decline in senior generations as role models is an intergenerational conflict perceived to affect the adolescents (younger generation), especially in the urban areas and amongst the less educated group. According to Saroya (2001), the context of rapid change create a disjunction between generations within the family and society, with the youth often accessing the trappings of modern culture while the adults close to them do not. The exposure to global norms seems to lead the adolescent to rebel against family guidance and authority. Therefore, the adolescents will gladly take up contraceptives not to be left out of sexual revolution. Their peers will greatly influence the manner in which they behave sexually and the contraception methods they would preferably use.

Much work has been undertaken internationally (e.g., in the UK, elsewhere in Europe, the USA, and Australia) on reducing the incidence of teenage pregnancies, and much of it has focused on sex education in schools, access to contraception and use of sexual health services(Kingston, 2010). Dei et al suggest that lack of contraceptive use by young Italian women is not due to lack of knowledge but to lack of ability to apply that knowledge, especially in situations where “irrational desire” takes over. In other settings, knowledge may be widespread but other factors, particularly alcohol, may influence the successful use of contraception. In particular, self-efficacy amongst girls is an important indicator of the likelihood of successful use of contraception (Larsson et al, 2007).

Research on attitudes to contraception has tended to focus on girls and young women. Where research has been conducted amongst youths of both genders, it suggests that boys have some of the same concerns as girls. A study conducted in United Kingdom by Durham University suggested that young women did not realise how easy it was to become pregnant, and if they knew, they would take precautions. However, being rational about contraception is unlikely when in “the moment” and irrational desire takes over. Also young men did not want to use condoms, and tried to persuade their partner to have sex without one, because it would be better, or because stopping to put on a condom would spoil “the moment”:

However, Rasch. (2000) conducted a study in Dar es Salaam, Tanzania among the adolescent girls entitled “Adolescent girls with illegally induced abortion Dar es Salaam: The discrepancy between sexual behaviour and lack of access to contraception” concluded that individuals might see sex as something that could strengthen a relationship, or as a way to please a partner where pregnancy

can even be sought as a way to keep hold of a boyfriend (Rasch , 2000). At this point the contraceptive will not be used as it interferes with the ultimate goal of the girl.

Further, Ankomah carried out a study “Condom use in sexual exchange relationships among young single adults in Ghana” in Accra, Ghana among young single adults made findings that carrying or buying condoms can imply sexual experience, scenario that is undesirable for women, although sometimes desirable for men (Ankomah, 1998). Paradoxically, despite the stigmatizing effect for women in carrying condoms or using other contraception, women, not men, are generally considered responsible for pregnancy prevention (Ferrer, 2002). By extension, the man might assume that the girl will take responsibility of pregnancy prevention. Apart from stigmatization as evident above, there is also the perception of lack of trust. In South Africa, “I’d never share a needle”—[but I often have unsafe sex]: considering the paradox of young people’s sex and drugs talk” was a study conducted among young people and found out that they worry that asking for their partner to use a condom implies that they think their partner is diseased; thus, condom-free intercourse can be seen as a sign of trust (Hillier *et al*, 1999). In Uganda, for example, many studies have been conducted on school going pupils. More notably was “The negotiation of sexual relationships among school pupils in south-western Uganda” that made the finding that wanting to use a condom can be interpreted as a sign of carrying HIV/ AIDS disease (Nyanzi *et al*, 2001).

In Kenya, misconceptions and barriers towards accessing contraceptive influence the attitude of adolescents towards contraceptive use. Even when awareness is high, poor knowledge of contraceptive methods and their side effects has been associated with poor uptake.(Remare, 2012).

A study on “Barriers to Modern Contraceptive Methods Uptake among Young Women in Kenya: a qualitative study conducted by Rhoune Ochako *et al* (2015) made a number of findings. Across

all age groups, perceived and actual side effects of contraceptive methods emerged as a primary barrier to use. The most common side effects expressed by the respondents were weight changes, bleeding, and lack of sexual desire. Headaches and blood pressure issues were also cited by a few (Ochako *et al*, 2015). Myths are heard about from peers and partners, whose influence on contraceptive demand and uptake is well documented in Kenya (Wafula, 2014). In the study by Uwera (2014) on Determinants of Modern Contraceptive Uptake Following Immediate Post Abortion Counselling among 15--24 Year Old Clients, Family Health Options Kenya, of all clients interviewed, 45 percent feared that using Family Planning will in future contribute to inability to conceive while 35 percent were afraid of the weight gain weight.

Population Services Kenya (PS Kenya) developed a campaign called the 'C-word'. This national campaign includes messages to address key myths and misconceptions identified, specifically: Contraceptives cause weight gain; Contraceptives can cause infertility; Condoms are not effective in preventing pregnancy; Contraception is women's business; and Contraceptives can cause cancer (Michellea, 2012).

Another key barrier is lack of physical and financial access to family planning commodities. Studies have shown that health facilities offering family planning are not equitably distributed throughout the country (Remare, 2012).

Shame is also a significant factor preventing use of family planning (specifically condoms), particularly for unmarried youth. Young people perceive women who carry condoms as promiscuous (Charles, 2004), and that asking a partner to use condoms would reveal them as sexually wayward or untrustworthy. Young people also noted that while married people may freely

ask for family planning, they are inhibited because of the shame associated with procuring contraceptives (Izugbara, 2011).

At service level, many providers and available health information indicate that family planning are only for those who are “mothers”, and are not suitable for those who have not yet had a child (Burke, 2011).

From the literature review, it is evident that barriers, myths and misconceptions about modern contraceptive methods may bias attitudes such that many adolescent who might benefit never accept to utilize contraceptives; it fails to either accept or deny if there has been any intervention to combat such attitude towards contraceptive uptake. This study seeks to investigate if there is such intervention.

2.3.4 Evaluating the roles of counseling in intervening risky sexual behavior among secondary school students.

Changing societal and family values, traditions as well as disintegrated community; form the bases for psychological and social issues affecting students in institutions of learning (Wambu & Fisher, 2015). Mapfumo and Nkoma, (2013) noted that students experience immense socio-economic and psychological pressures in today’s world, which disturb their learning process. These negative societal trends have underscored the increasing demand for the services of professional teacher counsellors to provide a comprehensive Guidance and Counselling Programme in secondary schools to effectively address the needs of students.

In response to this demand, Guidance and Counselling programme was implemented in the United States and it became prominent in American schools after the World War 1 (Corsini, 1987). In

Africa, the concept of Guidance and Counselling although relatively new in educational systems, has been embraced by most governments (UNESCO, 2001). Considerable progress has been made setting up administrative structures for the provision of Guidance and Counselling services in educational institutions to enhance personal, educational and vocational development of the students. Therefore Guidance and Counselling has been conceptualized as a programme of activities which has provided African countries with the gateway out of the existing numerous problems in the present age of complex scientific and technological development (Okobiah & Okorodudu, 2004).

Guidance and Counselling was formally implemented in Kenyan institutions of learning in 1971 to help students deal with emotional, psychological, educational, vocational and social problems that confront them in their daily lives (Wango, 2007). The implementation of Guidance Counselling programme was based on a number of recommendations and guidelines in various Education Commissions Reports, National Development Plans and Government Sessional Papers (MOEST, 2004).

Guidance and counselling programmes in schools are geared towards promotion of the development of students. According to Eyo, Joshua and Esuong (2010) guidance and counselling programmes for secondary school students are designed to address the physical, emotional, social, vocational and academic difficulties of adolescent students.

Literature reveals that implementing of guidance and counseling programmes is a challenge to most schools. According to Low (2009) there are four types of challenges of counselling in a school setting namely; internal, external, systems and personal challenges. Internal challenges are concerned with clientele groups, teachers' attitudes towards counselling and pupils' willingness to

seek counselling. External challenges are issues outside the school which include culture and globalization; system challenges are things within the programme which include law establishing its practice in schools, referral procedure and resource planning. Personal challenges include skills and techniques of the counsellor including training, supervision and attitude towards the school system.

In China there is stigma related to personal and emotional problems, hence reluctance by most students to seek counseling. The counseling recommended for anxiety, depression is qi-gong meaning (deep breathing) acupuncture and music therapy (Wong, 2012). In Malawi and Nigeria, teenagers tend to view sexual behavior positively. They keep their sex experiences secret for fear of disapproval by their elders and sometimes have a feeling of anxiety and shame. As a result, they receive little guidance about reproduction and how to protect themselves (Obiechna, 2010).

A study by Gatundu, (2009) on Counseling Interventions for Adolescent Sexuality Needs in Selected Secondary Schools in Nairobi Province came out clearly that teacher counselor in schools need training on how to deal with adolescents' sexuality issues and how to demarcate counseling, teaching and disciplining in order for any intervention to bear any fruits. Kenyan schools are still in need of coordinated guidance and counselling programmes. Lack of an organizational structure detailing how school counselling should be conducted in schools has led to inconsistencies and variations in how guidance and counselling is conducted in different schools (Wambu & Fisher, 2012).

Furthermore, Negesa (2018), on Influence of Teenage Sexual Behaviour on Academic Performance among Public Secondary School Students in Bungoma South Sub-County, Kenya conducted interviews with guidance and counseling teachers revealed that they used various

strategies. All the Guidance & Counseling teachers agreed that they used counseling to address teenage sexual behavior and use of contraceptives, corporal punishment as a mechanism to address teenage sexual behavior, peer counselling as a way of sex and relation education, individual counselling when students were found engaging in inappropriate sexual behavior. However, the same guidance and counseling teachers were asked whether the school has adequate support materials and personnel for training sex and relationship education, none of the teachers either strongly agreed or agreed, 10 (62.5%) disagreed while 6 (37.5%) strongly disagreed.

Therefore many emerging issues like school unrest, risky sexual behavior among others that ought to have been addressed by an effective provision of Guidance and Counselling services have continued to persist. Thus the study seeks to establish through empirical research the impact and/or challenges in the implementation of Guidance and Counselling programme in Nairobi county secondary schools Kenya with the view of improving this crucial service in Kenya's secondary schools.

2.4 Summary of Literature Review and Theoretical Framework

Adolescents who engage in risky sexual behaviors are vulnerable to STD, HIV, sexual abuse and violence. Pregnancy often forces teenagers from the poorer sections of society to take on low-paid jobs or work involving health risks to survive. When the pregnant girl is unmarried, she fears the reaction of parents, relatives, neighbours and friends. Fear of rejection by the family causes emotional and psychological problems (WHO, 2011). The above review of studies indicates that there is a connection between contraceptive use and risky sexual behavior. This is evident with those who access end up using contraceptive at the initial stage but either stop or inconsistently use it due to the familiarity that arose from a relatively stable pattern of relationships (Ochieng,

2013) cementing trust. Also, the use of contraceptive has been linked with promiscuity (Ndungu, 2015) since it encourages having more sexual partners on the basis that they will engage in safe sex. This study seeks to go further to investigate whether availability of contraceptives is a determinant for sexual debut and its impact on frequency of sexual activities.

Further, poor sexual and reproductive health outcomes are the reality for many youth today. Many adolescents still choose to initiate sexual intercourse and engage in risky sexual behavior despite knowledge of the consequences. Their decision is influenced by various factors like parents' marital status; family structure and stability all influence the adolescents' sexual behavior, Hogan, Sun & Cornwell (2000). Research also found a direct relationship between the amount of sexual content children see and their level of sexual activity or their intentions to have sex in the future (Brown, 2004; Jones, 2006). The studies fail to point out even imply if contraceptives is one of the decisions that influence risky sexual behavior. This study seeks to investigate whether contraceptives has had any role in promoting risky sexual behavior.

Adolescents have faced social, psychological and cultural barriers to contraceptives influencing their attitudes towards it. Myths are heard about from peers and partners, whose influence on contraceptive demand and uptake is well documented in Kenya (Wafula, 2014). Weight changes, bleeding, lack of sexual desire, headaches and blood pressure issues were also cited as side effects of contraceptives (Ochako *et al*, 2015). Shame is also a significant factor preventing use (specifically condoms), as young people perceive women who carry condoms as promiscuous (Charles, 2004). Bias attitudes arise therefore many adolescent might not benefit since they may never accept to utilize contraceptives; it will be important establish if there has been any

intervention to combat such attitude towards contraceptive uptake. This study seeks to investigate if there is such intervention.

Appropriate information availed to teenagers on sexuality should be adequate and correct both at school and home to intervene risky sexual behavior. Parents and counselor teachers are tasked in disseminating such information. According to Eyo, Joshua and Esuong (2010) guidance and counselling programmes for secondary school students are designed to address the physical, emotional, social, vocational and academic difficulties of adolescent students. Teacher counselor in schools need training on how to deal with adolescents' sexuality issues and how to demarcate counseling, teaching and disciplining in order for any intervention to bear any fruits(Gatundu, 2009). In Bungoma, Negesa (2018), guidance and counseling teachers were asked whether the school has adequate support materials and personnel for training sex and relationship education, none of the teachers either strongly agreed or agreed. Thus the study seeks to establish through empirical research the impact and/ or challenges in the implementation of Guidance and Counselling programme in Nairobi county secondary schools Kenya.

2.5 Conceptual Framework

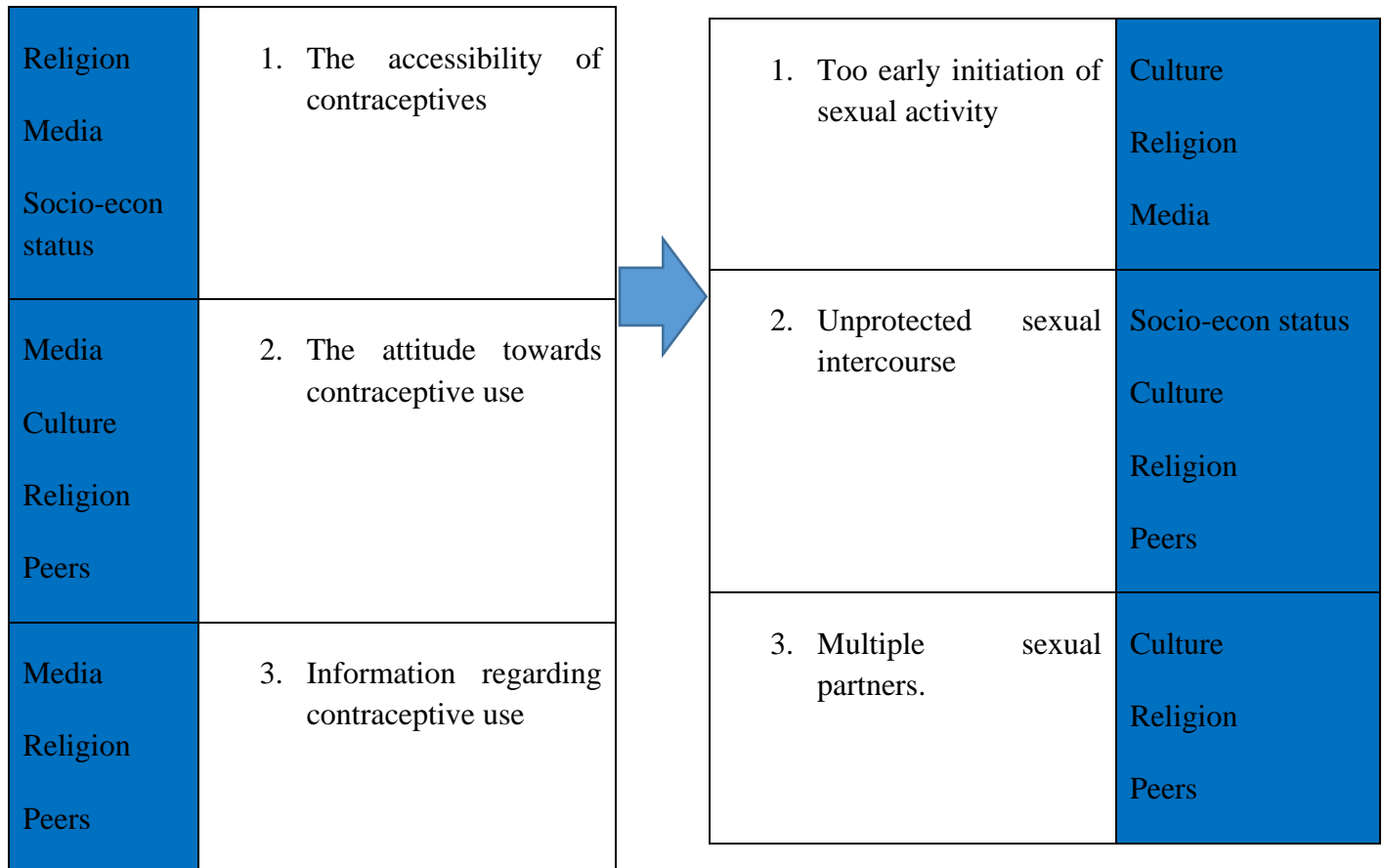
The following is a conceptual representation of the impact of the use of contraceptives on the sexual behavior of secondary school students in secondary schools in Nairobi County, Kenya.

Independent variable:

Use of contraceptives

Dependent variable:

Risky sexual behavior



- Media.
 - Culture.
 - Social- economic status.
 - Religion.
 - Peers
- variables**

Figure 2.1: Conceptual Framework

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This study evaluates the relationship between the use of contraceptive and risky sexual behavior among secondary school students in Nairobi County, Kenya. The chapter begins by giving research design, study variables, location of study and target population. Further it illustrates the sampling technique and sample size, research instrument, and validity and reliability. It concludes with data collection procedures, data analysis and presentation, and data management and ethical considerations.

3.2 Research Design

This study used mixed methods design; descriptive survey and correlational research designs. It involves combining or integration of qualitative and quantitative data in a research study. According to Cohen and Lawrence (1995), descriptive survey research design is a process of collecting data in order to test hypotheses or to answer questions concerning the current status of the subject in the study. It was appropriate and preferred in this study because it enabled the researcher to collect data useful for correlation analysis from the respondents of the study. Correlation- research design was also used. It involves collecting data in order to determine to what degree a relationship exists between two or more quantifiable variables. According to (Borg, 2007), a correlation design method permits analyzing relationships among a large number of variables in a single study. It also provides information concerning the degree of the relationship between the variables being studied as stated in the study hypotheses.

These designs ensured representation of ideas, opinions, suggestions and recommendations so as to determine whether there is a relationship that exists between use of contraceptive and risky sexual behaviors among the secondary school students in Nairobi County, Kenya.

3.2 Study Variables

The study had the use of contraceptive as the independent variables while the risky sexual behavior will be the dependent variable. The study assessed the relationship between the use of contraceptives among the secondary school students and their sexual behaviors, a correlation that may vary, can be positive, negative, or no correlation. The study also considered media, peer pressure and social- economic status as symmetrical extraneous variable while culture and religion as asymmetrical extraneous variable.

3.3 Location of Study

The study took place in Nairobi County, the capital city of Kenya. The site of study was selected because it is cosmopolitan thus representing teenagers from all background that include different religions, ethnic background, social-economic status, race and culture.

3.4 Target Population

There are seventeen sub-counties in Nairobi County. The number of secondary schools is two hundred and fifty nine in total within the county. According the data from County Director of education in Nairobi County, the number of students in Nairobi County was 8,930 boys and 12,301 girls giving a total of 21,231 students, although this data may vary from time to time due to new admissions and also dropout.

3.5 Sampling Techniques and Sample Size

The sample size was 384 participants from secondary schools in Nairobi County available. This was determined using the Fischer et al. (1998) formula:

$$nf = n / [1 + n/N]$$

Where nf = desired sample size ($N < 10,000$)

n = desired sample size ($N > 10,000$) N = estimated population size

Calculating the sample size: $n=384$ $N= 21, 000$

Therefore, $nf = 384 / [1 + 384/21,000] = 384.3083$ The minimum sample size was 384 students.

Multi-stage sampling approach will be used to obtain the desired sample as follows:

First, cluster sampling was used to select randomly three sub counties from seventeen sub-counties in Nairobi County. Stratified random sampling was used to select six public and six private secondary schools, two public and two private schools from each sub county giving a total of twelve schools. Then simple random sampling was used to obtain a sample of thirty two students from each twelve schools giving a total of 384 students. A non-probability sampling of quota sampling was used to form one focus group discussion (FDGs) (composing 8 to 10 persons per group) in each school.

One teacher from each school giving a total of 12 teachers was selected using purposive sampling. Purposive or judgmental sampling is where the researcher uses her/his own judgment, research skills and prior knowledge to choose settings and respondents. The guidance and Counseling

teachers were selected because they are the ones entrusted with the responsibility of conducting Guidance and Counseling to students in school.

3.6 Research Instruments

Interview schedule was administered to focus group discussion (FGDs) in order to explore knowledge and experiences in contraceptive use as well as impact of counseling services in school. Questionnaires and interviews were administered to students and counselors in order to explore accessibility, attitude, challenges of contraceptives use and its relationship on risky sexual behaviors as well as explore interventions through counseling services.

Questionnaires were used given the area of study is somewhat ‘taboo’; participants may be unwilling to give honest opinions face to face on their sexual behaviors and contraceptive use due to their cultural or religious beliefs. Interviews were used as they are more flexible hence the interviewer can clarify and elaborate yielding higher response and deeper understanding.

3.7 Pilot Study

A pilot study was conducted in two schools in Nairobi County, Kenya, one private and the other public, to test the instruments and process of study. 38 students representing 10 percent of final sample were used in the study where questionnaires and FGDs was administered to them while an interview conducted on two teachers. However, the pilot samples were excluded from the final sample. The pilot study was used to check on the flow and meaning of questions, language used in the tools and the time it took to administer each tool. The feed- back from the pilot was used to streamline the logistical arrangement for the main study as well as training of field assistants in readiness for the study.

3.7.1 Validity

(Mugenda, 2003) refer to validity as the degree to which results obtained from analysis of data actually represent the phenomenon under study. To ensure validity, the instruments were given to experts on the topic of study at Kenyatta University. They closely examined the instruments and give their suggestions which were incorporated in the revised instrument to be used in the actual study. Perhaps the most practical way of achieving greater validity was to minimize the amount of bias as much as possible (Cohen, 2007).

3.7.2 Reliability

To ensure reliability of the instruments, a pilot study was conducted on 2 Guidance and Counseling teachers and 38 students as suggested the total sample size lies within the minimum 10 per cent of the population (Mugenda, 2003) which in this study is 384 students and 12 Guidance and Counseling teachers. This determined the clarity of questions and if they can effectively provide the data necessary for the study. Test re-test was adopted, and the reliability coefficient calculated using Pearson's product moment correlation. The schools where the pilot study was conducted did not form part of the final study.

The Cronbach's alpha of the variables was reliable in testing the questionnaires. Contraceptive use had a Cronbach's alpha of 0.842, risky sexual behaviors with a Cronbach's alpha of 0.899 and attitude towards contraceptives with a Cronbach's alpha of 0.758. All the values were found to be above 0.7 an indication that the questionnaire was internally consistent.

3.8 Data Collection Procedures

The researcher was given introductory letter by Kenyatta University to authorize collection of data. A permit from NACOSTI was sort to authorize the research. One FGD was conducted in each school from the selected students aged 13-19 years. The groups had the following characteristics; different age, comparable levels of education, different ethnic background, different socio-economic backgrounds and different religions. The number of participants per group ranged from 8 to 10 persons. This number was preferred since it was manageable and small enough giving everyone the opportunity to express his or her opinion.

Questionnaires were administered to all participants in the study. Each participant responded to questions individually without any consultation. Interviews were conducted on 12 Guidance and Counseling teachers, one from each school to get more understanding the subject matter of the study related to interventions on risky sexual behavior.

3.9 Data Analysis and Presentation

On the relationship between the accessibility of contraceptives and risky sexual behavior, descriptive analysis was done on willingness to use contraceptive after unprotected sex, the relationship between unprotected sex and contraceptives availability and whether the use of contraceptives promotes promiscuity. To explore various risky sexual behaviors practiced by adolescents, descriptive analysis was done on the rise of adolescence engaging in risky sexual behaviors as well as sexual relation without the use of condom/any other contraceptive.

To determine the attitude towards contraceptives use among secondary school students, inferential analysis on preferred type of contraceptive as well as frequency of using contraceptives was

conducted. On the role of counseling in intervening risky sexual behaviour, a thematic analysis was done on content of current counseling program related to the use of contraceptives and the impact of counseling on risky sexual behavior.

A thematic framework approach was used to analyze the qualitative data collected. Qualitative data was transcribed, classified into various categories and reported according to emerging themes and sub themes for each of the objectives. Quantitative data was analyzed using descriptive statistics such as frequency counts, percentages and means to get the quantities of teenagers who are contraceptive users, sexually active etc. Pearson's r was used to test hypothesis. The analytical process followed five key steps: transcription of the tapes and field note, checking and validating the transcripts, development of the thematic framework, coding of the transcripts using the thematic framework and charting and interpreting the data using SPSS version 23.0.

3.10 Data Management and Ethical Consideration

Ethical consideration refers to the ethics of conducting research. The researcher observed most of the key principles and related considerations as stated by (Borg, 2007). This include: voluntary participation of respondents in the research, informed consent of participants, use of appropriate language and terminology in formulation of research instruments and during interviews, privacy and anonymity of respondents being observed by the researcher during field work. Written consent was obtained from the respondents not only to participate in the study but also on the responses or conversations that could be used in the final report. Confidentiality was maintained by assuring study participant's names are not used during data collection so the study used initials maintaining privacy and anonymity of respondents.

Permission was obtained to conduct the research from Kenyatta University, government offices and the school authorities. Ethical issues may arise based on participants' religion or culture. An explanation was given to the participants about the purpose of the study and the importance of their views in regards to the topic.

CHAPTER FOUR: RESEARCH FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter comprises of data analysis, findings and interpretation. Results are presented in tables and figures. The analysed data was arranged under themes that reflect the research objectives.

4.2 Response Rate

The questionnaires were administered to the respondents in the selected schools with the help of research assistant. The questionnaires that were used in pilot analysis were not included in the actual study. Thus a total of 346 out of 384 questionnaires were available for the study.

Table 1: Response Rate

Response	Frequency	Percentage
Returned	329	93.40%
Unreturned	17	6.60%
Total	346	100%

The number of questionnaires that were administered to the students in the schools in Nairobi, Kenya was 346. A total of 329 were properly filled and returned. This represented an overall successful response rate of 95.09% as shown on Table 1. The attrition on the response rate was due to incomplete answering of the questionnaires and some questionnaires were not well filled. This agrees with Babbie (2004) who asserted that return rates of 50% are acceptable to analyse and publish, 60% is good and 70% is very good. Based on these assertion 93.40% response rate was adequate for the study.

4.3 Pilot Results

4.3.1 Reliability Results

So as to check on the internal consistency, the study applied reliability analysis. The Cronbach's alpha was used for this case as it is deemed more precise measure of internal consistency; the test shows the association among items in a test and to the total coherence of data where the higher the coefficient tabulated the higher the more the reliable the test is. This is between the threshold coefficient of 0 and 1.00.

The results in Table 2 revealed that the Cronbach's alpha of the variables was reliable in testing the questionnaires. Contraceptive use had a Cronbach's alpha of 0.842, risky sexual behaviors with a Cronbach's alpha of 0.899 and attitude towards contraceptives with a Cronbach's alpha of 0.758. All the values were found to be above 0.7 an indication that the questionnaire was internally consistent.

Table 2: Reliability Results

Variables	Cronbach's Alpha	Number of items	Comment
contraceptive use	0.842	6	Reliable
risky sexual behaviors	0.899	7	Reliable
attitude towards contraceptives	0.758	3	Reliable

4.3 Demographic information

The respondents were requested to fill their demographic information. The results in Table 4.3 showed that majority of the students were girls (56.2%, n=185) and were slightly more than their male counterparts n=144 (43.8%). This implies that the prevalence is higher among males as compared to female students.

The results further indicated that majority of the respondents (58.4%, n=192) had both parents, 25.8% (n=85) had single parents while 15.8% (n=52) came from polygamous families. The results also revealed that majority of the students (62.3%, n=205) of the secondary school adolescents in Nairobi County were between 13 and 18 years. This shows that adolescents engage in sexual activities at a very young age.

The results also revealed that n=211 (64.1%) of the respondents were Christians while n=118 (38.9%) were Muslims. In addition, the results indicated that majority of the students in Nairobi County (n=206, 62.6%) have stayed in Nairobi since they were 6 years old. The results further, showed that majority of the students' economic status (63.5%, n=209) was average to poor.

Table 3: Demographic Statistics

Demographic Information	Indicator	Frequency	Percentage
Gender	Female	185	56.2
	Male	144	43.8
Type of family	Single	85	25.8
	Both parents	192	58.4
	Polygamous	52	15.8
Age	10 – 12 years	63	19.1
	13 - 15 years	135	41.0
	16 – 18 years	70	21.3
	Over 19 years	61	18.5
Religion	Muslims	118	35.9
	Christian	211	64.1
Duration of Stay in Nairobi	Less than 1 year	64	19.5
	1 – 5 years	59	17.9
	6-10 years	88	26.7
	Over 10 years	118	35.9

4.4 Accessibility of Contraceptives

The results in this section were geared to determining the objective of the relationship between accessibility of contraceptives and risky sexual behavior.

4.4.1 Willingness to use Contraceptive when accessible

The results in Table 4 revealed that majority of the students n=170 (74.1%) indicated that they were willing to use contraceptives when accessible. This implies that ease to access contraceptives has an influence on the risky sexual behaviour.

Table 4: Willingness to use Contraceptive when accessible

	Frequency	Percent
Most likely	85	25.8
Likely	85	25.8
Unlikely	159	48.3
Total	329	100

4.4.2 The use contraceptives in prevention of risky sexual behaviors

The respondents were asked to indicate if they would have more unprotected sex if contraceptives were always available. The results in figure 2 indicated that majority of the students n=175 (53%) indicated that that they will not have unprotected sex if contraceptives were available. 34% (n=111) of the students were not sure about it while 13% (n=43) of them would have more unprotected sex if contraceptives were always available. The figure indicates that the availability of contraceptives may not increase the incidence of unprotected sex.

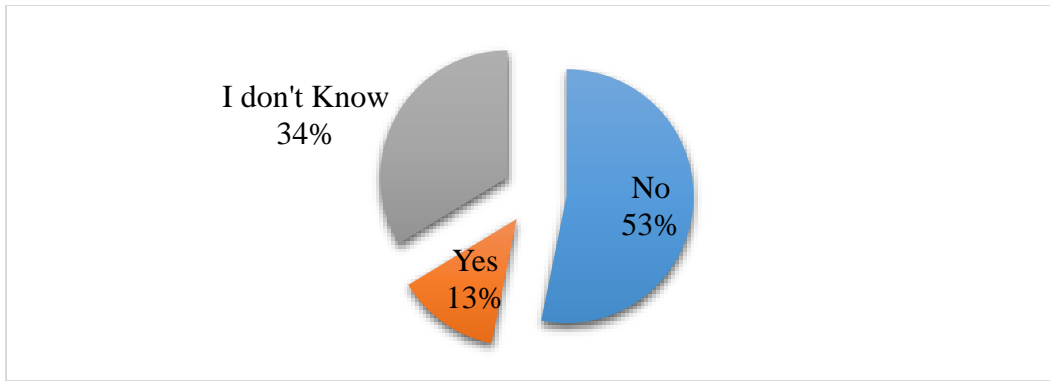


Figure 2: The use contraceptives in prevention of risky sexual behaviors

4.4.3 Whether the use of contraceptives promotes risky sexual behavior among adolescents

The respondents were required to indicate whether the use of contraceptives promotes risky sexual behaviors among secondary school students. This was done using the 5 point scale of Strongly Agree (5) Agree (4) Neutral (3) Disagree (2) and Strongly Disagree (1). The results are as shown in Table 4.5.

The results in Table 5 revealed that majority of the respondents (64.44%) agreed with the statement that the use of contraceptives promotes promiscuity among adolescents. The responses had a mean of 3.81 and a standard deviation of 1.26. Majority of the respondents (72.34%) agreed with the statement that increasing advocacy for contraceptives use influences adolescents decision to be sexually active. The responses gave a mean of 3.82 and a standard deviation of 1.28.

The results also indicated that 61.70% of the respondents agreed with the use of contraceptives leads to multiple sexual partners. The responses gave a mean of 3.72 and a standard deviation of 1.31. In addition, the results showed that 66.26% of the adolescents agreed that they stop using

contraceptives after several sexual encounters with a partner. This was supported by a mean of 3.82 and a standard deviation of 1.31.

From the results, 66.87% of the adolescents also agreed that they are inconsistent in the use of contraceptives. This was supported by a mean of 3.91 and a standard deviation of 1.23. The results however, revealed that 58.66% of the adolescents were not sure about the statement that adolescents experiment not using contraceptive. This was supported by a mean of 3.12 and a standard deviation of 1.10.

On a five point scale, the average mean of the responses was 3.70 which mean that majority of the respondents agreed with the statement; however the answers were varied as shown by a standard deviation of 1.25.

Table 5: Descriptive statistics on effect of contraceptive use on risky sexual behavior

Statement	1	2	3	4	5	Mean	Std Dev
Use of contraceptives promotes promiscuity among adolescents	7.29	8.81	19.45	24.01	40.43	3.81	1.26
Increasing advocacy for contraceptives use influences adolescents decision to be sexually active	9.42	8.81	9.42	34.65	37.69	3.82	1.28
Use of contraceptives leads to multiple sexual partners	8.51	5	18.54	23.4	38.3	3.72	1.31
I stop using contraceptives after several sexual encounters with a partner	7.9	10.9	4	14.89	22.49	43.77	3.83
I am inconsistent in the use of contraceptives	5.47	10.0	3	17.93	21.28	45.29	3.91
Adolescents experiment not using contraceptive	8.21	14.2	9	51.98	8.81	16.72	3.12
Average						3.70	1.25

4.5 To explore various risky sexual behaviors practiced by adolescents.

The second objective was to explore various risky sexual behaviors practiced by adolescents among secondary school students in Nairobi City County. Respondents were provided with questions to yield data to determine the objective.

4.5.1 Sexually active age

The results from Table 6 revealed that majority of the adolescents (n=151, 45.9%) became sexually active at the age of 12 to 15 years while n=92 (28%) indicated that they became sexually active at over 15 years of age. 26.1% (n=86) of the adolescents indicated that they were sexually active at under 12 years of age.

Table 6: Sexually active age

Age	Frequency	Percent
Under 12 years	86	26.1
12- 15 years	151	45.9
Over 15 years	92	28
Total	329	100

4.5.2 Sexual Relation without the use of condom/any other contraceptive

The results in Table 7 revealed that n=196 (59.6%) of the students indicated that they had had sexual relationships without a condom/any other contraceptive while n=133 (40.4%) had had sexual relationships with a condom/any other contraceptive

Table 7: Sexual Relation

Sexual Relation	Frequency	Percent
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Yes	196	59.6
No	133	40.4
Total	329	100

The students were also asked to indicate what had led to the decision to have sexual relations without a condom/any other contraceptive. These were some of their responses:

- I. *Curiosity since my friends claim it is sweeter that way (peer pressure)*
- II. *I was afraid to purchase the contraceptive from a chemist/shop (stigma)*
- III. *Some of the contraceptives have side effects on my health.*

Furthermore, they were requested to further report any risk(s) which followed having sexual intercourse without contraceptive. Majority indicated that sexual relations without contraceptives impose a risk to:

- I. *Getting pregnant*
- II. *Getting infected with HIV/AIDS*
- III. *Contraction of STIs infection*

4.5.3 Number of sexual partners

The results in Table 8 indicated that majority of the adolescents (n=136, 41.3%) had two to five sexual partners and (n=103, 31.3%) had more than 5 sexual partners while a small number of them (n=90, 27.4%) had one partner.

Table 8: Number of sexual partners

Partners	Frequency	Percent
1	90	27.4
2-5	136	41.3
over 5	103	31.3

Total	329	100
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4.5.4 Descriptive Statistics on factors that may lead to adolescence engaging in risky sexual behaviors

The respondents were required to rank the statements on the perceptions concerning factors that may lead to adolescence engaging in risky sexual behavior among adolescents. This was done using the 5 point scale of Strongly Agree (5) Agree (4) Neutral (3) Disagree (2) and Strongly Disagree (1). The results are as shown in Table 4.5.

The results in Table 9 revealed that majority of the respondents (62%) agreed with the statement about availability of contraceptives among the adolescents. The responses showed a mean of 3.64 and a standard deviation of 1.26. Majority of the respondents (53.5%) agreed with media exposure to sex related programmes. The responses gave a mean of 3.55 and a standard deviation of 1.39.

From the results, 62.00% of the adolescents agreed about availability of pornographic materials in the internet. This was supported by a mean of 3.71 and a standard deviation of 1.49. The results also, revealed that 66.57% of the adolescents agreed that there was peer pressure to fit in certain groups. This was supported by a mean of 3.51 and a standard deviation of 1.15.

Likewise, from the results, 78.72% of the adolescents agreed to lack of strong religious background and practices. The results were also supported by a mean of 3.95 and a standard deviation of 1.07. The results also, revealed that 46.87% of the adolescents agreed to the social economic status of one's family. This was supported by a mean of 3.29 and a standard deviation of 1.45. In addition,

Majority of the respondents 42.25% agreed to some cultural practices encouraging early sex. The responses gave a mean of 3.16 and a standard deviation of 1.41.

On a five point scale, the average mean of the responses was 3.754 which mean that majority of the respondents agreed with the statement; however the answers were varied as shown by a standard deviation of 1.32.

Table 9: Descriptive statistics on factors that may lead to adolescence engaging in risky sexual behaviors

Statement	1	2	3	4	5	Mean	Standard Deviation
Availability of contraceptives among the adolescents	8.51	11.55	17.93	31.91	30.09	3.64	1.26
Media exposure to sex related programmes	11.25	13.37	21.88	16.11	37.39	3.55	1.39
Availability of pornographic materials in the internet	13.37	12.16	12.46	13.98	48.02	3.71	1.49
Peer pressure to fit in certain groups	8.51	13.07	11.85	51.98	14.59	3.51	1.15
Lack of strong religious background and practices	5.17	6.38	9.73	46.2	32.52	3.95	1.07
The social economic status of one's family	16.11	15.81	21.28	17.02	29.79	3.29	1.45
Some cultural practices encourage early sex	17.33	15.81	24.62	17.63	24.62	3.16	1.41
Average						3.54	1.32

The students were also asked to indicate any incidence(s) which makes them justify lack of use of contraceptives. Some of them indicated the following:

- I. *Since I sneak to do it, I have no time to use a condom*

- II. *The injections and female condom is good but it is very expensive to buy*
- III. *I was forced to have sex so I did not have a choice*
- IV. *I first lost my virginity during a birthday party where I was drunk and unconscious*

The students were likewise asked to indicate whether the guidance and counselling sessions address risky sexual behaviour.

Most of the student agreed that they address the issues but do not follow up to some extent.

4.6 To determine the attitude towards contraceptives use among secondary school students

Data was collected to determine the objective of the attitudes of students towards contraceptives and risky sexual behavior among secondary school students in Nairobi City County.

4.6.1 Preferred type of contraceptive used

The students were asked to mention their preferred type of contraceptive that they used. From the Table 10 below, it was inferred that 46.8% of the students (n=154) preferred the use of male condom while 27.1% (n=89) of them preferred the use of an injection. In addition 14% (46) and 12.2% (n=40) of the students preferred the use of Emergency pill and a female injection respectively

Table 10: Type of contraceptive used

Contraceptive	Frequency	Percent
Emergency pill	46	14
male condom	154	46.8

female condom	40	12.2
an injection	89	27.1
Total	329	100

The students were asked to indicate the main reason of using contraceptives among the adolescents. They responded as follows:

- I. *Male condom is easily and readily available*
- II. *Condoms are free of charge*
- III. *Injections are long term and I don't have to worry about being pregnant.*
- IV. *Condoms care multipurpose (prevent pregnancy, HIV and STI s)*
- V. *P2 (Emergency pills) help if the condom burst during sex*

The students were asked to indicate whether the reasons change over time. *Most of them said that the reasons vary according to the situation such as money, place of the act and outcome of sexual act. Some of them indicated that it changes in order to please the other sexual partner.*

They were further requested to give reasons for their preference.

Most of the students indicated that they preferred using a male condom because it was better is easy to use, readily available and affordable and as well offers the best protection qualities against STIs (e.g. gonorrhoea and HIV). Some claimed that the use of pill has some side effects on the female after use besides being expensive as is the case with the use of an injection.

4.6.2 Frequency of using contraceptives

From the results in Table 11 it was inferred that most (n=174, 52.9%) of the students use contraceptives once, 30.7% (n=101) rarely use contraceptives while 16.4% (n=54) use contraceptives regularly. This attributes to the low usage of contraceptives among secondary school students.

Table 11: Use of contraceptives

Use of contraceptives	Frequency	Percent
Once	174	52.9
Rarely	101	30.7
Regularly	54	16.4
Total	329	100

The students were also asked to comment about adolescents being encouraged to use contraceptives. Most of the students indicate the following:

We are encouraged to use contraceptive however the main message is to avoid sexual relations and focus on studies.

They were further asked to indicate whether the approval or disapproval of their significant others influence their use of contraceptives. Majority agreed that the approval/disapproval of their significant others had a great impact on the use of contraceptives. Many indicated that they did not want to spoil their partners' mood upon mention of the use of contraceptive.

4.7 The role of counseling in intervening risky sexual behaviour

Data was collected to determine the objective on the role of counseling in intervening risky sexual behaviour hypothesis among secondary school students in Nairobi City County.

4.7.1 The content of current counseling program related to the use of contraceptives.

Table 12: Thematic Analysis

Informants	Themes
1.	<i>Education of students on the importance of knowing one's own HIV status.</i>
2.	<i>Educating the Teachers and laboratory technicians in schools on their roles in student counseling</i>
3.	<i>Engaging the students in regular Questions and Answer team meetings</i>
4.	<i>Advocating for voluntary testing of the students in schools</i>
5.	<i>Continuous and progressive counselling and guidance of the students on the</i>
6.	<i>Completing and analyzing monthly VCT statistics</i>
7.	<i>Monitoring and analysis of student quality (exit interviews)</i>

4.7.2 The counselors were asked to indicate how they handle cases of contraceptive counseling and what the frequency is.

Majority of the informants (n=5) indicated that the counsellors usually exercise professionalism in the process of student counselling. They also acknowledged the involvement of students in Contraceptive seminars and talks as well as Personal follow up of students who are found to be mentally and physically affected. Other informants also indicated they handle the case through the help of VCT programmes in the county.

Informant 5, 5 and 6 indicated that they strive to educate the students on the importance of abstinence and focus on studies to be given a first priority. In addition, most (n=6) of them agreed that the cases are frequently tabled on their desks.

4.7.3 The relationship between contraceptive use and risky sexual behavior among students.

From the results of the interview, all the informants (100%) indicated that the use of contraceptives has a negative impact on the prevalence of risky sexual behaviour among students. They also indicated that the prevalence is higher in male students as compared to female students. Increase in use of contraceptives reduces the likelihood of on to be exposure of STIs.

4.7.4 The impact of counseling on risky sexual behavior.

Upon being asked to indicate the impact of counseling on risky sexual behavior, the following were the responses from the key informants:

Table 13: Thematic Analysis

Informant	Themes
1.	The students become self-aware of the need to abstain from sexual relations at early stages
5.	The students become open to discussions with their teachers about their personal issues related to sexual relations
6.	The students acknowledge the importance of consultations to various contraceptives

4.7.5 The challenges that affect counseling on risky sexual behavior and/ or contraceptive use.

The key informants were further asked to indicate the challenges that affect counseling on risky sexual behavior and/ or contraceptive use. Majority of them (n=6) indicated that the main they are faced with a lot of challenges. These were some of their responses.

Table 14: Thematic Analysis

Informant	Themes
1.	<i>Fear of stigma and discrimination</i>

2.	<i>Lack of confidentiality with services personnel and partner trust. Some of the students are afraid of opening up to counsellors with fear of their statuses exposed to teachers and other students.</i>
3.	<i>Lack of stakeholder support such as the neglect of parents and other opinion leaders in the societies</i>
7.	<i>Inadequate, qualified, specialized and experienced personnel to handle the students which results in the cases falling out of hand</i>

4.7.6 Discuss on how you handle cases of students involved in risky sexual behaviors.

The key informants were also requested to discuss how they handle cases of students involved in risky sexual behaviors. These were some of their responses:

Table 15: Thematic Analysis

Informant	Themes
1.	In conjunction with the health care programme, we regularly conduct pregnancy tests to female students in the schools. We also offer encourage students to voluntarily check their status in VCTs.
3.	For the students who are infected with STIs, we refer them to a health practitioner for treatment. In case of HIV infection, the student is put on medication programme
4.	Issues of fear of opening up, stigma and discrimination among counsellors are addressed with utmost confidentiality to avoid stigmatizing the students.
5.	We encourage the students to be on their best behaviour and if they engaged in risky sexual behaviour, they should never hesitate to knock at our door for help

4.7.7 Are there any other thoughts or comments.

Most of the informants echoed the following sentiments:

Since girls mostly get negative information about the side effects that might come along with the choice of certain types of contraceptives especially from their peers, many adolescents have developed negative attitudes towards contraceptives, with some avoiding them and engaging in unprotected sexual relations.

Medical practitioners and counselors need to educate the students on the importance of them seeking medical council/advice before resorting to any unhealthy practices. They also recommended that VCT services be offered to students.

4.8 Hypothesis Testing

This is a method of statistical inference that explains the test of the relationship between each independent variable and the dependent variable. The study used Pearson correlation to establish the relationship between variables.

4.8.1 Effect of Accessibility to Contraceptives on Risky Sexual Behaviour

The first hypothesis (H_{01}) stated that there is no relationship between accessibility to contraceptives and risky sexual behavior among secondary school students in Nairobi City County. To test this hypothesis, the data was subjected to a bivariate correlation analysis by use of the Pearson's product moment correlation co-efficient.

The results in Table 16 show that there was a positive and significant relationship between accessibility to contraceptives and risky sexual behavior $r = 0.126$, $p < 0.05$ ($p = 0.022$). The null hypothesis was rejected. Therefore the data provided evidence that there was a significant relationship between accessibility to contraceptives and risky sexual behaviour. This is in agreement with Kigundu (2014) who claims that access to contraceptives has been accused of increasing risky sexual behaviour among young people. Robinsons (2012) notes that health providers fail to provide contraceptives to the youth on the basis that this promotes promiscuity.

Table 16: Pearson r for Effect of Accessibility of Contraceptives on Risky Sexual Behaviour

		Risky sexual behaviour
Accessibility to	Pearson	
contraceptives	Correlation	0.126
	Sig. (2-tailed)	0.022
	N	329

*Correlation is significant at the 0.05 level (2-tailed).

4.8.2 Effect of Contraceptive Use on Risky Sexual Behaviour

The second (HO2 :) hypothesis postulated that there is no relationship between risky sexual behaviors practiced by adolescents and use of contraceptives among secondary school students in Nairobi City County. However, the findings in Table 17 showed that contraceptive use has a positive and significant effect on risky sexual behaviour ($r = .18, p < 0.05$) ($p = 0.01$). Hence, hypothesis was rejected. Therefore the data provided evidence that there was a significant relationship between contraceptives use and risky sexual behaviour. Concurrently, Chipeta (2012)

revealed that by age 18, most teenagers have had sex with prevalence rates at 60% for the girls and 53% for boys. The condom is the most preferred contraceptive although its use is as low as 3% among the female and 13% among the male teenagers.

Table 17: Pearson r for Effect of Contraceptive Use on Risky Sexual Behaviour

		Risky sexual behaviour
Contraceptive use	Pearson Correlation	0.18
	Sig. (2-tailed)	0.01
	N	329

* Correlation is significant at the 0.05 level (2-tailed).

4.8.3 Effect of Students Attitudes on Risky Sexual Behaviour

The third (HO3) hypothesis postulated that there is no relationship between the attitudes of students towards contraceptives and risky sexual behavior among secondary school students in Nairobi City County. However, the findings in table 18 showed that student attitudes had significant effect on risky sexual behaviour ($r = 0.20$, $p < 0.05$) (0.01). Thus, hypothesis was rejected. Therefore the data provided evidence that there was indeed a positive relationship between students' attitudes and risky sexual behaviour. In line with the findings, Rasch (2000)

argued that individuals might see sex as something that could strengthen a relationship, or as a way to please a partner where pregnancy can even be sought as a way to keep hold of a boyfriend.

Table 18: Pearson r for Effect of Students Attitude on Risky Sexual Behaviour

		Risky sexual behaviour
Students attitude	Pearson Correlation	0.20
	Sig. (2-tailed)	0.01
	N	329

*Correlation is significant at the 0.05 level (2-tailed).

4.8.4 Effect of Role of Counseling on Risky Sexual Behaviour

The fourth (H₀₄) hypothesis postulated that there is no relationship between the role of counseling and intervening risky sexual behavior among secondary school students in Nairobi City County. Nevertheless, the findings in table 19 showed that counseling has a positive and significant effect on risky sexual behaviour ($r = 0.34$, $p < 0.05$) ($p = 0.00$). Thus, the hypothesis was rejected. Therefore the data provided evidence that there was indeed a positive relationship between role of counseling and risky sexual behaviour. Consistent with the findings of Obiechna (2010) teenagers tend to view sexual behavior positively. They keep their sex experiences secret for fear of

disapproval by their elders and sometimes have a feeling of anxiety and shame. As a result, they receive little guidance about reproduction and how to protect themselves and this may result to risky sexual behaviour.

Table 19: Pearson r for counseling on Risky Sexual Behaviour

		Risky sexual behaviour
Students attitude	Pearson Correlation	0.20
	Sig. (2-tailed)	0.01
	N	329

* Correlation is significant at the 0.05 level (2-tailed).

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary and discusses the findings in relation to the research problem and research objectives. The chapter is thus outlined into summary of the findings, conclusions, recommendations and suggestions for further research.

5.2 Summary of Findings

This section provided a summary of the findings from the analysis which was done in line with the objectives of the study.

5.2.1 The Relationship between Access to Contraceptives and Risky Sexual Behaviour

This study found that 72.34% of respondents thought that use of contraceptives promoted promiscuity. These statements were proven by the statements of the questionnaire which majority of them agreed. They also agreed that they are inconsistent in the use of contraceptives with results showing only 16.4% were regular users. This is in agreement with Kigundu (2014) who claims that access to contraceptives has been accused of increasing risky sexual behaviour among young people. Robinsons (2012) notes that health providers fail to provide contraceptives to the youth on the basis that this promotes promiscuity.

The correlation analysis obtained positive relationship between contraceptive availability and risky sexual behavior. This indicated that contraceptive availability may result to risky sexual behavior. The findings of this study are similar to those of Ndungu (2015) who established that contraceptives are associated with early sexual debut among high school adolescents Boys and Girls.

5.2.2 Various risky sexual behaviors practiced by adolescents.

The second objective of study was to explore various risky sexual behaviors practiced by adolescents. It was observed from the findings that most of the students in Nairobi County had had sexual relationships without a condom or any other contraceptive. The students further proved that the reasons for the decision was mainly due to the peer pressure from their mates/peers and the stigma that comes along the purchase of the contraceptives. The study further indicated that the students reported getting pregnant, getting infected with HIV/AIDS and contraction of STIs infection as the main risks associated with unprotected sex. The results further revealed that majority of the adolescents had two to five sexual partners. The findings of this study is also similar to that of Alexander and Hickner (1997) and Taffa *et al.*(2002) who argued that young people often face enormous pressure especially from peers to engage in sex, unlicensed erotic video films and the desire for economic gain. As a result of this, significant number of adolescents is involved in sexual activities at an early age.

The correlation analysis showed that there is a relationship between risky sexual behaviors practiced by adolescents and use of contraceptives among secondary school students in Nairobi City County. The findings of this study are similar to that of Ankomah et al. (2011) who fund that negative sexual permissiveness among young people is promoted by more frequent exposure to print, home video and the internet. On the other hand, promotion of condom use in protection of risky sexual behaviours among young people is also promoted through mass media.

5.2.3 Attitudes towards Contraceptive Use and Risky Sexual Behaviour

The third objective of study was to determine the attitude towards contraceptives use among secondary school students. It was found out that male condom was preferred over other

contraceptive types. It was attributed to the fact that male condoms are readily available, easily and cheap to purchase as compared to the other types of contraceptives. In addition, Condoms were indicated to be multipurpose in preventing pregnancy, HIV and STIs. However, injections were also preferred over emergency pills and female condoms. It was found out that the use of injections was as well preferred because Injections are long term and the students especially girls don't have to worry about being pregnant.

It was also underscored that the reasons to use the type of contraceptives would depend on the situation as well as the outcome of the sexual act. Some of them indicated that it changes in order to please the other sexual partner. The findings of this study was also in collaboration to that of Rasch (2000) who concluded that individuals might see sex as something that could strengthen a relationship, or as a way to please a partner where pregnancy can even be sought as a way to keep hold of a boyfriend.

The inferential analysis revealed that likelihood of risky sexual behaviour increases for those students who use pregnancy prevention pills, male condom and female condom as compared to those who do not use prevention pills, male condom and female condom. This can be associated with the change of reason for using contraceptives over time. This finding is similar to Ochako *et al* (2015) who established that across all age groups, perceived and actual side effects of contraceptive methods emerged as a primary barrier to use.

5.2.4 Role of Counseling in Intervening Risky Sexual Behaviour.

The fourth objective of study was to evaluate the role of counseling in intervening risky sexual behaviour among secondary school students. The findings from the analysis revealed that

education of the students forms a significant part of the current counseling program related to the use of contraceptives. The education extends from the students to the teachers and also their parents. Monitoring and follow up is also important in the schools since the students need to be counched and controlled to avoid misbehavior.

It was also found out that the counselors usually exercise professionalism in the process of student counseling. They also acknowledged the involvement of students in Contraceptive seminars and talks as well as Personal follow up of students who are found to be mentally and physically affected. Other informants also indicated they handle the case through the help of VCT programmes in the county. The counselors also strive to educate the students on the importance of abstinence and focus on studies to be given a first priority. The findings of the study were similar to that of Negesa (2018) who established that all the Guidance and Counseling teachers agreed that they used counseling to address teenage sexual behavior and use of contraceptives, corporal punishment as a mechanism to address teenage sexual behavior, peer counselling as a way of sex and relation education, individual counseling when students were found engaging in inappropriate sexual behavior

It was further indicated that the challenges that affect counseling on risky sexual behavior and/ or contraceptive use include fear of stigma and discrimination, lack of confidentiality with services personnel and partner trust, lack of stakeholder support such as the neglect of parents and other opinion leaders in the societies as well as the Inadequate, qualified, specialized and experienced personnel to handle the students which results in the cases falling out of hand. The findings of this study was also similar to that of Gatundu (2009) who established that, teacher counselor in schools

need training on how to deal with adolescents' sexuality issues and how to demarcate counseling, teaching and disciplining in order for any intervention to bear any fruits.

5.3 Conclusions

Based on the findings above the study concluded that majority of the secondary school adolescents in Nairobi County believe that the use of contraceptives can prevent risky sexual behaviors among adolescents. The study further concluded that the use of contraceptives among secondary schools in Nairobi County is not appreciated as much. The study also concluded that the use of contraceptives plays a critical role in the influence of risky sexual behaviour.

It was concluded from the findings that most of the students in Nairobi County engage in risky sexual behaviour at an early age and while still in school. The reasons for doing this is due to the availability of contraceptives, peer pressure from friends and peers as well as the ineffective counselling systems in schools. The study further concluded that the students are aware of the risks associated with unprotected sex yet they still engage in the act. They are aware of getting pregnant, getting infected with HIV/AIDS and contraction of STIs infection as the main risks associated with unprotected sex. The study also concluded that school going adolescents have more than one sexual partners which increases the risks of contracting HIV/AIDS and as well the increase in teenage pregnancies in schools. This ultimately leads to school drop outs.

From the findings, the study concluded that the students have strong and mixed attitudes towards contraceptives use among secondary school students. Male condom and use of injections were the most commonly preferred type of contraceptives used because the students perceived them to be easy to use and convenient to future applicability. Since male condoms are freely available in

clinics and hospitals, they are the ones that are being used as compared to other injections, emergency pills and female condoms. The study concluded that the students use male condoms because they also offer protection against Sexually Transmitted Infections.

However, it was concluded that the use of the contraceptives was not regularly and this increases the chances of cases of STI infections due to risky sexual behaviour. Thus, the likelihood of risky sexual behaviour is on the rise among the school going adolescents.

It was thus concluded that the counselors in the secondary schools collaborate with health practitioners to help in advocating the use of contraceptives and positive behavioural change among the students. They also extend the VCT services to schools in order to help the students know their status. For the students who are infected with STIs, they are referred to a health practitioner for treatment. In case of HIV infection, the students are immediately put on medication programme.

5.4 Recommendations

- There is need to take advantage of the positive attitude perception of students towards sexual education counseling by having programmes and counseling sessions for high school students regarding sexual behaviour.
- In addition, the study recommends the involvement of all stakeholders' right from the parents, the community, counselors and teachers, health practitioners as well as the government in the curbing of risky sexual behaviour among secondary school students.
- The study recommends constant follow up and monitoring of students' behaviour in order to ensure caching and maintenance of good morals in the society.

- The study further recommends the teachers and school counselors to be good role models to the students since they are at a vulnerable transition stage that requires sustainable moral reinforcement.

5.5 Areas for Further Studies

The study sought to establish evaluate the relationship between contraceptive use and risky sexual behaviors among secondary school students in Nairobi County. The study aimed to provide valuable information to address the risky sexual behaviors among the secondary school students.

The study, therefore, narrowed to the prevalence of risky sexual behaviour at County level specifically in Nairobi County. This leaves a window for further studies to extrapolate the research to other counties in the secondary schools in the neighbouring Counties. Additionally, further studies could be extended to other institutions such as the Universities and colleges to find out the effectiveness of contraceptive use. This would thus provide a wider scope of coverage and likewise be able to fill some knowledge gaps such as the contextual gap and conceptual gaps.

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APPENDICES

Appendix 1: Informed Consent of Participants

Iagree to participate in the research study
conducted by

I understand that the researcher will interview me in school.

I understand that my withdrawal from this study at any time I wish is possible if I do not want to
continue with the study.

I understand that this study is not aimed at harming me.

I also understand that the information I give to the researcher will kept confidential.

I acknowledge that the researcher has explained to me the need for the research and has offered to
answer any question I may have relating to the study. I freely and voluntarily consent to participate
in this research.

Signature of participant.....Date.....

Signature of interviewer.....Date.....

Appendix 2: Questionnaire for the Students

SECTION A: RESPONDENTS DEMOGRAPHIC INFORMATION

1. Gender

(a) Male []

(b) Female []

2. Type of family

(a) Single []

(b) Both parents []

(c) Polygamous []

(d) Any other? Specify _____

3. Age bracket (Tick Whichever Appropriate)

10 – 12 years []

13 - 15 years []

16 – 18 years []

Over 19 years []

4. In what grade/ class are you?

(a) _____

5. What is your religion?

(a) Christian []

(b) Muslim []

(c) Any other? Specify _____

6. How long have you been in the Nairobi County? (Tick as applicable)

Less than 1 year []

6-10 years []

1-5 years []

Over 10 years []

7. How do you rate your economic status?

(a) Very Poor []

(b) Poor []

(c) Average []

(d) Rich []

(e) Very Rich []

SECTION B: DETERMING ANY ASSOCIATION BETWEEN CONTRACEPTIVE ACCESSIBILITY AND RISKY SEXUAL BEHAVIOR

8. How likely can the accessibility of contraceptives expose adolescents to risky sexual behaviors?

Most likely []

Likely []

Not likely []

9. Can you engage in unprotected sex if contraceptives were always available? Please tick

Yes []

(b) No []

(c) I don't know []

10. The following are perceptions concerning effect of contraceptive use on risky sexual behavior among adolescents; they are rated in Likert Scale as: Strongly Agree (SA) Agree (A), Undecided (UD), Disagree (D) and Strongly Disagree (SD). Please agree with the statement by ticking (√) where applicable.

Statements	SD	D	UD	A	SA
Use of contraceptives promotes promiscuity among adolescents					5
Increasing advocacy for contraceptives use influences adolescents decision to be sexually active				4	
Use of contraceptives leads to multiple sexual partners					5
I stop using contraceptives after several sexual encounters with a partner				4	
I am inconsistent in the use of contraceptives				4	

Adolescents experiment not using contraceptive		2			
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11. Suggest ways through which the accessibility of contraceptives may not lead to risky sexual behavior among adolescents in Nairobi County, Kenya?

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SECTION C: EXPLORING RISKY SEXUAL BEHAVIOR

12. At what age did you become sexually active? Please tick

- (a) Under 12 years [] (b) 12- 15 years [] (c) Over 15 years []

13. Have you ever had sexual intercourse without condom or any other contraceptive?

- (a) Yes [] No []

(i) If yes, explain what led to such decision _____

14. Can you report any risk(s) which followed having sexual intercourse without contraceptive?

15. How many sexual partners do you have? Please tick

- (a) 1 [] (b) 2-5 [] (c) Over 5 []

16. The following are statement concerning the factors that may lead to adolescence engaging in risky sexual behaviors; they are rated in Likert Scale as: Strongly Agree (SA) Agree (A), Undecided (UD), Disagree (D) and Strongly Disagree (SD). Please agree to the statement by ticking (√) where appropriate.

Statements	SD	D	UD	A	SA
Availability of contraceptives among the adolescents				4	
Media exposure to sex related programmes					5
Availability of pornographic materials in the internet					5
Peer pressure to fit in certain groups				4	
Lack of strong religious background and practices		2			
The social economic status of one's family			3		
Some cultural practices encourage early sex	1				

17. Can report any incidence (s) which makes adolescents justify lack of use of contraceptives?...

.....

18. Do the guidance and counselling sessions address risky sexual behaviour? if yes, explain

.....

SECTION C: EXAMINING ATTITUDE TOWARDS CONTRACEPTIVE USE

19. What is the main reason of using contraceptives among the adolescents? _____

i) Give reason(s) for using contraceptive and do this reason change over time? If yes, why? _____

20. Kindly mention your preferred type of contraceptive that you used?

i) Give reason(s) for your preference _____

21. What is your frequency of using contraceptives? Please tick

(a) Once [] (b) Rarely [] (c) Regularly []

22. In your own opinion, comment about adolescents being encouraged to use contraceptives____

23. Does the approval or disapproval of significant other influence your use of contraceptives?__

_____ If yes, explain _____

24. If using contraceptive, state any challenges faced while using and how did it impact on the use of contraceptives?

(i) In your opinion, how best can these challenges be resolved?

Thank you.

Appendix 3: Student Focused Discussion Group Guide

1. Discuss contraceptives and possible risky behaviors that adolescents are exposed to due to its use.
2. Discuss the extent of effectiveness of contraceptives in preventing risky sexual behaviors among adolescents in Nairobi County, Kenya.
3. How do the following factors contribute to the rise of sexual activity among adolescents in Nairobi County, Kenya?
 - a) Contraceptives
 - b) Media
 - c) Lack of religious background and practices
 - d) Cultural reasons
 - e) Social economic status
4. Discuss content of sexuality issues during counseling sessions at school. What is left out in counseling at school?
5. Discuss the impact of what was learned about sexual behaviors during counseling sessions.
6. Discuss persons you are free to share with information on your sexual issues and why?
7. Are there any other thoughts or comments.

Appendix 4: Interview Guide for Counselors

1. Discuss the content of current counseling program related to the use of contraceptives.
2. Discuss how you handle cases of contraceptive counseling and what is the frequency?
3. Discuss the relationship between contraceptive use and risky sexual behavior among students.
4. Discuss the impact of counseling on risky sexual behavior.
5. Discuss challenges that affect counseling on risky sexual behavior and/ or contraceptive use.
6. Discuss on how you handle cases of students involved in risky sexual behaviors.
7. Are there any other thoughts or comments.

Appendix 5: Budget

Description	Amount (Kshs.)
Proposal Typesetting and Printing 50pgs @50	2,500
Stationery	5,000
Questionnaire Preparation and Testing	4,500
Data Collection Traveling Expenses	42,000
Data Analysis (Software Hire)	15,000
Typing and Report Binding	10,000
Airtime and Communication Expenses	5,000

Appendix 6: Work Plan

	JULY 2017	MARCH 2018	APRIL 2018	MAY 2018	AUG 2018	SEPT 2018	OCT 2018
Topic Identification							
Concept Paper Presentation							
Proposal Presentation							
Pretesting of Questionnaire							
Defense							
Proposal Submission							
Data Collection & Analysis							
Submission of Project Report to Graduate School							

Appendix 7: NACOSTI Permit

**THIS IS TO CERTIFY THAT:
MR. BENSON OKAL MAJIWA
of KENYATTA UNIVERSITY, 25342-603
LAVINGTON, has been permitted to
conduct research in Nairobi County**


**on the topic: THE RELATIONSHIP
BETWEEN CONTRACEPTIVE USE AND
RISKY SEXUAL BEHAVIOUR AMONG
SECONDARY SCHOOL STUDENTS IN
NAIROBI CITY COUNTY, KENYA**

**for the period ending:
5th February, 2020**


**Applicant's
Signature**

**Permit No : NACOSTI/P/19/40752/27946
Date Of Issue : 6th February, 2019
Fee Received :Ksh 1000**




**Director General
National Commission for Science,
Technology & Innovation**

Appendix 8: Educational Authorization



KENYATTA UNIVERSITY
GRADUATE SCHOOL

E-mail: dean-graduate@ku.ac.ke

P.O. Box 43844, 00100
NAIROBI, KENYA
Tel. 810901 Ext. 4150

Website: www.ku.ac.ke

Internal Memo

FROM: Dean, Graduate School

DATE: 6th December, 2018

TO: Benson O. Majiwa
C/o Psychology Dept.

REF: C50/CTY/FT/31234/2015

SUBJECT: APPROVAL OF RESEARCH PROPOSAL

We acknowledge receipt of your revised Research Proposal as per our recommendations raised by the Graduate School Board of 7th November, 2018 entitled "The Relationship between Contraceptive use and Risky Sexual Behaviour among Secondary School Students in Nairobi City County, Kenya".

You may now proceed with your Data Collection, Subject to Clearance with Director General, National Commission for Science, Technology and Innovation.

As you embark on your data collection, please note that you will be required to submit to Graduate School completed Supervision Tracking Forms per semester. The form has been developed to replace the Progress Report Forms. The Supervision Tracking Forms are available at the University's Website under Graduate School webpage downloads.

Thank you.

A handwritten signature in blue ink, appearing to read 'Eljah Mutua'.

ELJAH MUTUA
FOR: DEAN, GRADUATE SCHOOL

C.c. Chairman, Department of Psychology

Supervisors:

1. Dr. Robert C. Kipnusu
C/o Department of Psychology
Kenyatta University



KENYATTA UNIVERSITY
GRADUATE SCHOOL

E-mail: dean-graduate@ku.ac.ke

Website: www.ku.ac.ke

P.O. Box 43844, 00100
NAIROBI, KENYA
Tel. 8710901 Ext. 57530

Our Ref: C50/CTY/PT/31234/2015

DATE: 6th December, 2018

Director General,
National Commission for Science, Technology
and Innovation
P.O. Box 30623-00100
NAIROBI

Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION FOR BENSON O. MAJIWA – REG. NO. C50/CTY/PT/31234/2015.

I write to introduce Benson O. Majiwa who is a Postgraduate Student of this University. The student is registered for M.A degree programme in the Department of Psychology .

Benson intends to conduct research for a M.A Project Proposal entitled, “The Relationship between Contraceptive use and Risky Sexual Behaviour among Secondary School Students in Nairobi City County, Kenya”.

Any assistance given will be highly appreciated.

Yours faithfully,

PROF. ELISHIBA KIMANI
AG.DEAN, GRADUATE SCHOOL

EM/lmp