ATTITUDE AND PERCEPTIONS OF CONTRACEPTIVES ON PROTECTED SEX AMONG YOUTH IN INSTITUTIONS OF HIGHER LEARNING IN MACHAKOS TOWN, KENYA.

By

Susan Njeri Muhuhi

This dissertation is submitted in partial fulfilment of the requirements for the award of a Master in Development Studies from St. Paul's University.

May 2016

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DECLARATION

This dissertation is the product of my own work and is not the result of anything done in collaboration. It has not been previously presented to any other institution. I agree that this dissertation may be available for reference and photocopying at the discretion of the University

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Above all, I thank God for his faithfulness and strength his grace has been sufficient.

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ABSTRACT

The research was informed by personal experiences of university students who have conceived while on campus and the fact that they confessed never using any contraceptives. Hence, the researcher wondered why they never thought of using contraception yet they were sexually active and probably they knew chances of conception or getting sexually transmitted infections were very high. Was it because they did not have any contraceptive knowledge or they had the knowledge, but chose not to engage in protective sex. These many questions led the researcher wanting to find out why some university students would choose to indulge in a reckless and risky sexual behaviour. The study therefore sought to explore the attitudes and perceptions of contraceptives on protected sex among youth in institutions of higher learning in Machakos town. The study aimed at establishing contraceptive knowledge among the university students; finding out university students attitude towards contraceptives; establishing the sexual behaviour of the students in relation to protected sex and establishing the influence of contraceptives on protected sex among university students. In the final analysis, it was revealed that the students have a lot of contraceptive knowledge. The students have a negative attitude towards contraceptives and have many myths associated with contraceptives for example, contraceptives lead to barrenness. The students are sexually active; in addition, knowledge has not translated to protective sexual practice among them. Recommendations: The Universities have a responsibility of educating the students regarding contraceptives. This can be done through public lectures and seminars since the students have acknowledged being sexually active. There is need to encourage positive peer pressure by having younger counsellors in the family planning department and VCT centres. Having younger counsellors will help in dissemination of contraceptive information faster to their fellow youths. Hence the reason the students prefer VCT counsellors since they are young and they able to associate with them. The process of acquiring contraceptive information should not be so complicated, since issues of contraceptives are already embarrassing. The Government has a responsibility to educate the citizens regarding contraceptives; this will help in dealing with the stigma and myths associated with contraceptives. It will ensure that the public including students will get correct information.

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LIST OF ABBREVIATIONS

Abbreviations/Acronyms

W.H.O: World Health Organization

AIDS: Acquired Immune Deficiency Syndrome

CSR: Corporate Social Responsibility

STI's: Sexually Transmitted Infections

KNBS: Kenya National Bureau of Statistics

FGD: Focus Group Discussion

FP: Family Planning

IUD: Copper T Intrauterine Device

LNG IUD: Levonorgestrel Intrauterine System

EC: Emergency Contraception (Morning after Pill)

EP: Emergency Pills

KM: Kilometers

SCT: Social Cognitive Theory

TRA: Theory of Reasoned Action

TPB: Theory of Planned Behaviour

GRP: Group

Teens: Teenagers

SPU: St. Paul's University.

SEKU: South Eastern Kenya University

UON: University of Nairobi

MUC: Machakos University College

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CHAPTER ONE: INTRODUCTION

1.1 Background to the problem

Sexuality is a human component that defines the foundations of a society's life and it is a subject surrounded by cultural taboos, beliefs, attitudes and secrecy. Kioli (2013) observes that sexuality of young people has been a source of concern to people all over the world. The transition of people from childhood to adulthood is difficult in any culture, he further adds that traditional rituals of initiation prepared young people for their upcoming adult roles including education of responsibilities of sex, marriage and child bearing. Meekers (1994) observes that removal of sexuality from the control of the community resulted in individuals making decisions about when, where, with whom and for what purpose to have sexual intercourse. Kioli (2013) observes that ignorance has become the adolescent's jinx upon which their sexual behaviour can be described.

Ejembi & Otu, (2004) A majority of students on entry into the universities acquire independence from parental and secondary school restrictions. This increase in autonomy manifests in very permissive attitudes and increases sexual experimentation, replete with risky sexual practices. Due to their social positions, university students serve as role models to other youths and thus these negative tendencies may affect other youths. Adaji et al (2010) observes that adolescent's fertility and sexuality is a major public health issue in Kenya where adolescents constitute of 26% of the population. Sexual activity begins early with 42% of girls aged 15-19 having ever had sexual intercourse and 17% currently being sexually active. The age of first intercourse rose from 16.8 years in 1998 to 17.8 years in 2003. Marriage takes place later and in 1998 the difference between the age at first sex and first marriage was estimated to be three years. This gap between the median age of first sex and marriage was found to be widening in boys compared to girls.

Machakos town has several institutions of high learning namely one main University, which is Scott's Christian University; and Machakos University College, and four university campuses, which are St. Paul's University,

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University of Nairobi, African Nazarene University, and South Eastern Kenya University. Machakos town and the surrounding towns serve as a stopover town for long distance truck drivers, since it is a long Mombasa – Nairobi highway. Nyambane & Ndati (2014) did a study in *Mlolongo* (*Mlolongo* is a town along the busy Nairobi-Mombasa highway, where the weighbridge is situated making the town a sexual hub for truck drivers who spend days in the town as they wait for their trucks to be weighed. It is 43 kilometres to Machakos town), on the influence of television on the sexual behaviour of young women concluded that young women are more vulnerable to sexual exploitation and majority of the them become sexually active between ages 15 and 24 and others desire to experiment due to peer pressure. Meekers (1994) observes that, unmarried girls are also prone to use sexual relations and pregnancy to achieve certain goals.

Kiragu & Zabin (1995) observes that adolescent reproductive behaviour has been recognized as an important health, social and demographic concern in Kenya. In Kenya, adolescents are experiencing social turmoil resulting from conflicting values as the country becomes urban and industrial. Gage (1998) states that access to appropriate family planning is important to the health of women by preventing pregnancies that are too early or too late and extending the period between births. In light of the social consequences of early child bearing, unplanned pregnancy, and the transmission of AIDS, a great need exists to understand how the youth make sexual and reproductive decisions. The World Health Organization (2006) observes that sexual and reproductive health and well-being are essential if people are to have responsible, safe and satisfying sexual lives. Sexual health requires a positive approach to human sexuality and an understanding of the complexities that shape human sexual behaviour. These factors affect whether the expression of sexuality leads to sexual health and well-being or to sexual behaviour that put people at risk or make them vulnerable to sexual and reproductive ill health.

Gage (1998) observes that in order to understand how adolescents make decisions if or not they will engage in sexual activity, their perceptions of negative consequences, as well as the potential benefits of such activity must be considered. The decisions to engage in sex are not driven solely by fear of

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negative consequences; in many instances, adolescents in developing countries may have positive motivation for these behaviours. For girls, in particular the needs for affection and strong emotional relationships are important motivation for initiating sexual activity. Henslin (2004) observes that culture is the lens through which we perceive and evaluate what is going on around us and we usually obtain perception of reality. It provides real instructions, which tell us what we ought to do in various situations, and provides fundamental basis for our decision-making.

Ajayi et al, (1991) observe that lack of information and access are the two principal reasons for non-use of contraceptives given by the adolescents and most research overlooks the fact that most adolescents are sexually active. Wadi et al, (2012) observe that a study done in South Africa concluded that, the high rate of unintended pregnancies among the youth, remains a public health concern as the young people are still engaging in un protected sex. Knowing about family planning and accessing it are the crux of safe, responsible sexual behaviour. They should have the effect of decreasing unintended pregnancies, since contraceptives help women manage their reproductive health.

The research was informed by personal experiences of university students who are close friends who have conceived while in campus and the fact that they have confessed to never using any contraceptives. Hence, the researcher wondered why they never thought of using any form of contraception yet they knew they were sexually active and most probably they knew chances of conception or getting sexually, transmitted infections were very high. Was it because they did not have any contraceptive knowledge or they had the knowledge but made a choice not to engage in protective sex? These many questions led the researcher to want to find out why some university students would choose to indulge in reckless and risky sexual behavior.

1.2. Statement of the Problem

Oindo (2002) in a study done in Kisumu, revealed that majority of the youth are sexually experienced (73.5%) with most of the first sexual experiences

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occurring within the 15-19 years age group. There is a high level of knowledge (99.2%) of contraceptive methods and a positive attitude towards contraception. However, the level of contraceptive use is relatively lower (57.5%) even for the sexually active. Factors influencing this practice are associated with the individual's background as well as health delivery systems and policies. There is a wide disparity between contraceptive knowledge and practice, which needs to be, bridged. The study therefore seeks to explore the attitudes and perceptions on protected sex among youth in institutions of higher learning in Machakos town.

1.3 Aim of the study

The aim of the study is to look at the attitudes and perceptions on protected sex among youth in institutions of higher learning in Machakos town. With an intention of adding to knowledge and developing policy on how the universities and other institutions can address issues of sexuality among the youth.

1.4 Research Objectives

(i) To establish contraceptive knowledge among the university students.

(ii) To find out the university students' attitude towards contraceptives.

(iii) To establish the sexual behaviour of the university students in relation to protected sex.

(iv) To establish the influence of contraceptives on protected sex among university students.

1.5. Research Questions

(i) What contraceptive knowledge do university students have?

(ii) What is the attitude of university students towards contraceptives?

(iii) What is the sexual behaviour of the students in relation to protected sex?

(iv) How do contraceptives influence the protective sex practice?

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1.6. Justification of the Study

The findings of the study will help the Universities, other institutions know how to address the issues of sexuality among the youth, and they can start appreciating the benefits of family planning. The knowledge will be a revelation for the church to appreciate the struggles the youths go through and will help them have programs that can help the youths deal with sexuality issues.

1.7 Delimitation of the study

The study was limited to the Institutions of higher learning in Machakos town. Namely one main University, which is Scott's Christian University; Machakos University College (MUC), and four university campuses, which are St. Paul's University (SPU); University of Nairobi (UON); African Nazarene University (ANU); and South Eastern Kenya University (SEKU), these were the only universities in Machakos town when the research was being undertaken.

Ethical Considerations

Due to the sensitivity of the research, the researcher assured the respondents that what they wrote or discussed during focus group discussion would remain confidential and anonymous. The researcher encouraged them to know that the questionnaires did not require the respondents to provide their names, personal identification numbers, or their national identification numbers.

Limitation

The students may decide to go home with the questionnaire. Thus, the researcher used the research assistants to do a follow up.

1.8 Important terms and concepts

Young people - World Health Organization (WHO) designates three different categories of "Youth adolescents (10-19 years old), youth (15-24 years old), and young people (10-24 years old)." Whereas the UN program on youth defines youth as "those age 15-24". (World youth report 2005. www.un.org). The Constitution of Kenya defines youth as "the collectivity of all individuals in the republic who have attained the age of eighteen years; but have not attained the

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age of thirty-five years".(Interpretation 260). Hence, the reason the youth in this research will be youths between eighteen to thirty five age bracket and who are undergraduate students in the six institutions of high learning in Machakos town.

Contraceptive – they prevent the spread of sexually transmitted infections and unwanted pregnancies. There are five methods of contraceptives which include Intrauterine methods; hormonal methods; barrier methods; fertility awareness methods; permanent methods of birth control (www.cdc.gov 14/11/2014).

Protected Sex – also known as 'safe sex' this is the sexual contact that does not involve the exchange of semen, vaginal fluids or blood between partners. If used correctly, condoms will dramatically reduce the risk of most sexually transmissible infections (STIs) and unintended pregnancy (www.betterhealth.vic.gov – 23/05/2015).

Institutions of higher learning – An establishment where the students go to further their education after they have finished their ordinary level of education (O' Levels) and have attained the required pass mark to get an admission in the organization.

Sexual Health – "is a state of physical, emotional, mental and social well-being in relation to Sexuality, it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO, 2006).

Sexuality – WHO observe that sexuality is central to being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships" (WHO, 2006).

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Adolescence – The period of human development, that occurs between the beginning of puberty and adulthood. It is a stage in human development between childhood and maturity/adulthood or a stage in life between late childhood and early adulthood (Wanyoike, 2003).

Puberty – is the period at the beginning of adolescence when the sex organs become functional or is a stage where a person's sexual organs are maturing and he or she becomes capable of having children (Wanyoike, 2003).

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CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The main aim of the study was to find out the attitudes and perceptions on protected sex among youths in institutions of higher learning in Machakos town. Specifically, the study aimed at establishing contraceptive knowledge among the university students; finding out university students attitude towards contraceptives; establishing the sexual behaviour of the students in relation to protected sex and establishing the influence of contraceptives on protected sex among university students.

Baumeister, (2001) observes that one of the great events of the 20th century was the liberalization of sexual attitudes and behaviours and it was commonly called sexual revolution. He observes that the sexual revolution happened because of a major social event that is likely to have had multiple causes. Undoubtedly, one important factor was the invention of the birth control pill which gave women unprecedented advantage in convenience and reliability of contraception. He further states that many scientists remain sceptical of sexuality research for a variety of reasons. The federal granting agencies' remain reluctant to support research into sexuality even though many major national problems are associated with sexuality, including teen pregnancy and unwanted pregnancy, AIDS and other venereal diseases and sexual victimization and coercion.

The Kenya National Bureau of Statistics (2008) on the total fertility rate in Machakos, the contribution of the adolescence age group, which is 15-19 years to total fertility, states that it is 11 per cent. This shows a high prevalence of teenage motherhood in the district. Kimani et al, (2012) states that even after high school students have been introduced and taught of HIV/AIDS education, majority of the students still engage in un-protected sex and drug abuse and this makes students vulnerable to HIV/Aids transmission. This chapter explores what other scholars have said about youth having unprotected sex, how much

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contraceptive knowledge is available to the youth, accessibility and use of contraceptive and finally the attitude of the youth regarding contraceptives. The chapter will start by introducing the methods of contraceptives that are in the market.

2.2 Methods of Contraceptives

According to Center for disease, control and prevention there are five methods of namely intrauterine methods, hormonal methods, barrier methods, fertility Awareness-based methods and permanent methods of birth control. Among each are the different types listed below:

2.2.1 Intrauterine Contraception

Copper T intrauterine device (IUD): This IUD is a small device that is shaped in the form of a "T." It is placed inside the uterus to prevent pregnancy. It can stay in the uterus for up to 10 years; Levonorgestrel intrauterine system (LNG IUD): The LNG IUD is a small T-shaped device like the Copper T IUD. It is placed inside the uterus by a doctor. It releases a small amount of progestin each day to keep a woman from getting pregnant. The LNG IUD stays in the uterus for up to 5 years (www.cdc.gov – 14/11/2014).

2.2.2 Hormonal Methods

Implant: The implant is a single, thin rod that is inserted under the skin of a women's upper arm. The rod contains a progestin that is released into the body over 3 years. Injection or shots: Women get shots of the hormone progestin in the buttocks or arm every three months from their doctor; Birth control pills combined oral contraceptives: it also called "the pill," combined oral contraceptives contains the hormones estrogen and progestin. A doctor prescribes it. A pill is taken at the same time each day. It is not recommended for women older than 35 years and those that smoke and have a history of blood clots or breast cancer; Progestin only pill: the progestin-only pill (sometimes called the mini-pill) only has one hormone, progestin, instead of both estrogen and progestin. It is taken at the same time each day. A doctor prescribes it and it

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may be a good option for women who cannot take estrogen. The Patch: the skin patch is worn on the lower abdomen, buttocks, or upper body (but not on the breasts). It releases hormones progestin and estrogen into the bloodstream. A new patch is put on once a week for three weeks. During the fourth week, the woman does not wear a patch, so that they can have their menstrual period. Hormonal vaginal contraceptive ring: the ring releases the hormones progestin and estrogen. The ring is placed inside the vagina. One wears the ring for three weeks; then taken out for the week one has their periods, and then put in a new ring. Emergency contraception: Emergency contraception is NOT a regular method of birth control. Emergency contraception can be used after no birth control was used during sex, or if the birth control method failed, such as if a condom broke (www.cdc.gov – 14/11/2014).

2.2.3 Barrier Methods

Diaphragm or cervical cap: each of these barrier methods are placed inside the vagina to cover the cervix to block sperm. The diaphragm is shaped like a shallow cup. The cervical cap is a thimble-shaped cup. Before sexual intercourse, one inserts them with spermicidal to block or kill sperm. One has to visit the doctor for a proper fitting because diaphragms and cervical caps come in different sizes. Male condom: Worn by the man, a male condom keeps sperm from getting into a woman's body. Latex condoms, the most common type, help prevent pregnancy, and HIV and other STDs, as do the newer synthetic condoms. Female condom: worn by the woman, the female condom helps keeps sperm from getting into her body. It is packaged with a lubricant and is available at drug stores. It can be inserted up to eight hours before sexual intercourse. Spermicidal: These products work by killing sperm and come in several forms—foam, gel, cream, or tablet. They are placed in the vagina no more than one hour before intercourse. You leave them in place at least six to eight hours after intercourse. You can use a spermicidal in addition to a male condom, diaphragm, or cervical cap (www.cdc.gov – 14/11/2014).

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2.2.4 Fertility Awareness-Based Methods

Natural family planning or fertility awareness: Understanding the monthly fertility pattern, the fertility pattern is the number of days in the month when one is fertile (able to get pregnant), days when one is infertile, and days when fertility is unlikely, but possible. If one has a regular menstrual cycle, they have about nine or more fertile days each month. If one does not want to get pregnant, they do not have sex on the days they are fertile, or use a barrier method of birth control on those days (www.cdc.gov – 14/11/2014).

2.2.5 Permanent Methods of Birth Control

Female Sterilization: Tubal ligation or tying tubes a woman can have her fallopian tubes tied (or closed) so that sperm and eggs cannot meet for fertilization. The is an outpatient procedure done in a hospital and someone goes home the same day of the surgery and resumes their normal activities within a few days. Tran's cervical sterilization: a thin tube is used to thread a tiny device into each fallopian tube. It irritates the fallopian tubes and causes scar tissue to grow and permanently plug the tubes. It can take about three months for the scar tissue to grow, so a woman needs to continue using another form of birth control during this time. It is recommended that one returns to their doctor for a test to see if scar tissue has fully blocked the fallopian tubes. Male Sterilization– Vasectomy: this operation is done to keep a man's sperm from going to his penis, so his ejaculate never has any sperm in it that can fertilize an egg. The procedure is done at an outpatient surgical center. The man can go home the same day. Recovery time is less than one week. After the operation, a man visits his doctor for tests to count his sperm and to make sure the sperm count has dropped to zero; this takes about 12 weeks. Another form of birth control should be used until the man's sperm count has dropped to zero (www.cdc.gov – 14/11/2014).

Although there are very many methods of contraceptives as discussed above, the students' knowledge regarding all the methods was very limited. For example, hormonal methods, the pill and the emergency pill were the most common. Barrier methods the male condom was widely known and widely used. Fertility

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awareness methods although they knew about it, it was never discussed which could imply that they do not use it. For the permanent method they had the knowledge of vasectomy for the male and tubaligation for the female.

2.3 Contraceptive Knowledge

Baumeister, (2001) observes that although biological, clinical and technical aspects of sex are important it is also helpful, to examine sex as a social phenomenon; as a group of behaviour patterns that people engage in together under the influence of social pressure and indeed as ways that people relate to one another. In particular, it is subject to many of the main principles that regulate other forms of sexual behaviour. Put down your sexuality textbook and look instead at a textbook in social psychology and you can quickly see that many of the chapters in that book- attitudes, relationships, self-aggression, influence, prejudice decision making are potentially quite relevant to sex.

Kanku, (2010) citing reasons youth give for not using contraception include, ignorance, fears of parents finding out, shyness in going to the clinic and disapproval amongst older siblings have also been thought to influence the risk for younger teenagers. Health workers have been accused of turning away young teenagers from family planning clinics and accusing them of being too young for sex. At the clinic, teenagers are offered little choice of contraceptives method and given poor explanations of the side effects and mechanism of action, which contributes to a low uptake of contraceptives despite it being free.

Ejembi & Otu, (2004) The youth engage in these risky sexual practices with poor knowledge of the consequences and therefore, hardly take any precautions to protect themselves against the adverse consequences of unprotected sex. The consequences of such practices among the youth are disproportionately higher prevalence rates of HIV/AIDS, unwanted pregnancies and abortions and sexually transmitted diseases.

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Kanku, (2010) observes that high level of school education and family connectedness, a stable relationship with a partner and religious beliefs have been associated with protection from teenage pregnancy. Family planning and sexual knowledge, acquired from parents, health workers, teachers, priests or mass media can help to reduce the number of teenage pregnancies. Other interventions are based on abstinence, delayed sexual initiation and training in decision making or sexual negotiations skills.

Ejembi & Otu, (2004) Universities provide the highest level of education in the country. Their role in national development through the generation of knowledge and provision of skilled labour for both the public and private sectors is crucial. Unfortunately, discourses on tertiary institutions tend to focus on their contributions to knowledge generation and development, with little attention to the health and welfare of the students. In spite of the acknowledged prevalent risky sexual practices among students, their sexual and reproductive health needs hardly receive any attention. Access to reproductive health services to students on campus is limited because of structural problems and in many cases, the services do not adequately address the sexual and reproductive health needs and perspective of young people.

According to Barker & Rich, (1992) in Kenya, efforts to reach young people with accurate family planning information have been stalled or are small in scale. Policy issues further complicate the situation. In 1989, the Kenyan government declared that contraceptives were not be made available to unmarried youth. In effect other than promoting limited sex education, the declaration paralyzed governmental and nongovernmental actions dealing with the problems of unwanted pregnancy among youth.

Adaji et al, (2010) observed that Kenyan in-school adolescents portray strong conservative values, which could hide their true sexual behaviour, thereby increasing their vulnerability to reproductive ill health. Adebenro, (2006) states that schools have been found to be the important sites where young people can acquire knowledge and skills that equip them for responsible lifestyles now and

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in the future and to implement such a programme. The teachers are the school personnel that can be empowered with the responsibility of formally executing it in the classroom system. However, the teachers themselves have been found to be uncomfortable when discussing openly issues relating to human reproductive health.

Barker and Rich, (1990) observes that in Kenya, early pregnancy in urban areas and often in rural areas is characterized by out of wedlock births, forced school expulsion and a high rate of unsafe, septic abortion. Cherlin and Riley (1986) observes that, higher school enrolment and rising ages at marriage are pre-cursor to higher ages at first birth and increasing family planning use. In Kenya, however these factors, combined with a lack of access to and low use of family planning, have led to a high number of unintended pregnancies and in turn, this combination of factors has engendered a reliance on abortion.

Okanlawon et al, (2010) observes that a study done on refugee youth showed that they are vulnerable persons who have a need for contraception yet face challenges that limit its use. Findings revealed that respondents experience difficulty-gaining access to family planning services, which are not available in the camp. Most respondents had little correct information about contraceptives; and some had misperceptions about its safety, believing that contraceptives are dangerous and that chemical in contraceptives can damage their reproductive system. Such beliefs had resulted in low use of contraceptives and many unintended pregnancies, which have caused some refugee girls to drop out of school. Many young people in refugee situations face serious reproductive health challenges that put their lives and their health at risk.

2.4 Attitude towards Contraceptive

Ejembi & Otu, (2004) observe that the change in adolescent's lifestyle caused by globalization of communication, glamorization of sex in the media and breakdown of traditional systems of sexual control are additional major challenges confronting the youths. These have led to declining age at sexual

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debut increasing sexual activity characterized by unstable short-term unions and multiple sexual partners.

Adaji et al, (2010) states that sexual autonomy for women and girls, especially as it applies to pre-marital sex, prevention and termination of unwanted pregnancies remains a highly contentious issue in Kenya. As the population of adolescents in Kenya increases the debates about adolescent's sexuality, schoolgirl's pregnancy and its consequences become fiercer in the medical and lay press. This is because of concerns that sex education and distribution of contraceptives of adolescents and their voices on these issues remain largely unheard. It is imperative to understand attitudes of Kenyan adolescents towards premarital sex and unwanted pregnancies. In order to design appropriate sexual and reproductive health interventions for adolescents.

2.5 Reasons for engaging in unprotected sex

Evens, et al, (2014) observe that unsafe abortion accounts for 35% of maternal mortality in Kenya. Post-abortion care (PAC) reduces maternal death and provides an opportunity to prevent unwanted pregnancies. 49% of the youth between ages of 15 and 24, reported not using a family planning method due to fears of infertility, side effects or lack of knowledge. They observe that additional efforts are needed in Kenya to bolster the family planning services that young PAC clients receive and increase the uptake of contraception.

Kanku, (2010) states that teenage pregnancy is a socio economic challenge, an important public health problem and it is a risk factor for sexually transmitted infections (STIs) including HIV and is a reflection of inconsistent use of contraception. In addition, the risk of dropping out of school is considerable, which results in a lack of qualification and future unemployment. Teenage pregnancy has an increased risk of pre-term birth and teenage mothers have a worse mental health state compared to their peers. Teenagers who fall pregnant are most likely to live with their single unemployed parent or guardian and become an additional economic burden on the family.

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Abasiattai et al, (2007) states that over 80% of adolescents and young people aged 15-24 years do not use any form of contraception. Abortion is the leading cause of maternal mortality in Nigeria accounting for 40% of all maternal deaths. Kanku, (2010) observe that teenage pregnancies has been associated with frequent sex without reliable contraception; sexual coercion; poor sexual communication between partners; the perception that most of your friends have been pregnant, that one has to prove one's fertility; poverty and promiscuity; liberal attitudes towards casual sex alcohol consumption; fear of hormonal contraceptives. Poor school based sexual education have also been associated with teenage pregnancies.

Abasiattai, et al, (2007) states that a community based study of abortion prevalence in Nigeria showed that more than one-third of women who had induced abortions were adolescents as were 80% of the patients with abortion related complications. In comparison with adults, youths are more likely to delay abortions, resort to unskilled persons to perform them, use dangerous methods, and present themselves late to the hospital when complications occur. In addition, this is significant in Nigeria where abortion is illegal under the law unless the woman's life is threatened by the pregnancy hence most abortions are typically performed, often by unskilled providers, under unsanitary and dangerous conditions

Adaji, et al, (2010) observe that despite pre-marital sex and multiple sexual partners among Kenyan adolescents, the use of contraceptives including condoms is low. Studies have shown that even though adolescent's boys may have knowledge about condom use and the protection it offers against unwanted pregnancies and STIs including HIV/AIDS male norms favouring sexual experience without condoms often prevent them from using condoms correctly and consistently.

Abasiattai, et al, (2007) states that a study done in Nigeria shows that unwanted pregnancy particularly in most adolescents and youth is a major public and social issue in the developing world. Over 80% of pregnancies in unmarried

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youth are reported to be unintended. Several studies in Nigeria have also shown increased adolescents sexual activity and decreasing age at first coitus. These Nigeria youths are now initiating sexual activity earlier and are increasingly having pre-marital sex. These coupled with their low knowledge and utilization of modern methods of contraception exposes them to the risk of unplanned pregnancies and subsequently unsafe abortions.

Adaji, et al, (2010) observe that in 2001, a study in Kisumu showed that, by 14.5 years of age a quarter of boys and girls had already experienced sex; while at 17 years, half of both sexes would already have had sex. The widened gap between the age of sexual debut and the age at first marriage means that many young people in Kenya may be exposed to a prolonged period of premarital sex. Furthermore, many young people have sex with multiple partners. One study from Kenya showed that boys were seven times more likely than girls to have multiple sex partners.

Adebenro, (2006) observe that adolescents in Nigeria as in other countries of the world are faced with many reproductive health problems some of these problems are high rate of risky sexual activities, unwanted pregnancies (unintended) pregnancy (abortion, STIs, HIV/AIDS and school dropout). Some factors which were implicated as being responsible for these reproductive health problems are erosion of traditional moral values, negative peer group influence, love of money, women's economic dependence on men, desire to be loved, effect of western cultures such as pornographic materials/films that present sexual intercourse as being glamorous and finally poor knowledge of reproductive health education/sexuality education.

2.6 Accessibility of contraceptives among the youth

Wadi, et al, (2012) states that a study done in South Africa indicated that, the high rate of unintended pregnancies among the youth, remains a public health concern as they indicate that young people are still engaging in un protected sex. Knowing about family planning and accessing it are the crux of safe, responsible sexual behaviour. They should have the effect of decreasing unintended and/or

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unwanted pregnancies, since contraceptives help women manage their reproductive health.

Okanlawon et al, (2010) states that a study done in refugee camps observed that youth are vulnerable persons who have a need for contraception yet face challenges that limit its use. Findings revealed that respondents experience difficulty-gaining access to family planning services, which are not available in the camp. Most respondents had little correct information about contraceptives; 42.9 per cent had misperceptions about its safety, believing that contraceptives are dangerous and that chemical in contraceptives can damage their reproductive system. Such beliefs had resulted in low use of contraceptives and many unintended pregnancies, which have caused some refugee girls to drop out of school. Many young people in refugee situations face serious reproductive health challenges that put their lives and their health at risk. Adaji, et al, (2010) observes that societal norms limit young women's access to and use of contraceptives paradoxically, such norms emphasize sexual submissiveness and weaken young women's ability to negotiate the use of contraceptives as a result unwanted pregnancies and abortions are reported to be prevalent among Kenyan school girls.

Okanlawon et al, (2010) states that family planning has numerous health benefits for young refugee women because it is a first line of defence in protecting against maternal ill health in conflict affected settings, where resources are often scarce and adequate access to health care may not be available. Despite the benefits of family planning for the reproductive health of refugees including youths, contraceptive use has been found to be limited among many displaced persons around the world some of whom have difficulties in gaining access to reproductive health care services.

Although development experts increasingly recognize that ensuring universal access to contraception is a key component of sexual and reproductive health,

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some studies have highlighted factors that constitute barrier to the use of contraception among refugees. Among these factors are knowledge of contraceptives, access to contraception and beliefs, perceptions and attitudes of refugees toward contraceptive use. These studies have shown on one hand the existence of a high degree of unmet need for family planning in different refugee situations and on the other misconstrued information and false beliefs that constitute obstacles to the use of contraception among some refugees (Okanlawon, et al, 2010:17).

2.7 Sexual Behaviour of students in relation to protected sex

Wanyonyi, (2014) observes that past researchers in Kenya indicate high cases of sexual activity and mobility among the youths. This behaviour is manifested in the youths high incidences of pregnancies, stress and sexually transmitted infections including HIV.

Manlove, et al, (2004) state that teens who engaged in more intimate activities with their partners had greater odds of ever and always using contraceptives with that partner. Both greater intimacy and greater partner homogamy indicate a higher level of familiarity or potential comfort with partner at the time of first sex which may be linked to a better ability to effectively communicate and negotiate contraceptives use needs. Teens with experience practicing how to say no to unprotected sex and negotiating contraceptive use with their partners may be in a good position or well prepared to avoid unintended pregnancy.

Kiragu & Zabin, (1995) observe that, the negative association among women between contraceptive use and number of birth control methods maybe as a result of fears about side effects rumoured to be associated with contraceptives. Young women may know of many methods but may have heard only negative rumours about them. The data indicate that the main deterrent to contraceptives use among the young women was the belief that birth control methods are dangerous. The ability to name many methods does not necessarily imply correct knowledge about them. Therefore, it is possible that contraceptive knowledge is not a determinant of contraceptive use.

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Meekers, (1994) observes that, education authorities are often hesitant to introduce sex education into the curriculum because of fear of parental resistance, while parents often feel that the education system, should take over the responsibility of preparing adolescents for adult life. The demographic and health survey data show clearly that adolescent sexual activity and premarital sexual activity are a fact of life in most African countries as in many Western societies. In such a situation, it is necessary to educate young people about the responsibilities associated with sexual activity and its potential consequences.

Kiragu & Zabin, (1995) observe that, young people are not taught about contraceptives in Kenya, for the fear that this will encourage permissiveness and promiscuity. This policy leaves young people in an information vacuum. The authors observe that studies have shown that sex education does not increase sexual activity and can in fact lead to postponement of sexual initiation and to protective behaviour once sexual activity begins. Carefully constructed education programs that address the needs of young people, gain their trust, correct their many misconceptions and fears would be more successful than the present silence.

Evens, et al, (2007) observe that for young women, family planning counselling, focusing on the provision of information on family planning methods, issues related to correct and consistent use and efforts to dispel myths on how family planning use affect fertility, seems to be particularly important. Community education events could be an additional means of addressing discrepancies between youth and adult knowledge on family planning.

Manlove, et al, (2007) observe that a higher level of intimacy between sexual partners may also be associated with greater contraceptive use and consistency, perhaps because of the greater predictability of having sex. For example, one study found out that higher levels of intimate activities between sexual partners and connections to social networks are associated with grater contraceptive use and consistency among male teens.

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Behrman et al, (2002) observes that individuals make decisions not in social isolation, but in interaction with one another. Social scientists have recently begun to modify accounts of social change that focus on individual actors by taking communities, neighbourhoods, and network into account. The unobserved factors that may directly affect attitudes and behaviour may also directly affect choices of the units of social integration.

Manlove et al, (2004) observe that, contraceptive use patterns vary across the relationships, age at first sex with a partner and the romantic relationships type showed an opposite association with ever using contraception compared with always using contraception. Older teens and those in a romantic relationship at the time of sexual initiation with a partner may be more comfortable negotiating contraception with the partner. The positive association between partner homogamy and contraceptive consistency suggests that teen females who do not know their partner through their usual social networks, who have a partner of a different race/ethnicity or who have an older sexual partner may be less able to negotiate consistent contraceptive use.

2.8 Contraception influence to protective Sexual practice

Wanyonyi, (2014) observes that, the youth are aware of contraception as a way to prevent unwanted pregnancies. They are aware of condom use as a way to prevent sexually transmitted diseases including HIV and AIDS. However, the percentage of contraceptive use is lower as compared to the percentage of the sexually active youth. This indicates that not every sexually active youth is using contraceptives although they are ware of such contraceptives. This implies that knowledge does not always constitute practice since youth contraceptive knowledge is not a determinant to contraceptive practice.

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Manlove, et al, (2007) observe that teen's contraceptive use patterns vary across relationships and who communicated about contraception before sex has greater odds of contraceptive use and /or consistency. Teens in romantic relationships and who are older when engaging in sex for the first time have greater odds of ever using contraceptives. Teens with experience practising contraceptive consistency and females who previously have used hormonal contraceptives methods are better able to maintain consistency in subsequent relationships.

Kiragu & Zabin, (1995) observe that low level of contraceptive use probably reflect the spontaneity of teen's sexual activity and lack of knowledge as well as the many barriers young people face when they attempt to obtain contraceptives protection. To use birth control in Kenya, an adolescent must raise the issue with a possibly suspicious or resistant partner, regularly obtain funds for supplies, overcome fears about rumoured side effects that is not accommodating to adolescents clients. Use of natural family planning avoids some of these difficulties but require meticulous charting and comprehension of the female menstrual cycle that few young people possess. It is not surprising, then that few adolescents use contraceptives and that many rely on friends for information and supplies.

Further Kiragu & Zabin (1995) observe that, the practice of discouraging young people from obtaining professional birth control education and services places them at an increased risk of pregnancy and sexually transmitted diseases including HIV and AIDS.

Demissie & Tolossa (2014) say that in Ethiopia, contraceptive methods are accessible from both public and private providers and are accessible free of cost to most of the population in urban and rural areas. However, contraceptive use in the country is low. They observe that programmes and services for HIV and AIDS need to address the sexual and reproductive health services including proper family planning counselling and availing various effective contraceptive methods.

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Baumeister, (2001) observes that, sexuality is largely something that is learned and shaped by culture, socialization and situational influences. What people do sexually and even what they desire is regarded as something that is heavily dependent on the social context. This emphasizes differences between different cultures or different historical eras to argue that culture exerts a strong influence on sex.

2.8 Summary of literature review

From the afore-mentioned it is evident that various studies have been carried out in the field of contraceptives and the sexual behaviour of the students. However most of the studies have focused on the reasons the youth do not use contraceptives and why the youths are engaging in risky sexual behaviour. A study carried out by Ejembi and Out (2010) looked at sexual behaviour, contraceptives practice reproductive health among Nigerian University students but did not look at the attitudes and perceptions of university students. Hence the need for the study among university students in Kenya. Kiragu and Zabin (1995) looked at contraceptive use among high school students in Kenya. Hence the need to study about contraceptive knowledge among the university student and specifically the University students that are in Machakos town.

It is important to do the study so that the findings could be used to explain the university students knowledge about contraceptives, the attitudes, perceptions and sexual behaviour in relation to protected sex.

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2.7 Theories' related to the study

2.7.1 Social Cognitive Theory

The Social Cognitive Theory by Albert Bandura (1977) focuses on understanding the risks and benefits of changing one's behaviour, developing self-efficacy, and addressing outcome expectations of the changed behaviour. The central beliefs of the social cognitive theories are: self-efficacy – the belief in the ability to implement the necessary behaviour ("I know I can insist on condom use with my partner").

Outcome expectancies – belief about outcomes such as the belief that using condoms correctly will prevent HIV infection. UNAIDS, (1999) programmes built on Social Cognitive Theory integrate information and attitudinal change to enhance motivation and reinforcement of risk reduction skills and self-efficacy.

According to this theory, it means when someone recognizes the risk involved when they chose to continue in certain behaviour, they are expected to change and embrace good behaviour since they have come to understand the benefits that would come when they change. Supporters of this theory have confidence that when human beings understand the risks of a particular behaviour and the benefit they get from change of behaviour hence it leads to change in behaviour.

2.7.2 Theory of Reasoned Action

The theory of reasoned action advanced by Fishbein & Ajzen, (1980) is based on the assumption that human beings are usually quite rational and make systematic use of the information available to them. People consider the implications of their actions in a given context at a given time before they decide to engage or not to engage in a given behaviour and most actions of social relevance are under volitional control. The theory of reasoned action specifically focuses on the role of personal intention in determining whether behaviour will occur. A person's intention is a function of two basic

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determinants: Attitude (toward the behaviour) and Subjective norm that is social influence.

Normative beliefs play a central role in the theory and generally focus on what an individual believes other people, especially influential people, would expect him/her to do. For example, for a person to start using condoms, his/her attitude might be "having sex with condoms is just as good as having sex without condoms" and subjective norms (or the normative belief) could be "most of my peers are using condoms. They could expect me to do so as well.

The theory is relevant to this study in that it addresses the issue of human beings attitudes and the social influence that face them. This theory focuses on personal intention in determining if good or bad behaviour will occur. The theory compliments the social cognitive theory in that, for a human being to recognize the risks involved in certain behaviour and to make the decision of change, an individual has to have rationally addressed their intentions of why it is important to change and even appreciate the change.

2.7.3 Theory of Planned Behaviour

According to the theory of planned behaviour advanced by Fishbein & Ajzen, (2010) human behaviour is guided by three kinds of considerations. Beliefs about likely consequences of the behaviour (behavioural beliefs). Beliefs about the normative expectations of others (normative beliefs) and beliefs about the presence of factors that may facilitate or impede performance of the behaviour (control beliefs).

This theory is very relevant to this research because it explains human beings behaviour and what compels them to make decisions regarding behaviour change. This theory enriches the previous two theories discussed, in that for human beings to make a rational and informed decisions to change from a risky behaviour because of the benefits of change, it is usually influenced by the

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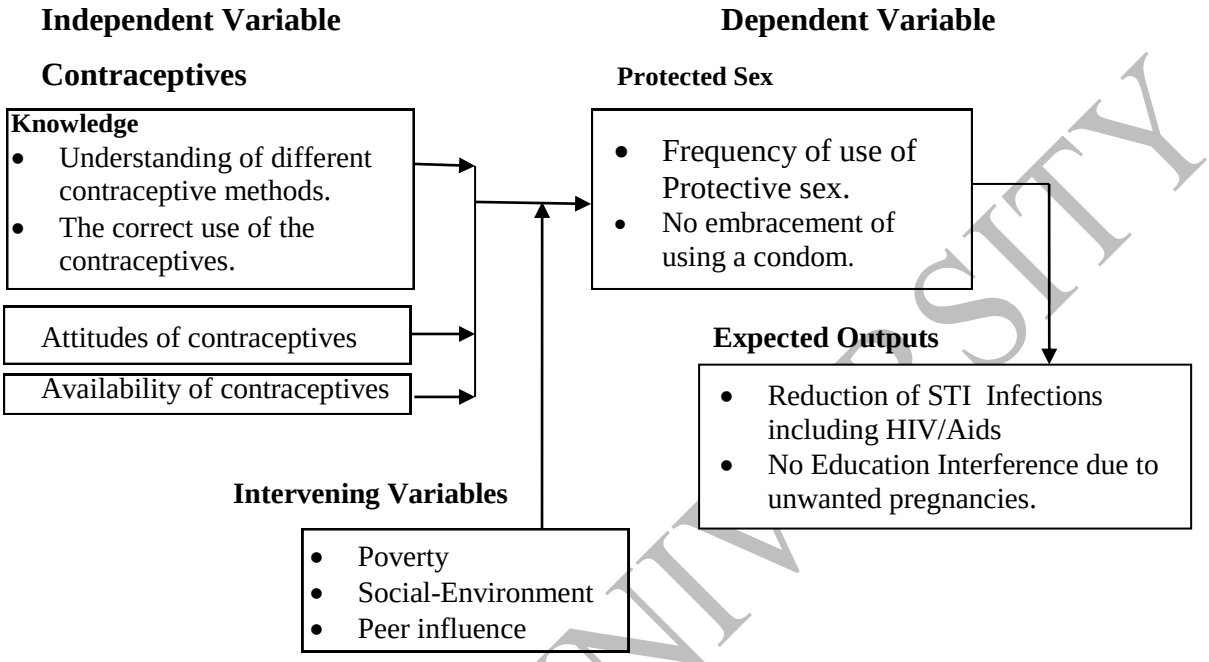
recognition of the consequences that an individual will encounter if they do not change and also because of societal expectation for an individual. The fact that they do not want to disappoint the people around them they choose to change their behaviour.

Supporters of this theory have confidence that change in human beings behaviour can occur because of the expectations that the society can have on an individual. The individual can change because of the realization that the consequences of certain behaviour may be very severe and hence based on that, the individual makes a rational decision to change his/her behaviour.

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2.8 Conceptual Framework

In this thesis, the variables are shown in the diagram below.



Expected Relations: If the students get the correct knowledge of contraceptives and they have the right attitudes towards contraceptive then they will choose to use protection whenever they have sex. This then will see the reduction of STI's infections including HIV/Aids among the students and no interruption of education due to unintended pregnancies.

With the correct knowledge and empowerment, they will also be able to withstand peer pressure because they will be able to make informed choices of using protection or abstaining from having sex.

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CHAPTER THREE: METHODOLOGY

3.1 Introduction

The main aim of the study was to find out the attitudes and perceptions on protected sex among youths in institutions of higher learning in Machakos town. Specifically, the study aimed at establishing contraceptive knowledge among the university students; finding out university students attitude towards contraceptives; establishing the sexual behavior of the students in relation to protected sex and establishing the influence of contraceptives on protected sex among university students.

The section describes the approaches, used in the study towards fulfilling the set objectives of the study detailed above. The section details the types of data used in the study as well as the sources. The chapter additionally details out the data collection techniques and data analysis.

3.2 Research Design

Yin, (2003) states that a research design is the logic that links the data to be collected and conclusions to be drawn to the initial questions of study. The study will adopt a multi-method study design combining the use of both qualitative and quantitative data research design. Berg & Lune, (2012) states that that qualitative research refers to the meanings, concepts, definitions, characteristics, metaphors, symbols and descriptions of things. Mugenda & Mugenda (2003) states that human behavior is also explained best by using qualitative research.

3.3 Study Area

The research was carried out, among the six institutions of higher learning in Machakos town and the focus was on the undergraduate students from the selected universities. Machakos town has several institutions of high learning namely one main University, which is Scott's Christian University and Machakos University College, and four university campuses, which are St. Paul's University, University of Nairobi, African Nazarene University, and

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South Eastern Kenya University. By the time the research was done these were the only institutions of higher learning in Machakos town.

3.4 Study population

The study, population was 2,326 students in the six different institutions of higher education, five voluntary counseling and testing workers in the three main general hospitals (which comprise of two private hospitals and one public hospital). Liverpool VCT center since they were more involved in VCT services in Machakos and frequently set up their testing tents regularly in Machakos town and people are more familiar with them; six student counselors in the institutions of high learning in Machakos.

3.5 Sampling Size and Procedures

According to Peter, (1994) a sample is a representative part of a population; thus by studying the sample, we can know about that population without having to study the entire population. Mugenda and Mugenda, (2003) states that a sample is a smaller group obtained from the accessible population and each member or case in the sample is referred to as a subject and sometimes as respondent or interviewees. The stratification sampling was done, where the six institutions were divided into three groups depending on the number of student. The university with student population of over four hundred students formed a group and the smaller populations were merged to form another group. Then as Gay suggests in (Mugenda and Mugenda, 2003) the sample should consist of 10% of the accessible population thus the sample size adopted in this study was 240 both students, VCT workers and the counselors. Then simple random sampling was used to select respondents since it enabled the sample to be representative of the population and this was done with the student's admission numbers. In the institutions with very small numbers the researcher interviewed more respondents. For the VCT workers the researcher interviewed one VCT worker in the institution. The researcher choose work with the student counselors, since they work closely with the students and are familiar with their affairs. In this

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study attention was paid to ensure that the focus group discussion were representative of different gender and age.

3.5.1Table 1.1 Study population table

Respondents	Universities	Population	Percentages	Sample Size
Group 1	Machakos University College	1,500	10%	**150**
Group 2	St. Paul's university	420	10%	**42**
Group 3	Africa Nazarene university	200		
	South Eastern Kenya University	60		
	Scotts Christian University	92		
	University of Nairobi	20		
		372	10%	**37**
VCT workers	Shalom Hospital	6		**1**
	Bishop Kioko Hospital	6		**1**
	Machakos General Hospital	6		**1**
	Liver pool VCT	10		**2**
		28		**5**
	Student counselors	6		**6**
	Total	**2,336**		**240**

3.6 Data Source and Acquisition Methods

The study employed both primary and secondary sources of information. Primary data was gathered through structured and unstructured questionnaires and focus group discussions. Secondary data was derived from books, thesis and journals among other literature. In focus group discussion, the respondents are introduced to a topic for discussion and the researcher controls the flow of discussion and is always mindful of the aim of the study.

3.7 Data Collection Instruments

The study employed the use of semi-structured questionnaires for the qualitative interviews designed to gather information related to the set objectives. The questions were administered to university students, Volunteer Counseling and Testing workers (VCT) and finally to the student counselors.

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3.7.1 Questionnaires

The questionnaire was used to collect data from students and the researcher based on the objectives of the study designed them. The tools were used to obtain quantitative information on attitudes and perceptions of contraceptives on protected sex among youths in institutions higher learning in Machakos.

The questionnaire was considered appropriate for this study because it is easy to administer, saves time, it is able to give respondents adequate time to respond to the items and it offers a sense of security (confidentiality and anonymity) to the respondents thus helping the researcher gather both quantity and quality information. The questionnaire was both close and open ended to enable the researcher gather as much information as possible.

3.7.2 Interview guide

The interview guide was used to collect qualitative data from the student counsellors and the VCT workers. Students counsellors because have a good understanding of the behaviour of the students since they associate with them regularly in the campuses. While the VCT workers do interact with the youths as they go to seek their services.

Owens (2002) observers that this instrument yields highest cooperation and lowest refusal rates and takes advantage of interviewer's presence. It is multi-method data collection instrument which combines questioning, cross-examination and probing approaches.

3.8 Data Analysis

The responses given in the questionnaires were coded and analyzed using Statistical Package for Social Scientists (SPSS) and Microsoft Excel. Descriptive statistical tools such as means and standard deviation were used while frequency distribution tables and computation of proportions in percentages were employed to investigate the most dominant responses amongst several choices given by respondents.

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3.9 Reliability and Validity of Research Instruments

3.9.1 Reliability of the Research Instruments

Mugenda and Mugenda, (1999) observes that reliability is a measure of the degree to which a research instrument yields consistent results or data after repeated trials. If a researcher administers a test to a subject twice and gets the same score on the second administration as the first test, then there is reliability of the instrument. The error may arise at the time of data collection and may be due to inaccuracy by the researcher or inaccuracy by the instrument. Reliability is concerned with consistency, dependability or stability of a test.

3.9.2 Validity of Research Instrument

Mugenda and Mugenda, (2003) state that validity is the accuracy and meaningfulness of inferences, which are based on research results. In other words, validity is the degree to which results obtained from the analysis of the data actually represent the phenomenon under study. Validity, therefore, has to do with how accurately the data obtained in the study represents the variables of the study. Mugenda and Mugenda, (1999) states that to enhance validity of a questionnaire data should be collected from reliable sources, the language used on the questionnaire should be kept simple to avoid any ambiguity and misunderstanding.

The validity of data collection was made through collecting data from the relevant respondents having obtained consent to collect data from the various universities, National Commission for Science, Technology and Innovation and the County Commissioner of Machakos, for the researcher to be permitted to collect data and accorded assistance during collection of data.

The validity of the instrument was also established by being presented to experts with experience in the area of study who approved the instrument for data collection.

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Focus Group Discussions were used to confirm specific issues related to students' knowledge, attitudes and sexual behavior. The perceptions obtained from the use of quantitative and qualitative methods greatly increased the strength of the conclusion. The combination of results from FGDs and what is on the entire document adds to validity.

3.10 Ethical Considerations

Berg and Lune, (2012) Observe that social scientists, perhaps to a greater extent than the average citizen, have an ethical obligation to their colleagues because, they study populations and the larger society. The reason for this is that social scientists delve into the lives of other human beings. Thus, researchers must ensure the rights, privacy, and welfare of the people and communities that form the focus of their studies. Mugenda and Mugenda, (2003) observe that respondents should be protected by keeping the information given confidential, especially if confidentiality has been promised. In some cases, the respondents may not be very concerned about confidentiality but their consent must be sought before revealing any information

The following research ethical principles were observed in this study:

Voluntary participation: respondents were not forced to participate in this study and were free to decline to fill the questionnaire at any time. All the respondents were fully informed about the aim of the study.

Confidentiality: All the respondents were informed that data collected will not be made available to anyone and that it will only be used for the purpose of this study.

Anonymity: The respondents were requested not to write their names, their identification numbers and phone contacts on the questionnaires.

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CHAPTER FOUR: DATA ANALYSIS

The aim of the study was to find out the attitudes and perceptions on protected sex among youths in institutions of higher learning in Machakos town. Specifically, the study aimed at establishing contraceptive knowledge among the university students; finding out university students attitude towards contraceptives; establishing the sexual behaviour of the students in relation to protected sex and establishing the influence of contraceptives on protected sex among university students.

Questionnaire Rate of Returns

Table 4.1 Distribution and Returns of Questionnaires According To Gender

The table shows the distribution and the rate of return of the questionnaires distributed and in their genders.

Group	Gender	Distribution Of Questionnaires	Non Returns	Usable Questionnaires
		NO.	NO.	NO.
Group 1	Male	75	30	45
Group 2	Male	21	0	21
Group 3	Male	19	4	15
	Total Usable			**81**
Group 1	Female	75	43	32
Group 2	Female	21	0	21
Group 3	Female	19	0	19
	Total Usable			**72**

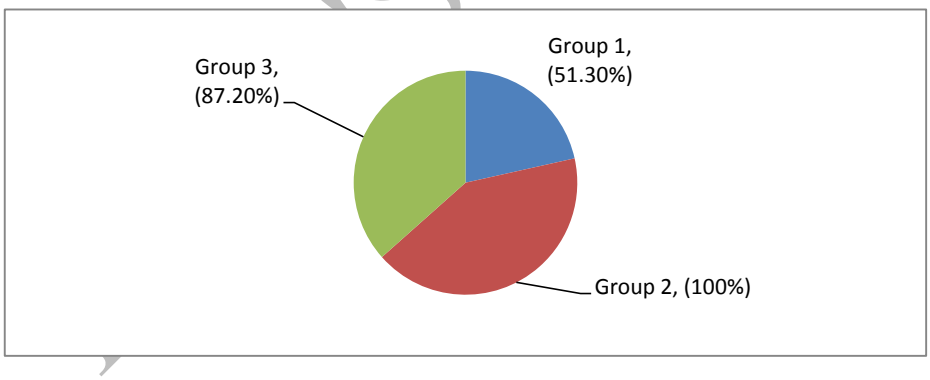
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Table 4.2 Distribution and Returns of Questionnaires

The table below shows the total distribution and the rate of returns of the questionnaires distributed and their representation in percentages. With Group 2 reporting 100% return rate, followed by Group 3 87.2% and group 1 with 51.3%. In total the rate of return was 66.2% which was good.

Group	Distribution Questionnaires	Non Returns	Usable Questionnaires	Percentages
	NO.	NO.	NO.	%
Group 1	150	73	77	51.3%
Group 2	42	0	42	100%
Group 3	39	5	34	87.2%
Total	**231**	**78**	**153**	**66.2%**

Table 4.2. Presents the rate of questionnaire returns by the students in the six institutions of higher learning. In addition, as shown on the table above the total number of questionnaires distributed to the students was 229 and 153 of them were returned and were usable making that 66.2% of returned and usable questionnaires.



This shows that in all the six universities which were divided into three groups the rate of return of the questionnaires was above fifty per cent with group 2 showing a hundred per cent return of the questionnaire; group 3 rate of return was 87.2% and finally group 1 rate of return was 51.3% and all being usable questionnaire. This shows the researcher was able to administer questionnaires to 66.2% of the expected respondents in the six institutions of higher learning.

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Knowledge of Familiar Contraceptives

When the students were asked, to list six contraceptives they were familiar with, the following were the most common, Condoms (male/female); E pills; Coils; Vasectomy & Tubaligation; Injections; Natural Methods and Withdrawal method. This indicated that the students are familiar with the five methods of contraceptives, which include intrauterine methods; hormonal methods; barrier methods; fertility awareness methods; permanent methods of birth control.

The VCT counsellors acknowledged that the youth are familiar with contraceptives like the male and female condoms, emergency pills, and injectable among others. They observed that even though the students know about these contraceptives the most commonly used among the students are the male condoms and Emergency pills.

Table 4.3 Seen a Male Condom

The table below sought to find out how many respondents had seen a male condom.

Group	**Male**				**Female**				**Total No. of Respondents**
	Yes	%	No	%	Yes	%	No	%	
Group 1	45	58.4			25	32.5	7	9.09	77
Group 2	21	50.0			21	50.0			42
Group 3	15	44.1			19	55.9			34
Total	81	52.9			72	47.0	7	9.09	153

As shown in table above 4.3, 52.9% (81) of male respondents and 47.0% (72) of female respondents indicated that they had seen a male condom, whereas 9.09% (7) of the female respondents indicated that they had never seen a male condom.

This shows that the male condom is perhaps the most common form of contraceptive with 52.9% (81) male respondents indicating to have seen it and 47.0% (72) of female respondents indicated they had seen a male condom. Only 9.09% (7) female respondents who had never seen a male condom. In the focus group discussion many respondents were dismissive of the few who said they

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had never seen a male condom. They argued that the male condom was so common for someone to claim that they had never seen one. Since they are even distributed free. They actually advised anyone who claims to have never seen a male condom to go to a VCT center where they will be given one and even be instructed on how it is used.

It is interesting that, in this era there are some students who have never seen a male condom and they are in the universities where the students are expected to be open to learning many things. Learning in this case would be in form of being curious to find out how a condom looks like since there is a lot of information about condoms through the media or on the website. The researcher is of the opinion that students ignorance would be a result of how students have been socialized that curiosity of an item like condom is wrong.

Table 4.4 Seen a Female Condom

The table below shows how many respondents had seen a female condom.

Group	**Male**				**Female**				**Total No. of Respondents**
	Yes	%	No	%	Yes	%	No	%	
Group 1	11	14.2	34	44.1	13	16.8	19	24.6	77
Group 2	6	14.2	15	35.7	9	21.4	12	28.5	42
Group 3	10	29.4	5	14.7	6	17.6	13	38.2	34
Total	27	17.6	54	35.2	28	18.3	44	28.7	153

As shown in table 4.4 above 17.6% (27) of male respondents and 18.3% (28) of female respondents indicated that they had seen a female condom, whereas 35.2% (54) of the male respondents 28.7 (44) of female respondents indicated that they had never seen a female condom.

This shows that 64.0% (98) of all the respondents have never seen female condom. Only 35.0% (55) of the respondents have seen a female condom. What is worrying is that the number is very high especially among the female respondents, which is 28.7% (44). Who if they had more information about the female condom would have it as an option of having protective sex. Rather than

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say they did not have a condom with them hence resulting in unprotected sex (see Table 4.11).

Through the focus discussion groups, the respondents reported that female condom is not very common and some of them have only seen it in the VCT centres when the workers are demonstrating how they are used. They reported that female condoms are very expensive and students cannot afford to buy them and thus the reason the students prefer to use the male condom. Many also reported that chemists do not stock them and chemist attendants say that people do not buy them and hence they end up expiring on the shelves. When the female students were asked if they have used a female condom the female respondents declined to respond. There is need for sensitization given that 28.7% (44) of the female respondents indicated that they had never seen a female condom. One would expect that, the female students would show some curiosity and seek to find out how a female condom looks like.

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Table 4.5 Best Suited To Teach On Contraceptives

The table below shows who the respondents thought was the ideal person to teach them regarding the issues of contraceptives.

Category	Group 1	Group 2	Group 3	Total	%	Total No. of Respondents
Parents	16	21	8	45	29.4	153
Teachers	16	13	8	37	24.1	153
VCT Workers	33	9	15	57	37.2	153
Social Worker	15	9	5	29	18.9	153
Peers / friends	7	9	7	23	15.0	153
TV $ Radio	3	5	2	10	6.5	153

As indicated in table 4.5 above 37.2% (57) of the respondents indicated that they prefer VCT workers teaching on contraceptives issues, followed by parents with 29.4% (45) and teachers with 24.1% (37). All the respondents also seem to prefer social workers 18.9% (29) as compared to their peers/friends 15.0% (23) and TV & Radio 6.5% (10).

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The students indicated that the person they would prefer to teach them on issues regarding contraceptives should be the VCT workers. Surprisingly they indicated that parents should be able to teach their children regarding contraceptives. Through the focus discussion group the students observed that VCT workers are not shy when sharing information regarding contraceptives and they even demonstrate especially how both the male and female condoms are used. The youths also observed that parents have a responsibility of teaching their children regarding contraceptives rather than getting information from their peers.

Availability of Contraceptives in Machakos town

When asked to list three places where one can go to get free condoms in Machakos, the following institutions were named by all the respondents. The hospitals namely (Machakos Level 5, Shalom Hospital, Bishop Kioko Hospital); VCT Centres especially Liverpool and The Red Cross offices; Bars and Lodging and also public toilets.

There are many places available in Machakos for the students to go and access free contraceptives especially the male condom. The opinion of the researcher is that there is a lot of stigma associated with contraceptives such that students would rather have unprotected sex than go for contraceptives in the said places. They have indicated that 54.2% (83) of all the respondents would rather not use protection because they are too ashamed to go and buy condoms (see Table 4.11) .

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Table 4.6 Purchase of E. Pills from Chemists in Machakos

The table below shows the respondents knowledge of chemists in Machakos, which sell emergency pills.

GRP	**Male**						**Female**						**No. of Respondents**
	Yes	%	No	%	I do not know	%	Yes	%	No	%	I do not know	%	
Grp 1	30	38.9	-		15	19.4	29	37.6	2	2.5	1	1.2	77
Grp 2	16	38.0	-		5	11.9	21	50.0	-				42
Grp 3	9	26.4	-		6	17.6	16	47.0	-		3	8.8	34
Total	55	35.9			26	18.9	66	43.1	2	1.3	4	2.6	153

As indicated in table 4.6 above approximately 35.9% (55) of the male respondents indicated that they knew where emergency pills were sold in chemists in Machakos while 18.9% (26) did not know if E. Pills were sold in chemists in Machakos town. While approximately 43.1% (66) female respondents indicated, that they knew that Emergency pills were sold in chemists in Machakos. 2.6% (4) indicated that, they did not know if E. Pills were sold in Machakos, while 1.3% (2) indicated that they were not sold at all in Machakos. Hence 79.0% (121) of all the respondents acknowledged that they know emergency pills otherwise known as E-Pills were available and could even be purchased in chemists around Machakos. During focus group discussion, the female students seemed to shy away from discussing about it. The researcher's opinion was that maybe the female respondents did not want to be seen, as having a lot of knowledge which would be construed to mean they usually use the E. pills.

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Table 4.7 in your opinion are Condoms and Other Contraceptives Easily Available to Students.

The Table below shows respondents knowledge of availability of condoms and other contraceptives.

Group	**Male**				**Female**				**Total No. of Respondents**
	Yes	%	No	%	Yes	%	No	%	
Group 1	14	18.1	31	40.2	25	32.4	7	9.0	77
Group 2	16	38.0	5	11.9	17	40.4	4	9.5	42
Group 3	15	44.1	-	-	16	47.0	3	8.8	34
Total	**45**	**29.4**	**36**	**23.5**	**58**	**37.9**	**14**	**9.1**	**153**

As indicated in Table 4.7 above, approximately 29.4% (45) male respondents felt that condoms and other contraceptives are easily available to the students. 23.5% (36) of the male respondents indicated that condoms and other contraceptives are not easily available to students. 37.9% (58) female correspondents indicated that condoms and other contraceptives were easily available to the students, while 9.1% (14) of the female respondents thought that condoms and other contraceptives were not easily available to students.

This shows that 67.3% (103) of all the respondents acknowledge that condoms and other contraceptives are easily available to students. 79.0% (121) students say that Emergency pills can be easily purchased in chemists in Machakos (see Table 4.6). The researcher is of the opinion that there is need to sensitize the students more on the benefits of using contraceptives. Since the students have acknowledged that they know where they can access contraceptives, it is imperative to turn that knowledge to use for the greater good of individuals who are sexually active.

Through the focus group discussion the students observed that condoms are available in pubs and lodgings; the VCT centres and hospitals. However, their concern especially with the hospitals is that they were embarrassed to go for condoms in the hospitals because some of the hospital workers were their relatives or some knew their parents. They were afraid to be reported to their parents that they had visited the hospital or had gone for condoms.

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Some female respondents indicated that the procedure of acquiring contraceptive information was cumbersome especially in public hospitals because one is required to pay, to have a personal file opened in the hospital registry, one goes to queue in the family planning section of the hospital where a client can finally have an audience with the nurse. They indicated that they also do not like the way the nurses' makes funny remarks regarding how young they are to be seeking contraceptives information. The nurses also openly express concerns on the reasons why the students want to know more about family planning methods.

Sexual Behaviour of Students In Relation To Protected Sex

Table 4.8: Would You Use a Condom When Having Sex with a Regular Partner

In this section, the researcher sought to establish the sexual behaviour of the students in relation to protected sex. The table below shows that the students would use a condom when having sex with a regular partner.

Group	**Male**				**Female**				**Total No. of Respondents**
	Yes	%	No	%	Yes	%	No	%	
Group 1	24	31.1	21	27.2	20	15.4	12	15.5	77
Group 2	13	30.9	8	19.0	13	30.9	8	19.0	42
Group 3	14	41.1	1	2.9	10	26.4	9	26.4	34
Total	51	33.3	30	19.6	43	28.1	29	18.9	153

The data presented on Table 4.8 above shows 33.3% (51) of the male respondents that would use a condom when having sex with a regular partner. 19.6% (30) indicated that they would not use condoms when having sex with a regular partner. 27.4% (42) of the female respondents indicated that, they would use a condom while having sex with a regular partner and only 18.9% (29) indicated that they would not use a condom when having sex with a regular partner. Thus 61.4% (94) of all the respondents indicated that they would use a condom when having sex with a regular partner. While 38.5% (59) indicated that, they would not use a condom with a regular partner. The question is why

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this behaviour when the students know the consequences of having unprotected sex.

In the focus group discussion, the students would not agree on whether they would use a condom with a regular partner or not, some stated that they trusted their partners and hence did not see the need of using protection. While others indicated that they would not trust anyone and they preferred therefore protected sex.

Table 4.9 in your opinion are the students Sexually Active.

The Table below shows the respondents' responses on whether the students are sexually active.

Group	Male				Female				Total No. of Respondents
	Yes	%	No	%	Yes	%	No	%	
Group 1	40	51.9	5	6.4	21	27.2	11	14.2	77
Group 2	15	35.7	6	14.2	7	16.6	14	33.3	42
Group 3	12	35.2	3	8.8	15	44.1	4	11.7	34
Total	67	43.7	14	9.1	43	28.1	29	18.9	153

The Table 4.9 shows that approximately 43.7% (67) of the male respondents indicated that the students are sexually active and only 9.1% (14) indicated that the students were not sexually active. While 28.1% (43) of the female respondents indicated, the students are sexually active 18.9% (29) indicated they were not sexually active. This shows that 71.8% (110) of all the students' respondents indicated that the students were sexually active. In addition, what is worrying is that 38.5% (59) have already said they would not use protection with a regular partner (see Table 4.8). Yet they clearly indicated that condoms and other contraceptives are easily available to the students (see Table 4.7). The researcher is of the opinion that the students are faced with many challenges as they make a decision to have protective sex or not. The choice of going for the free condoms and risk being spotted by people who know them, who might later report them to their guardians. The choice of using contraceptives with inadequate information on how they correctly used. Basically we can draw a

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conclusion that students make informed decision to not use protection because of all the decisions they have to make and then deal with the consequences later of having unprotected sex.

In the focus group discussion, the researcher observed that the female students shied away from contributing to the discussion and declined to respond. While the male students did not shy away from discussing about their sex life to a point of bragging about it. The researcher observation in regards to shying away of the girls and not the boys, would be due to communities socialization which encourages the boys to speak about their sexual conquest and the girls are frowned upon if they are known to have lost their virginity.

The students' counsellors and the VCT workers also agreed that the students are sexually active and do not seem to use protection because there are many cases of abortions reported in the campuses and off the campus they have dealt with.

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Table 4.10 Indicate How Often You Engage In Protected Sex

The table below shows the frequency of protection use when the students have sex.

Grp	Male								Female								Total No. of respondents
	Every time I have sex	%	Most of the time	%	Never	%	Refused to answer	%	Every time I have sex	%	Most of the time	%	Never	%	Refused to answer	%	
Grp 1	16	20.7	9	11.6	15	19.4	5	2.5	12	15.5	2	2.5	15	19.4	3	3.8	77
Grp 2	5	11.9	6	14.2	5	11.9	5	11.9	5	11.9	4	9.5	4	9.5	8	19.0	42
Grp 3	5	14.7	4	11.7	4	11.7	2	5.8	6	17.6	3	8.8	8	23.5	2	5.8	34
Total	26	16.9	19	12.4	24	15.6	12	7.8	23	15.0	9	5.8	27	17.6	13	8.4	153

The Table above, shows that 16.9% (26) of the male respondents indicated that they use protection every time they have sex; 12.4% (19) of the respondents use protection most of the time when they have sex; 15.6% (24) of the respondents never use protection when they have sex; and 7.8% (12) of the respondents refused to answer the question. 15.0% (23) of the female respondents indicated that they use protection or condoms every time they have sex; 5.84% (9) of the respondents use protection most of the time when they have sex; 17.6% (27) of the respondents never use protection when they have sex; and 8.48% (13) of the respondents refused to answer the question.

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It shows that 33.3% (51) of all the respondents said that they never use protective sex and the number may be higher judging by the number of the students who refused to answer the question which is 16.3% (25). It is a worrying trend because 18.3% (28) indicated they have protective sex most of the time that means there are other times they do not use protective sex even though they know the importance of protective sex. The big question here is what makes them fluctuate from using protection to not using protection sometimes when having sex. The question of not being prepared cannot arise because they have already indicated to being sexually active.

In the focus group discussion, the students did not feel comfortable responding to the question and declined to respond. The researcher observed that none of the students wanted to be seen by their colleagues as being sexually active and not having protective sex.

Table 4.11 What Are the Reasons Youth Give For Not Using Protection When Having Sex

The Table below shows the reasons the youth give for not using protection when they decide to have sex.

	It reduces sexual pleasure	%	The sex just happened	%	I did not have it with me	%	My partner does not like using condoms	%	I trust my partner	%	Too ashamed to go buy and buy condoms	%	Respondents
Male	55	35.9	41	26.7	44	28.7	38	24.8	48	31.3	43	28.1	153
Female	58	37.9	45	29.4	45	29.4	46	30.0	53	34.6	50	32.6	153
Total	113	73.8	86	56.2	89	58.1	84	54.9	101	66.0	83	54.2	

A look at the Table 4.11 above reveals that approximately 73.8 (113) of the respondents (153) have the view that the use condoms reduces sexual pleasure; 56.2% (86) of the respondents (153) indicated that the reason the youth have unprotected sex is because it just happens it is never planned; 58.1% (89) of the

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respondents (153) indicated that the reason the youth give for not having protected sex is that they did not have the condom with them; 54.9% (84) of the respondents (153) indicated that the reason the youth give for having unprotected sex, is because the partners do not like using condoms; 66.0% (101) of the respondents (153) indicated that the reason the youth engage in unprotected sex, is because they trust their partner; 54.2% (83) of the respondents (153) indicated that the reasons the youth give for having unprotected sex, is because they are too ashamed to go and buy condoms.

The results shows that the most common reason given by all the respondents that is 73.8% (113) indicated that the reason for not using the condoms was that they reduce sexual pleasure. With 66.0% (101) also indicating the reason for not using protection when having sex is because they trusted their partners. Based on those results, the researcher is of the opinion that the knowledge students have on the benefits of using contraceptives does not really count when it comes to sexual preferences.

During the focus group discussion, the students observed that one of the things people say was that condoms reduce sexual pleasure. Some observed that sometimes the sexual act is usually spontaneous and they do not want to lose a chance when it avails itself. Some male respondents refuted the notion that it reduces sexual pleasure by saying that they like using condoms since they feel safe especially if they do not really know the partner they are having sex with that well.

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Table 4.12 if your Partner Wanted to Have Sex without a Condom What Would You Do?

The Table below shows the views of what a student would do if their partner insisted on having sex without protection

	Refuse to have sex	%	Go along and have sex	%	Insist they use a condom	%	I do not know what I would do condoms	%	Respondents
Male	18	22.2	32	20.9	10	6.5	21	13.7	81
Female	25	34.7	24	15.6	15	9.8	8	5.2	72
Total	**43**	**28.1**	**56**	**36.6**	**25**	**16.3**	**29**	**18.9**	**153**

A look at Table 4.12 reveals that 22.2% (18) of all the male respondents indicated they would refuse to have sex without protection. 20.9% (32) would go along and have sex without using protection. 6.5% (10) would insist they use protection when having sex and 13.7% (21) of the male respondents indicated they did not know what they would do. 34.7% (25) of all the female respondents indicated, that they would refuse to have sex without protection. 15.6% (24) would go along and have sex without protection. 9.8% (15) would insist they use protection when having sex and 5.2% (8) of all the female respondents indicated they did not know what they would do.

This shows that the highest number that is 36.6% (56) that would have sex and there is a very high likelihood that even the 18.9% (29) of the ones who say they do not know what they would do will more likely have sex given the history we have seen of students having sex without protection even with enough knowledge of contraceptives and condoms. The interesting thing is even as 16.3% (25) say they will insist on use of condoms, one wonders how they will achieve that given 63.3% (97) of the students indicated that they would not carry condoms with them every time or it would be to too embarrassing for them to been seen with condoms (see Table 4.13).

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Table 4.13 Would you carry with you (Male/Female) condom every time?

The Table below shows the response on whether a student would be comfortable carrying some condoms every time or it would be embarrassing for them.

Grp	Male						Female						Total
	Yes	%	No	%	Too Embarrassing	%	Yes	%	No	%	Too embarrassing	%	
Grp 1	18	23.3	15	19.4	12	15.5	17	22.0	14	18.1	1	1.2	77
Grp 2	8	19.0	10	23.8	3	7.1	3	7.1	14	33.3	4	9.5	42
Grp 3	5	14.7	9	26.4	1	2.9	5	14.7	13	38.2	1	2.9	34
Total	31	20.2	34	22.2	16	10.4	25	16.3	41	26.7	6	3.9	153

As indicated in Table 4.13 above, 20.2% (31) of all the male respondents indicated that they would carry a condom with them. 22.24% (34) indicated they would not carry condoms at all and 10.4% (16) indicated that they were too embarrassed to carry condoms every time with them. On the other hand, 16.3% (25) of all the female respondents indicated, that they would carry condoms every time. 26.7% (41) indicated that they would not carry condoms every time and 3.9% (6) indicated that they would be too embarrassed to carry condoms with them every time.

The students even having admitted that some of them are sexually active (see table 4.9) that is 71.8% (110), yet only 36.6% (56) indicated that they would carry condoms with them. The others 63.3% (97) respondents indicated that they would not carry condoms with them. Through the focus group discussion, some students especially the female acknowledged that they had never thought of the idea but observed it was a good idea because then they would have protected sex since sometimes sex is usually spontaneous. Some students felt it was too embarrassing to carry condoms, they were afraid that the condoms can fall off in front of their parents and some female respondents indicated that they have young siblings who are very inquisitive might show it to their parents.

The researcher observes that the idea of being seen with a condom is quite embarrassing and seems to have a lot of stigma. Even when there are benefits of

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carrying condoms, being seen with them seems to be very costly. In addition, the students would go to great lengths to distance themselves from the condoms the researcher is of the opinion that the idea of condoms is only appreciated in the privacy of their rooms but outside the students want minimal association with contraceptives. Hence the conclusion that there is a lot of stigma associated with contraceptives.

Table 4.14 Where Would You Prefer To Buy (Male/Female) Condoms?

The table below shows where the students would be most comfortable buying condoms.

Group	Male						Female						Total
	Supermarket	%	Kiosks	%	Chemists	%	Supermarket	%	Kiosks	%	Chemists	%	
Grp 1	8	10.3	5	6.4	32	41.5	6	7.7	1	1.2	25	32.4	77
Grp 2	4	9.5	-	-	17	40.4	3	7.1	3	7.1	15	35.7	42
Grp 3	6	17.6	1	2.9	8	23.5	1	2.9	-	-	18	52.9	34
Total	18	11.7	6	3.9	57	37.2	10	6.5	4	2.6	58	37.9	153

As shown in Table 4.14 above, approximately 37.2% (57) of all the male respondents indicated that they would prefer to buy condoms in a chemist. 11.7% (18) indicated that they prefer to buy condoms in a supermarket and only 3.9% (6) would buy condoms from a kiosk. On the other hand, 37.9% (58) of all the female respondents indicated, they would prefer to buy condoms in a chemist. 6.5% (10) would buy condoms in a supermarket and 2.6% (4) indicated they would buy condoms from a kiosk.

The vast majority that is 75.1% (115) of all the respondents indicated that chemists offered more privacy when buying the condoms and there was less stigma associated with the purchase of condoms from the public. From this statistic, the researcher is of the opinion that in the fight against unprotected sex the Government and other stakeholders should collaborate with chemists since many students prefer to buy their contraceptives and condoms from the chemists.

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Through the focus group discussion, the students indicated that they preferred to purchase condoms from the chemists citing privacy reasons. Most students felt that buying from supermarket is not as private because of meeting someone who knows you were very high. In reference to buying condoms from the kiosks, they indicated that they felt it was embarrassing because the kiosk attendant knows them and they would not want to be associated with condoms, since they were their customers.

The procedure of acquiring contraceptive information in public hospital was cumbersome because one is required to pay, to have a personal file opened in the hospital registry, then one goes to queue in the family planning section of the hospital where a client can finally get a turn to go and have an audience with the nurse. They indicated that they also do not like the way the nurses make funny remarks regarding how young they are to be asking for contraceptives information. Also that the nurses openly express concerns on the reasons why they want to know more about family planning methods.

When Asked To Give a Reason for Their Choices of Either Supermarket, Kiosk and Chemist

They indicated that in a supermarket goods sold there are original and chances of counterfeits is minimal; it is less embarrassing and less conspicuous since the tellers usually mind their own business. Regarding the chemist, the respondents indicated that they offer a lot of privacy; their products are well stored; there are no chances of buying expired goods because many people buy from chemists; the chemist attendants are friendly and ready to advice on the best contraception to use. Some also were of the opinion that it is unlikely to get counterfeits from chemist; and finally chemists are reliable and they are all over the country. The respondents indicated that it was easy to acquire condoms in kiosks without being noticed; it was less embarrassing for those who opts for this form of purchase.

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Table 4.15 If Your Partner Insisted That You Use Protection How Would You Feel?

The Table below captures what one would feel if their partner insisted on using condoms instead of having unprotected sex.

Grp	Male						Female						Total
	Insulted	%	Mistrusted	%	Respected	%	Insulted	%	Mistrusted	%	Respected	%	
Grp 1	5	64	8	10	32	41.5	1	1.2	5	6.4	26	33.7	77
Grp 2	-	-	2	4.7	19	45.2	2	4.7	1	2.3	18	42.8	42
Grp 3	1	2.9	1	2.9	13	38.2	-		-		19	55.8	34
Total	6	3.9	11	7.1	64	41.8	3	1.9	6	3.9	63	41.1	153

As shown in Table 4.15 above, approximately 41.8% (64) of all male respondents indicated that they would feel respected if their partner insisted on using a condom. 7.1% (11) indicated they would feel mistrusted and 3.9% (6) of all male respondents indicated they would feel very insulted if their partner insisted they use a condom. However 41.1% (63) of all female respondents indicated they would feel respected if their partner insisted on using condoms. 3.9 % (6) indicated they would feel mistrusted and 1.9% (3) of the female respondents felt they would be insulted.

This shows that even when the students say that they like having unprotected sex that is not true if it were true why then would 83.0% (127) of all the respondents indicate they would feel very respected if their partner insisted they use a condom. The researcher is of the opinion that the students would like to use protection when having sex as indicated by the overwhelming response that they would feel respected if their partner insisted on protective sex. It is also interesting to note that there are students who like having unprotected sex because 16.9% (26) indicated that they would feel very insulted and mistrusted if their partner insisted on using protection.

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Table 4.16 Do You Think Universities Should Provide Free Condoms on Campus?

The table below shows if the students feeling on whether the universities should provide free condoms on campus or not.

Group	Male				Female				Total No. of Respondents
	Yes	%	No	%	Yes	%	No	%	
Group 1	37	48.0	8	10.3	28	36.3	4	5.1	77
Group 2	19	45.2	2	4.7	18	42.8	3	7.1	42
Group 3	10	29.4	5	14.7	15	44.1	4	11.7	34
Total	66	43.1	15	9.8	61	39.8	11	7.1	153

As shown in Table 4.16 approximately 43.1% (66) of all male respondents indicated that the universities should provide condoms on campus and only 9.8% (15) indicated that condoms should not be provided on campus. 39.8% (61) of all female respondents indicated that Universities should provide condoms on campus, while only 7.1% (11) indicated that condoms should not be provided on campus.

Majority of the students indicated that the university should provide condoms to students on campus because the students are sexually active. Through focus group discussion respondents were in agreement that majority of students are sexually active on campus. Moreover, some acknowledged that some of their friends have procured abortions and others have been treated in the hospital with sexually transmitted infections and others are always on E- pills. The students observed that it was embarrassing to go to the hospital for free condoms. Hence if condoms were availed in the students hostels or the washrooms it would be easier because the students would know where to pick them. The students were of the opinion the university health centres are very unreliable since they take too long to replenish their stock once it runs out.

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When Asked To Give A Reason For Their Choice Of Yes or And No, if the Universities Should Provide Free Condoms on Campus. Below is Their Response.

The respondents indicated that the students are sexually active and condoms on campus will help reduce the spread of STIs and HIV/AIDS and unwanted pregnancies; it will help remove stigma associated with condoms because the students are embarrassed to go and buy condoms; sex is a reality and safe sex should be taught to the youth and some youth on campus cannot afford condoms and are too ashamed to go to the hospital for free condoms.

The respondents opposing the idea of condoms on campus indicated that, it will encourage immorality among the students, the students will misuse sex and others thought universities are an institutions of higher learning and based on good ethics. The students should be encouraged to practice abstinence.

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CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATION

Summary

The main aim of the study was to find out the attitudes and perceptions on protected sex among youths in institutions of higher learning in Machakos town. Specifically, the study aimed at establishing contraceptive knowledge among the university students; finding out university students attitude towards contraceptives; establishing the sexual behaviour of the students in relation to protected sex and establishing the influence of contraceptives on protected sex among university students.

Machakos town has several institutions of high learning namely one main University, which is Scott's Christian University; and Machakos University College. There are other four university campuses, which are St. Paul's University, University of Nairobi, African Nazarene University and South Eastern Kenya University.

One questionnaire consisting of four parts was designed for the study and administered to the University students. One questionnaire was designed and was administered to the student counsellors in the six institutions. One questionnaire was designed and administered to the voluntary counselling and testing workers in the three main general hospitals (which comprise of two privates hospitals and one public hospital) and the Liverpool VCT centre since they are the ones who are actively involved in VCT services in Machakos.

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Frequency tables and percentages were used to analyse data. The data generated by the study has revealed important and fundamental facts about the knowledge students have regarding contraceptives; the attitude the students have towards contraceptives; the sexual behaviour of students and use of protected sex and the influence of contraceptives on protected sex among university students.

Conclusions

The findings of this study are a revelation on the students' knowledge regarding contraceptives, on sexual behaviour and attitudes of the students towards protective sex.

The students have a lot of knowledge about the contraceptives available in the market. The male condom was generally very famous amongst all the respondents but the female condom was not very familiar among the respondents. The respondents know that E-pills are available for purchase in the chemists and condoms are distributed free in the hospitals, VCT centres, and even Red Cross offices hence readily available to students. In addition, the students reported that the best person suitable to teach on contraceptives should be VCT workers and the parents. The students reported that Government system of educating the youth was lacking and cumbersome hence the reason the students do not feel comfortable going to the public hospital for contraceptive education.

The students have a negative attitude towards contraceptives. Some seem to think that use of contraceptives especially hormonal and intrauterine methods would make them barren and believe that condoms reduce sexual pleasures; some indicated that their partners do not like using condoms. Albeit with all the knowledge they have regarding benefits of protective sex, the students still engage in unprotected sex blaming it on spur-of-the-moment when they decide to have sex. Finally, they acknowledged that it was also embarrassing purchasing condoms, even though they had indicated they could carry condoms it was still embarrassing to be seen with them.

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Students are sexually active and even with the knowledge on contraceptives and the benefits thereof, they are still not engaging in protected sex. The knowledge they have does not seem to translate into safe sexual practices.

Recommendations

1. The Universities have a responsibility of educating the students regarding contraceptives. This can be done through public lectures and seminars since the students have acknowledged being sexually active.

2. There is need to encourage positive peer pressure by having younger counsellors in the family planning department and VCT centres. Having younger counsellors will help in dissemination of contraceptive information faster to their fellow youths. Hence, the reason the students prefer VCT counsellors since they are young and easily associate with them.

3. Organizations that deals with distribution and contraceptive education should work more closely with chemists since the youth seem to have a lot of confidence with them in regards to purchase of contraceptives.

4. The process of acquiring contraceptive information should not be so complicated, since issues of contraceptives are already embarrassing, as the students have indicated.

5. The Government has a responsibility to educate the citizens regarding contraceptives; this will help in dealing with the stigma and myths associated with contraceptives. It will ensure that the public will get correct information including students.

6. The universities should embrace and encourage health providers to set up regular VCT tests on campus and workshops.

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7. Companies should be encouraged as part of their corporate social responsibility (CSR) to sponsor students to come up with effective strategies for positive peer influence to counter the negative peer pressure narrative and publicize it as an alternative narrative.

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APPENDIX I: Questionnaire for the Students

The researcher is interested in learning more about the effects of contraceptive knowledge on protected sex among the youth in institutions of high learning in Machakos town. Any information you give will be private and confidential.

1. Gender
   i. [ ] Male Female [ ]

2. Indicate your age bracket by ticking against the following age categories
   i. 18 - 24 [ ]
   ii. 25 - 29 [ ]
   iii. 30 - 35 [ ]

3. What is the name of your college or university?
   i. St. Paul's university [ ]
   ii. Machakos University [ ]
   iii. Africa Nazarene University [ ]
   iv. South Eastern Kenya University [ ]
   v. Scott's Christian University [ ]
   vi. Nairobi University [ ]

4. List the Methods of Contraceptives that you are familiar with

5. Have you ever seen a male condom?
   i. YES [ ] NO [ ]
6. Have you ever seen a female condom?
   i. YES [ ] NO [ ]

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7. According to your point of view who do you think should teach the youth regarding contraceptive please tick one?

   i. Parents [ ]
   ii. Teachers [ ]
   iii. Social worker [ ]
   iv. Peers/friends [ ]
   v. TV and Radio [ ]
   vi. VCT workers [ ]
   vii. Other

8. Where can one go to get free condoms in Machakos? Please list

9. In your opinion can emergency contraceptives be purchased from chemists in Machakos?

   i. YES [ ]
   ii. NO [ ]
   iii. I Don't know [ ]

10. In your opinion, are there specific chemists shops that the youth prefer to purchase morning after pills from in Machakos?

    i. YES [ ]
    ii. NO [ ]
    iii. I Do Know [ ]

11. In your opinion, are condoms and other contraceptives easily available to the students?

12. Would you use a condom when having sex with a regular partner?

    i. YES [ ]
    ii. NO [ ]
    iii. Other

13. In your opinion, are the students sexually active? Tick one

    i. YES [ ]
    ii. NO [ ]

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13b. If yes, please indicate how often you think they engage in protected sex.

i. Every time I have sex [ ]
ii. Most of the time [ ]
iii. Never [ ]
iv. Refuse to answer [ ]

14. What are the reasons youth give for not using condoms when having sex?

i. Reduces sexual pleasure [ ]
ii. The sex just happened [ ]
iii. I did not have it with me [ ]
iv. My partner does not like using condoms [ ]
v. I trust my partner [ ]
vi. Too ashamed to go and buy it [ ]

15. If your partner wanted to have sex without a condom what would you do?

i. Refuse to have sex [ ]
ii. Go along with them and have sex [ ]
iii. Insist they use a condom [ ]
iv. I do not know what I would do [ ]

16. Would you carry with you (Male/Female) condoms every time?

i. NO [ ]
ii. YES [ ]
iii. Too Embarrassing [ ]

17. Where would you prefer to buy (Male/Female) condoms?

i. Supermarket [ ]
ii. Estate shops (kiosks) [ ]
iii. Chemist [ ]

17b. Please explain your choice above.

18. If your partner insisted that you use a protection how would feel?

i. Insulted [ ]
ii. Mistrusted [ ]
iii. Respected [ ]

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19. Do you think the University should provide free condoms on campus? YES/NO

19b. Please explain your answer

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APPENDIX IV: Focus Group Discussion Questions

1. Have you seen a female condom?
2. Are emergency pills purchased in chemists in Machakos?
3. Are contraceptives easily available for students?
4. Would you use a condom when having sex with a regular partner?
5. In your opinion are the students sexually active?
6. How often do you engage in protected sex?
7. What are the reasons youth give for not using protection when having sex?
8. Would you carry a packet of condoms every time when you go out?
9. Where would you prefer to buy condoms: Chemist, Supermarket or Kiosks?
10. Do you think Universities should provide free condoms on campus for students?

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APPENDIX II: Questionnaire for VCT Workers

1. Are there some contraceptive that the youth are familiar with YES/ NO?

2. If yes, which are they? please list them.

3. Do you think the youths use any contraceptives?
   3. (ii) Please explain your response

4. Do you feel the youth have the correct knowledge of contraceptives? YES /NO
   4. (ii) Please explain your answer

5. What attitude do the students have on contraceptives?

6. Do you think the university students are sexually active? YES/NO
   (b) please explain your response above.

7. Are there times of the months that the youth mostly frequent the VCT center, please explain your response.

8. Are there youths who come for condoms even without coming to get tested?

9. Are contraceptives easily available for the students?

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APPENDIX III: Questionnaire for the Students Counsellor

1. (i) Do you think the youth have adequate information on contraceptives?

   (ii) Please explain your answer.

2. What do you think is their source of knowledge?

3. (i) Do you think the university should teach students about contraceptives? YES /NO

   (ii) Please, explain your response.

4. What do you think are the student's attitudes towards contraceptives?

5. What are your recommendations of how the youth can be empowered.

6. Do you think the students are sexually active? YES / NO

7. What are the indicators that students in your campus are sexually active?

8. (i) Do you think students should be provided with free condoms in campus?

   (ii) Please explain your response.

9. How can the students be empowered if they are sexually active, to make informed choices for themselves.

10. Are contraceptives easily available for the students?

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APPENDIX IV: Research Authorization Letter



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471, 2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

Date:
8th April, 2015

NACOSTI/P/15/2799/5362

Susan Njeri Muhuhi
St. Pauls University
P.O. Private Bag-00217
LIMURU.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Effects of contraceptive on protected sex among youth in institutions of higher learning in Machakos Town, Kenya"*** I am pleased to inform you that you have been authorized to undertake research in **Machakos County** for a period ending **25th September, 2015.**

You are advised to report to **the County Commissioner and the County Director of Education, Machakos County** before embarking on the research project.

On completion of the research, you are required to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

DR. S. K. LANGAT, OGW
FOR: DIRECTOR GENERAL/CEO

Copy to:

The County Commissioner
Machakos County.

The County Director of Education
Machakos County.

National Commission for Science, Technology and Innovation is ISO 9001: 2008 Certified

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APPENDIX V: Research Clearance Permit – page 1

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

NACOSTI

National Commission for Science, Technology and Innovation

RESEARCH CLEARANCE PERMIT

Serial No. A 4830

CONDITIONS: see back page

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APPENDIX V*I*: Research Clearance Permit – page 2

THIS IS TO CERTIFY THAT:
MS. SUSAN NJERI MUHUHI
of ST. PAULS UNIVERSITY, 0-217
Limuru,has been permitted to conduct
research in *Machakos County*

Permit No : NACOSTI/P/15/2799/5362
Date Of Issue : 8th April,2015
Fee Recieved :Ksh 1,000



on the topic: *EFFECTS OF CONTRACEPTIVE ON PROTECTED SEX AMONG YOUTH IN INSTITUTIONS OF HIGHER LEARNING IN MACHAKOS TOWN, KENYA.*

for the period ending:
25th September,2015

.....
Applicant's Signature

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

ST. PAUL'S UNIVERSITY

APPENDIX VII: Deputy County Commissioner (Machakos) Research Authorization

THE PRESIDENCY
MINISTRY OF INTERIOR AND COORDINATION
OF NATIONAL GOVERNMENT

Telephone: 21009 and 21983 – 90100
Address: countycommasaku@gmail.com
Fax No. 044-21999

When replying please quote

OFFICE OF THE
County Commissioner Email
P.O. Box 1 - 90100
MACHAKOS.

REF CC ADM 5/9 VOL I /56

20th April 2015

Deputy County Commissioners
MACHAKOS

RE: RESEARCH AUTHORIZATION

This is to confirm that Susan Njeri Muhuhi of St Paul's University has been authorized to carry out a research on ***"Effects of contraceptive on protected sex among youth in institutions of higher learning in Machakos Town, Kenya"*** for a period ending 25th September 2015

Kindly accord him the necessary support to enable him achieve his goal.

Thank you

G O Onyanga
For: County Commissioner,
MACHAKOS