

Original Research Article

Socio-cultural factors influencing utilization of contraceptives among girls aged 15 to 19 years in Kuria West Subcounty, Migori County

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ABSTRACT

Background: Insufficient contraceptive use among 15–25-year-olds leads to unwanted pregnancies, unsafe abortions, disabilities, infant mortality, and high teen pregnancy rates, with Kenya's high rate of teen pregnancies despite efforts.

Methods: Analytical cross-sectional study design was used and 361 teenage girls between 15-19 years in the selected electoral wards at Kuria West Sub County in Migori County, Kenya. Data was collected using administered structured questionnaire, and key informant interview. Quantitative data analysis was conducted using statistical package for the social sciences (SPSS) version 26.0 and involved univariate and bivariate analysis. Bivariate analysis was done through logistic regression was used to test the significance of the association between the dependent and independent variables ($p < 0.05$). Qualitative data was analyzed by thematic content analysis.

Results: More than two third 249 (69.0%) of respondents had utilized contraceptives such as condoms (33.3%), injection (25.3%), implants (22.9%), and pills (15.7%). Religious affiliation ($\chi^2 = 5.576$, $df = 1$, $p = 0.018$) was significantly associated with utilization of the contraceptives. Additionally, religion supports the use of contraceptives ($\chi^2 = 0.061$, $df = 1$, $p = 0.804$), culture prohibits the use of contraceptives ($\chi^2 = 1.496$, $df = 2$, $p = 0.473$), discuss contraceptive methods with family ($\chi^2 = 1.423$, $df = 2$, $p = 0.491$), and difficult to engage in sexual discussions with my parents/guardian ($\chi^2 = 2.707$, $df = 2$, $p = 0.258$) had no statistical relationship with utilization of the contraceptives.

Conclusions: Central and county government, stakeholders and NGOs should organize health education targeting parents, community and the society which should include, schedules and benefits/importance of utilization of FP services to counter the cultural beliefs.

Keywords: Teenage girls, Adolescents, Contraceptives, Pregnancy, Infant mortality

INTRODUCTION

Teenage pregnancies, unwanted pregnancies, unsafe abortions, birth defects, and infant mortality are all issues caused by adolescents' insufficient use of contraceptives. Despite progress, the global unmet need for contraception remains high, particularly in poorer countries. Unintended pregnancies among sexually active teens are primarily due to contraception non-use.¹ Each year, nearly 16 million females between the ages of 15 and 19 and 1 million females under the age of 15 give birth. Girls in their

adolescent years, particularly younger females, are particularly vulnerable due to the risks involved with early pregnancy and delivery. Complications during pregnancy and delivery are the second highest cause of death for females aged 15-19 worldwide.² Around 3 million females aged 15 to 19 experience unsafe abortions annually. Contraceptive usage has grown globally, particularly in Asia and Latin America.³

Religion can influence teenagers' sexual and contraceptive choices, with some studies suggesting a protective factor

in relation to sex delay. However, there is no evidence that discouraging adolescents from using contraception results in abstinence or a delay in sexual development. When teenagers perceive contraceptive constraints, particularly the use of condoms, they are more likely to engage in risky sexual conduct.⁴ Educating adolescents about contraception does not result in increased sexual activity, an earlier age of first sexual contact, or an increase in the number of partners. The availability of contraceptives has no causal relationship with sexual experimentation. Social and cultural barriers make it difficult to have a conversation about adolescent sexual and reproductive health (ASRH), leading to stigmatization of sexual health issues. Cultural taboos create barriers to open dialogue about sexuality both at home and in the classroom.^{5,6}

Comprehensive sexual education is essential for adolescents as it teaches them the appropriate contraceptive strategy at each developmental stage and educates them about the side effects of the contraceptives they use. However, the quality of the curriculum directly correlates with the quality of comprehensive sexual education.⁷ Lack of knowledge regarding contraception use among schoolgirls has led to a rise in the transmission of sexually transmitted diseases, unwanted pregnancies, and abortions done by individuals with dubious credentials. There is no evidence that denying teen contraception results in abstinence or a delay in sexual activity. In Sub-Saharan Africa, only 27.6% of adolescent females take contemporary contraception, despite 72 percent seeking to avoid pregnancy. Kenya has a low rate of adolescent contraception use (14.2%), with an estimated 5.5 million adolescent females giving birth each year.^{8,9}

METHODS

This research was conducted in Kuria west subcounty, Migori County. Migori County is located in southern Kenya, in the old Nyanza Province. Kuria West Sub-County has an estimated population of 174,253 and covers an area of 316.9 square kilometres. Crop cultivation, livestock keeping, brick manufacturing, and sand collecting are all prevalent socioeconomic activities in the study region along the river Hibwa.¹⁰ This study was an analytical cross-sectional design using both quantitative methods (issuing interviewer-administered questionnaires to the respondents) and qualitative methods (use of key informant interviews from healthcare workers in Kuria west subcounty) from selected wards with the data collection done between March 2023 to June 2023. The study included girls aged between 15 and 19 years, parents of girls below 18 years who provided consent for the study, and health care workers from selected health facilities and girls who exhibited unusual, strange conduct, difficulties with attention, or difficult-to-explain speaking were excluded from the study. A multistage sampling technique was applied in this study with convenience sampling to select Kuria West due to its high prevalence of teenage pregnancies in Migori County. Two wards, Tagare ward and Bukira Central Ward, were then selected using a

stratified random sampling technique from the list of available wards in Kuria West subcounty. The sample size for each ward was determined based on proportional stratification. Systematic random sampling method was used among 361 respondents aged 18-19 years and below 18 years accompanied by a guardian as well health care workers from selected health facilities willing to participate and consented for the study. A pilot study was done at from the Makerero ward in the Kuria West subcounty with the Pearson moment correlation coefficient (r) used to determine reliability. The Cronbach alpha reliability coefficient test showed 0.758 reliability for the questionnaire for contraceptive utilization, and 0.799 for socio-cultural factors. Interviewer-administered structured questionnaires were used to collect quantitative data while key informant guide was used to collect qualitative. Quantitative data was analysed using statistical package for social science (SPSS) version 29.0. Descriptive data was presented using frequencies, percentages, means and standard deviation while inferential statistics used chi-square test to measure association between independent and dependent variables. P values less than 0.05 were considered statistically significant.

RESULTS

Socio-demographic characteristics of study respondents

The respondents age ranged from 15 years to 19 years, the mode was 18 years, median 17.0 years and the mean age was 17.01±1.31. The findings showed that 99 (27.4%) were 18 years, 86 (23.8%) were 16 years, and 57 (15.8%) were 15 years. Slightly more than three quarter 295 (81.7%) never married and 281 (77.8%) were living with parents/guardian during the study period. Approximately 2.2% of respondents had no formal education with most 124 (34.3%) of respondents had secondary level of education. Most of respondents 225 (62.3%) had parents/guardian participating in income generating activities of which 71 (19.7%) being formally employed and 154 (42.7%) were self-employed (Table 1).

Known contraceptives

Condoms (83.8%), injection (62.4%), and pills (58.4%) were commonly known contraceptives (Figure 1).

Use of contraception method

More than two third 249 (69.0%) of respondents had utilized contraceptives such as condoms (33.3%), injection (25.3%), implants (22.9%), and pills (15.7%) (Table 2).

Majority of girls come for contraceptive purporting to be feeling sick and during examination they ask for contraceptive injections. So, their parent will belief that their adolescent girl gone to facility for certain illness like stomach-ache, and headache.

“Most of girls who report here for contraceptives they ask for depo.....and request to be a secret between a nurse working in this health centre and her” (KII 4).

“One girl narrated to me why they don’t like pills.... she said one day her mother saw pills she had put somewhere and asked her: Where did you get these pills from? ” And she replied that she was given by friend. Her mother was angry calling her so many names.... since then, she has been using injections since the girl can’t stay long without sexual intercourse” (KII 3).

Table 1: Socio-demographic characteristics of study respondents.

Characteristics	Frequency	Percent
Age group (years)		
15	57	15.8
16	86	23.8
17	67	18.6
18	99	27.4
19	52	14.4
Marital status		
Single	295	81.7
Married	52	14.4
Separated	14	3.9
Live with parent/guardian		
Yes	281	77.8
No	80	22.2
Level of education		
No formal education	8	2.2
Primary dropout	35	9.7
Primary	194	53.7
Secondary dropout	34	9.4
Secondary	90	24.9
Parents/guardian employment status		
Employed	71	19.7
Self-employed	154	42.7
Unemployed	136	37.7

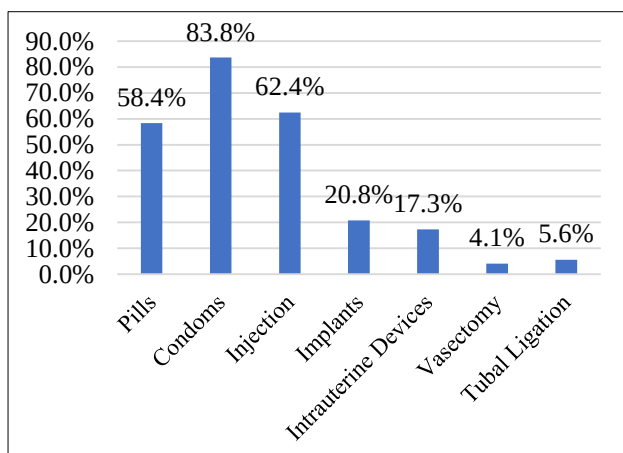


Figure 1: Known contraceptives.

Engaging in sexual activities

Slightly less than two third 238 (65.9%) of respondents had engaged in sexual activities with 124 (52.1%), 20 (8.4%) and 4 (1.7%) had first coitus at age 15 years or less, at 18 years and at 19 years respectively. Additionally, almost a third 74 (31.1%) engage sexual activities on weekly basis and 45 (18.9%) on daily basis (Table 3).

Table 2: Use of contraception method.

Characteristics	Frequency	Percent
Use of contraception method		
Yes	249	69.0
No	112	31.0
Method used		
Pills	39	15.7
Injection	63	25.3
Condoms	83	33.3
Implants	57	22.9
IUCD	7	2.8
Source of contraceptive		
Health facility	137	55.0
Pharmacy	95	38.2
Friends	17	6.8

Table 3: Engaging in sexual activities.

Characteristics	Frequency	Percent
Engaged in sexual intercourse		
Yes	238	65.9
No	123	34.1
Age of first coitus (years)		
≤15	124	52.1
16	58	24.4
17	32	13.4
18	20	8.4
19	4	1.7
Frequency of coitus		
Daily	45	18.9
Weekly	74	31.1
Monthly	50	21.0
After months	69	29.0

The rate of contraceptive among girls is increasing daily, few years ago few adolescents’ girls had courage to visit a facility for contraceptive uptake. The only big problem is they are afraid of pregnancy and not sexually transmitted infections.

“.... If a young adolescent gets pregnant, everything stops moving. Parents (female) cannot go to work because they will be busy taking care of the adolescent at the hospital since she is young. They will not have time to go to the farm if it is rainy season. As a result, they will have no food at home and there will be severe hunger” (KII 5).

“I have been encouraging girls to abstain or use dual protection method, but majority don’t want to hear that, they need to hear.... this will protect you from getting pregnancy for this period.... that’s all, that’s why you will find them lining up for long term contraceptives” (KII 3).

Socio-cultural factors influencing utilization of family planning services

In Table 4, most Christian respondents 231 (70.9%) utilized family planning services, similarly, 68 (68.0%) and 96 (72.7%) of respondents whom religion supports the use of contraceptives and traditional/cultural belief are against use of contraceptive methods utilized the contraceptives. Additionally, respondents comfortably discussing contraceptive with relatives 40 (75.5%), parents 7 (75.0%), and healthcare workers 62 (72.9%) utilized the contraceptives, further, respondents agreed culture

prohibits the use of contraceptives 168 (68.3%), discuss contraceptive methods with family 54 (73.0%), and had difficult to engage in sexual discussions with my parents/guardian 209 (69.9%) utilized the contraceptives. Further analysis with an aid of chi-square test was carried out in order to establish association between respondent’s socio-cultural characteristics with utilization of the contraceptives. The Pearson Chi-square in Table 4 shows that religious affiliation ($\chi^2=5.576$, $df=1$, $p=0.018$) was significantly associated with utilization of the contraceptives. Additionally, religion supports the use of contraceptives ($\chi^2=0.061$, $df=1$, $p=0.804$), culture prohibits the use of contraceptives ($\chi^2=1.496$, $df=2$, $p=0.473$), discuss contraceptive methods with family ($\chi^2=1.423$, $df=2$, $p=0.491$), and difficult to engage in sexual discussions with my parents/guardian ($\chi^2=2.707$, $df=2$, $p=0.258$) had no statistical relationship with utilization of the contraceptives (Table 4).

Table 4: Socio-cultural factors influencing utilization of family planning services.

Variables	Yes (%)	No (%)	Statistics
Religion			
Christian	231 (70.9)	95 (29.1)	$\chi^2=5.576$, df=1, p=0.018
Muslim	18 (51.4)	17 (48.6)	
Religion supports the use of contraceptives			
Yes	68 (68.0)	32 (32.0)	$\chi^2=0.061$, df=1, p=0.804
No	181 (69.3)	80 (30.7)	
Traditional/cultural belief are against use of contraceptive methods			
Yes	96 (72.7)	36 (27.3)	$\chi^2=1.369$, df=1, p=0.242
No	153 (66.8)	76 (33.2)	
Comfortably discussing contraceptive			
Relatives	40 (75.5)	13 (24.5)	$\chi^2=3.132$, df=3, p=0.372
Friends	138 (65.4)	73 (34.6)	
Parents	7 (75.0)	5 (25.0)	
Healthcare workers	62 (72.9)	23 (27.1)	
Culture prohibits the use of contraceptives			
Disagree	64 (68.1)	30 (31.9)	$\chi^2=1.496$, df=2, p=0.473
Neutral	16 (81.0)	5 (19.0)	
Agree	168 (68.3)	78 (31.7)	
Discuss contraceptive methods with family			
Disagree	155 (66.8)	77 (33.2)	$\chi^2=1.423$, df=2, p=0.491
Neutral	40 (72.7)	15 (27.3)	
Agree	54 (73.0)	20 (27.0)	
Difficult to engage in sexual discussions with my parents/guardian			
Disagree	22 (57.9)	16 (42.1)	$\chi^2=2.707$, df=2, p=0.258
Neutral	18 (75.0)	6 (25.0)	
Agree	209 (69.9)	90 (30.1)	

Key informants narrated that there are two different situations often happen in households. In one situation, a parent refuses to allow his girls to use contraceptives for traditional beliefs and also religious perspectives.

“There are so many taboos regarding contraceptives such as girls will become cold.... their ovaries will freeze... and never bear children, will have disabled children...and so

many beliefs, these beliefs hinder uptake of contraceptives” (KII 1).

“Most of these girls keep their contraceptive use secret from parents, they fear their parents, and whenever they are in need of contraceptive, they use a relative or an older friend” (KII 3).

In addition, not getting pregnant outside of marriage is an expectation in communities, as it is a source of dishonour for girls and their families, and may even prevent a girl from finding a husband.

“In our neighbourhood here, girls are forced by their mothers to use the abstinence method to prevent them from getting pregnant, because getting pregnant while unmarried is strictly forbidden in our community. However, peer pressure, media, etc. “force” girls to engage in sexual act, so whom will they run to for pregnancy protection? Definitely not parents” (KII 6).

Participants further stated that boys lead in making decisions around contraceptive use. Girls usually have no much say in the relationship when it comes to sex.

“Cultural beliefs have very huge impact of contraceptive uptake, in this community..... when you are in a relationship, boys usually lead in decision making the same as in marriage. That is why girls believe that because of love, they cannot make a decision Which will not impress a partner, you go by what he says otherwise he will dump you” (KII 1).

DISCUSSION

The study revealed that more than two third 249 (69.0%) of respondents had utilized contraceptives. This is far more less than adolescents' birth control practices reported by Kantorová et al in the United States of America, who found that a majority (78%) of sexually active adolescent girls had used contraceptives for the first time during their sexual activity.¹¹ A study by Sanchez-Paez et al in Malawi found high demands for contraception (at 84.7%) and fertility in that region is also high (at 80%).¹² Despite these high demands, the percentage of this group of people who use contraception is just 38.6% of the global percentage of 60.8%. According to a study conducted in Ghana by Gbagbo on adolescent girls' use of contraception, modern contraception use is quite low, with religion, education, and money being major factors for this low usage.⁸ In Kenya, a study on contraception uses among adolescent female students in secondary schools found that only 23% of the sexually active adolescents used modern contraception methods, such as pills, injections, and condoms.¹³

The study found that most Christian respondents 231(70.9%) utilized family planning services. However, religion ($p=0.018$) was significantly associated with utilization of contraceptives by and religion support contraceptive ($p=0.804$) was not significantly associated with utilization of contraceptives. A study by Marrone et al found that religiosity is a double edged sword-exhibiting both advantages and disadvantages depending on the desired outcome.¹⁴ It may influence adolescents' decisions about sex and contraception use; however, the direction of its effect is not clear. Some studies have shown that religious affiliation, behaviour, or attitudes may be a

protective factor associated with delay of sex. A study by Obat et al found little association between religiosity and sexual behaviour while some have reported a positive correlation between importance of religion and sexual activity.¹⁵ Additionally, a number of studies have shown religiosity to be associated with less frequent use of condoms and/or hormonal contraception.⁶

The study found that 64 (68.1%) and 168 (68.3%) of respondents utilized the family planning services had the disagreed and agreed that the culture prohibits the use of contraceptives respectively. Additionally, cultural belief against contraceptive methods ($p=0.242$) were not significantly associated with utilization of family planning services. A study by Muneene found that cultural taboos prevent open dialogue about sex at home or in school.¹⁶ Few adolescents receive comprehensive sex education, and often teachers do not have enough training or information to provide it. Existing evidence also suggest that the provision of information to adolescents about contraception does not result in increased rates of sexual activity, earlier age of first intercourse, or a greater number of partners.¹³ Several other studies have concluded that the availability of contraception is not causally related to sexual experimentation.^{12,17,18}

Limitations

The study on contraceptive use and sexual behaviour in Kenya has several limitations, including time constraints, sensitive information, and a specific geographical area. These factors may have influenced the research process and the generalizability of the findings. The study's focus on girls aged 15-19 in rural areas may not fully represent the diversity of adolescent populations in other settings. Additionally, the study's self-reported data may introduce recall bias and potential measurement errors. The study's findings should be applied to different demographic groups, considering factors such as socioeconomic status, educational background, and cultural norms. Also, the researcher was faced with some difficulties in meeting the costs related to the study especially printing and stationers as well transport costs and lunch allowance to the supporters/assistants considering that the researcher was a self-sponsored student.

CONCLUSION

It can be concluded from this study that most of girls had utilized contraceptives such as condoms, pills, injection and implants with majority sourcing from health facility. Further, slightly more than half had engaged in sexual activities with most of girls had first coitus at 15 years or below. Additionally, more than half engage sexual activities on weekly basis. Most Christian respondents had higher rates of utilized family planning services with religion affiliation influencing contraceptive use, however, religion support contraceptive, culture prohibits use of contraceptive and cultural belief against contraceptive methods were not significantly associated with utilization

of family planning services. additionally, there was stronger positive relationship between a difficult to engage in sexual discussions with my parents/guardian and discuss contraceptive methods with family, religion supports the use of contraceptives and a discuss contraceptive methods with family, and between religion supports the use of contraceptives and religion affiliation. The county government and MOH should promote condom use among all age groups, emphasizing prevention of STIs and unplanned pregnancies. Increased funds should be allocated for awareness creation and sensitization through various channels. Health workers should be empowered with modern contraceptive trends. Health education should be organized by central and county governments, stakeholders, and NGOs to counter cultural beliefs.

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