OPEN ACCESS

Journal of Advanced Research in Social Sciences
ISSN 2538-919X

Contraceptives and the Youth: Examining the Social Meaning of Contraceptives among Undergraduates in Kenya

Jacqueline I. Adolwa*, Willice O. Abuya and Jamin M. Masinde

Department of Sociology and Psychology, Moi University

ARTICLE INFO

Keywords:
Contraceptives and the youth,
social meanings,
social construction,
Kenyan youth

ABSTRACT

Sexuality is a development milestone in one's life cycle, and each generation has its own struggles with it. It becomes more complex when the biological forces that accompany it initiate the sexual maturation process. The youth are very prone to risky sexual behaviour at this stage due to their perceptions of personal invulnerability, that leaves many exposed to HIV/AIDS infection, early pregnancies and abortion incidences. The unmet need for contraceptive use in sub-Saharan Africa has left the youth exposed to the aforementioned vices, making this a matter of great public health concern. Through a qualitative approach, this article examines the social meaning that the youth bestowed on two contraceptives (condom and the E-pill) and assesses how these meanings influence their sexual behaviour. The study concludes that there is need for policy makers to understand youth perceptions towards various contraceptive methods if effective campaign on reproductive health is to be realised.

1. Introduction

Globally, among 1.9 billion women in their reproductive age (i.e. aged between 15-49 years), 1.1 billion have a need for contraceptives. As of 2019, about 842 million were using contraceptives with approximately 270 million having an unmet need for contraception (Kentrova, Wheldon & Dasgupta, 2020, p.1). Early sexual debut has particularly been associated with inconsistent use and/or none use of contraceptives with varying long-term health consequences. Allan Guttmacher Institute (1999) indicates that eight out of ten young women in sub Saharan Africa (SSA) have had their first sexual experience before the age of 20. Contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in SSA. Generally, the unmet need for contraceptive use in SSA among the youth is estimated to stand at more than 40%.

The youth in SSA who initiate sex are exposed to sexually transmitted infections (STIs), HIV, and unintended pregnancies (Lloyd, 2005; Patton *et al*., 2007, pp.1130-1139). This risk of unintended pregnancies is heightened by the low use of contraceptive use during their early sexual experiences. The poor sexual and reproductive health outcomes has led to other adverse effects such as maternal deaths, poor education and/or high school dropout rates, with the attendant lack of employment opportunities later in life (Gupta and Mahy, 2003, pp.41-53;

*Corresponding author E-mail address: adolwaj@yahoo.com

Cite this article as:
Adolwa, J. I., Abuya, W. O., & Masinde, J. M. (2022). Contraceptives and the Youth: Examining the Social Meaning of Contraceptives among Undergraduates in Kenya. *Journal of Advanced Research in Social Sciences, 5*(1): 18-34. https://doi.org/10.33422/jarss.v5i1.583

Sign, 1998, pp. 117-136). According to the South African Demographic Health Survey (SADHS, 2003, pp. 54- 65), 97% of sexually active youth in South Africa (SA) have knowledge of at least one contraceptive method but by 2007, the contraceptive prevalence rate among young people aged between 15-24 years was only 52%. In Kenya, the unmet need for contraception among the youth is 30% (KDHS, 2008/9). A survey in 2015 on youth and adolescents in Uasin Gishu County (Kenya) revealed that the unmet need for contraceptive use was 22% with about one in every five girls aged 15-19 years having unintended pregnancy (National Council for Population and Development, 2017).

While most research have focused on knowledge of contraceptives (see African population and Health Research 2002 and Nalwadda *et.al*., 2010, pp.530-541 for instance), on challenges on modern contraceptive use (see South African Department of Health, 1998 for instance), on attitudes and practices (see African Health Science, 2002 for instance), little has been done on how the youth socially construct contraceptives, and how this affects their sexual behaviour. To social constructivists, reality is socially constructed with meanings bestowed from shared lived experiences (Berger and Luckmann, 1966). As happens with the larger society, the youth too are well-known for bestowing meanings on items in their environment, and contraceptives are no different. These meaning would emanate from interaction with family members, their peers, religious values, and the media, all which tend to influence the meanings they acquire.

Despite the advanced knowledge on contraceptives among the youth, studies indicate that many young people still engage in unprotected sex. The SADHS (2003) indicates that 97% of sexually active youth in South Africa have at least knowledge of one contraceptive method but only half of these young people were found to be using contraceptives. Could this be because of the social meanings that the youth bestow on these devices? This study aimed at investigating this complexity.

2. Literature Review

There are various types of contraceptives mostly used by the youth in Kenya and this is indicated in Table 1:

Table 1.
Contraceptives favoured by the youth in Kenya

Type of Contraceptive	Description	Use
Birth control pill	Prescription pill containing oestrogen and progestin that's suppresses Ovulation	Must be taken daily, regardless of the frequency of intercourse
Condom, female	Lubricated sheath that is inserted into the vagina. Similar in shape to the male condom, with a flexible ring	Applied immediately before intercourse, for single use
Condom, male	Latex or polyurethane sheath placed over erect penis, widely available in drugstores	Applied immediately before intercourse, for single use. Best protection against sexually transmitted diseases
Depo-Provera injection	Injection that inhibits ovulation, obtained by prescription	Injections performed at a doctor's office, once every three months
IUD (intrauterine device)	T-shaped device inserted in the uterus during a visit to the doctor	Can remain in place for up to one or 10years, depending on type
Morning-after pill (emergency contraceptive)	Pills similar to regular birth control pills, obtained by prescription	Must be taken within 72 hours of unprotected intercourse,
Type of Contraceptive	Description	Use

Safe days	Refraining from intercourse when conception is likely	Requires regular menstrual cycles and close monitoring of body functions pertaining to ovulation
Withdrawal/coitus interruptus	Having intercourse, but removing the male penis before ejaculation	Not recommended for teens, and some seminal fluid leaks before ejaculation, making it an ineffective method of birth control

(Planned Parenthood, 2004).

2.1. Factors Affecting Contraceptive Use among the Youth

Various factors have been identified as influencing contraceptive use among young people. Some of these factors include the following:

1. Low perception of risk of pregnancy has been identified as a critical factor that influences attitudes and sexual behaviour amongst the youth. Risk denial is also a major factor that influences risk behaviour as some youth think they are invulnerable to infection and pregnancy, and as such they do not use condoms or other contraceptives. This type tend to sleep with as many people as they can (Sonnenberg et. al., 2013, pp. 1795 - 1806).

2. Level of satisfaction with their contraception method is another factor that has been cited as leading to unintended pregnancy. Beekle (2006, pp. 269-276) noted that nearly 40% of youth were unsatisfied with the various contraceptive methods as they allegedly reduce sexual pleasure. Others are said to have unpleasant side effects. These reasons consequently result in the inconsistent use of these methods.

3. Religious and other cultural beliefs have also been found to affect contraceptive use. Religious beliefs come in when they preach against contraceptives and instead advocate for abstinence which the youth have difficulties with (Agadjanian *et.al*., 2009, pp.462 and Gyimah *et.al*., 2006, pp.235 -252). Religion also influences contraceptive practice as it often the basis for the recurrent morality bashing by opponents of youth contraception. Religion thus regulates sexual behaviour, through attitude formation that in turn affects behaviour. However, the chastity stand has been singled out as also posing several dilemmas for the sexually active faithful who being only human, do not know which is the lesser evil.

Some family planning methods also do challenge certain cultural beliefs, with the result that some opt not to use these methods. For instance, they challenge gender roles, challenge societal beliefs on pregnancy prevention, challenge marriage models (like polygamy, same family marriages, incestuous marriages etc.), as well as challenging sexual behaviours (premarital sex, infidelity, marriage prohibitions etc.) (Ochako *et.al.,* 2015, pp.15-118).

4. Unavailability of contraceptives is another factor that affects contraceptive use. Some youth lack access to contraceptives. Access to contraceptives in rural areas is also lower compared to urban settings. For instance, there were persistent problems of accessibility, affordability, and unavailability of the contraceptives prevailing in the rural/village areas in a study in Punjab (Ali, 2015, p.25). A male respondent in Punjab was quoted as saying “The men and women in this area want to practice family planning but it is not within their reach; it is difficult for them to access family planning centres as these as far away from our residence”.

5. Media also significantly influences use of contraceptives. Access to media (the frequency of reading newspapers / magazines, frequency of listening to radio and frequency of watching TV shows) has been shown to have a significant association with contraceptive use (Shaweno and Kura, 2016, pp.7-10).

6. Demographic factors which include age, gender, educational status, ethnicity, marital status have also been mentioned as factors. Age influences contraceptive use for the reason that at different stages of a youth's life, one battles with his/her conscience on whether or not to use contraceptives. First, the younger a youth is the less likely he/she is to use contraceptives. Secondly the younger the respondent is during the first sexual experience, the lesser the probability he/she is of using a contraceptive method during their first sexual act. Third, the older the youth is, the greater the probability of using contraceptive (Vasundhara *et. al*., 2012, pp.43 - 47). Qualitative data shows that the more mature one becomes, the more responsible one becomes and the more likely one will make rational decisions as relates to their sexuality (including use of contraceptives) (Mutungi *et.al*., 1999, pp.541 -546).

7. Women's education has a great influence on many health indicators. Education is one of the most commonly studied determinants of the use of contraception and unmet needs. Women attitudes towards family planning are heavily influenced by (level of) education. Studies have indicated that as the level of education increases, the number of children decreases (Mosher *et.al*., 2004, pp.184 -191).

8. It was also found in a study in Kenya that educated partners with a higher education were more likely to use contraceptives as compared to the uneducated partners (Becker, 1996). Another study in Mexico indicated that non-use of contraception was higher among illiterate women than among those who had completed secondary school (see Beutelspacher *et.al*., 1999). Jejeebhoy (1995) revealed that inadequate knowledge about contraception and how to obtain health services was one of the reasons why many adolescent women in developing countries were not able to use contraceptives. Inadequate knowledge about contraception brings fear, rumours and myths about family planning which prevents youth from seeking contraceptives. Rumours and myths about the side effects, safety and effectiveness of the various methods (Nalwadda *et.al.,* 2010, pp.530-541) revealed that women believed that the pill caused deformities in babies, bought about cancer, and increased infertility among women as it was believed it scorch women eggs. Stigma around young people sexuality is also a deterrence for young people seeking services and, in some cases, they are actually denied the sought-after reproductive health services. Most young people seeking services are usually afraid, embarrassed and even shy while seeking family planning services (Biddlecom, Munthali and Singh, 2007, pp.99-100).

9. Studies have shown that the attitudes the youth have on contraceptives is also a major determinant for use or non-use of contraceptives. Positive attitudes are associated with a greater use of contraceptives while negative attitudes are associated with less or complete absence of contraceptive use (Salako *et.al*., 2006, pp.26-36). Furthermore, the attitudes the youth develop over contraceptives have been found to be shaped differently among males and females. On a contrary note, however, Ryan *et.al*. (2007, pp.149-57) suggests that an increase in contraceptive knowledge does not necessarily translate to a positive attitude as this can also lead to negative attitudes as an increase in knowledge enables them to become more aware of the side effects of the various contraceptives.

10. Some youth develop a negative attitude towards contraceptives because of lack of insufficient information of the various contraceptive methods, over fear of their side effects, upon experience of contraception failures, on the tedious routine involved with certain methods (such as the oral pill, IUD etc) and over societal disapproval of contraception among young and unmarried persons (Salako *et.al*., 2006 and Ugoji, 2008). Hence most youth do not use contraceptives because of the perceived side effects. On the other hand, the youth tend to have positive attitude towards condoms reporting it as the most favourable method of contraception

because of its dual functions of pregnancy prevention and STI protection without the associated complications that comes with the other methods.

Contraceptive attitudes thus play a large role in sexual behaviour. Understanding youth attitude on contraceptive use, gaps in knowledge or trends in behaviour may be utilized to address such issues.

Next, we look at the concept of social meaning and how this influences behaviour.

3. Social Meanings

Social meaning is defined as the semeiotic content attached to various actions or objects within a particular context (Lessing, 1995, p. 951). Meanings not only lead to our understanding of actions and objects, but also to our understanding of objects and their symbolic radiance within our spaces. In most cases, most are subjective and personal. They also reflect that we are social-beings dependent on others and necessarily involved in social practices. They also remind us that we don't just think and interact, but that we also evaluate things as they have happened in the past, and conjecture how they may happen in the future (Archer, 2009, pp.249 -266).

Social meanings are important and non-optional, and they empower or constrain individuals whether or not the individual chooses the power or constraint (Lessing, 1995, pp.943 -1045). Meanings are collective and public and such meanings affect us and our interactions even if we reject their content. These meanings are not fixed or stable or uniform across any collection of people; they differ across communities and individuals. Abuya (2013) illustrates how meanings have an effect on the life of a community in Kwale. He examined the ethno-ecological meanings that the community attached to resources and to the environment, where he noted that the environment (land, houses, crops and cultural artefact such as graves etc) bears meanings that provide identity, continuity and fulfilment to individuals and groups in that particular area.

Meanings guide, constrain and also act as tools and means to a chosen end. They are a way of directing and coercing one another to conform to something. As individuals' intentions change, so does the world around. In phenomenological studies, it is argued that knowledge does not exist independent of man but that it has to be gained from man's experience of the world; and that the world can only be understood in reference to man, and only through his intentions, attitudes and experiences (Relph, 1976, pp.4-7).

4. Methodology

The study was qualitative in nature as it sought to understand the meanings that the youth had bestowed on contraceptives and how these meanings influenced their sexual behaviour. This can be best obtained through a qualitative study as this focuses on views, attitudes, emotions, opinions and behaviours in a social context (Macqueen, Guest, Namey, 2005), thus bringing out their idiographic experiences.

The research site for the study was Moi University, main campus at Kessess, Uasin Gishu County, as here one would readily find a collection of youths. The sample size was determined through saturation as determined by Morse, Lowery and Steury (2014, pp.557 -571)—this was achieved with 60 respondents. The respondents were selected through convenience, chance and snowball methods.

The methods used to collect data included in-depth interviews, focus group discussions (FGDs) and key informant interviews. These methods are best for unearthing attitudes, emotions and opinions. These methods enabled the collection of rich and 'thick' data that were obtained

through narratives. Since one's sexual behaviours is a sensitive subject, in-depth interview offers researchers the opportunity and time to interview at length, and through reflexivity, obtain the information needed (Macqueen, Guest, Namey, 2005). Six FGDs were conducted for this purpose.

Key informant Interviews were also conducted with people who have specialized knowledge on the topic. This included 4 key informants from Moi University Health Service (2 nurses, a student counsellor from the counselling unit and the Dean of Students), a social worker, a peer educator and 2 youth centre coordinators (one from the Family Health Options Kenya and the other from MTRH youth programme). Data was transcribed, categorised then analysed thematically and through content analysis. To ensure trustworthiness of data, interviews were recorded, field notes taken and through triangulation of methods.

5. Research Findings

This section discusses the various meanings the youth bestowed on contraceptives and assesses how this in turn influenced their sexual behaviour. The study found that the most popularly used methods were the condom and the E-pill. This article thus examines the social construction of these two methods.

5.1. Social meanings of condoms and its influence on sexual Behaviour

The article first examines the various social meanings bestowed on the condom (female and male).

Condoms as 'Protection / Prevention Tool' **1.** Various social meanings were found to have been bestowed on the condoms. The first was that of the condom as a "tool of protection" (against STI, HIV and unintended pregnancy). 'Mark', a 24-year-old explained this as follows:

> *Condoms offer protection. Neither I nor my girlfriends want to have a baby now because we are in school, and as such, condoms offer this relief. Again, it offers us protection against HIV/AIDs.*

'Careen', 27-year-old elaborated thus:

> *We refer to condoms as a 'blockage' which means "stop" so when we use blockage it prevents the sperm from fertilizing the egg but this only applies when am still a youth, when we get to 23+married you cannot be having sex with a condom even your partner cannot allow so you will have to use other means to prevent yourself from getting pregnant.*

'Vela' further opined that:-

> *I don't trust men with condoms; some don't even look at expiry dates. So when you wear yours, you are sure you've been protected from pregnancies and sexual infections.*

These findings support Dicenso & Guyatt's (2002, p.324) findings which noted that aside from offering more effective protection against pregnancy and STI, the female condom also gives women the control they need over their sexuality. Studies (see Chizororo & Natshalanga, 2003, pp.101-116 for instance) shows that the most preferred form of physical protection was the male condom with approximately 93% of the women between the ages of 20-39 making use it. The argument against the female condom was that since it's not easy to hide, one would have to seek permission from their partners to use it, an almost impossible task in African setting. The difficulty with its use, lubrication, size and appearance also rendered it unfavourable. It was also more expensive and less available compared to the male condom.

Given that condoms were perceived to offer protection, this was found to influence the youth sexual behaviour. One was that it made the youth be more promiscuous with multiple sexual partners. Says 'Eric', 26 year old:-

> *If you operate with 'jeshi' (an army of girlfriends) it gives you assurance, motivates you and even boosts your confidence and sex drive; you can have sex with all of them and get away with it because you know you are safe.*

And lastly 'Marley', 25year old elaborated that:-

> *I cannot trust anyone yet I am young am not married and I hook up with anyone, it's not fixed to one person. We (youth) are just sexually active are exercising our freedom and tasting anything and everything on sight, anywhere and with anyone; all you need is a condom.*

Clearly, the perception that one is safe when using condoms appear to have given the youth the feeling of invulnerability and many felt that they can now act with abandonment.

***Condoms as 'a planning tool'* 2.** Another meaning that emerged was that of condoms as a tool that one can use to plan one's life. 'Nancy' elaborates: -

> *It enables me to plan my life as a youth that's why it's good to use condoms; at least these few minutes of pleasure should not interfere with my life plans and education.*

She further explains:

> The *first guy I had sex with didn't want to use a condom so I had to get an option because I didn't want to be infected or get pregnant. When I asked him why he didn't like it he replied that it is because it doesn't give pleasure. I opted to use the female condom and am safe. It gives me a choice because I don't want a kid right now so it enables me to have children by choice and not by chance. Families should be able to have children they can take care of. So it helps me to plan.*

The findings of this study imply that the youth perceive condoms as a tool that one can use to plan one's live. The youth appear to be very concern on the need to complete one's education, and perceive condoms as the appropriate tool to provide this necessary purpose.

And since it can be used as a planning tool (prevent any unfortunate incident), many respondents stated that they now felt that they have a license to engage in as much sex, and with as many multiple partners, as they wished.

'Steve' explains:

> *Currently am a student and I have a life, I want to graduate, get a job; I still have a lot of things to do. I already have like 5 partners. So, condoms have really helped me achieve this.*

***Condoms as a 'Power Tool' and reflection of masculinity* 3.** Men are usually portrayed as the decision makers and as heads of households. As such, they are normally ranked higher in society. This has brought about power imbalances which make women subordinates in many matter, including matters of sexuality. This power play exhibits itself in the use or non-use of condoms. The existing dominant norms that place men higher than women in matters of sexuality tend to expose young people to unprotected sex with the risk of HIV /AIDs infection and unwanted pregnancy. The study found that women left it to their male counterparts to decide on the use (or non-use) of condoms. 'Frank', a peer educator, explained: -

> *During sex it's a one man show as it is the guy who calls the shots, not the ladies. Most ladies mess up because they do not want to disappoint the guy as they cannot insist on*

> *the use of contraception. Women may not be able to negotiate for safer sex (for the use of condoms) because men decide whether or not a condom is to be used.*

'John', 24-year-old agreed with this:

> *Some men want to show their superiority and they do this by not using condoms. You see, the society portrays real men as those who don't use condoms. We do use condoms so as to show our superiority; so we choose to 'go dry'.*

Cohen, (2004, pp.5-8) indicates that the gender inequalities are a major contributory factor in the spread of HIV. The development of the female condom was to some extent, aimed at giving women a greater control over their own protection. However, this control is yet to be fully realised. 'Lilian', 27 admitted to this: -

> *However in as much as female condom was designed to give females more power, partner cooperation is necessary before a woman uses it. That partner has to consent and this is the big challenge. Most men refuse to cooperate.*

'Anne ', elaborates other challenges associated with the female condom: -

> *It's complicated when a woman produces her female condom. Some men will question why you have it, with some choosing not to have sex with you due to the perception that you are a 'bad' girl.*

This view is supported by Nantambi (2017) who explains that when a woman pulls out a condom and tells the man to use it, there is always that negative perception coming from the man that such a woman has multiple partners hence the caution. These perceptions thus influence sexual behaviour.

On the flipside, there were those who supported the use of the female condom as giving women this power to determine their sexuality.

She explains further that:

> *Most men prefer unprotected sex so it is up to the ladies, especially those who participate in transactional sexual relations, and in cases where the guy refuses to use protection, to use the female condom and be safe, as this is within her purview.*

Though the youth who used the female condom were able to negotiate and have protected sex, there are some who stated that in cases where one's partner refuses to use it, one would find oneself engaging in unprotected sex. In regard to sexual behaviour most of the participants would engaged in unprotected sex did so due to the reasons already discussed earlier. Gender roles and power dynamics tend to decrease condom use, with condoms being portrayed as an antithesis of masculine behaviour (Kazembe *et al*., 2012, pp. 47 -55). This was emphasised by 'Ray' who stressed this point:

> *In the society if a man uses a condom you are perceived as less of a man. Imagine when I go sit with the boys and we are discussing sex issues and I tell them I used a condom….my friends would be like….you are not a man. That's so demeaning.*

***Condoms as a sexual thrill 'minimiser'* 4.** Another meaning that emerged from the study is the meaning attached to condoms as a minimizer of sexual thrill. 'George' offers clarity on this: -

> *Hauwezi kula sweet na karatasi, sisi kama youth wa mtaa tunajua unafaa kuenjoy the real thing (You cannot eat sweets with paper. One has to feel the real thing; I like it 'raw' even as I know the impacts of non-use).*

'Dennis' adds that: -

> *Condoms to me choke my penis, so I don't like it. Using it is not exciting as it minimizes the sexual thrill*.

Most youth perceived condoms as "minimiser of sexual thrill" as, in their view, it reduces sexual pleasure. Neetu *et.al*., (2015) agrees with these findings as he states that there is a misconception that a barrier reduces sexual pleasure. Plummer *et.al.,* (2006, pp. 29 - 40) noted in his research that the youth refer to the use of protection as "farming with your hoe in the sack".

Others hated the female condom with 'Caren', 21-year-old stating: -

> *Female condoms are big and just disgusting, and the fact that you have to wear it like hours before having sex makes it even more uncomfortable. And what if you end up not having sex? All that effort for nothing. I don't like them.*

The perception that protected sex is not exciting has led to many not using condoms. Many are thus end up exposed to the risk of pregnancy and contracting STIs. From the narratives above, it can be deduced that many of the youth engage in risky sexual behaviour because of this perception.

***Condoms as 'a social stigma'* 5.** Another social meaning that emerged was that of the condom as a "social stigma". This perceptions on the condom was used to discourage the youth from using it. Such stigma would act as deterrence especially for young people seeking services from family planning facilities—most young people seeking these services would feel embarrassed and shy (Biddlecom *et.al*., 2007, pp. 99 -100). Condoms in the society have generally been associated with immorality and as such, anyone associated with condoms was deemed to be immoral.

'Caleb' explains: -

> *The thought of being seen buying a condom from a supermarket or be found picking it from a dispenser, just makes one to instead just have unprotected sex. No one wants to be associated with such stigma. Imagine people are buying flour, sugar, bread and there you are buying durex or kiss it; it just feels immoral, like something is not right.*

There is also the gender stereotype that arises from the society where it's okay for men to carry or purchase condoms but not women. Holland *et.al*., (1990, pp.336 -350) argues that women carrying condoms often bear negative reputations and are viewed as actively seeking sex.

'Sheila' agrees with this argument: -

> *Carrying a condom is difficult for a woman. When one is found carrying it in one's purse, people tend to think that you are just a prostitute. Even the person you are going to have sex with sees you as such.*

The stigma thus expressed by service providers, peers and the society at large thus encourages unprotected sex. 'Henry' elaborates on this: -

> *When you go to buy a condom people just see you as immoral. For instance, there is a day I went to buy a condom from the chemist and the guy was asking me questions, so, from that day onwards I have not gone back to that centre as I don't want to be asked traumatising questions—that's an intrusion of one's privacy!*

Said another:

> *You cannot just go and a pick a condom from a dispenser in front of your peers? Noo….!. So that everyone knows you going to have sex..? Even here in campus,*

> *condoms are everywhere in toilets, hostels but I just have to pick them at night because who wants the stares... it feels like one is announcing his status*.

Hence young people also tend to engage in unprotected sex because of the stigma from peers. Youth seen to be accessing condoms from the Ministry of Health dispenser are labelled as defiant and considered as prostitutes, and no one fancies that. The alternative is to have unprotected sex.

***Condoms as status symbol* 6.** The youth were found to perceive condoms as a sign of status. The type of condom used reflected the value one placed on one's partner.

> *We perceive condoms in terms of its value, which is then translated to stand for the value one places on one's partner. If your guy uses government distributed condoms that are given out for free, then this means that he treats you as cheap or of low value (as government issued condoms are considered of low quality) (says 'Victoria').*

Said another:

> *You know some ladies don't even like the free condoms given by the government, like that SURE condom. The ladies considers that you see her to be as cheap as that cheap condom.*

Rigillo (2009, pp.12 -27) found that the youth equates free condoms to cheap clothes which tear easily because their material is of low quality. One of her respondents indicated that he "would rather buy his own condoms than use the free one", for as he puts it, "it is a matter of quality and perception" Another respondent stated that "hospital condoms are unsafe! If something is free, it's not good; one must pay for quality ". Rigilo's respondents went further to express that free condoms were for those who have no option or for those living in rural areas—for these people cannot afford to buy condoms. Free condoms were perceived to be of low quality and unsafe (as they had the tendency to burst during intercourse).

It was found that this social meaning influenced sexual behaviour. It was noted that those who bought fashionable condoms (those of a higher cost), were more likely to quickly get partners, than those who produce/use government issued (free) condoms. At the end of the spectrum, cheap condoms lead to instances where the female counterpart would prefer to have unprotected sex, rather than degrade themselves by using the free condoms.

***Condoms as 'a sign of Distrust'* 7.** Use of condoms was also associated with lack of trust. Asking your partner to use a condom was considered as a sign of distrust. Unprotected sex was therefore taken as a sign of trust (Leslei and Takavarsha, 2014, pp. 165 -173). Those in long-term relations would normally not use condoms as the relations are assumed to have been built on trust over time.

'Anita' elaborates on this saying:

> *Using a condom depends on how long you have been in a relationship; if you know your status and that of your partner then there is no need for protection. I have been with my guy for like 2 years so I don't need protection. Bringing in a condom will only bring issues of distrust.*

While 'Steve' 27 years old explains that:

> *If I use a condom on a lady it means I don't trust her. But if we have dated for a while then you can have unprotected sex.*

Holland *et* al*.,* (1992 pp.73 -83) noted that youth who assume that they are in monogamous relations tend not to engage in protected sex. The authors noted that serious relations encourage

trust of partners and this trust can only be expressed in the none use of condoms. Asking one to use a condom therefore risks the dissolution of the relationship.

'Cheryl' explains:

> *I think it's getting used to one person or being in a relationship for long that makes you trust your partner. So most people in such relations tend to use needles or the IUD. If I am to ask my guy to use a condom now it will be taken that I either don't trust him anymore, or am the one who is now cheating on him.*

Chimbiri (2007, pp.1102 -1115) in his research also noted that condoms play a major role in signifying whether a relationship is based on trust or not. Where a relationship was long term, it had a major influence on the decision on whether or not to use condoms—in most cases, condoms are not used. Choi and Gregorich (2008, pp.841 -1848) stress that increased relationship intimacy leads to reduced condom use because of the feeling of trust. This feeling thus influences sexual behaviour (as evidenced in the various foregoing narratives).

5.2. The social meaning of E-pill

This section examines the social meaning of the E-pill.

E pills as 'Prevention'/Protection' 1. Youth refer to the Emergency pill, Postinor-2, as "P2". The Emergency pill was introduced as an option for women after unprotected sex in the 1970s to prevent unplanned pregnancies and help avert abortions after an unplanned, unprotected sexual encounter (Ellertson, 1996, pp. 44-48). Emergency pills are effective in pregnancy prevention when taken within 72 hours after unprotected sex (Trussell, 1999). It is for this very reason that the E-pills was considered by the youth as a tool for preventing unwanted outcomes. One female youth had this to say about it:

> *For us students in campus, what we are more scared of is pregnancy and not HIV. So, we would rather buy P2. If the guy can buy it then why do I have to care as long as I won't get pregnant.*

'Becky', 25 years old supported this: -

> *My boyfriend at times does not want to use a condom and just wants `free sex; on these occasions I will go for the E-pill to protect myself from pregnancy as am still a student*.

Finally 'Ken ', a 28 year old adds that: -

> *Here in campus most people just have sex and don't use condoms because they know they will go for the E-pill in the morning. They know they are protected.*

Since they would be used for prevention after unprotected sex, some of the youth refer to them as "saviours". 'Saviours' would then deliver or rescue them from harm (which in this case is pregnancy) after a night/session of sexual indulgence. One of the respondents 'Sally' explains it as follows:

> *It's such an easy way out for me, especially here in campus where we have house parties where alcohol and random sex flows; nobody usually remembers or cares to use protection so the following day I will just get a P2 and am safe.*

The bestowed social meaning was found to influence sexual behaviour among the youth. It influenced the youth to act with abandonment towards sex, as they can now have sexual freedom without the fear of pregnancy. 'Velma' explains this:

> *After a night with a 'hook up' (a stranger one has just met) I just get an E-pill. No worries.*

Other similar narratives in different shades also emerged. 'Julie' 24 year old for instance remarked that:

> *For me P2 comes in handy because you meet someone today, you know those flings, and then you have sex that is abrupt and thereafter discover you messed up….most of us are scared of the responsibility [of pregnancy and kids] so P2 comes in handy. We don't need to worry so much about unplanned sex anymore as far as pregnancy is concerned.*

'Chris', 20 years old also agrees with the protective attribute of the E-pill:

> *We never plan for sex; For us sex is fun; we don't really care about who we do it with, where or how. E pills helps in removing anxiety over unplanned pregnancies.*

Trussel *et al*. (1999, pp. 246) explains that the emergency pills is a reliable pregnancy prevention contraceptive. The authors remark that it is the only immediate pregnancy prevention method available for someone who has had unprotected sex and is not ready for parenting. The youth therefore engage in sex with the assurance that they have a protector in the name of "P2".

E-pills as "Insurance" 2. E-pills were also socially constructed as an "insurance" by the youth. This was explained by 'Cate':

> *Nowadays sex is like a handshake; it's casual, random, abrupt and with no strings attached. At times we find ourselves in compromising situations like maybe you were drunk; so at that moment one is unable to use a condom. So we will just have unprotected sex as we know that we have insurance in the name of the E-pill.*

'Mel' also adds that:

> *If a girl unfortunately had sex while they were drunk, there no longer have to worry too much, as today there is an insurance cover—the E-pill. It definitely insures me against unwanted pregnancy.*

The introduction of emergency pills has helped in preventing much of the unwanted pregnancy previously witnessed among the vulnerable population. The E-pill has thus been considered by the youth as an insurance against pregnancy (Mulligan, 2016, pp.455 - 469). The youth today have sex at will because of this assurance.

***E-pills as 'License for Enjoyment'* 3.** The research found that that many of the youth prefer having unprotected sex, and that the E-Pills has given them the license to do this. 'Hassan' explained this as follows:

> *Sex is sweet, more so without a condom. So, I will just have sex with my girlfriend and thereafter give her cash to go buy the E-pill. This is so convenient and easy. This pill gives me the license to enjoy life.*

'Claire,' 24 years old added:

> *I love my guy, so when we cannot use a condom we just have sex then I go buy the E-pill. The pill therefore helps us enjoy life as young people should.*

Despite the risks associated with unprotected sex, young people still engage as they are more interested in protection against pregnancies (which is their greatest fear). The E-pill therefore provides the youth with the license to enjoy sex without the risk associated with pregnancy. The E-pill has therefore influenced the youth to engage more in unprotected sex.

6. Discussion

Youth comprise of a large population globally with a total population of almost 23% in developing countries (Unicef, 2016). As of 2017, 36 million young girls were sexually active with many not wanting to become pregnant, even when 20 million were not using contraceptives of any kind (Darroch *et. al*., 2016). Though the youth had knowledge of contraceptives, their use still remained low, even in instances where there is increased government efforts to make these services accessible. Then again, knowledge in itself does not necessarily translate to a positive attitude and change in behaviour (i.e. use of contraceptives). It therefore becomes an issue of concern as this low uptake causes rates of teenage pregnancies to remain high, with a negative effect on maternal child health, followed by increased in HIV/AIDS infection rates, increased abortion rates, low attainment of girl child education, loss of human capital resource and a continuation of the cycle of poverty.

As society changes to modernity and traditional structures are giving way to new ways, most adults are still uncomfortable to discuss the issues of sex with their children (Elias, 2016). Consequently, young peoples' use of contraceptives has majorly been informed socio-cultural, political, and religious systems operating across various levels of youth environments (Hall *et al*., 2017, pp. 95-597); which has in turn, through interaction among themselves, led to contraceptives being socially constructed with varying meanings now attached to these various contraceptive methods.

The understanding of meanings that the youth have bestowed on contraceptives thus provides the crucial missing link that enlightens researchers on the attitudes and perceptions of youth regarding contraception and their sexual behaviour. Policy makers need to realise that the young people are not just filling spaces, but are important members of the society who should be incorporated at all levels of decision making. Their sentiments can be used in policy making so as to meet the objectives of a nation with regard to the planning for their respective populations. In the International conference on population development 1994 held in 2019 in Nairobi, Kenya, it was emphasised that government needs to support young people meet their basic needs and aspirations. This can best be understood by understanding their perceptions. Governments can also use these perceptions to build policies and channel informative communication that will influence change of attitude towards contraceptive use with the accompanying change in sexual behaviour. The Reproductive Health Care Bill (2019) currently being debated in the Kenyan Parliament would most certainly benefit from these insights.

References

Abuya, W.O. (2013). What is in a coconut? An ethnoecological analysis of mining, social displacement, vulnerability, and development in rural Kenya, *African Studies Quarterly Review,* and Vol. 14 (1&2): 3 - 5.

African Population and Health Research Centre (APHRC). (2002). Population and Health Dynamics in Nairobi's Informal Settlements. Nairobi. Occasional Study Report 2002. APHRC, Nairobi

Agadjanian, V, Yabiku S. & Fawcett, L. (2009). History, community milieu, and Christian-Muslim differentials in contraceptive use in Sub Saharan Africa. *Journal for the Scientific Study of Religion,* 48(3): 462-79. https://doi.org/10.1111/j.1468-5906.2009.01460.x

Ali S.K. Azmart, Ali. M., Ishaque M. (2015). Assessing Predictors of Contraceptive use and Demand for Family Planning Services in Underserved areas of Punjab Province in Pakistan:

Results of a Cross – Sectional Baseline Survey. *Reproductive Health* Vol. 12, 25. https://doi.org/10.1186/s12978-015-0016-9

Allan Guttmatcher Institute (1999). Sharing responsibility: Women, society and abortion worldwide. The Berne Convention for protection of literary and artistic work. New York. https://www.guttmacher.org/pubs

Archer, J. (2009). Does sexual selection explain human sex differences in aggression? *Behavioural and Brain Sciences*, Vol.32 (3-4): 249-266. https://doi.org/10.1017/S0140525X09990951

Austreberta Nazar – Beutelspacher, Dolore Molina – Rosales, Izaba B., Salvatierra,M. and Zapata E,Halperin D. (1999). Education and Non use of Contraceptives among Poor Women in Chapas, Mexico. *International Perspectives on Sexual and Reproductive Health*, Vol 25, 3. https://doi.org/10.2307/2991962

Becker S. (1996). Couples and Reproductive Health: A Review of Couples Studies. *Studies in Family Planning*, 27(6): 291-313. https://doi.org/10.2307/2138025

Beekle A.T. (2006). Awareness and Determinants of Family Planning Practice in Jimma , Ethiopia. *International Nursing Review,* Vol 53(4):269-276. https://doi.org/10.1111/j.1466-7657.2006.00492.x

Berger P. & Luckmann T. (1966), The social construction of reality: A treatise in the sociology of knowledge. Harmondsworth: Penguin.

Biddlecom A. E, Munthali A, Singh S., and Woog V. (2007). Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. *African Journal of Reproductive Health*, 11(3): 99-100. https://doi.org/10.2307/25549734

Chimbiri A., (2007), The Condom is an 'Intruder' in Marriage: Evidence from Rural Malawi." *Social Science and Medicine*, Vol. 64(5): 1102–1115. https://doi.org/10.1016/j.socscimed.2006.10.012

Chizororo Francis, Natshalanga M. N.R (2003), The Female Condom: Acceptability and Perception among Rural Women in Zimbabwe. *African Journal of Reproductive Health*, Vol. 7(3): 101 -116. https://doi.org/10.2307/3583295

Choi K.H, Hoff C., Gregorich S.E, Grinstead O., Gomez C., and Hussey W. (2008). The efficacy of female condom skills training in HIV risk reduction among women: a randomized controlled trial. *Journal of Public Health*, Vol.98 (10): 841–1848. https://doi.org/10.2105/AJPH.2007.113050

Cohen A. Susan (2004). The Broad Benefits of Investing in Sexual and Reproductive Health. The Allan Guttmacher Institute and UNFP, 2006. Vol.7 (1), pp.5-8.

Darroch J.E, Audams, B. A., Kopplin G, Riley T, and Singh S. (2016). Adding it up: Costs and Benefits of meeting Contraceptive needs of Adolescents in developing regions.

Dicenso, A., Guyatt G. and Griffth, L., (2002). Interventions to reduce unintended Pregnancies among Adolescents: A systematic Review of Randomised Controlled Trial. Available: https://doi.org/10.1136/bmj.324.7351.1426

Elias, C.J., (2016). Why Family Planning is an issue we should all Care about, World Economic Forum. Available: https://www.weforum.org/2016/02

Ellertson, C., (1996). History and Efficacy of Emergency Contraception: Beyond Coca – Cola. *Perspectives on Sexual and Reproductive Health*, Vol.28 Issue 2: 44-48. https://doi.org/10.2307/2136122

Gupta, N., & Mahy, M. (2003). Sexual initiation among adolescent girls and boys: trends and differentials in sub-Saharan Africa. *Archives of sexual behaviour*, Vol.32 (1): 41-53. https://doi.org/10.1023/A:1021841312539

Gyimah, S.O., (2006), Migration and fertility behaviour in sub-Saharan Africa: The case of Ghana. *Journal of Comparative Family Studies.37 (2):235-252.*

Hall K., Sales D., Jessica M.C, Komro A. Kelli and Santelli J. (2017). The State of Sex Education in the United States. *Journal of Adolescent Health*, Vol.58 (6): 595 -597. https://doi.org/10.1016/j.jadohealth.2016.03.032

Holland J., Ramazanoglu C., Scott S. and Thomson R. (1992). "Risk, Power and the Possibility of Pleasure: Young Women and Safer Sex." *AIDS Care,* Vol. 4: 73-83. https://doi.org/10.1080/09540129208253099

Holland Janet, Ramazanoglu Caroline,Scott Sue ,Thomson Rachel (1990), Sociology of Health and Illness ,Vol.12(3) pp.336 -350. https://doi.org/10.1111/1467-9566.ep11347264

Jejeebhoy J.S., (1995). Women's Education, Autonomy and Reproductive Behaviour. Experience from Developing Countries. Claredon Press Publication. Oxford University Press.

Kahari Leslei and Takavarasha P. (2014). Discourse of Prevention or Pleasure: A Discourse Analysis of Condom Use and Non Condom, Use Scripts of University of Zimbabwe Students, Department of Linguistics, University of Zimbabwe. *International Journal of Humanities and Social Science*, Vol. 4 No. 4:165-173.

Kantorová V, Wheldon MC, Ueffing P, Dasgupta ANZ (2020) Estimating progress towards meeting women's contraceptive needs in 185 countries: A Bayesian hierarchical modelling study. PLoS Med 17(2):e1003026. https://doi.org/10.1371/journal.pmed.1003026

Kazembe E., Kapito A., Maluwa A., Malata A., and Odland J. O. (2012). Attitudes towards contraceptive use among schooling adolescents in Malawi. *Journal of Research in Nursing and Midwifery*, (4):47-55.

Kenya Demographic and Health Survey (2008), retrieved from https://dhsprogram.com/pubs/pdf/fr151/fr151/fr151.pdf

Lessing, L. (1995). The Regulation of Social Meanings. *The University of Chicago Law Review*, 62 (3): 943-1045. https://doi.org/10.2307/1600054

Lloyd, C. B. (Eds.). (2005*), Growing up global*: The changing transitions to adulthood in developing countries. Washington DC: National Research Council and Institute of Medicine of National Academies Press. https://doi.org/10.17226/11174

Mack N. W., MacQueen C. K, Guest, G. and Namey, E. (2005) Qualitative Research Methods: A Data Collector's Field Guide. Research Triangle Park, NC: Family Health International.

Morse C. Wayde.Morse , Damon R. Lowery and Todd Steury (2014) , Exploring Sturation of Themes and Spatial Locations in Qualitative Public Participation Geographical Information Systems Research ,School of Forestry and Wildlife Science , Auburn University , Alabama , USA 27:5, 557-571. https://doi.org/10.1080/08941920.2014.888791

Mosher W.D, Martinez G.M. Chandra A, Abma J. C and Wilson S.J. (2004). Use of Contraception and use of Family planning services in the United States. Advance data from Vital and Health Statistics no.350:184-191. Available: http://www.cdc.gov/nchs/data/ad/ad350.pdf

Mulligan Karen (2015), Emergency Contraception and its Impact on Fertility and Sexual Behaviour: Health Economics vol.25 (4), pp.455-469. https://doi.org/10.1002/hec.3163

Mutungi A.K, Mango E.O, Rogo K.O, Kimani V.R, and Karanja J.G (1999). Abortion: behaviour of adolescents in two districts in Kenya. *East African Medical Journal*, 76(10): 541-546.

Nalwadda G., Mirembe G., Byamugisha F., J.and Faxelid E. (2010). Persistent high Fertility in Uganda: Young people Recount obstacles and enabling factors to use of Contraceptives. *BMC Public health*, 10: 530 – 541. https://doi.org/10.1186/1471-2458-10-530

Nantambi A, (2017). Call for Remodelling of Female Condoms, Retrieved from https://www.newvision.co.ug/new_vision/news/1462292/activistsremodelling-female-condom

National Council for Population and Development (2017), Central Bureau of Statistics, Office of the President, Ministry of Planning And Development. *Kenya Demographic Health Surveys.*

Ochako Rhoune ,Mwende Mbondo,Stephen Aloo ,Susan Kaimenyi ,Rachel Thompson ,Marleen Temmer and Megan Kays (2015). Barriers to Modern Contraceptive Methods, Uptake among Women in Kenya: Qualitative Study. Bmc Public Health: 15-118. https://doi.org/10.1186/s12889-015-1483-1

Patton, G. C., and Viner, R. (2007), Adolescent health 1: Pubertal transitions in health. *Lancet*, Vol.369: 1130–1139. https://doi.org/10.1016/S0140-6736(07)60366-3

Planned Parenthood Federation of America (2004). National Medical Committee. *Manual of Medical Standards and Guidelines*. PPFA, New York.

Plummer M. L., Wight D., Wamoyi J., Mshana G., Hayes, R. J., and Ross D. A. (2006). Farming with your hoe in the sack: condom attitudes, access, and use in rural Tanzania. *Studies in Family Planning*, 37: 29–40. https://doi.org/10.1111/j.1728-4465.2006.00081.x

Relph Edward, (1976), An Inquiry Into Relations Between Phenomenology and Geography: University of Toronto.

Rigillo N. (2009). "Free Condoms are Like Cheap Clothes, They tear quickly": Mistrust in Condoms among Young People in Windhoek, Namibia. *Explorations in Anthropology*, Vol 9 (2): 12-27.

Ryan S, Franzetta K, Manlove J, Holcombe E. (2007). Adolescents' discussions about contraception or STDs with partners before first sex. Perspectives on Sexual and Reproductive Health. 2007; 39:149–57. https://doi.org/10.1363/3914907

Salako A.A, Iyaniwara. C.A, Jeminusi .O.A and Sofowora, R. (2006). Sexual Behaviour, Contraception and Fertility among in school Adolescents in Ikenna Local Government, South Western Nigeria. *Nigerian Journal of Clinical Practise*, 9(1): 26-36.

Senate Bills (2019). The Reproductive Health Care Bill; Kenya Gazette Supplement no.186 (Senate Bills no.23).

Shaweno T. and Kura Z. (2016). Determinant of modern contraceptive use among sexually active men in Ethiopia: Using EDHS National survey. *Contraception and reproductive Medicine BMC,* 5: 7-10. https://doi.org/10.1186/s40834-020-00108-7

Sonnenberg P., Soazig C., Beddows S., Nigel F. Soldan K., Totan C. (2013). Prevalence, Risk Factors and Uptake of Interventions for Sexually Transmitted Infections in Britain: Findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). *The Lancet,* 382 (9907): 1795 -1806. https://doi.org/10.1016/S0140-6736(13)61947-9

South African Department of Health. South African Demographic and Health Survey (2003): 54-65. Available: HTTP://WWW.Doh.gov.za/facts/index.html

Stella Babalola, Neetu John, Bolanle Asavo, Illene S.Speizer (2015) , Ideation and Intention to Use Contraceptives in Kenya and Nigeria: Demograph Res.2015 33;2,pp.211-238. https://doi.org/10.4054/DemRes.2015.33.8

Trussel J,Vaughan B,Stanford J(1999) , Are all Contracepives Failures Unintended Pregnancies ? Evidenc of 1995 National Survey of Family Growth Fam.Planning Perspective, 31(5), 246-7. https://doi.org/10.2307/2991573

Ugoji F.N. (2008). Attitudes of Undergraduates towards Contraceptives use. Pakistan. *Journal of Social Sciences*, Vol. 5: 111-115.

UNICEF (2016), Adolescent Demographics. Available: https://dataunicef.org/topic/adolescents demographics

Vasundhara S, Uday M, Vinita D., Shally, A. (2012). A Socio demographic determinants and Knowledge, attitude, practise: Survey of family planning. *Journal of Family Medicine and Primary Care*, Vol.1:43-47. https://doi.org/10.4103/2249-4863.94451