

**UNIVERSITY OF NAIROBI**

**DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK**

**EFFECTS OF SEXUAL AND REPRODUCTIVE HEALTH EDUCATION ON THE  
SEXUAL AND REPRODUCTIVE HEALTH AND WELLNESS AMONG MALE  
ADOLESCENTS: A CASE STUDY OF ROYSAMBU SUB COUNTY IN NAIROBI  
CITY COUNTY**

**BY:**

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**A project proposal submitted in partial fulfilment of the requirements for the award of  
the Degree of Master of Arts in Sociology (Medical Sociology), University of Nairobi.**

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## DECLARATION

### STUDENT

I, the undersigned, declare that this research project is my original work and that it has not been presented in any other university or institution.

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**Prof. Edward K. Mburugu**

## **DEDICATION**

This study is dedicated to my family – my husband Cris, and our two children Malcolm and Wema for their support and encouragement. Second, to my parents, Mr. and Mrs. Mwenje, who made me know the value of education.

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## **ACRONYMS AND ABBREVIATIONS**

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>AMREF</b>	African Medical and Research Foundation
<b>ASRH</b>	Adolescent Sexual and Reproductive Health
<b>AYAM</b>	Adolescent and young adult men
<b>CSE</b>	Comprehensive Sexuality Education
<b>FHI</b>	Family Health International
<b>HIV</b>	Human Immunodeficiency Virus
<b>ICPD</b>	International Conference on Population and Development
<b>IPPF</b>	International Planned Parenthood Federation
<b>KIE</b>	Kenya Institute of Education
<b>MDG</b>	Millennium Development Goal
<b>MoE</b>	Ministry of Education
<b>MoH</b>	Ministry of Health
<b>NACC</b>	National AIDS Control Council
<b>NGO</b>	Non-Governmental Organization
<b>RH</b>	Reproductive Health
<b>SDG</b>	Sustainable Development Goal
<b>SRH</b>	Sexual and Reproductive Health
<b>SIECUS</b>	Sex Information and Education Council of the U.S
<b>STI</b>	Sexually Transmitted Infection
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organization

<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children’s Fund
<b>USAID</b>	United States Agency for International Development
<b>VCT</b>	Voluntary Counselling and Testing
<b>WHO</b>	World Health Organization

## ABSTRACT

Adolescence refers to a stage of human growth where young person acquires the skills, knowledge, and attitudes required to be sexually active. In the previous decade, the topic of adolescent sexual and reproductive health has been a major focus for many policy makers, researchers, and experts in public health. This study sought to find the sexual and reproductive health (SRH) education male adolescents were provided with. Specifically, what kind of SRH information they received, the sources of this information, the topics of discussion they had, SRH concerns they had that affect male adolescent sexuality. It also explored the available services and information to male adolescents so as to assist them have a good knowledge of their SRH. The broad objective of the investigation was to examine the effect of SRH education among male adolescents and the actions they take to maintain their SRH and wellness. Specifically, the research sought to identify sources of information for SRH among male adolescents, to establish the level of adequacy of knowledge gained from sexual and education, to determine the types of SRH services offered to males adolescents in Nairobi county as well as to show the effects the SRH education had on the male adolescents sexual together with reproductive health outcomes. Descriptive survey design research method was employed in this research. It was employed in the process of gathering data in order to answer questions touching on the relationships of sexual education, knowledge, and information with SRH wellness amongst male adolescents. A sample of 120 respondents aged 18-24 years was selected using simple random sampling technique. Further, 10 respondents were also interviewed as key informants. Research instruments included use of structured questionnaires and key informant interview questionnaire. Quantitative data was analysed using Microsoft Excel. Qualitative data was transcribed and content analysis was carried out. Results were shown in charts, graphs, tables, and narrative form. The study established that male adolescents had some form of sexuality education which they acquired from different sources including the peers, internet, parents, and topics taught in school. The study established that the most preferred sources of information were the internet as it was seen as confidential, parents and medical personnel. The study also established that they had several concerns on their sexual health such as on puberty, sexual development, dating and sexual function/dysfunction. Yet despite all these concerns, only 33% knew where to seek SRH services. The male adolescents also acknowledged that SRH education was important for their sexual health decision making. To improve SRH care, prevention of pregnancy and HIV and STI's needed to be addressed. The study established that male adolescents were able to cite different correct methods for preventing pregnancy including use of contraceptives, use of condoms, abstinence, the withdrawal method and using the safe day's method. The male adolescents were also able to state several correct methods of preventing sexually transmitted infections. Those stated included using condoms, avoiding unsafe sex, abstinence, avoiding multiple sexual partners and knowing one's HIV status. From the study results, it was suggested that male adolescents need to be specifically targeted for SRH education and services. Youth friendly clinics should adequately sensitise communities on the need for male uptake of SRH services. The findings also indicated that the male adolescents had a positive attitude towards receiving and learning SRH information and schools can take this to their advantage to have comprehensive sexuality education specifically geared towards males. Older males and parents need be a support system that male adolescents can rely on to obtain reliable information concerning SRH. The study concludes that Comprehensive SRH Education for male adolescents should be given more emphasis as it has many positive effects and will greatly influence both male and female sexual and reproductive health.

## CHAPTER ONE: INTRODUCTION

### 1.1 Background to the Study

In their entire life, human beings are sexual creatures. Freud, Maslow et al (1992) remark that “We are sexual from birth, and sexual expression is a basic human need throughout our lives. Sexual expression is an essential component of healthy human development for individuals of all ages”. Developmental stages in human life come in different ways where SRH desires manifest themselves.

There are no universally accepted definitions of adolescence and youth. Adolescence is a vigorously developing theoretic concept learned via cultural, psychological, physiologic, as well as temporal perspectives. According to Steinberg (2014), this crucial evolution stage is commonly comprehended as period between the start of puberty and the institution of social individuality. As per APA (2002), the widely used logical meaning of adolescence ranges between 10 and 18 years, however, it may include a period of 9-26 years depending on where it originate. In the life span of a person, adolescence is among the most complex and interesting transitions. The rate of changes and growth that take place during this period is fast. Often, individuals going through it may not even have a full understanding of the many aspects of growth and development that they are undergoing. The changes that are taking place include physical, biological, emotional, mental and social changes. As a matter of fact, few growth stages are differentiated by so many changes at various degrees. Perhaps the most remarkable are the genetic changes that accompany puberty. Such shifts include tense changes in body shape, change in brain architecture, as well as increases in hormones. As reported by UNICEF (2002), many aspects of this growth and development are driven through biological processes, with the commencement of puberty that signifies the passage from childhood to adolescence.

As defined earlier on, adolescence refers to the period when a young person develops skills, knowledge, and attitudes needed to be sexually active. Young persons should receive accurate information concerning their sexuality during their growth and maturity stages. On the other hand, policy makers, guardians, parents, and educators require information regarding young persons’ behaviours, knowledge, and attitudes to offer educational opportunities of high quality as well as other necessary support (SIECUS).

Over the previous decade, adolescent SRH has been the key focus among policy makers, researchers, and public health experts. Today, there is considerable literature showing the adolescents encounter complex reproductive health problems. This is contrary to the early growth philosophical idea that adolescents were deemed to be a comparatively healthy age group (one with reduced disease burden) compared to elderly adults or new-born infants (Riedner & Dehne, 2005).

The importance of improving the knowledge of the SRH needs of adolescents is being reinforced through the Sustainable Development Goals and renewed Global Strategy for Women's, Children's and Adolescents' Health. This's critical to make sure that adolescents thrive, survive, as well as change their societies.

Just like adults, adolescents are entitled to information and education regarding health such as SRH to allow them to responsibly and freely make decision on matters of sexuality and reproduction. According to Human Rights and Reproductive Health Matrix (2006), preventing adolescents from accessing information and education breaches their rights and puts them at risk of HIV, Sexually Transmitted Infections, pregnancy, as well as complications of abortion.

Promoting Adolescent Sexual and Reproductive Health (ASRH) in Kenya implies offering information on and strategies for preventing unwanted pregnancy; empowering adolescents with age-appropriate comprehensive sexuality education; giving adolescents services to thwart, diagnose, and cure STIs such as HIV; and ending harmful practices that negatively impact adolescent sexual and reproductive health. ASRH is a major aspect under the Ministry of Health in Kenya. This's clearly demonstrated in the National ASRH Policy 2015.

In Sub-Saharan Africa, a majority of youth and adolescent population contribute greatly to economic growth. As per PRB (2013), the area has the rapidly increasing population of young persons across the globe. Adolescents, aged between 10 and 19 years, account for 22.5% (10.5 million adolescents) of Kenya's total populace (Adolescent Contraceptive Use, compiled by WHO 2016). This means they make a fifth of the population in Kenya and it's of great significance to invest in them for economic and social development of this country.

A report by Sexual and Reproductive Health of Adolescents and Youths in Malaysia (p.13) reveals that adolescents are at risk since they have no access to appropriate, acceptable and affordable reproductive health services and information as well as lack required skills and

knowledge to avoid indulging in dangerous behaviours. Generally, it is known that adolescents from African countries are sexually healthy and struggle with effects of usual unprotected sexual activities including STDs, teenage parenthood, and unlawful abortions.

The risks for adolescents in Kenya include:

Unwanted pregnancies - Adolescents have one of the highest rates of unmet need for family planning. For example, as per KDHS 2014 studies, 86.4% of sexually healthy adolescent girls not married state not being in a position to get a child in the following two years, however, only 42.9% of them are presently applying any approach to avoid being pregnant.

Pregnancy-related complications – there are no mortality data that affect a specific nation. But statistics from third world nations show that pregnancy as well as complications during delivery (unsafe abortion) come second as the main causes of death for ladies under the age of 20 years (Mayor, 2004).

Unsafe abortions – according to Kenya National Incidence and Magnitude of Unsafe Abortion Study (2012), young women and adolescent girls constituted over 48 percent of after-abortion healthcare patients in 2012, Kenya.

HIV/AIDS and STIs - According to the National Aids Control Council, Kenya has 435, 224 adolescents living with HIV. In 2015, young persons (between 15 and 24 years) played a part 51 percent of adult new HIV diseases and 30 percent men and 70 percent women in the age group 15 to 19 years contribute to new HIV infections (Kenya AIDS Progress Report, 2016).

Investing in SRH is crucial for young individuals since they are in the transition period. Countries can make sure that young persons make a successful transition via this important stage by making right investments (Jimenez et al., 2007).

Much of the current discourse around sexual and reproductive health focuses on the need to manage certain realities and vulnerabilities of women as well as girls, and for proper justification. Today, continued violence and discrimination against girls and women is the main problem. Young and adolescent girls are more susceptible to encountering dangerous practices such as female genital mutilations as well as forced, child, and early marriages; are at risk of HIV/AIDS infection; more prone to intimate and gender-based violence; have high



chances of bearing the consequences of unwanted pregnancy; and are more likely to be excluded from educational setting.

However, SRH services should be designed and delivered with consideration for young men. Whereas young and adolescent men might be advantageous because of their gender, the field of sexual and reproductive health is a unique one. There should be more sexual and reproductive services and education that are tailored to the unique needs and are friendly to young men.

Progressively, supporters of gender equality are beginning to appreciate the need for effectively involving boys and men to create change. There are many reasons why involving boys and men in completely supporting equality for girls and women are important.

Currently, there's a substantial study on boys and men, especially on masculinities, health, and sexuality that shows that their fruitful engagement in gender equality generates favourable changes in their behaviours, attitudes, and perceptions. These are the very changes which benefit their sexual, intimate, and emotional associations with girls and women together with other boys and men.

Having said that, following the latest evaluation of the adoption of the ICPD Programme of Action, male participation and gender norms was the main concern for just 22% of governments across the world and it wasn't a concern for many lower and low middle-income nations (UNFPA,2014:35).

According to African Journal of Reproductive Health (2001), even with an increasing body of knowledge concerning young adult and adolescent girls, there is little information regarding male SRH and how it is related to individual well-being, specifically, the danger of being infected with and spreading AIDS.

SRH services are critical to the healthy development of boys and young men, to aid them define their identities and assist them in learning the role of sexual activity in intimate relationships. Without SRH services, young men risk missing important information and opportunities to incorporate health promotion behaviours into their SRH practices as they form relationships and engage in responsible sexual behaviours. Generally, SRH services offered to young men do not meet their unique needs and life circumstances. Many SRH services—including sexuality education, pregnancy/HIV/STI prevention education, and

sexual violence prevention education and response—are intended for and provided to young and adolescent female. Few comprehensive sexuality education programs or prevention programs specific to young men exist. Even fewer resources for SRH health care services specific to young men are available, in either men’s or general health care settings. (Healthy Teen Network, 2016)

It’s imperative to recognise that male contribute greatly in females’ sexuality. It is important to take cognisance of the fact that services for Adolescent Sexual Reproductive Health seek to offer education, care services, and information to adolescents to aid them develop an understanding of their sexuality as well as prevent them from getting unwanted pregnancy or STIs like HIV/AIDS.

It’s recommendable that such ought to be merged with young men’s education to uphold independence of women and distribute duties with girls concerning reproduction and sexual issues (IPPF, 2008).

All the above showed that there was a need to establish adequately if the young men and male adolescents were provided with SRH education.

## **1.2 Statement of the Problem**

In sub-Saharan Africa, a majority of youth and adolescent populace plays a key role in the economic development. As reported by PRB (2013), the area has the rapidly increasing population globally. According to CIA World Factbook (2017), Kenya’s youthful population, aged between 15 and 24 years, stands at around 18.8 percent. This means they make around a fifth of the populace in Kenya and it’s critical to invest in them for the economic and social development of this country.

World Health Organization defines sexual health as “*a state of complete physical, emotional, mental and social well-being in relation to sexuality; not merely the absence of disease, dysfunction or infirmity.*” (WHO, 2002) The International Conference on Population and Development Programme of Action incorporated sexual health as major component of the broader meaning of human reproductive health (ICPD, 1994). It appreciated the fact that populace is all about people and not numbers, and that political, social as well as economic equality, together with rights for SRH, was the source for sustainable growth and individual well-being.

Kenya as a country agreed to the 1994 ICPD Programme of Action and in 2014 went on to further agree to partner with the United Nations and other governments in implementing ICPD Beyond 2014. In its statement named: ICPD Beyond 2014: Where are we now? Kenya's Progress in Implementing the ICPD Programme of Action 1994-2014, under the section on reproductive health and rights, the results documented mostly targeted female and none specifically on the male and more so none specifically on adolescents. The key highlights in this section included: The country's total fertility rate standing at 4.7 children per woman in 1995-97 and 4.6 children per woman in 2006/2008. Maternal mortality fell from 590 per 100,000 live births in 1990 to 488 in 2008 and that up to one third of women in reproductive age cannot access and effectively use RH services including family planning. In line with this, The Kenya government has in addition to domesticating a number of international conventions enacted a number of legislative actions and policies to implement rights of reproduction as well as act as a guideline for offering reproductive health facilities.

The MoH embraced the National Reproductive Health Policy 2009-2015 that aimed at improving the reproductive health condition for all citizens in Kenya. The aim of this policy was to offer a structure for effective, equitable, and efficient provision of quality sexual and reproductive health services. Specifically targeting adolescents is the National adolescent Reproductive Health Policy 2015. This policy seeks to improve sexual and reproductive health condition of Kenyan adolescents as well as play a role in attaining a full capacity during national growth. However, despite these efforts, the male adolescent continues to be vulnerable and at risk. For example, according to the Kenya AIDS Response Progress Report 2016, young persons substantially contributed to increased cases for HIV/AIDS load in the nation. They constituted a huge fraction of individuals suffering from AIDS. Remarkably, they played a part 51 percent of new adult HIV contractions signifying rapid increase from 29 percent in the year 2013. Nduku Kilonzo, Executive Director of the National Aids Control Council, said the following during the launch of the report in October 2016. "Out of the 71,034 new infections among adults, 35,000 were among adolescents and young people. This translates to 97 new infections daily."

The Kenya Demographic Health Survey (KDHS, 2014) indicates that the chances of young men (21%) engaging in sexual practices before attaining the age of 15 is two times that of young women (12%). When it comes to age, approximately 55% of men and 47% of women have engaged in sexual practices.

Some become sexually active as early as 12 years of age, long before they are physically mature. Adolescent partnerships are sometimes not exclusive and sexual activity is often unprotected (NCPD and MOH, 2003).

This shows that teens begin their sexual practices before appropriate time when they are not physically mature and end up with complications. Adolescent young men and boys have high chances of having multiple partners as opposed to adolescent girls. Among sexually active young men of ages 15-24, few girls than boys stated having multiple partners (2% and 10%, in that order). Male teens also tend to be sexually active earlier – 15% of women within the age bracket of 20 to 49 engaged in sexual practice for the first time before attaining 15 years, 50% by 18 years, and 71% by 20 years while 22% of male in the age bracket of 20 and 49 indulged in sexual behaviour for the first time before attaining 15 years, 56% by 18 years, and 76% after 20 years.

Young men also are more likely to have multiple sexual companions-3% of women aged 15 to 19 years state to be in a polygamous marriage. Given the scarcity of information that exists on male adolescent sexuality education in Kenya, the research expanded on the existing body of knowledge on sexuality.

### **1.3 Research Questions**

Study objectives and questions assist the research to remain focused, guide the manner in which the study is to be carried out and convey to other people the study purpose (Maxwell, 2012).

The inquiry was directed by the following study questions:

- i. How adequately are adolescent males targeted with education of comprehensive sexuality?
- ii. Which are the concerns for the adolescent male regarding SRH?
- iii. What are the specific SRH desires of the adolescent male?

### **1.4 Objectives of the study**

#### **1.4.1 Main Objective**

The primary goal of this investigation was to examine the effect of SRH education in male adolescents to allow them maintain their reproductive and sexual health and wellness.

### **1.4.2 Specific Objectives**

Specifically, the study sought to:

- i. Identify sources of information on Sexual and Reproductive Health in male adolescents in Nairobi County.
- ii. Establish level of adequacy of knowledge gained from Sexual and Reproductive Health education in Nairobi County.
- iii. Examine the types of Sexual and Reproductive Health services offered to male adolescents in Nairobi County
- iv. Demonstrate the effects of Sexual and Reproductive Health education on SRH outcomes.

### **1.5 Significance of the Study**

This inquiry was of great value as it enabled the researcher to add to the limited body of knowledge and literature on the male adolescent in Kenya particularly concerning the matter of SRH education. This was a crucial gap existing with regard to the knowledge of subjective duties and experience linked to the sexual health of male adolescents.

This study was found to be beneficial to the society in providing an understanding that the male adolescent contribute greatly in making the sexual health outcomes for females better. Outcomes such as sexual control, pressure, or in some instances even violence by male adolescents on their female partners. Not just as adolescents, but even later in life. The findings of the study provided information on adolescent sexual and reproductive health education programming so as to better meet the needs of the male adolescents in Nairobi, and other urban areas.

Lastly, the findings of the study provided valuable information to the government and other bodies that offer golden opportunities for additional support and training, are able to address concerns, and direct potential strategies so as to promote male involvement in a host of SRH areas including avoidance of sexually transmitted infections and HIV/AIDS, unsafe abortions, lack of contraception, sexual abuse, rape, as well as early and unintended pregnancies.

## **1.6 Scope of the Study**

This examination concentrated on a selected number of male adolescents aged between 18 - 24 years and was carried out within Roysambu Sub-county of Nairobi County.

The issues addressed were whether these male adolescents had received adequate information on knowledge and awareness about human sexuality that they considered important to enable them make responsible decisions on their health and well-being. The study also addressed the need to make adolescent males feel that they were allies in the reproductive health of females.

## **1.7 Limitations and Delimitations of the Study**

The investigation was limited geographically as it only studied one sub-county - Roysambu sub-county in Nairobi County. Another limitation of this was that only older male adolescents aged 18 – 24 were part of the study. Being that the data was only from one Sub-county of Nairobi County, the results could not be generalised to other older male adolescents in Nairobi County or even other counties of Kenya because the SRH education and services may differ. There was also lack of statistical data on the exact population of 18 - 24 year old male adolescent in Roysambu sub-county. Roysambu sub-county does not have a homogenous population. Therefore the characteristics of the respondents were different based on such things as socio-economic background, educational level and this may not reflect all regions in Kenya as resources differ in terms of economic, social and political inclinations of each region.

The study was not also able to assess the depth in which all the topics revolving around SRH education were addressed due to the use of a self-administered questionnaire. In relation to the self-administered questionnaire, the questionnaire was written out in English, therefore some may not have been able to adequately express themselves in English.

The research topic was sensitive in nature and not a comfortable subject to discuss. As a result some of the respondents were not be comfortable in answering some questions honestly or might give what they consider desirable answers to the researcher. “One respondent clearly stated out that the questions were very personal.” This likely did affect data validity and reliability.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1 Introduction**

Discussed in this section is a review of literature that was relevant in getting a clearer understanding of the topic of the study on male adolescents. This section of the study discussed male adolescent sexuality education within current and prevailing literature. This section closely examined an array of issues that influenced SRH education for male adolescents and young men. The chapter also provided a theoretical framework. These are the sociological theories relevant to the topic of study and they addressed how they were relevant in understanding the topic. The chapter went on to present the conceptual framework that was to be adopted for conducting the study.

### **2.2. Sexual and Reproductive Health and Education**

WHO defined sexual health as "the integration of the physical, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love . . . every person has a right to receive sexual information and to consider accepting sexual relationships for pleasure as well as for procreation" (WHO, 1975).

As defined by Olin Health Centre (University of Michigan) sexual health refers to, "the development of sexual health is a lifelong process of acquiring information and forming values, beliefs and attitudes about identity, relationships, and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image and gender roles. Sexual health encompasses the biological, sociocultural, psychological, and spiritual dimensions of sexuality from the cognitive domain, the affective domain, and the behavioural domain, including the skills to communicate effectively and make responsible decisions" (OHC, 2001).

Schneewind KA (2001) takes education to mean a structured, purposeful process of imparting skills and knowledge, as well as influencing a person's development course. There is more to literacy than just identifying symbols and learning facts. Knowledge incorporates necessary skills required to merge knowledge in a useful manner, enabling a person to make decisions, solve problems, and express ideas. Study on sexuality education proposes that appropriate plans ought to foster sexual education-surpassing the provision of knowledge to encompass the growth of social and personal skills (Kirby D, 2001).

Through fostering sexuality education, sexuality knowledge contributes to both psychosocial well-being and development in the entire adulthood and adolescence stages. The lack of sexual knowledge can be the basis for increased social and health risks such as unwanted pregnancies and STDs. Dr. Michael Krychman, the Southern California Center for Sexual Health and Survivorship Medicine's executive director, stated that "Decreased sexuality education is troublesome for our youth as it allows perpetuation of sexual myths and mysteries — our youth are needing facts and information concerning normal sexual functioning and how to properly protect themselves from sexual transmitted diseases and unwanted pregnancy. Frank, open, and honest communication will help empower our young adults to be in better control of their sexual self-esteem and enhance sexual wellness, as well as help build relationship intimacy. Education will help curb unwanted teenage pregnancy, sexual transmitted infections, and, in some cases, depression or severe extreme suicide for gender identity or orientation concerns."

### **2.2.1 Young men's Sexuality and Reproductive Health information**

Much of the current discourse around sexual and reproductive health has centred on the need to deal with certain realities and risks of both women and girls. The whole process of human reproduction entails a woman and a man. Even with this fact, attempts to enhance reproductive health across the world have more often than not focused on girls and women (Ndong, Becker, Haws & Wegner, 1999).

The SRH advice for men has been ignored, with concentration usually offered to SRH needs of women ([www.familyplanning.org.nz/news/2017/mens-sexual-and-reproductive-health](http://www.familyplanning.org.nz/news/2017/mens-sexual-and-reproductive-health)).

Social programs, governments, and health care professionals have progressively overlooked the SRH needs of young men. An assumption regarding this omission was that parenting, pregnancy prevention, as well as teen pregnancy only concerns females on which girls and women ought to be enlightened. But effective prevention programs and policies demand the education as well as involvement of adolescent and young men. Creating more awareness regarding the provision of counselling on SRH needs, the role of male parenting and pregnancy, promoting healthy associations, as well as exposing gender labelling and stereotypes is very vital in shaping young males into responsible and knowledgeable fathers, spouses, adult men, and citizens. Due to this, the remarkable lack of research studies and educational resources concerning the SRH needs of young males' calls for instant resolution and attention (Health Teen Network, 2011).



### **2.2.2. Historical Perspective of Male Sexuality Education**

Reaching out to young males with SRH facilities was not a new idea. Several studies and projects had been undertaken to support the need for having young men on board for initiatives for reproductive health.

In America, the Office of Family Planning of DHHS had financed a bundle of exhibition programs to inspire the participation of young males during 70s (Urban Institute, 2000).

In addition, Johns Hopkins Center for Communication Programs conducted a study entitled *Better Together: A Report on the African Regional Conference on Men's Participation in Reproductive Health*. The findings from the study stated, "The largest-ever generation of young people is now approaching adulthood—there are 1.6 billion young adults between the ages of 10 and 24 throughout the world. There is a growing understanding of the need to help these young people take control of their reproductive health, and that male—as well as female—participation in sexual and reproductive health services is a necessity." (Johns Hopkins University, 1997).

Further, preventing teenagers from having unplanned pregnancies was found to be a crucial objective that has been tracked ever since 70s, the period when births to teens were initially diagnosed as the main social issue. According to Moore et al (1995); Miller and Paikoff (1992); Kirby (1997); Frost and Forrest (1995), much had been learned concerning the types of interventions that are effective and ineffective. An existing gap identified, nonetheless, was the absence of logical information concerning the manner in which men should and could engage in pregnancy prevention battles (Sonenstein et al., 1997).

Whereas human reproductive health is an area of interest for males in all age brackets, early adulthood, the initial section of life course and adolescence is of great significance. Fostering the SRH of young males is a first step to reducing some of the main dangers they encounter, creating habits that would protect them in their entire lives, and improving their overall health. Fostering SRH education for young males, a group that has been typically overlooked, is able to result in new inroads in preventing disease spread, reducing births with complications, reducing unwanted pregnancies, and promoting healthier lifestyles that have negative implications for kids. Boys and young males ages 10 to 24 are an important target group for SRH programs since they are at critical ages for gender role formation, have many misconceptions about sexuality (their own and their partners'), may have their own issues of abuse, and tend to not be thinking about family planning, contraception, and STI/HIV

prevention. At the same time they may be more open to considering alternative views about gender roles than their older counterparts (UNFPA, 2003).

### **2.3 The role of sexual and reproductive health education among male adolescents**

SRH Education for the male adolescent means delivering accurate, accessible, and relevant knowledge and information concerning SRH that are particularly meant for young males and boys who have attained 10 to 24 years. This would mean information tailored for their purposes, so that they may stop viewing reproductive health solely as a women's concern.

Preferably, initiatives for boys and young males ought to enlighten about reproductive health and at the same time promote the health well-being of those involved as well as being empathetic to male feelings, values, and motivation. The plans ought to incorporate life planning and decision making skills that merge human sexual health with a wide array of general health facilities (SIECUS, 1998).

#### **2.3.1 Male Sexual and Reproductive Health Education and Pregnancy Prevention**

Literature review showed that many inquiries have been carried out to examine the general role of male adolescent involvement to reduce teen pregnancy and HIV infection and STIs. Little research had been done specifically on the effect of provision of SRH Education for the male adolescent towards pregnancy prevention.

Healthy Teen Network state that women and men altogether require age-appropriate and discreet SRH education so as to minimize cases for STIs, create stronger families, and reduce unplanned for pregnancies. Further, they state that increased educational attempts aimed at increasing men's reproductive and health needs are important in molding young males into responsible and knowledgeable spouses, citizens, fathers, and adult men.

The Guttmacher Institute conducts research at the country and regional levels to assess accessibility of adolescents to education on SRH, which according to them serves as the main element in a comprehensive method to deal with the adolescents' SRH needs around the world. Further, they indicate that CSE is crucial in warranting that teenagers possess the skills and knowledge required to live healthy reproductive and sexual lives.

Learners appreciate the value of such skills -89 percent of the investigated students in Guatemala, who stated having acquired education on sexuality thought it very useful or useful

during their personal lives (From Paper to Practice: Sexuality Education Policies and Curricula and Their Implementation in Guatemala, 2017).

The goal for SRH among adolescent males among providers should not just focus on the prevention of unplanned for pregnancies, HIV/AIDS infection, cancers related to reproductive health, and sexually transmitted infections but instead ought to foster responsible fatherhood, adolescent and sexual health development, responsible behavior, healthy intimate associations, and minimize issues associated with infertility and sexual dysfunction. Care givers need the confidence, knowledge, and skills to monitor and assess adolescent men as well as hold a discussion with them and offer relevant education concerning the bounds of SRH care for adolescent men (WHO, 2002). However, projects, researches and studies conducted found that male adolescents hardly receive adequate sexuality and reproductive health education that would specifically help to address teenage pregnancies.

In a study conducted in Ghana by STEP UP in four favela environment in Greater Accra and Brong Ahafo areas, the Evidence Brief October 2015 gave some of the findings as follows: a comprehensive, well-designed sexuality education curricula relevant for each level of education conducted by trained persons was required. The study also found that gender variations in sexual and reproductive health practices, knowledge, and attitudes ought to be considered during the development process of educational curriculum.

The CDC, one of the main running elements of the Department of Health and Human Services in the US, discussed male involvement in Reproductive health matters: They acknowledged that male contribute greatly in reproductive health but it was important to note that the major involvement they discussed was on teen pregnancy. On male involvement they state, few interventions that are based on evidence are designed specifically for men even with the crucial role they play in prevention of early and unintended pregnancy. With this finding, a joint plan amid the CDC and the HHS Office of Adolescent Health, had conducted an inquiry that supported thorough examination of creative interventions designed for young males whose age ranges from 15 to 24 years to minimize the likelihood of fathering an early and unplanned pregnancy and which can be practicably be embraced in desired environments (Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, August 2016). Further, CDC had funded three 5-year research projects. Of the three funded projects, one specifically incorporated reproductive health education for young

males: Promundo which adapted and thoroughly assessed a creative early pregnancy prevention Program, Curriculum H, for male teens whose age ranges 16 to 22 years.

The program addressed proactive and explicit support contraceptive use by female partners, healthy masculinity, knowledge of reproductive health, and healthy relationships.

Closely related to CDC funded projects, studies conducted found that many teens were getting less sex education, at least in a formal setting, and majority of teens in the United States were not getting educated about sex at all, as per “Changes in Adolescents’ Receipt of Sex Education, 2006 – 2013” by Lindberg Laura, chief scientist at the Guttmacher Institute. For the study, Dr. Lindberg and her teammates reviewed data on teens aged 15- to 19 years for a period of five years starting 2006 to 2010 of the Prevention’s National Survey for family Growth and CDC.

Specifically for the male, the results indicated the following: The teens who said they received classroom education concerning family planning went down from 61% to 55% among males. And, in 2011-2013, 57 percent of adolescent males received no information on control of births prior to their initial sex. The study found that one in 33.3% of men didn’t get sex education instruction concerning control of birth from either their parents or other formal sources.

Dealing with SRH of male teenagers includes things such as prevention of HIV/AIDS and sexually transmitted infections. Evidence from one such study supported this – the reproductive needs of men include a broad array of facilities like infertility, family planning, sexual problems, treatment and prevention of HIV and STDs.

All the above therefore demonstrated that there was a need to specifically address young men and adolescent male with sexuality and reproductive health education.

### **2.3.2 Male Sexual and Reproductive Health Education and Sexual Encounters**

Prevention of teenage pregnancy has been central focus in adolescent sexual health. Though this concentration is commendable, the same weight should be allocated in dealing with a range of issues that exposed young persons to early encounters with sex and possible parenthood. One key reason why male adolescent needed to be specifically targeted with sexual and reproductive health information was that statistics indicated that male teenagers started practising sexual intercourse earlier compared to girls, and that they were more likely to have multiple partners over time.

Compared to young women, young men had higher chances of becoming sexually healthier during their childhood ages (12% as opposed to 4%). According to Kaiser Family Foundation (2000), male were more probable to state having had at least for sexual companions. For instance, In Kenya, The Demographic Health Survey (KDHS) (2014) indicated that the chances of young men engaging in sexual behaviour before attaining 15 years is two times (21%) that of young female (12%). More than half (55%) of men and around half (47%) of women had had sexual intercourse by the age of 18 years. Some become sexually active as early as 12 years of age, long before they are physically mature. Adolescent partnerships are sometimes not exclusive and sexual activity is often unprotected (NCPD and MOH, 2003). This shows that teenagers start their sexual practices early in life when they not physically mature and end up with complications. Male teens were more probable than female teens to have multiple partners. Among sexually active young men of ages 15-24, few women compared to men stated to have had at least two sexual companions (2% and 10% respectively). Adolescent males tended to be sexually active earlier – 71% of women within the age bracket of 20 and 49 had engaged in sexual intercourse for the first time by 20, 15% by age 15, and 50% by age 18. 76% of men within the age bracket of 20 and 49 had engaged in sexual intercourse for the first time by 20, 22% by age 15, and 56% by age 18. Young men also tended to have multiple sexual lovers- 3% of women in the age bracket of 15-19 stated to have come from polygamous marriage.

To increase the male participation in sexual and reproductive health, the primary focus should be on strategies to "encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and familial roles." Under the Research and Intervention in Sexual Health: Theory to Action (RISHTA) project at the International Institute for Population Sciences, a male health clinic was established in one of the three experimental communities. RISHTA interventions successfully demonstrated the strategies of effective community health education programmes and also the efficacy of engaging Ayurveda, Unani, Siddha, Homeopathy and Allopathic providers in HIV/STI risk reduction among men. (Sekher and Stephen, 2009). Further, The Talking about SRH Issues telephone helpline located in New Delhi received a greater number of its calls from adolescent males. On successive calls, male customers stated masturbating rather than visiting a commercial sex worker, delaying penetrative sex, and taking up other dangerous sexual activities (Green, 2009).

### **2.3.3 Male Sexual and Reproductive Health Education and Sexual Violence**

The knowledge of healthy sexuality can assist stop sexual aggression through management of gender inequality and norms. In excluding men from taking responsibility for their own actions, 33 percent of the world's female population will remain susceptible to violence. (Better Sex Education for Boys Would Reduce Violence against Women, October 2016).

All-inclusive sexual and reproductive health literacy has been ignored as an effective tool for preventing sexual assault. Sex education empowers teenagers to understand their own sexuality and understand how to have a say when their rights to sex are breached. Many forms of gender norms are believed to extend sexual aggression because they normally foster female submission and male dominance, the principles of normative sexual violence based on stereotypes. An all-inclusive sex education acts as an exemplary example of what healthy sexual practice entails and set it apart stop sexual assault and aid consensual sexuality. Also, it encourages all genders to adopt and communicate their sexuality in a safer manner as well as teaches sexuality without underlying tones of gender labelling and stereotypes. A complete sex education includes every other form of commonly used prevention device. Comprehensive sex education is among the most useful techniques employed to minimize the severity and prevalence of sexual aggression when looking at sexual aggression as a public and global health problem. Elsewhere, comprehensive sex education is one of the most useful measures to change oppressive, apathetic, and victim-blaming attitudes towards the issue when looking at sexual aggression as a social problem. From whichever perspective, an all-inclusive sex education enhanced the process of healing among survivors of sexual assault and stop further imminent assaults, inspiring the future generation in a healthy, sustainable manner.

Programs and studies conducted showed that when male were involved, there were better outcomes. For instance, In Kenya a program developed by No Means No Worldwide addressed the issue of society in constructing and sustaining associations between archetypal masculinity and violence, strength and power directly by working with boys to re-conceptualize masculinity. The study program for males sought to alter feelings and attitudes that caused young men and adolescent boys to imagine it was okay to rape or assault their female colleagues. The brief curriculum generated prolonged improvements in altering the attitudes young men and adolescent boys have toward female peers, according to a Stanford University e-curriculum (Journal of Interpersonal Violence, June 2015). The inquiry encompassed 1, 543 males aged between 15 and 22 years residing in the slums of Nairobi.

In 29 secondary schools, 1,250 of them were subjected to seven two-hour learning shifts from No Global No Means. The mediation study program entitled “Your Moment of Truth,” concentrated on assisting them appreciate the cultural stabilization of gender violence against females, as well as gather courage and skills to prevent it. Discussion topics were: how and when to safely intervene if you notice someone treating a woman violently; what constitutes consent to sexual activity; myths regarding women; and negative gender labelling and stereotypes. It found that the program transformed attitudes towards women and rape. Class participants were also more likely to intervene in the event of an assault. These interventions acknowledged the profound importance of cultural and social phenomena on the use of violence. They presented the more optimistic view that male violence is not immutable—it can be transformed, if only we acknowledge that men can change. The success of this examination with comparatively young men fitted in with earlier study revealing that it was simpler to alter unfavourable gender labelling and stereotypes in groups of young people.

#### **2.3.4 The role of peers in Male Adolescent Sexuality**

The sexual behaviours of peers, are expected to, and generally do, influence the sexual behaviour of individual adolescents. Several studies and researches conducted supported this. Research supported the increased conviction that colleagues contributed greatly in the lives of adolescents. Teens that have sexually healthy and active peers tend to engage in sexual intercourse among themselves (Miller Et.al, 1997). However, it wasn't the behaviour of the peers that was of great interest; teenager's view regarding their conduct also mattered. According to Kinsman et al (1998), teens who thought their peers were engaging in sexual intercourse had higher chances of initiating sex at prime age. Of great importance was also the peer perception toward the use of contraceptives. Teenagers who think that their friends don't like using or do not use protective measures have low chances of using them (Whitaker and Miller, 2000).

As evidence suggested, a group of peers was an essential element during the development stages of adolescent and had an implication on the decisions of teens regarding sex. As reported by Kaiser Family Foundation (2000a), adolescents aged between 13 and 18 years agree that they tend to obtain information concerning sexual health matters from their colleagues. Fraser (1997) remarks that the pressure to practice sexual intercourse elevates during mid-adolescence. As per Advocates for Youth (1997), sexually active adolescents are likely to think that majority of their peers are also sexually healthy and active, that sex is

generally a good thing, that it's okay for unmarried teens who have attained 16 years to have sex, and that the benefits offset the costs of sexual involvement.

Evidence also suggested that, youth who resisted having sex were more likely to have friends who also valued abstinence. More so, they were more likely to have the perception of favourable parental responses and uphold strong personal conviction in abstinence (Advocates for Youth, 1997). Strasburger (2005) argues that we already have gotten lots of messages regarding sexuality by the time we reach adolescence. Whereas a number of teens may get comprehensive and accurate messages from parents and school, others still may have access to little or no information. Gruber and Grube (2000) note that lack of realistic, healthy information about sexuality may compel many teens to seek information from others sources including the internet, media and peers. This leaves young people with no knowledge of consent, how to indulge safely in sexual behaviours, healthy relationships, and boundaries.

Therefore, developing an understanding of the factors affecting early engagement in sexual intercourse as well as coming up with potential strategies for postponing first sex have serious consequences on the health of many adolescents. Manlove et al (2001) and Kirby (2001) contend that parents, friends, sexual partners, and siblings are the most powerful sources of social influence. To increase the chances of success, plans aimed at suspending young sexual practices ought to manage norms for sexual conduct among intimate friends of the adolescents together with the individual behaviour, perceptions, and skills of the teenagers (Perspectives on Sexual and Reproductive Health, 2006).

## **2.4 Theoretical framework**

In reviewing the literature, it was clear that theory contributed greatly to the evolution of a number of methods to providing sexual and reproductive education. Theoretical frameworks can be helpful in developing feasible plans that put into consideration what other researchers, psychologists, and sociologists have been able to write as affecting human relationships and behaviour. Majority of theories within health promotion and health education aim at seeking responses to the basic question of why individuals act the way they do. Theories in specific are utilized to understand as well as foretell why and how individuals change their behaviours to healthy ones.



This study was guided by several theories:

#### **2.4.1 The Theory of Reasoned Action (TRA)**

TRA was initially developed by Martin Fishbein in late 60s and was further revised and improved by Icek Azjen and Fishbein in the successive years. The theory is built on the assumption that people are normally reasonable and make logical use of the available information. It emphasizes the role of personal intention in determining whether behaviour will take place. An implication for this theory is that individual behaviour normally succeeds intention and will not take place without it. The TRA is specifically centred on the part played by personal intention in establishing if behaviour will take place. The intention of a person is a function of two fundamental elements:

1. Attitude (toward the behaviour), - the intentions of people are determined by other feelings toward the behaviour like if they think the behaviour is worthy. Attitudes are the sum beliefs about a particular behaviour which is evaluated by an individual.
2. 'Subjective norms', i.e. social influence - what they believe other individuals – particularly, influential individuals like friends and colleagues– would expect him/her to do.

According to Chang (1998), the TRA argues that a person's behavior is more often influenced by this person's "behavioral intention" to carry out the behavior under consideration. The theory proposes that the "behavioural intention" act as a good and accurate predictor of an individual's behavior, and it's advanced from the attitude of this person- serves as the most accurate possible prediction of the behaviour of an individual, and it is developed from this individual's attitude—a "person's general feelings or favorableness or unfavorableness for a behaviour"—as well as an individual standard—an individual's conviction that significant others believe she or he ought to embrace a specific behavior (Chang, 1998). For all intents and purpose, theory of reasoned action concerns itself with behaviors that can be managed by the person.

Briefly, as per theory of reasoned action, a person's decision to engage in a certain behavior ("behavioural intention") is determined by her or his attitudes concerning how appropriate is the behavior, together with her or his view on the social environment regarding the suitability of behavior (Hansen et al, 2004).

Therefore, this model can be employed to assist in how sexual education is taught to male adolescents. It can be used to influence male adolescents' attitude to sexual health positively so as to foster more informed and safer sexual experiences.

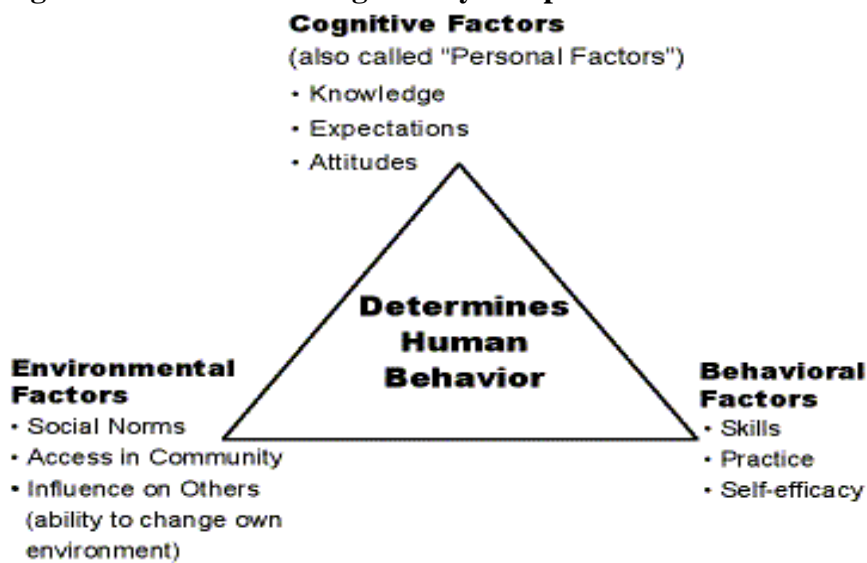
## 2.4.2 The Social Learning Theory (SLT)

According to Bandura and Walter (1963); Bandura (1977), SLT is a theory of learning that is built on the assumption that mankind behavior is influenced by a three-folded association amid environmental and cognitive behaviors and forces.

Referring to the original words of its developer, Albert Bandura, "Social learning theory approaches the explanation of human behavior in terms of a continuous reciprocal interaction between cognitive, behavioral, and environmental determinants" (Social Learning Theory, 1977).

The three-folded inverse association is shown in the figure below:

**Figure2.1: Social Learning Theory Reciprocal Interaction**



While using the social learning theory, the student is urged to:

- Ensure positive behaviors designed and put into use,
- Get help from their environment so as to utilize new skills,
- Raise their confidence and ability to embrace new skills,
- Detect and imitate others' behaviors, and
- Acquire positive attitudes regarding implementation of new skills.

SLT has not only been used in sexuality education but also other health education fields. Social learning theory is specifically a perfect match for HIV, sexually transmitted infections, and early pregnancies prevention initiatives since: Personal attitudes, environmental influences, personal skill, knowledge, and interpersonal relationships are the key determinants of sexual behavior. These elements are altogether explained in the social learning theory.

Adolescents get few, if any, favorable theories for fit sexual behaviour. It is extremely important to model healthy and positive youth behavior that are related concerns sexuality.

Since sexual activities more often take place in private environment, much of what teens describe about sex occurs in movies and on TV, reputable magazines and music. A great number of this displayed behavior has no discussion about risks, early sexual practice, no mention of protection, and has violence joined with sex. This is contrary to what educators of family life are striving to instill in adolescents.

This theory can be used to offers adolescents with behavioural practical skills. For instance, saying “no” when compelled to put on condoms or have sexual intercourse -which they will employ throughout their lives. In the field of sexuality, teens usually are not given a chance to put into use such prevention skills prior to real life circumstances where they require them (<http://recapp.etr.org>). Teaching adolescents certain behavioural skills is important in guaranteeing effective prevention initiative. Unluckily, many programs on sexuality put more emphasis on mental learning and overlook the behavioral elements of staying and becoming sexually active and healthy.

### **2.4.3 Application of the Theory of Gender and Power (TGP)**

This theory was developed by Robert Connell in the year 1987. TGP is founded on philosophical documentations that discover the intenseness of sexual inequity along with power and gender inequality (DiClemente & Wingood, 2000). TGP is made up of three social frameworks: structure of cathexis, sexual division of labor, and sexual division of powers.

The terms can be understood as follows:

- Labor – is the distribution of certain types of tasks to certain groups of individuals
- Power – associations of power which behave like a series of restraint on social practice
- Cathexis – framework guiding emotional bonds to persons especially linkages amid masculinity and femininity as well as women and men.

As said by Connell (1987), the triple structures are different but interrelate, and work jointly to describe and define the heterosexual association amid women and men, and affect the health being of women (Connell, 1987). These constructs of the theory of gender and power exists at two levels: institutional level and societal level. Wingood and DiClemente ( 2000) state that with regard to public health perspective, the TGP’s structures identify exposure, biological and risk factors concerning issues that negatively affect the health of women including sexually transmitted diseases and HIV/AIDS risk regarding aggression against women and the use of condoms. The theory of gender and power has been employed by investigators in managing health problems common among women and dig deeper into disparities and inequalities based on gender that affect female health.

HIV education as well as human sexuality that is built upon educational curriculum is the backbone of interventions to stop unintended pregnancies, sexually transmitted infections, as well as HIV in young population. Research associates conventional intimate partner violence, gender norms, and unequal power in sexual relations with adverse SRH outcomes.

A number of research works done across the world, especially the US, show a definite relation amid adverse SRH outcomes and clinging on outdated male gender norms. According to Courtenay (2000), evidence still demonstrate that sticking to traditional male gender norms has been accompanied with various unfavorable health consequences among males. This does not mean that gender norms solely contribute to these consequences, but it plays a greater part. Pleck et al (1993) state that when a greater number of men and boys subscribe to outdated gender norms (masculinity), they tend to assume sexual risks. Traditional gender norms teach boys and men to be tough, risk takers, strong, self-reliant, aggressive, and competitive. A person's "manliness" is demonstrated through having and practicing control and power. Whereas these qualities are not bad at all, it's the stiffness of these gender norms, and the tension to stick to these standards time and again that poses a challenge. How boys and men are taught to demonstrate these qualities is of great significance too. A young man can, for example, realize that "toughness" is demonstrated through by being violent and dominant towards his partner or by running in a marathon. The former presents a number of health challenges to the boy together with his relations.

Data obtained from two college studies carried out with undergraduate young men (Thompson et al., 1985; Noar & Morokoff, 2002), data gotten from the National Survey of Adolescent Males with national sample of teens aged 15 to 19 years (Marcell et al., 2007; Pleck & O'Donnell, 1985; Pleck et al., 1993), along with other research works (Marsiglio, 1993; Kandrack et al., 1991;) show that, as opposed to their conventional colleagues, adolescent boys and men who stick to conventional gender norms concerning masculinity are:

- Tend to have multiple sexual partners in previous year
- Less likely to use preventive measures such as condoms
- Have low chances of using condoms regularly
- Low possibilities of receiving health care
- Low chances having tested in the previous year
- Believe men are not responsible to prevent pregnancy

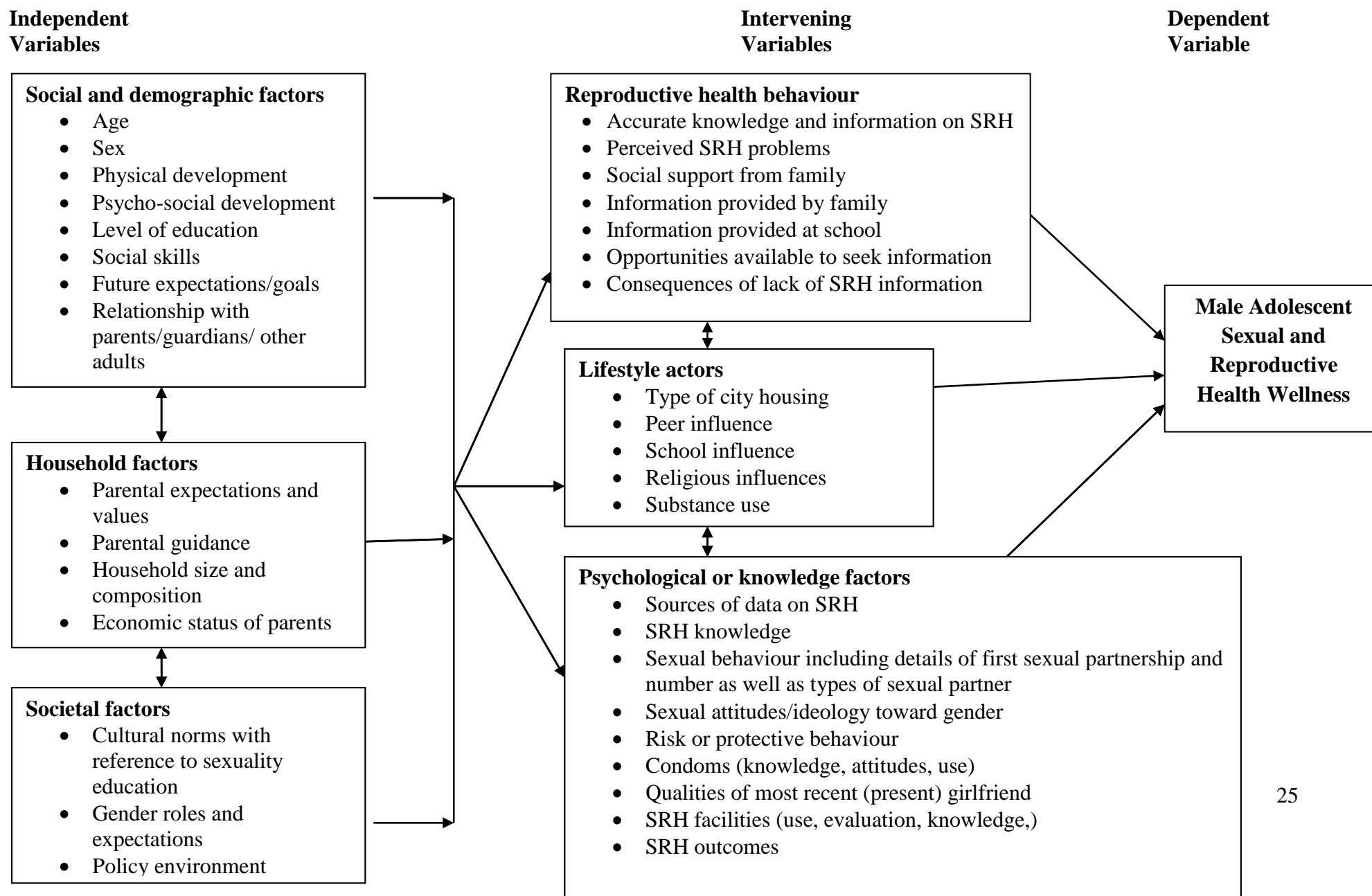
- Tend to assume pregnancy validates masculinity
- Tend to approve uneven decision making power with close companions
- Tend to have reduced intimate relation at previous intercourse
- Tend to believe that relations amid men and women are dangerous

Such behaviors, beliefs, and attitudes have all been reported as factors affecting adverse SRH outcomes and sexual risk taking behavior (Lepore & Kirby, 2007).

From the above, there is a strong reasoning for why a focus on power and gender has the ability to enhance curriculum-based SRH education initiatives for male adolescents.

## 2.5 Conceptual Framework

**Figure 2.2 – A conceptual framework of Independent and Intervening variables that influence male sexual and reproductive health and wellness**



## **CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY**

### **3.1 Introduction**

Orodho (2003) defines research design as a structure needed to generate solutions to research questions. The most important component in any research is the construction of a well-defined methodology. Described in this section is the target population, research design, sample, sampling procedure, study tools, procedures for data collection, and the data processing and analysis procedures that were used to conduct this study. It also described how the reliability and validity of the research instruments were tested and details the ethical considerations of the study.

### **3.2 The Site of Study**

The research was conducted in Nairobi County specifically Roysambu Sub-county.

Out of the 47 Kenyan counties, Nairobi County is the smallest yet most populous. It borders with Nairobi city, the largest city and capital city of Kenya.

It was established in 2013 on similar territories as Nairobi province, following the sub-division of 8 provinces into 47 counties.

Roysambu Sub-county has 5 wards - Githurai, Kahawa West, Zimmerman, Roysambu, Kahawa. It has a population of about 202, 284 and covers approximately 49 square kilometers.

### **3.3 Research Design**

Trochim (2005) argues that study design "provides the glue that holds the research project together. A design is used to structure the research, to show how all of the major parts of the research project work together to try to address the central research questions."

The examination employed a descriptive research design. This provided evidence concerning the inherently happening health attitudes, status, behavior, or other qualities of the male adolescents to demonstrate associations or relationships of sexuality education, knowledge on SRH with sexual behavior and reproductive health wellness. This was a research with information from different male adolescents being collected and compared at the same time to draw inferences on effects of sexuality education. The survey method was used for descriptive research. Zikmund et al (2010) define survey as study tool where a representative sample is interrogated in certain forms or respondents' behavior is described and observed in certain way.

### **3.4 Unit of Analysis and Units of Observation**

#### **3.4.1 Unit of analysis**

A unit of analysis is an object that a person wishes to speak of after the conclusion of the inquiry, Perhaps what one would deem to be the main study focus.

The unit of analysis for this study was the impact of SRH education on the wellness of the group of male adolescents aged 18 to 24.

#### **3.4.2 Units of observation**

A unit of observation is an object (s) that a person in reality measure, observes, or gathers while attempting to learn something concerning their unit of analysis.

(Open Textbooks for Hong Kong, 2016)

The units of observation for this study were the male adolescents who provided the information on the effects of sexuality education as well as the key informants who provided the insightful information on the behavior of their male adolescents.

### **3.5 Target Population**

A universe or rather a population refers to a whole set of items including shops, organizational employees, university students, and people that have common qualities. Zikmund et al (2010) define a population element as an individual member of the study population.

The target population in this study was adolescent males aged between 18 and 24 within Roysambu Sub-County. This age bracket was preferred since the literature showed that it's at this life stage that youths were more likely to look for sexuality messages and newly begun sexual practices.

### **3.6 Sample Size and Sampling Procedure**

#### **3.6.1 Sample Size**

Determination of sample size refers to the practice of selecting the number of replicates or observations to incorporate in numerical representative sample. For any scientific study whose objective is to make deductions concerning a sample populace, sample size proves an important element. The selected sample size for the survey was 150 male adolescents aged 18 – 24 years either as an individual or from a youth group, institutions and churches in the Sub-County. There were no exact statistics on the male adolescent population in Roysambu Sub-county, therefore the researcher decided to have 150 as a reachable sample size with the aim of getting a more meaningful result, as there were also going to be sub-groups within the sub-county as it comprises of five wards.



### **3.6.2 Sampling Procedure**

Ogula (2005) takes sampling to mean the process of selecting a sub-section from a study populace to take part in the inquiry; it's a technique or process of choosing certain number of persons for a research in such a manner that the chosen persons represent the general population from which they were chosen.

This research employed simple, stratified random sampling and purposive sampling procedures.

#### **Stratified Sampling Procedure**

The target populace comprised of male teens aged 18 – 24 years and residing within Roysambu Sub-County. The sample size for the study was 150 male adolescents. The study used stratified sampling across the wards within the sub-county which are Githurai, Kahawa West, Zimmerman, Roysambu and Kahawa. From each ward, the researcher targeted to reach 30 male adolescents. The respondents were sourced as individuals, from existing youth groups and football clubs that had the criteria of adolescents stated above. For the youth groups, once identified, if the youth group/club had more than 30 members who fit the criteria, only 30 members were to be selected by use of the simple random sampling method.

For respondents who agreed to participate as individuals, the researcher explained the study purpose and if agreeable, the feedback form was given out.

For the youth groups/football clubs, the researcher was able to get three wards – Zimmerman, Kahawa and Kahawa West with organised groups, 2 church youth groups – in Zimmerman and Kahawa wards, and 2 football clubs in Kahawa and Kahawa West wards. Hunt and Tyrrell (2001) argue that primary benefit of this method is that it had the ability of giving the most representative sample of the general populace as the members of these groups/clubs were not homogenous. However, in the case of the youth groups/football clubs, the number of respondents did not get to the anticipated 30 respondents from any of the groups.

#### **Simple random sampling**

In a simple random sampling, each population element has equal probabilities of being selected to make up the sample. The researcher utilized simple random sampling procedure to select 10 participants (2 from each ward) who provided the feedback. This applied in the case of three wards where the investigator was in a pole position to get groups that were organized.

### Purposive sampling

Purposive sampling provides qualitative data and is also referred to as “non-sampling. For the two wards (Roysambu and Githurai) with no organised groups, the researcher selected two individuals who served as youth group leaders to provide the feedback.

### **3.7 Methods of Data Collection**

An inquiry is a logical examination that seeks to produce understanding and knowledge concerning certain concept. But the type of this knowledge differs and mirrors your research goals. A number of research goals aims at making logical and standardized comparisons while others aims at examining a situation or concept in depth. Such varying objectives demand varied methods and approaches that are commonly classified as either qualitative or quantitative (Save the Children, 6 Methods of Data Analysis).

This research was highly explorative and focused on sensitive issues. For this reason, the research employed both qualitative and quantitative study. Using both qualitative as well as quantitative study provided different perspectives and complemented each other.

#### **3.7.1 Collection of Quantitative Data**

Quantitative approaches put emphasis on objective tests as well as the numerical, statistical or mathematical evaluation of data gathered via manipulation of already available numerical data by use of computational methods, or collected through surveys, polls, and questionnaires. Babbie (2010) posits that qualitative study concentrates on obtaining statistical information and generalizing it to describe a certain concept or across people.

To collect quantitative data, the researcher administered questionnaire with multiple choice and closed-ended questions. The questionnaire was meant to report outcomes, behavior, knowledge, and beliefs in the area of young male SRH and fitness.

The feedback form was adopted majorly from a World Health Organization tool constructed as a template for investigators to come with a research on SRH behavior among adolescent people (WHO, 2001).

### **3.7.2 Collection of Qualitative Data**

Qualitative research very so often respond to study questions including “how?” and “why?” to add to the data gathered from statistical surveys that consequently is inclined to give a summary of “how many”, “what”, and “where”. Carrying out a thorough qualitative study depends on the selection of a study question that is wide enough so as to include an array of structural, social, and cultural factors and at the same time remain very focused to produce data that are used to make clear inferences (WHO, 2012).

To collect qualitative data, the researcher interviewed 10 key informants. The ten key informants were used to solicit further information on how adolescents perceive their sexuality and effects of sexuality education on their SRH and wellness. Hence the qualitative method of use of key informants was well suited to explore and study meanings, experiences, and processes and provide male adolescents with the opportunity to give accounts of their experiences in their own words.

### **3.8 Ethical Considerations**

The topic of human sexuality is very sensitive in most communities, and religious as well as cultural values greatly contribute in establishing the manner in which sexuality is thought about and is organized.

Conducting research with young people is fraught with practical and ethical pitfalls (McIlwaine and Datta, 2006). Lie (2008) remarks that dealing with matters of SRH entail keen reflection of the manner in which individuals should be handled, for example, the manner of ensuring that a person’s honest and integrity is cared for and the manner of demonstrating respect for established subcultural and social values. The following actions were considered to guarantee respondent’s right to confidentiality and privacy:

We sought consent from all respondents prior to the actual interview process.

They were informed of the study theme and told that it was not compulsory for them to take part. Participants were assured of the privacy of the study and that the study outcomes were to be utilized for educational reasons only and that no given names were to be put on the questionnaire to ensure anonymity.

### **3.9 Data Analysis**

Zikmund et al (2010) define data analysis as the use of reasoning to develop an understanding of the obtained data. Data analysis might entail establishing regular patterns as well as summing up suitable information uncovered in the study (in its simplest form).

There was need to analyse the data from the qualitative research study in order to make sense of it and to make accessible for reading.

As reported by University of Leicester (2009), both quantitative and qualitative analysis encompasses coding as well as labeling the entire data so that differences and similarities may be realized.

The analysis of data involved procedures like categorizing, coding, and generating meaningful conclusions about the concept.

The analysis of quantitative data is a logical approach to examinations in which statistical information is obtained or and the investigator alters what's observed or gathered into computational data. Since there was no system for pre-coding, once I received the questionnaires I labeled each one of them Form 001 to 120. Responses from the questionnaire were keyed in the computer so that it can be counted, analyzed, and coded. In so doing, I was able to do content analysis to provide meaningfulness of the data as well as identify key features, results or information by organizing it, summarizing it and then doing exploratory analysis.

The quantitative data was used to find where responses were similar, if there were differences and if relationships existed.

To communicate the meaning to others the data was presented as charts, graphs and frequency tables which were easy to interpret and understand.

## CHAPTER FOUR: DATA ANALYSIS, PRESENTATION AND DISCUSSION

### 4.1 Introduction

This section contains findings and interpretation of the major study findings. It focuses on questionnaire return rate, demographic characteristics of respondents, analysis and interpretation of findings. The data analysed both qualitatively and quantitatively by use of descriptive and inferential statistics, has been arranged according to the objectives of the research.

### Questionnaire Return rate

The study targeted a sample of 150 male adolescents aged 18 - 24. Of these 120 (80%) questionnaires were administered and collected. This rate of return was deemed sufficient for the study. The study also engaged 10 key informants from among them who provided further information on SRH services for better understanding.

### 4.2 Social and demographic information of respondents

This section had questions that enabled the researcher to obtain background information of the male adolescents who participated in the research. The demographic information collected included age of respondents, level of education, relationship status, occupation, religious affiliation and place of residence. This is supported by evidence as suggested by Gupta G.R. 2000, "Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors, influence an individual's sexuality."

#### 4.2.1 Distribution of the respondents by age

Age distribution can influence the level of Sexual Reproductive health education received. The respondents were requested to show their age by marking on the blank spaces given in the feedback form.

**Table 4.1: Respondents Age Distribution**

Age Distribution	Frequency (N)	Percent (%)
18 – 19	36	30.0
20 – 21	36	30.0
22 – 24	48	40.0
<b>Total</b>	<b>120</b>	<b>100.0</b>

#### 4.2.2 Level of Education

Educational level was considered as one of the variables for determining the level of male sexual and reproductive health education and wellness, as studies show that the degree of men participation in SRH issues was accompanied with experiences in school (Bishwajit et al (2017).

There were no respondents without formal education, the same as for not having completed primary schooling. 2.0% of the respondents had only up to primary school level education. Those who were still in high school represented 3.0% while those who had finished high school accounted for 36.0%. Those with university education accounted for 47.0%. Some respondents indicated they had other skills. Those who had not completed high school and had other skills accounted for 1.0%, and those who had completed high school and had other skills accounted for 8.0%. Those with university education and other skills accounted for 3.0%.

The association amid educational attainment and SRH has shown that it affects getting into sexual and reproductive facilities, access to messages, as well as getting into sexual networks. Increased formal educational attainment is associated with healthier sexual and reproductive behaviors.

Table 4.2 indicates the frequency of the distribution regarding level of education.

**Table 4.2: Distribution by level of Education**

<b>Level of Education</b>	<b>Frequency (N)</b>	<b>Percent (%)</b>
Primary school education (completed)	2	2.0
High school (not finished)	4	3.0
High school (finished)	42	36.0
University education	56	47.0
High school (not finished plus other skills)	1	1.0
High school (finished plus other skills)	9	8.0
University education (plus other skills)	4	3.0
<b>Total</b>	<b>118</b>	<b>100.0</b>

### 4.2.3 Relationship Status

Since the 1994 ICPD in Cairo, gender elements of reproductive health gained much attention.

Men not only have reproductive health worries of their own, however, their behaviors and health status influence the reproductive health of women as well. It was therefore important to consider the relationship condition of the participants.

As per Table 4.3, the number of male participants who were not married or engaged accounted for 69.0%. Those who were dating accounted for 30.0% and 1.0% were married.

Being in a relationship has been considered a major determinant for SRH and wellness. According to Martinez et al (2011); Gibbs (2013), a report from the NSFG (National Survey of Family Growth), more than 50% of young males and around 75% of women state that initial sex contact took place within the setting of a dating or romantic association.

**Table 4.3: Distribution by relationship status**

<b>Relationship Status</b>	<b>Frequency (N)</b>	<b>Percent (%)</b>
Single	82	69.0
Dating	36	30.0
Married	1	1.0
<b>Total</b>	<b>119</b>	<b>100.0</b>

### 4.2.4 Type of occupation

With the age group 18 – 24 being the respondents, it was not unusual to find that the main occupation was students at 60.0%. Being students would mean they are more often within an organized institution where they would have access to a medical facility where they would access SRH services, or a medical personnel they can seek SRH information from. These institutions may also have Wi-Fi services and they can access SRH information on the internet easily.

There were some who were employed, accounting for 10.0% and some who were self-employed accounting for 15.0%. Those who were neither students nor employed accounting for 10.0%. 3.0% were students and self-employed and 2.0% were students and employed. The results are as shown below in Table 4.4.

**Table 4.4: Distribution by type of occupation**

<b>Occupation</b>	<b>Frequency (N)</b>	<b>Percent (%)</b>
Student	72	60.0
Employed	12	10.0
Self employed	18	15.0
Unemployed	13	10.0
Student, Self Employed	3	3.0
Student, Employed	2	2.0
<b>Total</b>	<b>120</b>	<b>100.0</b>

#### **4.2.5 Religious affiliation**

As per WHO (2006), the relationship between spiritual, biological, social, cultural, economic, legal, religious, psychological, and political factors influences human sexuality.

Results as shown on Table 4.5 indicated that Protestants accounted for 66.0%, Catholics for 24.0% and Muslim for 3.0%. 7.0% indicated they were Christians.

**Table 4.5: Distribution by Religious Affiliation**

<b>Religion</b>	<b>Frequency (N)</b>	<b>Percent (%)</b>
Protestant	78	66.0
Catholic	28	24.0
Muslim	3	3.0
Other – Christian	8	7.0
<b>Total</b>	<b>117</b>	<b>100.0</b>

#### **4.2.6 Frequency of attendance of religious services and importance of religion**

Having known the religion, the respondents were asked to indicate how regularly they attended religious services and how important religion was to them. Table 4.6 shows the attendance's frequency of religious facilities and Table 4.7 shows how important religion was to the respondents.



**Table 4.6: Frequency of attendance of religious services**

Frequency of attendance of religious services	Frequency (N)	Percent (%)
Every day	11	9.0
At least once a week	87	73.0
At least once a month	11	9.0
At least one a year	7	6.0
Less than once a year	1	1.0
Never	3	2.0
<b>Total</b>	<b>120</b>	<b>100.0</b>

**Table 4.7: Importance of religion**

Importance of religion	Frequency (N)	Percent (%)
Very important	93	78.0
Important	25	20.0
Not important	2	2.0
<b>Total</b>	<b>120</b>	<b>100.0</b>

**4.2.7 Place of Residence**

According to Morris (2015), the SRH of an adolescent is heavily connected to their specific economic, social and cultural setting. Besides geographical differences, encounters are set apart through schooling, migration, socioeconomic status, age, migration, marital status, sexual orientation, and sex among other features.

The study thus aimed at determining the respondents' place of residence within Roysambu Sub-county. The results are shown in Table 4.8.

**Table 4.8: Distribution by place of residence**

Place of Residence	Frequency (N)	Percent (%)
Githurai	29	24.0
Kahawa	22	18.0
Kahawa West	20	17.0
Roysambu	23	19.0
Zimmerman	26	22.0
<b>Total</b>	<b>120</b>	<b>100.0</b>

### **4.3 Sources of Information on Sexual and Reproductive Health**

The research sought to find out how the respondents learned about sexuality and matters of reproductive health.

Access to quality information is vital to making informed decisions and choices. According to Rogers (2003), the availability of reliable information is critical for reducing uncertainty and enabling people to make choices among a set of alternatives in problem solving situations. In particular, health information is important as it empowers people —to make choices, take control, and be responsible for completing diagnostic and therapeutic regimes (Houston & Ehrenberger, 2001).

Making informed decision and having control over one’s reproduction and sexuality, therefore hinges on the availability of adequate and quality information.

#### **4.3.1 Parents/Guardians as sources of information**

Holding open family conversation on issues of reproductive health very so often results in more knowledge on reproductive health issues and minimizes harmful practices amongst young people.

Effective child-guardian/parent discussion of SRH issues results in greater knowledge on matters of sex and reproduction, and protect the adolescents for SRH

Yadeta et al (2014) affirm that parent-child communication of sexual and reproductive health matters leads to increased awareness on sexual and reproductive matters and is protective for adolescent sexual and reproductive health.

Three closely related questions to gather information on this were given as if the respondents had discussed sex-related matters with any of their parent/guardian, if so, which parent and how often.

Table 4.9 below shows that of 120 respondents, 40.8% had had sex-related discussions with a parent. Further on, of these respondents, the mother was identified by 59.2% as the parent they had a discussion with, 30.6% with the father, while 10.2% said they had a discussion with both parents. (See Table 4.10). Table 4.11 shows how frequently the discussions took place.

The following are the results of the three questions:

**Table 4.9: Discussion with parents**

<b>Discussion with parents</b>		
<b>Response</b>	<b>Frequency (N)</b>	<b>Percent (%)</b>
Yes	49	40.8
No	71	59.2
<b>Total</b>	<b>120</b>	<b>100.0</b>

Study has revealed that young people prefer holding discussions with their guardians or parents regarding sex though such conversations are seldom (Turnball T., 2012).

**Table 4.10: Which parent discussion was with?**

<b>Parent discussion was with</b>		
	<b>Frequency (N)</b>	<b>Percent (%)</b>
Mother	29	59.2
Father	15	30.6
Both	5	10.2
<b>Total</b>	<b>49</b>	<b>100.0</b>

This is similar to results from a study of adolescents aged between 18-19 years in Pondicherry, India from February 2014 to March 2014. Out of 251 teenagers, who offered responses to the study question on preferred person for discussion on SRH, 38.2% suggested mother as the most preferred for such discussions. (International Journal of Community Medicine and Public Health, January 2017).

**Table 4.11: Frequency of discussions**

<b>How often discussions happen</b>		
	<b>Frequency (N)</b>	<b>Percent (%)</b>
Often	10	20.0
Occasionally	38	78.0
Once	1	2.0
<b>Total</b>	<b>49</b>	<b>100.0</b>

### **Ease or Difficulty talking about sexual matters to different sources**

Even though parents have the opportunity to be the major sources of messages concerning reproductive health matters, parents and their teens are still silent on such issues.

Taffa (1999) states that research works have indicated that just 20 percent, 46 percent, and 20% in Ethiopia, the United States, and Lesotho respectively held conversations with their adolescent on such matters. Consequently, occasional knowledge of most adolescents on reproductive health matters frequently are gotten from messages shared by their peers, who might be or might not be knowledgeable.

The study conducted among the male adolescents showed similar results according to Table 4.12 with 84.3% who found it mainly easy to discuss SRH matters with their male friends.

The respondents discussed SRH issues least with their fathers at 11.7%.

**Table 4.12: Ease or difficulty discussing SRH matters with different sources among male adolescents**

<b>Person</b>	<b>Mainly Easy</b>	<b>Mainly Difficult</b>	<b>Not talk at all</b>	<b>Total</b>	
				<b>Frequency (N)</b>	<b>Percent (%)</b>
<b>Mother</b>	23.3%	21.6%	55.1%	<b>116</b>	<b>100</b>
<b>Father</b>	11.7%	27.0%	61.3%	<b>111</b>	<b>100</b>
<b>Guardian</b>	19.5%	14.6%	65.9%	<b>82</b>	<b>100</b>
<b>Male Friends</b>	84.3%	11.3%	4.4%	<b>115</b>	<b>100</b>
<b>Female Friends</b>	51.3%	32.7%	16.0%	<b>113</b>	<b>100</b>
<b>Teacher</b>	16.4%	28.2%	55.4%	<b>110</b>	<b>100</b>
<b>Religious Leader</b>	13.2%	29.8%	57.0%	<b>114</b>	<b>100</b>

The key informants were further asked to elaborate on how friends participated in the SRH discussions among males. They were asked:

- i. What role their friends had played in discovering about contraception, relationships, and sex.
- ii. What issues they discussed about with friends on sexual matters and sexual health.

### **The role friends played**

“My friends have helped me understand issues of relationships, sex and contraception.”

“They have given me advice at the level they can.”

“They have incited me to have sex.”

“They forced me into having sex. They made it a type of lifestyle and once one has sex, they gain identity.”

“So far, my friends in high school seemed not to care about it. There was too much pressure on books that there was no time to engage in matters of relationships and sex.”

“They have initiated some very informative discussions and debates on sex, relationships and contraception.”

“Some have been misleading while others make sure you are on the right track.”

### **Issues discussed on sexual matters and sexual health**

“When is the right time for sex, how sex should be done, how one can get sexual diseases and the best way to prevent it.”

“Sex as a topic is what is mostly discussed. Along with the risks associated with it such as unwanted pregnancies and sexually transmitted diseases.”

“Contraception. How to get girls to sleep with you.”

“The consequences of having several sex partners. Different types of contraceptives.”

“Their personal sex experiences.”

“More of how many girls you have had sex with and how many you are still hunting. Not much on sexual health.”

“Nothing that I would consider really helpful.”

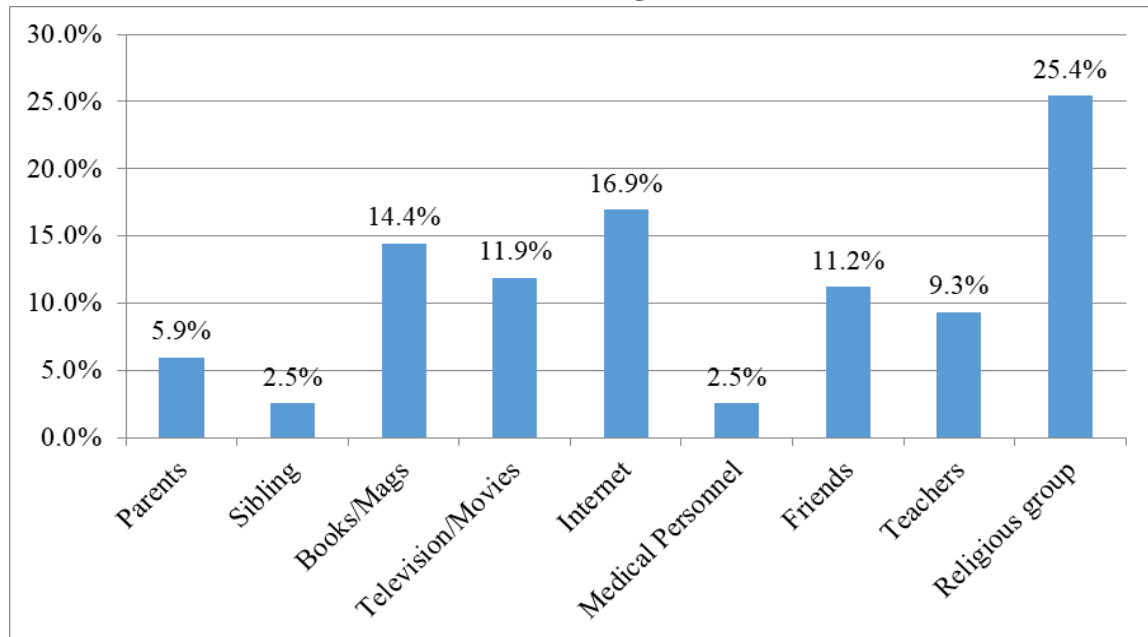
“The importance of sex. The best time for doing sex.”

### **4.3.2 Sources of Sexual and Reproductive Health Information**

In terms of sources of SRH information, the study sought to find out their sources of information and in connection to this, their preferred sources.

Figure 4.1 below shows the male adolescents’ sources of SRH information.

**Figure 4.1: Sources of Information on SRH among male adolescents (N=118)**



Social and religious sub-groups tend to sway youths in two ways: via certain programs for teens, and at times through their teachings.

Given that the respondents in this study found religion important to them as demonstrated earlier in Table 4.7, it is no wonder that the 25.4% cited religious groups as their source of information. The key informants further supported these findings. The responses they gave backed these findings.

“Most of the knowledge I have is from school. But I have also learnt from church/religious forums and also on my own through research from internet sources. The media has also played an important role.”

“From my friends at school mostly. They tell me about their experiences. I have also learnt from my sibling. And also from television especially movies and music.”

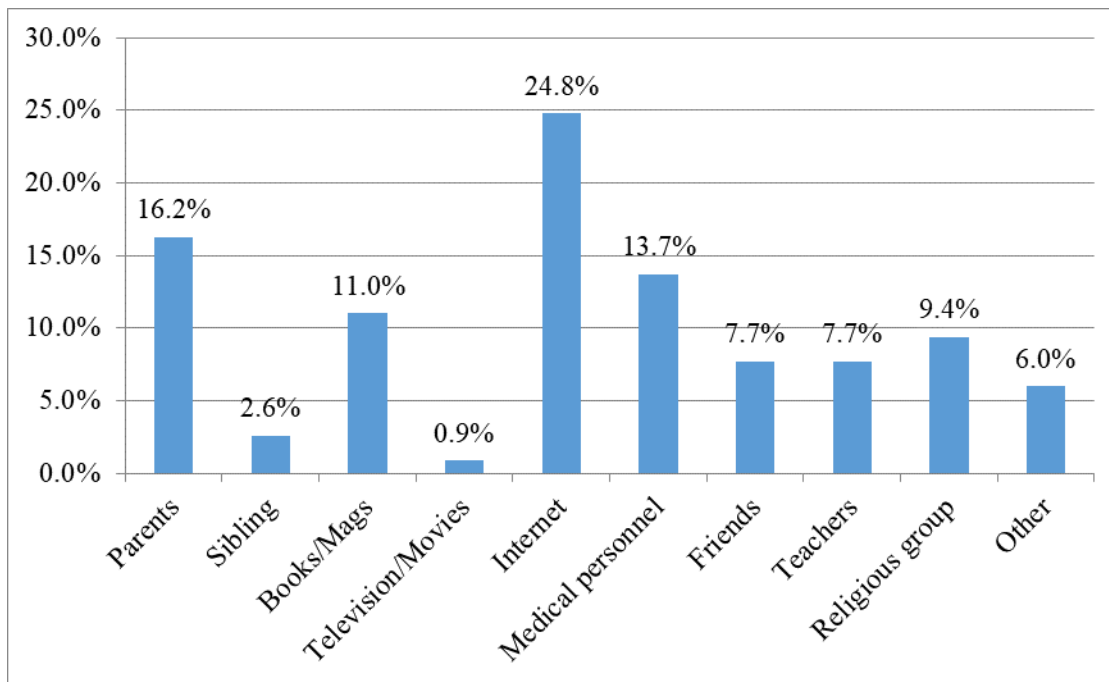
“Through school work (syllabus), life skills sessions and peer talks.”

“This knowledge was made aware to me in school courtesy of the science subject and the Chill Club – a programme organized by the USAID to impact teenagers with knowledge on the relationships and mostly about how to handle the changes that come with adolescence stage.”

### **4.3.3 Preferred Sources of Sexual and Reproductive Health Information**

Although the respondents cited religious groups as their source of information, this was not their preferred source of information.

**Figure 4.2: Preferred sources of SRH information (N=117)**



The most preferred source of information was the use of the internet at 24.8%. The reasons why the respondents liked the internet were confidentiality, personal preferences, easy to use applications and the ability to remain anonymous while using them. They also indicated that the internet did not hold back anything and it was a great resource with a wide range of information. The results are strengthened by other studies. “Teenagers in urban areas have access to mobile phones.” It is also notable that most teenagers have access to Internet connectivity. Trust and anonymity is slightly more important to teenagers than credibility when teenagers ask for SRH advice. (Omondi F., July 2015)

The second preferred source of information was parents at 16.2%. Parents are seen as credible and easily available and reachable by those who cited them as a preferred source.

Other generally preferred sources were medical personnel at 13.7% and books and magazines at 11.0%. Medical personnel at 13.7% were seen as specialists who had information, were easy to find and understood the different growth stages for males.

The key informants’ responses further backed these responses.

The internet - “Nowadays the internet is a major source.” “The internet provides wide information.”

Books – “Books are very essential as data collected from them has a factual basis.

Medical personnel – “Their approach on the matter of sexual and reproductive health has no bias”

Counsellors – “They provide clearer and more elaborate information.”

One key respondent indicated several sources. “I rely on the internet, books, other people, media. Each source is important because I am able to gauge the information I get from all sources and look at the reliability of that information.”

#### **4.4. Knowledge on Sexual and Reproductive health**

This section aimed at determining the adequacy and level of information as well as knowledge on various SRH subject matters. The absence of exact and reliable knowledge concerning SRH among young males proves to be harmful to their sexual and reproductive health together with that of their sexual companions.

Research works have revealed that lots of misbeliefs and misconceptions concerning matters associated with sexuality in teenage exist. Singh et al (2014) claim that such misbeliefs and misconceptions ought to be dealt with completely by divulging formal sex and puberty education.

##### **4.4.1 Lessons/Classes on different SRH Topics**

Several SRH topics were sampled to be able to demonstrate the respondents’ level of knowledge.

Table 4.13 illustrates the percentage of the frequency of the topics they received.



**Table 4.13: Lessons/Classes provided on different SRH Topics and number of times attended**

<b>Topic/ Frequency of attending</b>	<b>Many Times</b>	<b>A Few Times</b>	<b>Once</b>	<b>No Lesson</b>	<b>Can't Remember</b>	<b>Frequency (N)</b>	<b>Total Percent (%)</b>
<b>Sexual Feelings</b>	48.3%	36.4%	2.5%	9.3%	3.5%	<b>118</b>	<b>100</b>
<b>Puberty</b>	44.1%	40.7%	11.0%	1.7%	2.5%	<b>118</b>	<b>100</b>
<b>Girls Bodies Develop</b>	39.3%	38.5%	14.5%	3.4%	4.3%	<b>117</b>	<b>100</b>
<b>Boys Bodies Develop</b>	48.7%	30.4%	15.7%	3.5%	1.7%	<b>115</b>	<b>100</b>
<b>Menstruation</b>	26.3%	39.5%	16.7%	15.8%	1.7%	<b>114</b>	<b>100</b>
<b>Wet dreams</b>	30.1%	38.1%	18.6%	11.5%	1.7%	<b>113</b>	<b>100</b>
<b>Safer Sex Techniques</b>	45.8%	28.0%	12.7%	12.7%	0.8%	<b>118</b>	<b>100</b>
<b>Contraception</b>	32.8%	29.3%	11.2%	22.4%	4.3%	<b>116</b>	<b>100</b>
<b>Pregnancy</b>	40.4%	35.1%	8.8%	13.2%	2.5%	<b>114</b>	<b>100</b>
<b>Marriage</b>	35.3%	30.3%	10.9%	19.3%	4.2%	<b>119</b>	<b>100</b>
<b>HIV and AIDS</b>	67.5%	22.2%	7.7%	2.6%	0.0%	<b>117</b>	<b>100</b>
<b>STI's</b>	63.9%	24.4%	6.7%	3.4%	1.6%	<b>119</b>	<b>100</b>
<b>Sexual Violence</b>	30.8%	41.0%	7.7%	15.4%	5.1%	<b>117</b>	<b>100</b>
<b>Violence against females</b>	31.9%	37.9%	6.9%	17.2%	6.1%	<b>116</b>	<b>100</b>

Adolescents must have knowledge of major sexual and reproductive health themes for them to make informed choices to take care of their well-being and health.

As Table 4.13 shows, the male adolescents indicated that they had many lessons on HIV and AIDS at 67.5% and STI's at 63.9%. This was not a surprise as these topics are covered within the Kenyan school syllabus at primary, secondary and tertiary levels of education.

Other topics they had classes on were how boys' bodies develop at 48.7%, sexual feelings at 48.3%, and Safer sex techniques at 45.8%.

Working with young men and boys on SRH issues is often motivated by the desire to enhance girls and young women's health by changing male behaviour, but boys and young men need knowledge for their own sake as well. Additionally, studies reveal that present constructions of masculinity and gender norms put boys and young males in great danger for an array of adverse health consequences associated with unplanned pregnancies and sexually transmitted infections. With this kind of information, it was interesting to note that topics with lower rates of frequency, a few lessons or no lessons at all included information on puberty, menstruation, contraception, sexual violence and violence against females.

Adolescents have some knowledge on RH. However, efficient and effective educational intervention is still needed to foster more healthy and sensible behavior, and study results reveal that health education classes are useful in creating more awareness (Upadhyay et. al, 2012).

#### **4.4.2 Usefulness of the different SRH Topics Provided**

The participants were also requested to show how useful the lessons they had been provided with were to them.

According to Table 4.14, there was a correlation between the classes they had received and how useful they found the lesson. The male adolescents indicated they found the following lessons very useful. HIV and AIDS at 75.6%, STI's at 71.6%, safer sex techniques at 58.1%, sexual feelings at 56.4% and how boys' bodies develop at 47.5%.

**Table 4.14: Usefulness of lessons provided on different SRH topics**

<b>Topic/ Usefulness of topic</b>	<b>Very Useful</b>	<b>Useful</b>	<b>Not Very useful</b>	<b>Not at all useful</b>	<b>Frequency (N)</b>	<b>Percent (%)</b>
<b>Sexual Feelings</b>	56.4%	27.4%	8.5%	7.7%	<b>117</b>	<b>100</b>
<b>Puberty</b>	38.7%	49.6%	9.2%	2.5%	<b>119</b>	<b>100</b>
<b>Girls Bodies Develop</b>	28.7%	40.0%	27.0%	4.3%	<b>115</b>	<b>100</b>
<b>Boys Bodies Develop</b>	47.5%	40.7%	9.8%	2.0%	<b>118</b>	<b>100</b>
<b>Menstruation</b>	24.6%	42.1%	22.8%	10.5%	<b>114</b>	<b>100</b>
<b>Wet dreams</b>	31.9%	37.2%	21.2%	9.7%	<b>113</b>	<b>100</b>
<b>Safer Sex Techniques</b>	58.1%	30.8%	3.4%	7.7%	<b>117</b>	<b>100</b>
<b>Contraception</b>	42.7%	35.5%	11.8%	10.0%	<b>110</b>	<b>100</b>
<b>Pregnancy</b>	37.4%	45.2%	12.2%	5.2%	<b>115</b>	<b>100</b>
<b>Marriage</b>	50.9%	29.3%	9.5%	10.3%	<b>116</b>	<b>100</b>
<b>HIV and AIDS</b>	75.6%	20.2%	3.4%	0.8%	<b>119</b>	<b>100</b>
<b>STI's</b>	71.6%	21.8%	5.8%	0.8%	<b>117</b>	<b>100</b>
<b>Sexual Violence</b>	40.0%	36.5%	13.9%	9.6%	<b>115</b>	<b>100</b>
<b>Violence against females</b>	40.0%	38.3%	10.4%	11.3%	<b>115</b>	<b>100</b>

#### **4.4.3 Sexuality Education influencing sexual health outcomes for males**

Likert's five point scale ranging from strongly disagree to strongly agree with seven statements on sexual health and wellbeing outcomes was used to find out how the male adolescents viewed sexuality education.

Table 4.15 shows results of the role of sexuality education among male adolescents.

**Table 4.15: Role of sexuality education for wellbeing of male adolescents**

<b>Statement</b>	<b>Strongly agree (Percent)</b>	<b>Agree (Percent)</b>	<b>Uncertain (Percent)</b>	<b>Disagree (Percent)</b>	<b>Strongly disagree (Percent)</b>	<b>Total Frequency (N)</b>	<b>Total Percent (%)</b>
Sexuality education helps in giving accurate information on how best to deal with issues of sex, relationships and HIV	63.2%	29.9%	1.7%	4.3%	0.9%	<b>117</b>	<b>100</b>
Sexuality education has a major role to play in enhancing male sexual health and wellness	57.4%	29.6%	8.7%	4.3%	0.0%	<b>115</b>	<b>100</b>
Sexuality education for male has a major role to play in enhancing female sexual health and wellness	41.2%	29.8%	21.9%	5.3%	1.8%	<b>114</b>	<b>100</b>
Sexuality education helps males make informed decisions about sexual behaviour	52.6%	31.0%	8.8%	6.7%	0.9%	<b>116</b>	<b>100</b>
Sexuality needs to be discussed more openly with and among males	55.2%	25.9%	10.3%	6.0%	2.6%	<b>116</b>	<b>100</b>
HIV and AIDS is a serious issue for young people	66.4%	23.3%	8.6%	1.7%	0.0%	<b>116</b>	<b>100</b>
Teenage pregnancy is a serious issue	68.4%	23.9%	5.1%	0.0%	2.6%	<b>117</b>	<b>100</b>

According to Table 4.15 above, majority of the male adolescents agreed that sexuality education gave accurate information on how best to deal with issues of sex, relationships and HIV at 63.2%, that it played a major role in enhancing male sexual health and wellness at 57.4%, it helped them make informed decisions about sexual behaviour at 55%, HIV/AIDS (66.4%) and teenage pregnancy (68.4%) were both serious issues to contend with among young people.

52.6% of the male adolescents indicated that sexuality education needed to be discussed more openly with and among male adolescents.

Only 41.2% of the respondents felt that education on sexuality had a big part to play in enhancing female sexual health and wellness and 21.9% of the respondents were uncertain about this. Dworkin et al (2013) argue that because the role of men is to act as gatekeepers to SRH of women, it's of great importance that males get constant help to sustain transformed attitudes and behaviors all for gender balance.

According to statistics from the Kenya NACC, there are 238,987 youths aged 15 to 24 years living with HIV. This is an important fact because 63.2% of the respondents (and they fit in this age group) strongly agreed that HIV is a serious issue among young people.

In relation to this, the key informants were asked to state some key barriers to SRH education for adolescent males. The following were the responses given:

- Stereotypes informed by media and culture. This encourages sex habits and behaviour at an early age.
- Sexuality education could end up being too hyped yet too cliché.
- Lack of accountability and follow up.
- Lack of life skills programs in schools.
- Lack of correct information from the teachers.
- Girls being given first priority in getting SRH information.
- Not enough attention being given to males.
- Lack of interest from most males in SRH matters.
- Male adolescents have left the females to handle reproductive health matters.
- Fear of guys opening up to say/ask the truth.
- The curriculum overemphasises on technical education and tends to neglect life skills.
- Peer pressure from friends.

#### **4.4.4. Prevention of Sexual and Reproductive Health Issues**

##### **Preventing pregnancy**

The respondents were able to state several correct methods of preventing pregnancy. According to Table 4.16, these included use of contraceptives (41.7%), abstinence (44.2%), using condoms (41.7%), use of emergency oral contraceptives (8.3%), vasectomy (1.7%), use of womb barriers/intrauterine devices/coils (2.5%), withdrawal method (pouncing out) (2.5%), using calendar/date timing (safe period) (9.2%), use of spermicides (0.8%), use of hormonal injections (2.5%) and cutting of the fallopian tube (0.8%). 0.8% respondents stated that in case of a sexual assault it was important to visit a health centre immediately.

There were respondents who stated that having self-control (1.7%), avoiding dangerous/unsafe places to avoid rape (0.8%), keeping good friends (1.7%), constant guidance and counselling/sex education (4.2%), avoiding peer pressure (1.7%) and avoiding pornography (0.8%) were ways of preventing pregnancy. These responses do not directly prevent pregnancy, however may have implications on sexual decisions a male adolescent may make.

0.8% respondents stated Pre-Exposure Prophylaxis as a means of preventing pregnancy. PrEP (Pre-exposure prophylaxis) refers to a method for HIV negative people but who are exposed to high risk of being infected to avoid getting it by swallowing a pill on a daily basis.

Table 4.16 shows the responses provided:

**Table 4.16: Methods to prevent pregnancy (N=120)**

<b>METHODS TO PREVENT PREGNANCY</b>	<b>Frequency (N)</b>	<b>Percentage (%)</b>
Contraceptives	50	41.7
Avoiding unplanned sex	2	1.7
Abstinence	53	44.2
Use of condoms	50	41.7
Use of emergency oral contraceptive pills (after sex)	10	8.3
Vasectomy	2	1.7
Avoiding unsafe sex	2	1.7
Withdrawal method	3	2.5
Avoiding being alone with opposite sex to avoid sex	1	0.8
Use of safe days	11	9.2
Use of womb barriers – Intrauterine coil device	3	2.5
Use of hormonal injections	3	2.5
Use of Spermicides	1	0.8
Cutting of the fallopian tube	1	0.8
Sexuality education	5	4.2
Visit a health centre immediately in case of rape	1	0.8
Avoiding dangerous places (against rape)	1	0.8
Having self-control	2	1.7
Keeping good friends	2	1.7
Being faithful to one's partner	1	0.8
Pre-Exposure Prophylaxis	1	0.8
Advice from guardians	1	0.8
Avoid watching pornography	1	0.8
Avoid peer pressure	2	1.7

### **Preventing Sexually Transmitted Infections**

According to Table 4.17, the respondents were able to state several correct methods of preventing sexually transmitted infections. These included using condoms 45.8%, avoiding unsafe sex (8.3%), abstinence (43.3%), keeping away from two or more sexual companions (2.5%), going for regular medical checkups with one's partner (4.2%), having only one sexual companion (0.8%), knowing one's HIV status (4.2%), prior HIV test before sex (2.5%), avoiding sharing cutting instruments (0.8%), avoiding prostitution sex (0.8%), early treatment of STI's (1.7%), avoiding sexual contact with infected person (0.8%), and avoiding sharing towels or underclothing (0.8%).

There were respondents who stated that guidance and counseling/sex education (1.7%), keeping good company/avoiding wrong friends (1.7%), avoiding pornography and other sex-stimulating videos (0.8%) as ways of preventing STI's. These responses do not directly prevent STI's, however may have implications on sexual decisions a male adolescent may make.

0.8% respondents stated vaccinations as a way of preventing STI's. It is important to note that HPV, Hepatitis A, and Hepatitis B are currently the only three STI's that can be prevented by vaccines.

Circumcision was another response cited (0.8%). Circumcision does not prevent sexually transmitted infections, rather it lowers the risk of HIV infection.

**Table 4.17: Methods to prevent Sexually Transmitted Infections**

<b>METHODS TO PREVENT STI's</b>	<b>Frequency (N)</b>	<b>Percentage (%)</b>
Condoms	55	45.8
Avoiding unsafe sex	10	8.3
Abstinence	52	43.3
Avoiding multiple sexual partners	3	2.5
Being faithful to one sexual partner	12	10.0
Going for regular medical checkups with one's partner	5	4.2
Early HIV testing	4	3.3
Testing before sexual act	3	2.5
Regular testing for HIV	5	4.2
Vaccination	1	0.8
Avoiding prostitution sex	1	0.8
Avoiding sexual contact with infected person	1	0.8
Avoiding sharing under clothing	1	0.8
Avoiding sharing of sharp/cutting instruments	1	0.8
early treatment of STI's	2	1.7
avoiding pornography and other sex-stimulating videos	1	0.8
Circumcision	1	0.8
Use of contraceptives	10	8.3
Guidance and Counselling/Sexuality education	2	1.7
Proper hygiene	2	1.7
Keeping good friends / avoiding wrong company	2	1.7



## **4.5 Male Adolescent Sexual and Reproductive Health Services**

The SRH needs of male adolescents very so often remain unachieved within the primary health care environment (American Academy of Pediatrics, 2011).

Male SRH facilities seek to enhance the quality and range of sexual and reproductive facilities offered that satisfy the diverse and specific needs of boys and male adolescents. These services cover boys and young males in all their multiplicity, and utilizes a desired method to SRH, not perceiving it as lack of complication but expressing one's sexuality, gender, and sex positively.

### **4.5.1 Sexual and Reproductive Health concerns**

Concerns of sexual health are conditions in one's life that can be dealt with. This study sought to find out specific concerns associated with SRH care of male adolescents. The respondents cited many concerns which were grouped into twelve major themes. The themes were found to be in line with the core knowledge of male teens SRH (American Academy of Pediatrics, 2011).

#### **A. Puberty**

There are some concerns and questions concerning changes in puberty and the growth of reproductive ability.

Some of the concerns under this included: desires to experience sex, raging hormones and how to deal with small penis size.

#### **B. Changes in Growth Related to Puberty**

Health situations associated with growth and development in men are common and can be very stressful.

The concerns indicated by respondents included involvement in risk-taking behaviors, decreased self-efficacy and confidence levels, substance abuse, embarrassment, low self-esteem, depression and anxiety.

#### **C. Sexuality**

WHO (2002) defines sexuality as a key element of the human life progression and includes intimacy, reproduction, sexual orientation, sex, as well as gender roles and identities.

The concerns the respondents indicated under this were love versus lust, having little information on safer sex techniques, having irresponsible sexual acts, on issues dealing with abstinence, relationships, issues on safe days, and prevention of STI's/HIV and pregnancy.

#### **D. Sexual Development**

Youths start the process of growing a sexual self-concept while in adolescence. This entails the merging of age-relevant behaviours, physical sexual maturation, as well as construction of a favourable sense of well-being and sexual identity.

It's common for raise questions and concerns regarding genital function and size, particularly when likening himself with other men and following sexual behaviour.

Under this core area concerns indicated included how to deal with small penis, wanting to know about sperm development, seeking a personal identity and how to deal with homosexuality.

#### E. Masturbation

The respondents cited wanting to get more information on masturbation and their sexual physiology.

#### F. Sexual Behaviour and Its Consequences

The concerns under this included varying types of sexual behaviour - engaging in higher-risk sexual behaviours, concerns on male adolescents having multiple sexual partners and not being cautious on matters of sex.

They also stated the risk factors associated with these behaviours such as the risks of acquiring HIV and STI's and getting girls pregnant as some of their concerns. The fear of rejection and how to deal with infidelity were also stated as concerns.

#### G. Unwanted Sex

We are inclined to believe that it is mainly females who experience unintended sexual attentions. But males also experience lots of unintended sexual advances.

There were concerns on what to do when males were enticed by female.

#### H. Violence in Dating

Aggression in youth relations may take form of sexual harassment, coercion, threats, bullying, and dating violence. A concern on being sexually assaulted / raped was raised by a respondent.

#### I. Sexual Dysfunction and Function

Active and healthy sexual function plays a big part in the development and well-being of young adults and adolescents.

Concerns indicated under this included fear of impotence, how to use condoms correctly.

#### J. Adolescent Fatherhood, AIDS/STDs, and Pregnancy

Engagement in sexual practices exposes adolescent male and their sexual companions to risk of adverse SRH consequences that can be prevented including unplanned pregnancy, Sexually transmitted infections, and HIV/AIDS contraction. These were recurring concerns for the respondents.

They also stated leaving the contraception decisions to females, the fear to acquire contraception and how to make a choice on the use of contraceptives as some concerns.

#### K. Preventing Pregnancy, HIV, and STIs Infections

The adolescent male needs information on preventing the negative consequences of sexual behaviour. These were also recurring concerns for the respondents.

#### L. SRH Care Use of Male Adolescents

There has been little attention and poor definition of the major components of sexual and reproductive health of most young men. Such challenges are: absence of social help; fear; denial; stigma; and shame. The following were stated as some of the concerns in this core area; not having enough SRH classes, lack of advice on SRH matters, lack of enough sex education, lack of communication with guardians and lack of people to guide them through adolescence.

Further, the key informants were asked to state some specific adolescent sexual health problems and how male sexuality would play a role.

The responses they provided fit in within the twelve major themes stated above. Table 4.18 shows the responses provided by the key informants and the theme it fits under.

**Table 4.18: Male adolescent sexual health problems, role played by sexuality education to help and the core theme it fits under.**

<b>Male adolescent sexual health problem</b>	<b>Role played by sexuality education to help</b>	<b>Core theme/themes it fits under</b>
Having sex at a younger age	Boys would understand how to keep from indulging in sexual behavior	Sexuality Sexual development
Ignorance	Creating an awareness that could help people think more on their sexual health	Sexuality
Premature/Premarital sex	Minimize the risk of more adolescents engaging in sex. Adolescent males get to avoid indulging in sexual intercourse irresponsible.	Sexuality Sexual development
Early pregnancy	Advance knowledge of this keeps adolescents aware of the eventualities and thus holds them back from it. Sexual health education helps us understand the consequences of unsafe sexual practices.	Sexual behaviour and its consequences. STI's/HIV, Pregnancy and Adolescent fatherhood
Sexually Transmitted Infections	Gives more information on reality of these infections and knowledge on what causes them. And how they could be avoided. Would help to know the signs and symptoms of various STI's	STI's/HIV, Pregnancy and Adolescent fatherhood
Contraception	To learn ways of contraception	Preventing pregnancy
Seeing girls as sex objects	To give guys a paradigm shift and get to see girls as fellow human beings	Sexuality
Having sex with just anyone	To get guys to be more serious and to get to know people before having intimate relationships.	Sexual behaviour and its consequences
Rape/Sexual assault	Helps promote awareness on respect towards the females	Dating violence

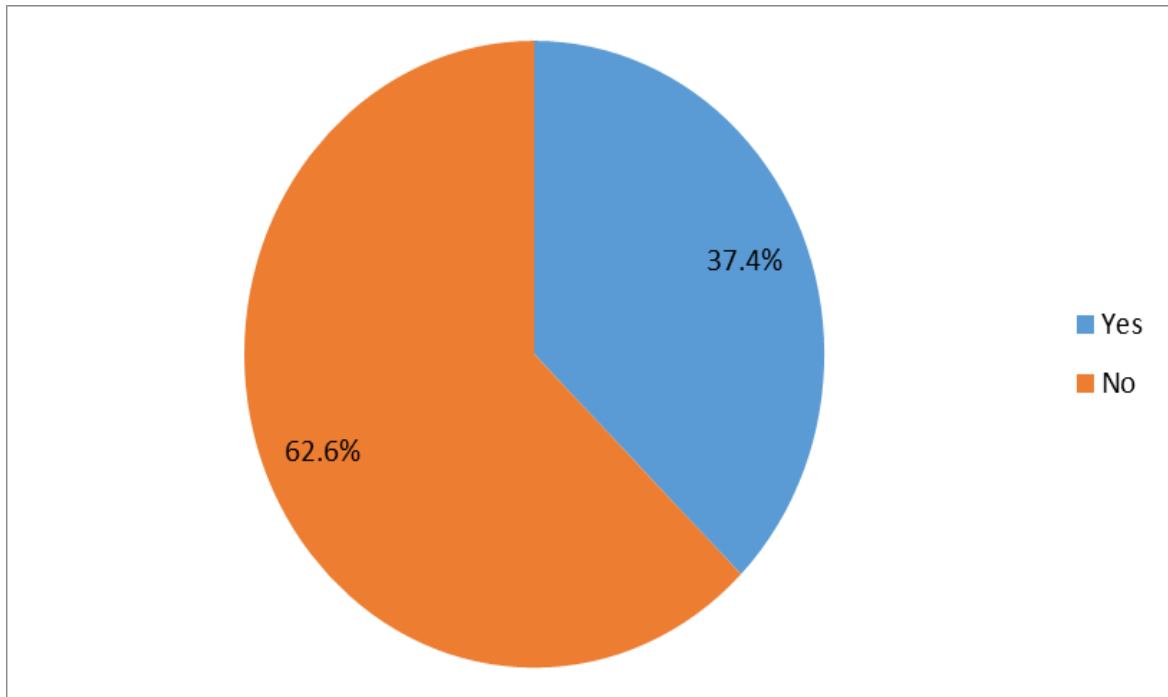
#### 4.5.2 Knowledge of places for male to seek SRH services

According to Gavin et al (2014), male teens aged between 15 and 24 years may profit from societal-based networks to health care because countless have SRH needs.

The respondents were asked if they knew any places they knew that provided SRH services for adolescent males.

Figure 4.3 below shows that only 37.4% of the male respondents knew where to seek services.

**Figure 4.3: Knowledge of places to seek male SRH services (N=107)**



Those that gave a “yes” response were further requested to indicate the places/people they could seek services from. Table 4.19 shows the places where the male adolescents indicated they could receive SRH services.

**Table 4.19: Places adolescent male can seek SRH services**

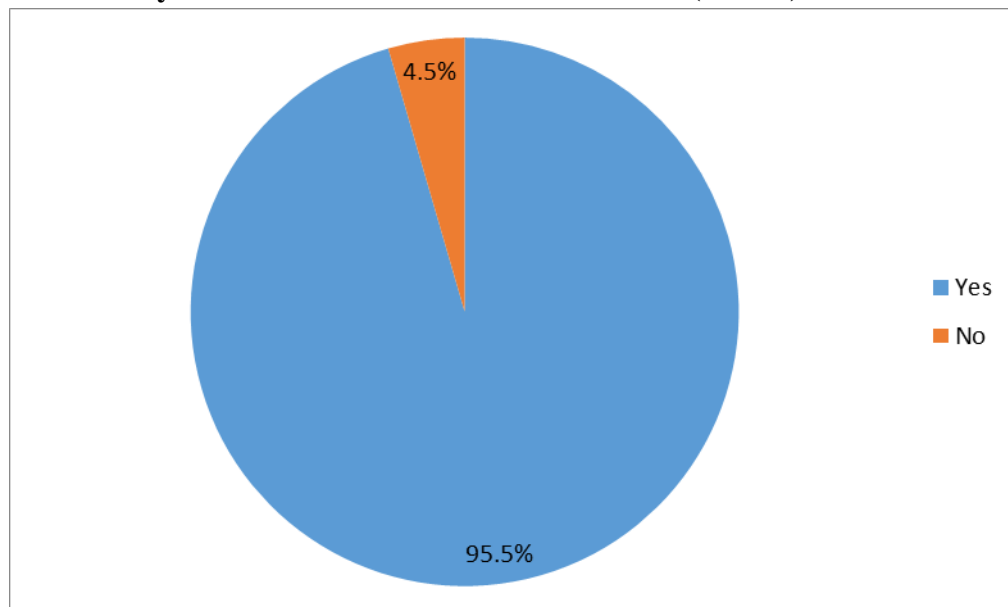
<b>Where to Seek SRH Services</b>	<b>Frequency (N)</b>	<b>Percentage (%)</b>
Kenyatta National Hospital	1	2.5
Rafikistry Youth Center	1	2.5
Kenyatta University Health Centre	3	7.5
Kamiti VCT Clinic	2	5.0
Neema Health Clinic	5	12.5
Pambazuka Clinic	1	2.5
Mathare Youth Sports Association	2	5.0
St. Joseph Mukasa Clinic Kahawa West	5	12.5
Casino - Special Treatment Center	1	2.5
AMREF Flying Doctors	1	2.5
Thika Level 5 VCT Centre	1	2.5
Roysambu VCT Centre	1	2.5
Government Hospitals in general	1	2.5
Clinics within universities	4	10.0
Marie Stopes	2	5.0
WarMemorial Hospital	1	2.5
Coptic Hospital	1	2.5
Village Hope Center	1	2.5
East African Breweries Clinic	1	2.5
Pumwani Dispensary	1	2.5
Amua Government Clinic	1	2.5
Jamii Medical Health Centre	1	2.5
World Vision	1	2.5
*** Counsellors within Universities	1	2.5
<b>Total</b>	<b>40</b>	<b>100</b>

### 4.5.3 Sexual and Reproductive Health – Services and Importance of services that should be provided to adolescent males

Understanding what young men want from sexual health services – by asking them – is also key to drawing them in to an environment where you can then provide education. (Sex educator Justin Hancock, who runs bishUK.com)

The respondents were asked to state if they felt SRH services were necessary for them, and also what services they would like to be provided for them. Figure 4.4 shows the extent to which male adolescents felt SRH services were necessary for them and Table 4.20 indicates the SRH services the male adolescents felt they should be provided with and how the particular service would help them.

**Figure 4.4: Necessity of SRH services for male adolescents (N=111)**



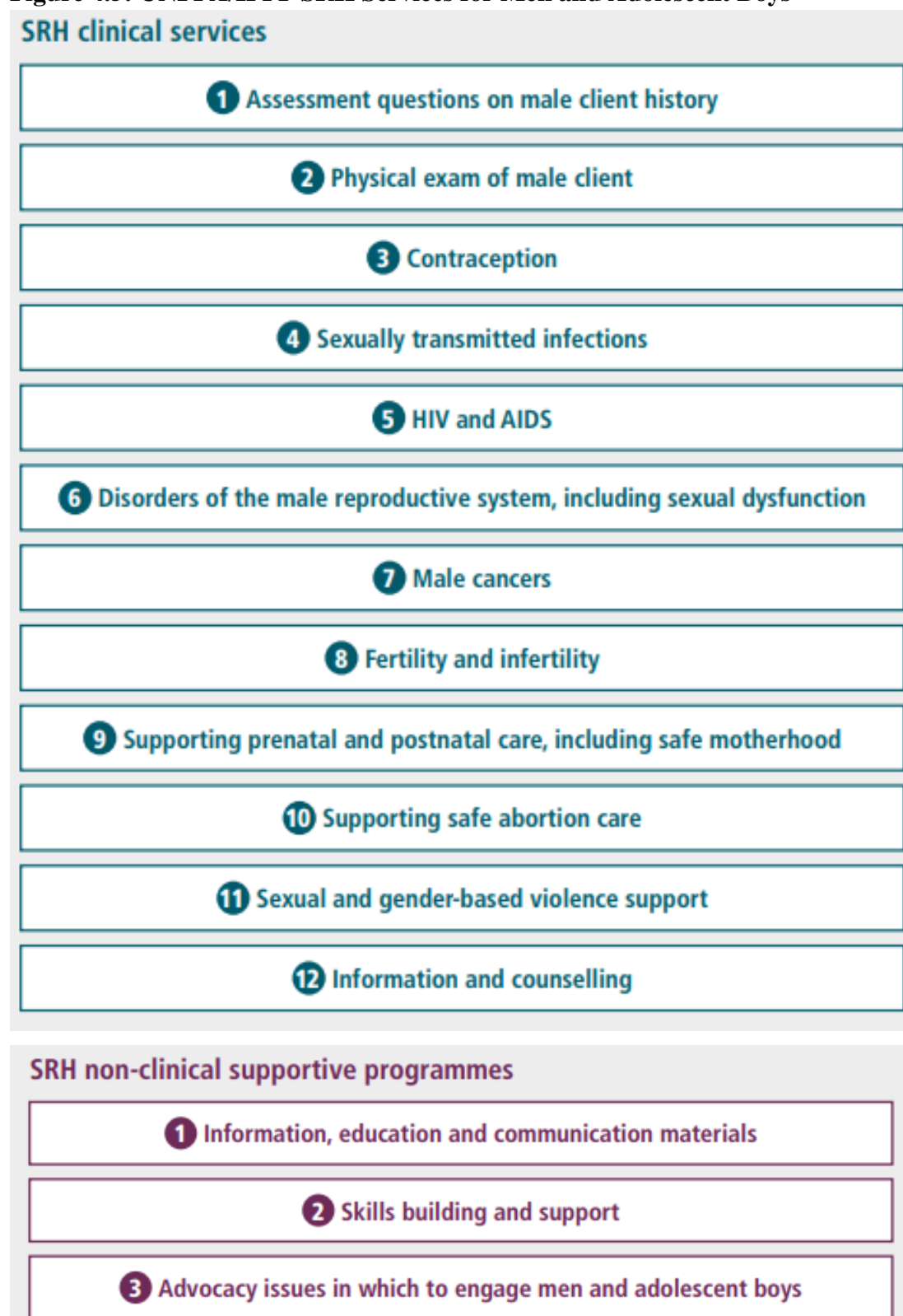
Of 111 responses, 95.5% of the participants showed that they thought it was crucial for male adolescents to be provided with SRH services.

4.5% thought it was not important. Some of the reasons they gave included SRH is not important for males since they are not like females and that the topic of SRH is uncomfortable so not necessary to have discussions on it.

#### **What services would they like to be provided for them?**

A blend of sexual and reproductive health facilities are needed to address adolescent boys and men's needs in all their multiplicity. Suggested elements are classified within twelve groups medical facilities, plus three non-clinical supportive strategies, which seek to reflect common understandings (UNFPA and IPPF, 2017).

**Figure 4.5: UNFPA/IPPF SRH Services for Men and Adolescent Boys**



The respondents' answers on what services they should be provided with as adolescent males are provided in Table 4.20. Alongside, how they felt the service would help them and the UNFPA/IPPF category it fits under.



**Table 4.20: SRH services that should be provided to male adolescents and how it would help male adolescents**

<b>SRH Service that should be provided to male adolescents</b>	<b>How it would help Male Adolescents</b>	<b>UNFPA/IPPF Category – Clinical and Non-clinical</b>
Providing Condoms	To avoid pregnancy, HIV and STI's	Contraception, STI's and HIV and AIDS
Guidance and Counselling	To avoid peer pressure	Skills building and Support
VCT services	To help male adolescents know their HIV status	HIV and AIDS
Early sex education		Information and Counselling
Rape counselling	To help them know what to do in case of sexual assault	Sexual and Gender-based Violence Support
Contraceptives	To avoid pregnancy	Contraception
Discussions on Abortion	To understand the risks of abortion	Supporting Safe abortion care
Reproductive Health Talks		Information and Counselling
Screening for male reproductive system	To detect prostate cancer for early treatment	Disorders of the male reproductive system
Paternal education for males	To help them know on parenting	Supporting pre and post-natal care, including safe motherhood
STI testing and screening	To prevent transmission of STI's	Sexually Transmitted Infections
Marriage Counselling	To help males know the right way to get into marriage	Information and Counselling
Self-Control	To reduce transmission of STI's	Skills building and Support
Abstinence	To reduce transmission of STI's	Skills building and Support
Awareness education/ Advertisements		Information, Education and Communication materials
Sexuality Education in Churches and Schools	To help male adolescents grow in morals	Information and Counselling

<b>SRH Service that should be provided to male adolescents</b>	<b>How it would help Male Adolescents</b>	<b>UNFPA/IPPF Category – Clinical and Non-clinical</b>
Drug and substance abuse forums	To help male adolescents not engage in irresponsible behaviour	Skills building and Support
Sexual Violence education	To protect both genders not inflict harm on each other	Sexual and Gender-based Violence Support
SRH Seminars	To educate adolescent males	Information and Counselling
Counselling on Girl Child	To understand female emotions so as to respect them	Skills building and Support
Counselling on pressures of sexuality	To help them make wise decisions	Skills building and Support
Counselling for victims of sexual violence		Sexual and Gender-based Violence Support
Affordable treatment	To treat STI's and for better sexual health	Sexually Transmitted Infections
SRH services at community level	To help male adolescents with their issues	Skills building and Support
Booklets	To help spread the SRH information	Information, Education and Communication materials
Dating advice	To have and keep a steady relationship	Skills building and Support
Awareness camps	To help male adolescents to bond and open up	Information and Counselling

#### **4.6 Male Adolescent Sexual Experience and Relationships**

To deal with the adolescents' SRH care needs, it is important to collect a comprehensive sexual history from each person (American Academy of Pediatrics, 2018).

When giving STI/HIV, contraceptive and reproductive guiding and counseling, a logical first step would be to look at the history of sexuality. It's a golden opportunity to offer support and information to customers, can screen for detrimental sexual behaviors, and is able to identify sexual issues.

Statistics reveal that engaging in sexual intercourse is common for young adults and teenage patient, or for any other client who thinks and imagines he or she is healthy. Therefore, developing an understanding of sexuality and sex of our patient is crucial in assisting to minimize clinical anxieties associated with sexual orientation and behavior (ACRIA, Winter 2005/2006).

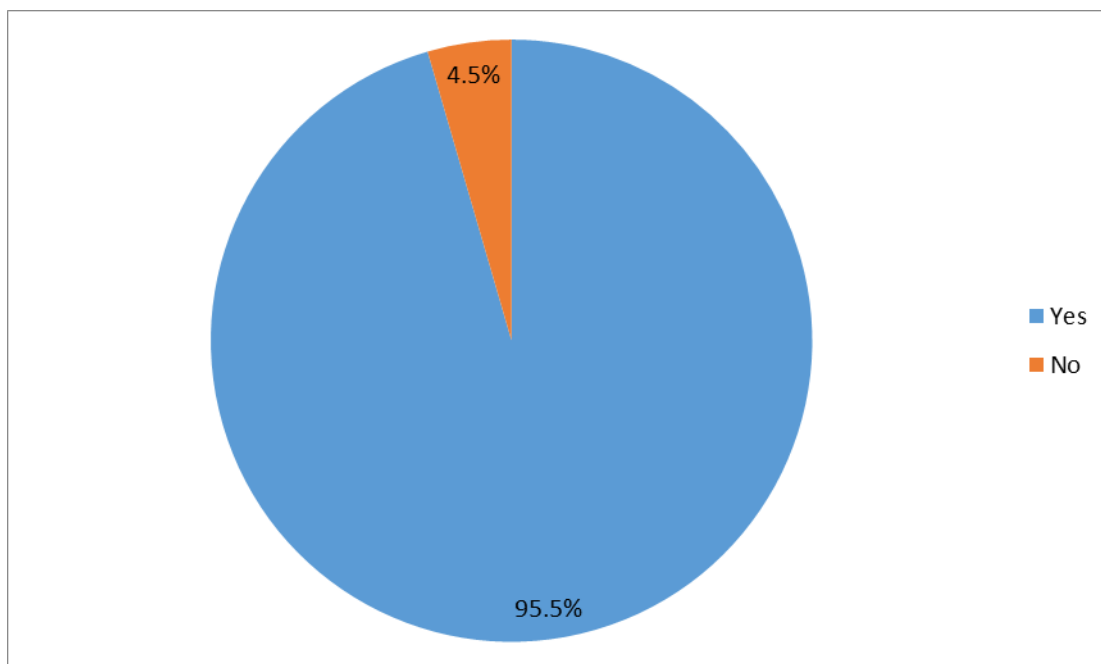
#### 4.6.1 Sexual Partner Assessment

The first part of this section sought to find out if they had a partner, the number of lifetime partners, the type of the association (one-time versus serial monogamy occasions) plus if they had been sexually active.

##### Do you have a girlfriend?

The respondents were asked if they had ever had a girlfriend i.e. someone they were emotionally or sexually attracted to.

**Figure 4.6: If respondents had ever had a girlfriend (N=111)**



According to Figure 4.6, a great deal of participants (95.5%) showed that they had ever had a girlfriend.

#### 4.6.2 Number of girlfriends during their lifetime

Of the 95.5% respondents who indicated they had had a girlfriend, they were asked to indicate how many girlfriends they had had over their lifetime. According to Table 4.21, 57.5% of the male adolescents respondents had between 2 to 5 girlfriends. This is supported by other studies.

Moreover, among sexually active youth, it's approximated that 52 percent of male and 61 percent of female youth state to have one to three lifetime sexual companions (Abma et al., 2010).

**Table 4.21: Number of girlfriends had**

Range of girlfriends	Frequency (N)	Percentage (%)
1	24	22.7
2 – 5	61	57.5
6 – 10	9	8.5
11 – 15	2	1.9
16 - 20	2	1.9
21 – 25	0	0.0
26 – 30	1	0.9
Many	7	6.6
<b>Total</b>	<b>106</b>	<b>100</b>

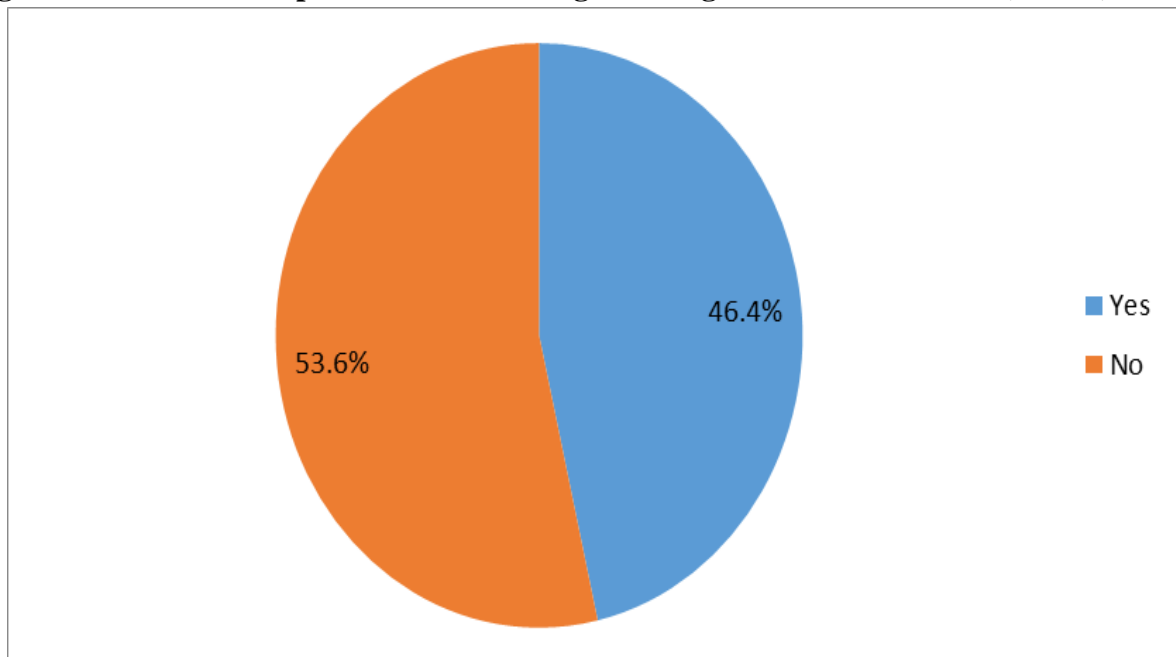
The questionnaire had specifically requested the respondents to indicate a specific number of girlfriends they had, however 6.6% respondents just stated many as their response. This could be related to the “hook-up” culture. Hook-up, a short unattached sexual experiences amongst people who are not dating each other or are not in romantic relationship, has grown within the sociocultural environment of youths, women and women, as well as growing adults across the globe. Bogle (2007, 2008) states that in the previous six decades, the preference of conventional forms of pursuing romantic relations and courting has taken another form, “hookups” (Bogle, 2007, 2008). Involvement in hookups might have an impact on other cognitive health consequences including the self-esteem of an individual. Paul et al (2000), the only researcher who investigated how self-esteem is linked to hookups among university students, discovered that the self-esteem of both men and women who have engaged in hookups before was lower compared to their counterparts.

#### **4.6.3 Nature of the relationship**

The participants were requested to show whether when they were dating a particular girl, whether they dated anyone else.

Figure 4.7 demonstrates the responses provided.

**Figure 4.7: Whether respondents were dating several girls at the same time (N=112)**

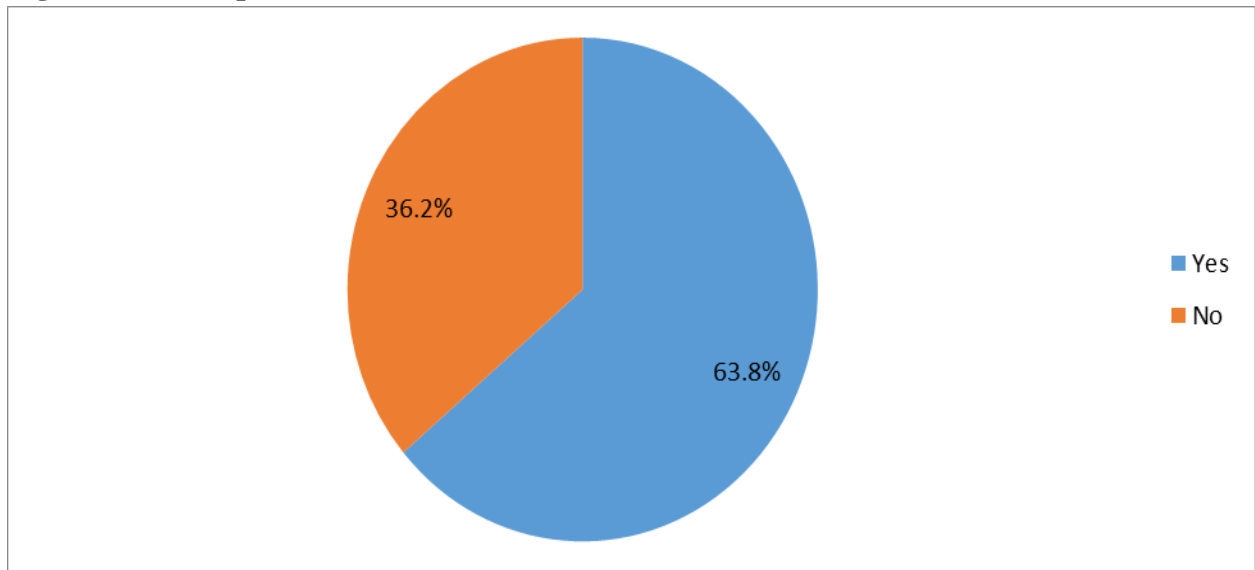


The findings showed that 46.4% of the respondents did date or had dated someone else when they were dating a particular girl. Other studies conducted had similar findings. “To have a ‘regular partner’ did not necessarily imply monogamy. It was not uncommon for the adolescent boys to report having several parallel sexual partners that overlapped for some time.” (Perceptions of male adolescents concerning premarital sexual relations in Zambia: Nov 2009)

Dating does not necessarily mean that an individual is having sexual intercourse. However, being in a romantic relationship has been found to be a predictor for sexual experience (Blum et al. 2000). Due to this reason, it was crucial to explore if the respondents were sexually active.

#### 4.6.4 Have you had sexual intercourse?

**Figure 4.8: If respondents had had sexual intercourse (N=116)**



According to Figure 4.8, the findings indicated that 63.8% of the participants had engaged in sexual act before.

For those who had not had sexual intercourse (36.2%), they were asked to indicate reasons why they were abstaining.

Table 4.22 shows the responses indicated by the respondents.

**Table 4.22: Reasons for abstaining from sex**

Reasons for abstaining from sex	Frequency (N)	Percentage (%)
Religious values	17	40.5
Fear of pregnancy	4	9.5
Wish to wait for marriage	7	16.7
Not emotionally ready	9	21.4
Fear of HIV	0	0.0
Fear of STI's	0	0.0
Other reasons	5	11.9
<b>Total</b>	<b>42</b>	<b>100</b>

Of the responses – other reasons: the reasons indicated were reluctance from the lady, I have signed an agreement to wait until marriage, I am busy hustling with other things thus have put aside things like having sex and I have been brought up in my family with certain values about sex so I am waiting until marriage.

#### 4.6.5 Age of "sexarche" (the onset of sexual activity)

The timing of sexual debut is one of the most crucial factor in determining the future sexual behavior and health. Hawes et al (2010) argue that early sexarche (predominantly referred to as prior to 16 years) has been reported to be accompanied, for instance, with high possibilities of early pregnancies, increases the chances for STIs, as well as usually filled with regrets.

According to Table 4.23, the average age range for sexarche among the male adolescents was 15 to 19 at 63.5%. This is in line with other studies done. Youths are engaging in both sexual and dating relationships. Statistics reveal that sexual practice is predominant, with around 70 percent of people documenting sexual act by their late teenagers (Finer & Philbin, 2013; Child Trends, 2013 ).

**Table 4.23: Distribution of age of sexarche**

Age at first sexual activity	Frequency (N)	Percentage (%)
9 – 10	1	1.4
11 – 14	12	16.2
15 – 19	47	63.5
20 – 24	14	18.9
<b>Total</b>	<b>74</b>	<b>100</b>

Table 4.24 presents findings of the age of the female they first had sexual intercourse with:

**Table 4.24: Distribution of age of female partner at first sex**

Age of female partner at first sex	Frequency (N)	Percentage (%)
9 – 10	1	1.4
11 – 14	12	16.2
15 – 19	46	62.1
20 – 24	15	20.3
<b>Total</b>	<b>74</b>	<b>100</b>

#### 4.6.6 First sexual experience

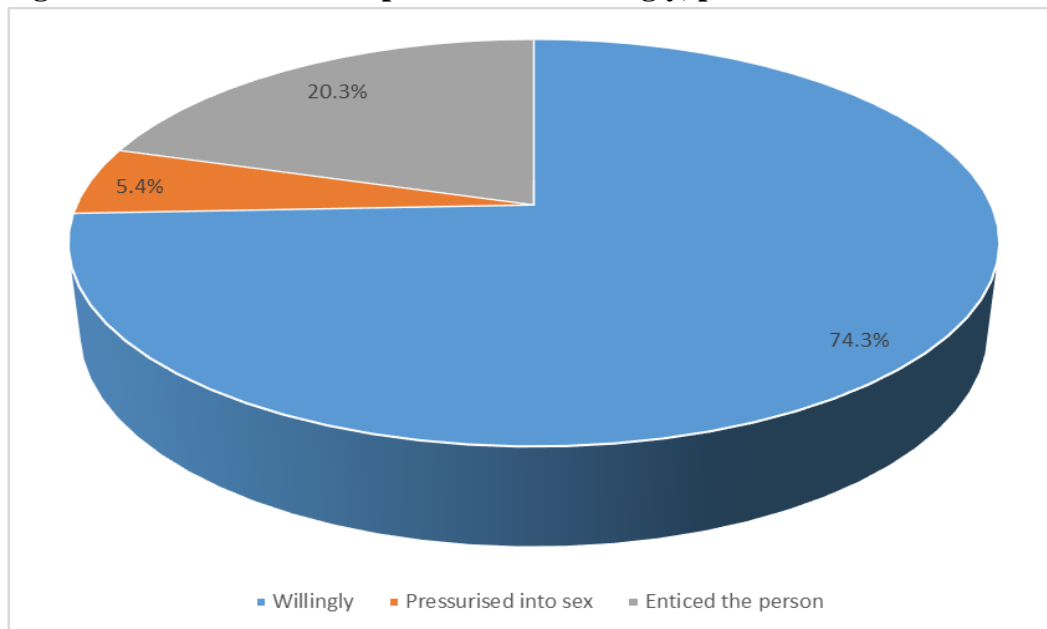
As per WHO (2012), the adolescents' sexual conduct is crucial because of the rising number of sexually healthy youths throughout the world. The introduction into sexual activity is an important milestone in young men's lives. It is one sign of entering into adult life ( Ku et al., 1993).

This study sought to find out what the young men's sexual experiences were.

#### Was first sexual experience was wanted or unwanted?

Figure 4.9 indicates that for majority of the participants (74.3%), their first sexual experience was willingly done. 20.3% of the respondents enticed the partner into having sex with them and 5.4% had been pressurized into sex.

**Figure 4.9: If first sexual experience was willingly, pressurized or enticed**



There has been little or no attention on the part of public health issue of unwanted sexual experiences (USE). According to Figure 4.9, 5.4% of the respondents indicated that it was coerced sex. One particular respondent indicated he was 9 years of age and the female about 17.



### Feelings about the first sexual experience

The respondents were asked how they felt about their first sexual experience.

Table 4.25 indicates how the respondents felt about their first sexual experience.

**Table 4.25: Feelings about first sexual experience**

Feelings about first sexual experience	Frequency (N)	Percentage (%)
Happened too early	32	45.1
Happened too late	2	2.8
Was about the right time	32	45.1
Didn't want it to happen at all	5	7.0
<b>Total</b>	<b>71</b>	<b>100</b>

45.1% of the respondents indicated it happened too early and 7.0% indicated they did not want it to happen at all, supports the above statement.

Some statements the respondents made pertaining to this were:

- I had a lot of anxiety when having sex.
- I should have known the usage of protective measure (condoms), pills and any other safe means used to protect oneself.
- At that time I was still green in matters pertaining sex and its controls.
- I should have known more on how to romance before sex/foreplay
- That sex is non-pleasant
- How sex is done
- That one may get bruised out of a long sexual engagement
- That after sex one gets weird feelings
- The importance of waiting until marriage for sex
- The emotional and spiritual consequences after sex
- How to restrain oneself from sexual advances
- That it is not a must to have sex as a teenager

Data from other studies support the findings on unwanted sexual experiences among male adolescents and the feelings associated with their first sexual experience. Similar to very young women, experiences of coercion, unwantedness and regret appear to be salient to young men's very early sexual experiences.

While first sex for U.S. adolescent men was not frequently unwanted (5% reported unwanted sexual behaviours), many had mixed feelings, with 34% reporting that “part of me wanted it to happen at the time and part of me didn’t” (Martinez et al., 2010). In a British national survey, only 8% of young men reporting initial sexual act aged between 18-24 years expressed regret, whereas 42% reporting very early first sexual intercourse (13–14 years) wished they waited longer (Wellings et al. 2001).

#### 4.6.7 Pregnancy, STI/HIV prevention practices

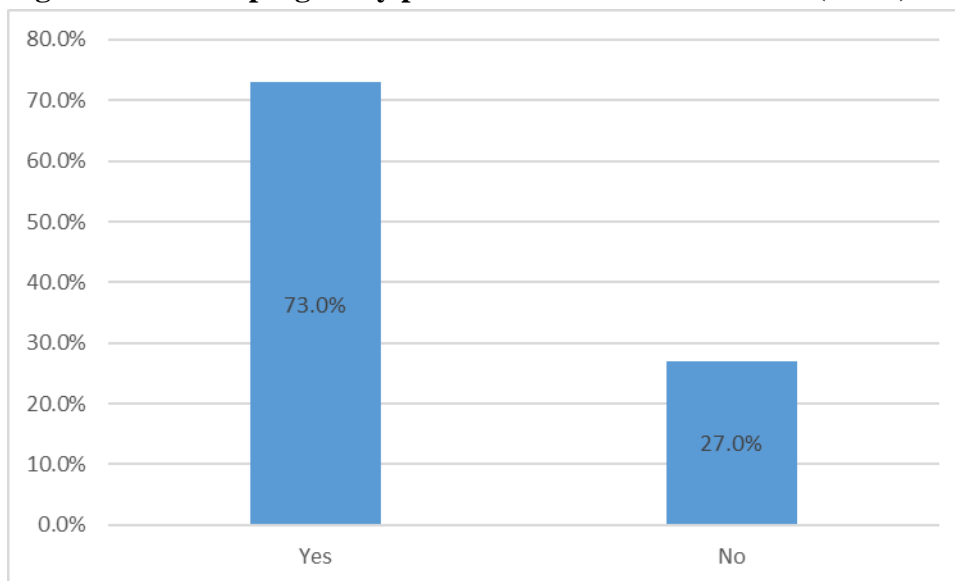
Having been asked on their sexual practices, it was also necessary to find out if the adolescent males were adequately equipped with knowledge and skills on protective measures against STIs and unplanned pregnancies. The research asked several questions to find out more on this.

##### Pregnancy prevention

The participants were requested to show whether they had carried out any measure to prevent unintended pregnancy on their initial sexual intercourse.

According to Figure 4.10, 73.0% indicated they had, and 27.0% had not, prevented pregnancy on first sexual intercourse.

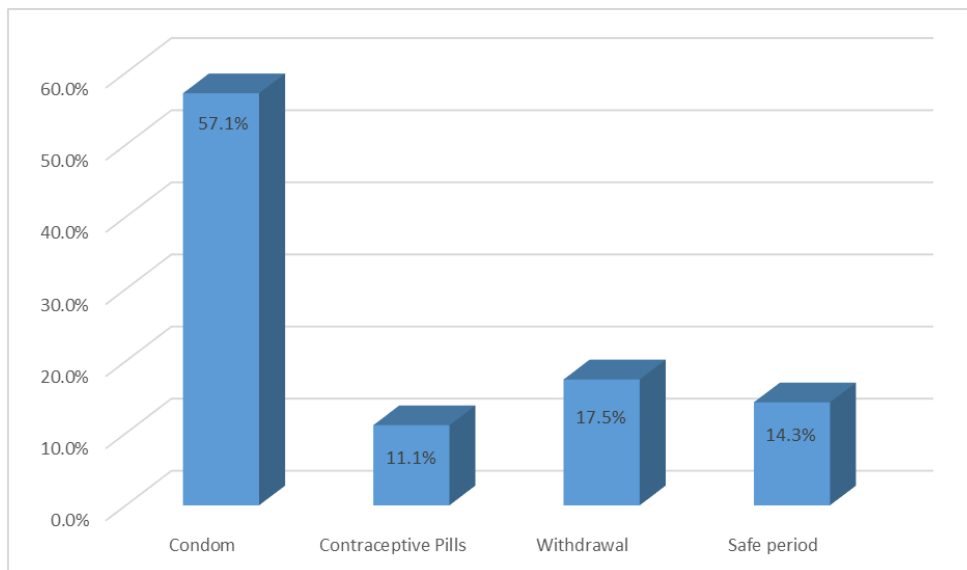
**Figure 4.10: Was pregnancy prevented on first intercourse (N=74)**



Of the 73.0% respondents indicated they had used a method to avoid pregnancy, they were further asked to indicate what method they had used that first time.

According to Figure 4.11, condom as the method used was reported by 57.1% of the respondents, withdrawal method by 17.5% of the respondents, female sex partners using the safe period at 14.3% and use of the female contraceptive pill by the female sex partner at 11.1%.

**Figure 4.11: Method used to prevent pregnancy the first time**



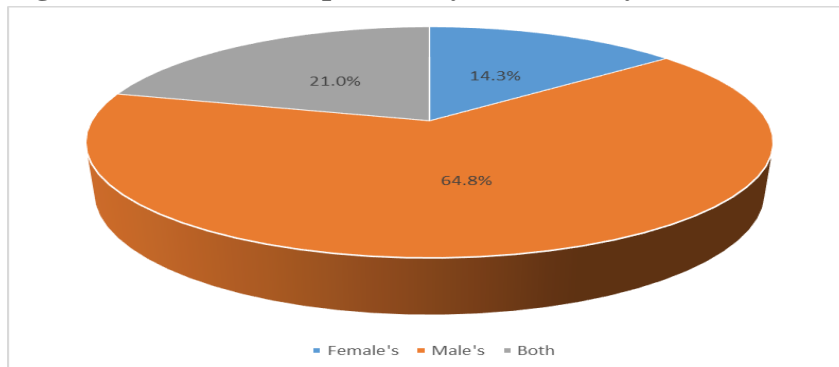
### Attitudes towards condoms

With the condom being the most commonly used method of prevention at 57.1%, the research sought to examine attitudes regarding condom. The respondents were asked whose responsibility it was to carry a condom – the females or the males.

According to Figure 4.12, the majority of the respondents (64.8%) felt it was the males' responsibility, 14.3% felt it was the females responsibility and 21.0% felt that it should be a responsibility for both.

Safe sex is everyone's personal responsibility. It shouldn't be a question about who is more responsible for the stoppage of STIs and unplanned pregnancy in a relation because ultimately, both people are. Carrying a condom should be a shared responsibility.

**Figure 4.12: Whose responsibility is it to carry a condom? (N=105)**



Some of the responses provided on whose responsibility it was to carry a condom were as shown below.

**Females responsibility:**

Because they always have bags to carry, it is easy for them to carry the condoms.

Because they should take care of themselves even incase of rape.

Because boys have a lot of work.

She will be confident.

They then get prevented from more risks of STI's and pregnancy.

They do not forget.

They dictate the nature of sex and frequency of sex.

**Males responsibility:**

Because they are not ready to take risks

It's a guys duty to protect a girl. That's being a gentleman.

It shows responsibility on the part of the guy.

The males are the ones in control.

He is the stronger sex.

It's normal in society.

To prevent unwanted pregnancy.

It shows maturity.

They are incharge of the sexual act.

He is the one using it.

They remember to use it.

It is what the friends have told him.

It's awkward receiving a condom from a girl.

It shows concern and respect.

They know what they are supposed to do with it.

He's the one giving out sperms.

I need to protect myself and I can confidently trust the one I'll use.

**Both:**

They are responsible for each other.

Sex is consented.

It's bothe their duty.

For protection.

Incise the other partner did not carry.

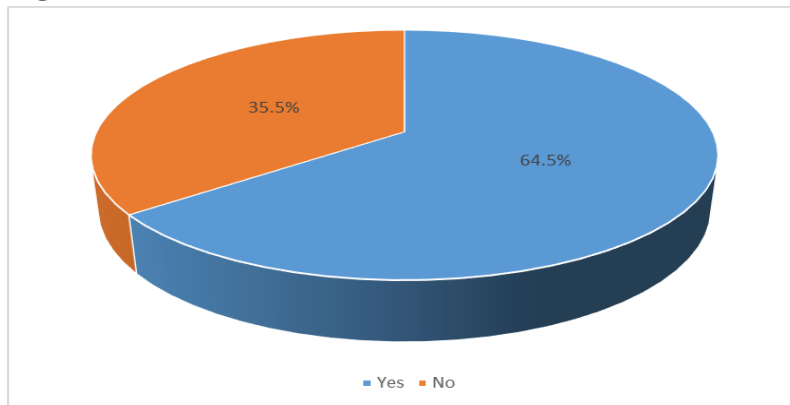
## HIV Prevention

Commencing 2013, HIV voluntary counselling and testing has proposed that all people aged between 15-65 should frequently visit the physician. Many people tend to think that establishing a routine doctor visit is “right thing to do” or will aid end this plague. Myhre and Sifris (MD) confirm that the advantages to anyone, as a person, can be countless, be it if he or she wants to offer herself/himself the means through which informed decisions regarding his/her health can be made or if he/she wants to relieve his/her mind concerning HIV condition.

One of the key behavioural HIV prevention strategies is knowing one’s HIV status. The inquiry aimed at determining whether the participants had taken a HIV test.

Figure 4.13 indicates that 64.5% of the participants had taken a HIV test, while 35.5% had not taken a HIV test.

**Figure 4.13 Tested for HIV (N=110)**



For those respondents who indicated they had not taken a HIV test, they were asked to give reasons why. The reasons they indicated included:

- I am not emotionally ready.
- Not really ready.
- I have no time.
- Lack of interest.
- I believe I am HIV negative and healthy.
- I have never thought about it.
- I don't see the reason to.
- Not ready yet.

The reasons cited are similar with other researches conducted that have cited structural and professional factors that act as barriers to HIV testing, even when programmes and guidelines exist to encourage it. These factors include lack of awareness, lack of time and resources and not being emotionally ready.

## **CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

### **5.1 Introduction**

This section is split into three sections: first, it sums up the matters on male adolescent wellness based SRH education as discussed in this research. The second section provides the major conclusions based on the research findings. The third section gives recommendations drawn from the study results. Recommendations for further studies related to the topic of the study are also given.

### **5.2 Summary**

This inquiry sought to investigate the effect of SRH education among male adolescents on the actions they take to maintain their SRH and wellness.

#### **5.2.1 Findings Based On the Research Questions of the Study**

Findings indicated that the male adolescents did have sexual and reproductive health education which they acquired from different sources, with their most preferred source of information being the internet. The most common reason cited for the internet was that it was anonymous and thus they felt they could ask anything.

The findings also indicated that the male adolescents had some level of knowledge and information on different SRH themes with the themes on HIV/AIDS being the most covered. The reason for this being that it was taught within the Kenyan school syllabus at secondary, tertiary, and primary educational levels. However, the findings of the study showed that some topics are covered more adequately than others, and this influenced the way the male adolescents found the topics useful for them. The more a topic was taught, the more it was found useful.

The examination also aimed at determining the types of SRH services provided to male adolescents. The male adolescents' raised concerns on several male sexual health concerns they had such as puberty, growth during puberty, sexuality and relationships, sexual development, masturbation, sexual behaviour and its consequences, unwanted sexual attention, dating violence, sexual function and dysfunction, STI's, HIV, pregnancy and adolescent fatherhood and SRH care and use. Despite all these concerns only 33% of the respondents knew where they could go for different SRH services. Some of the services they indicated that male adolescents should be provided with included access to condoms, guidance and counselling, HIV testing services, sex education, rape counselling, access to contraceptives, discussions on abortion, reproductive

health talks, screening for male reproductive system, Paternal education for males, STI testing and screening, Marriage Counselling, drugs and substance use and abuse and sexual violence education.

The study also sought to find out if male adolescents felt that SRH education had an effect on their SRH. The findings showed that they felt it was important for them. Some of the reasons given as to how it would help them were to help them avoid pregnancy, HIV and STI's, to help avoid peer pressure, to help male adolescents know their HIV status, to help them know which action to take in the event they are assaulted sexually, how to avoid pregnancy, to better understand the risks of abortion, to detect prostate cancer for early treatment, to help them know how to parent better, to prevent transmission of STI's, to help males know the right way to get into marriage, to understand female emotions so as to respect them and to help them make wise decisions in general.

## **5.3 Conclusions**

### **5.3.1 Role of Comprehensive Sexuality Education for young people**

It is estimated that 50% of population across the world are below 25 years. This means that around 3 billion youths and children will or are already in their reproductive stage. Teenagers, especially those from third world countries, suffer excessively from adverse SRH outcomes, including HIV/AIDS, unwanted and early pregnancies, STIs, and unsafe abortions. As reported by Suzanne Petroni, Senior Director at ICRW, these consequences are associated with economic, emotional, and social costs that impact national, individual, as well community growth.

The overall results of the research provide convincing evidence of the relevance and importance of CSE. CSE contributes greatly in dealing with youths and children's health and well-being. While using an approach that focuses on the learner, Comprehensive Sexual Education besides offering young people and children with phased and age-relevant education about risky sexual behaviours, relationships, prevention of ill-health, human rights, reproduction, and gender balance; it also offers a golden chance to express sexuality through positive means, putting emphasis on values like empathy, reciprocity, respect, equality, responsibility, non-discrimination, and inclusion.

### **5.3.2 Impact of Comprehensive Sexuality Education on young people**

Substantial evidence on the effect of education on human sexuality exists. It stresses that:

- Education on sexuality is beneficial; improve the attitudes of young people and increase their knowledge associated with SRH and conducts.
- Education on sexuality carried out in or out of schools doesn't increase HIV/STI rate of infection, sexual activity, or sexual risk-taking conduct
- Initiatives that encourage abstinence as the sole alternative have been considered useless in reducing the number of sexual partners, delaying sexual introduction, or reducing the frequency of sex. Joint programmes that are centred on suspending sexual practice with content from other plans are deemed useful.
- Programmes that focus on gender are significantly more useful compared to those that are gender-blind at meeting health results including reducing sexually transmitted infections and early and unintended pregnancy.
- Education on sexuality greatly are more influential when institution-based initiatives are harmonized with the engagement of youth-friendly facilities, training institutions, teachers, and parents (UNESCO, 2018)

### **5.3.3 Conclusions based on the findings of the study**

Some of the major findings of this inquiry were that majority of the male adolescents indicated that they had some sexuality education. Based on objectives of this study however, it can be concluded that the SRH information the young males have is better in some areas than others, especially topics that were taught in school. The findings indicate that the male adolescents acknowledge that sexuality education has positive effects and they were able to state how sexuality education could help them in different areas of their sexual and reproductive wellness. The findings also indicate a positive attitude among male adolescents on the teaching and receiving information related to their SRH. Overall, the findings indicate that education on sexuality has a critical role in enhancing SRH results of male adolescents.

The findings also indicate that the extent to which the male adolescents receive SRH messages it's not comprehensive enough. Many topics on the broader aspects of sexuality, including male adolescents' sexuality, relationships and reproductive health needs are not being discussed adequately.



The findings indicate a need from the male adolescents to have more information, that there exists inadequacies and measures need to be taken to improve on this. The findings also indicate a necessity for more SRH facilities that are specifically geared towards male adolescents.

## **5.4 Recommendations**

In view of the objectives of this study and various factors that emerged from the study results, the study recommended that:

### **5.4.1 Policy Recommendations**

#### **5.4.1.1 Targeting the male adolescent**

It is important that the existing Youth Friendly Clinics specifically address the sexual needs for adolescent males if they are expected to be involved completely as responsible spouses in protecting and improving their SRH and those of others via adequate community mobilization and sensitization by the youth friendly clinics to specifically promote male uptake of SRH services.

#### **5.4.1.2 Schools as partners in provision of Comprehensive Sexuality education**

Comprehensive sexuality education for the male adolescent, where all topics are taught, should not be seen as out of the curriculum but rather should be provided within schools so as to prepare the male adolescent for future life especially in the context of the changing society.

#### **5.4.1.3 Taking advantage of the positive attitude towards learning SRH**

Since the male adolescents have a positive attitude towards receiving and learning SRH, they ought to be encouraged to seek for the correct information that would help them.

### **5.4.2 General recommendations**

#### **5.4.2.1 Participation of older male**

Older male need to take up passing on of correct SRH information to younger male. This would create generations of males with correct information and skills and can aid better decisions and outcomes and would also address the myth that SRH is a females issue/women's domain.

#### **5.4.2.2 Parental support**

Changing family structures have led to the breakdown of traditional approaches in many ways including provision of SRH information. Parents and guardians should be encouraged to seek out and have correct SRH knowledge which they can then pass on to the male adolescents.

### **5.4.3 Recommendations for further study**

This inquiry has addressed a crucial issue within public health setting by concentrating on men's SRH. It has played a big part in generating important messages on how proper SRH education can go a long way in promoting SRH wellness. Nonetheless, an additional investigation ought to be carried out to obtain more insight into the health behaviours of adolescent male.

Other areas recommended for study can be:

- i. The influence of sex education programmes on the sexual behaviours of male adolescents.
- ii. A study on the psychological well-being at sexarche for adolescent males.
- iii. The level of adequacy of delivering SRH services and care for male adolescents.

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## APPENDICES

### Appendix I – Introduction Letter

#### Introduction Letter

Joan Njeri M. Mwangi,  
P.O.BOX 11041-00100,  
Nairobi.

I am a student at the University of Nairobi pursuing a Masters Degree in Sociology (Medical Sociology Cluster). I am conducting an academic research on effects of sexual and reproductive health education among male adolescents on their wellness.

I am kindly requesting you to fill in the questionnaire as accurately and honestly as possible.

This questionnaire is about human sexuality: including topics on human development, relationships, personal skills, sexual behaviour, sexual health, and society and culture.

As such you may be asked questions that are private and involve your sexual and reproductive practices and knowledge. However, utmost confidentiality will be observed and the results will be used for research purposes only.

Participation in the research is voluntary and you can withdraw after beginning if uncomfortable. Since this research is for advancement of knowledge only, no monetary motivation is available. However, the researcher greatly appreciates your participation.

Thank you.

Yours faithfully,

Joan Njeri.

## Appendix II – Male Adolescents Questionnaire

### Instructions

1. Do not write your name anywhere on the questionnaire
2. Please tick, circle or fill in information at the appropriate place
3. You may feel that some questions are hard to answer. Other questions may even not apply to you at all. However, it is important that you answer all those questions that are relevant to you as honestly and accurately as possible. So please take your time and ask your interviewer for assistance if you need any.

### **Section A: Socio-demographic data**

#### **First I would like to ask some questions about you and your background.**

1. Age of respondent (please tick the appropriate box):
  - 18 – 19 years
  - 20 – 21 years
  - 22 – 24 years
2. Level of education (highest level completed):
  - No formal education at all
  - Primary school education (not completed)
  - Primary school education (completed)
  - High school but not completed
  - High school (completed)
  - University education
  - Other professional skills/training (please specify) \_\_\_\_\_
3. What is your relationship status?
  - Single
  - Dating
  - Married
4. What is your occupation?
  - Student
  - Employed
  - Self employed
  - Unemployed

5. What is your religion?
- Protestant
- Catholic
- Muslim
- Other (please specify)\_\_\_\_\_
6. How often do you usually attend religious services?
- Every day
- At least once a week
- At least once a month
- At least one a year
- Less than once a year
- Never
7. How important is religion in your life?
- Very important
- Important
- Not important
8. Where do you reside within Roysambu Sub-County? \_\_\_\_\_

**Section B: Information sources on reproductive health**

**Now I would like to ask some questions about how you learned about sexuality and matters of reproductive health**

1. Have you ever discussed sex-related matters with any of your parents/guardian? Please tick where appropriate.

Yes

No

a) If yes, which parent? Mother  Father

b) If yes, how often?

Often

Occasionally

Never

2. How easy or difficult is it for you to talk to the following people about sexual matters: Please tick ONE box in each row.

Person	Mainly easy	Mainly difficult	Did not talk to them at all
Mother			
Father			
Guardian			
Male friends			
Female friends			
Teacher			
Religious leader			

3. Young people learn about puberty - I mean the ways in which boys' and girls' bodies change during the teenage years - from many sources. What has been the most important source of information for you on this topic? Please tick ONE only.

Parents

Brother/ sister

Books/magazines

Television programs/movies

Internet

Medical personnel  Friends  (at home or school?) \_\_\_\_\_

Teachers/school group  Church/ religious group  (specify) \_\_\_\_\_

Other (specify) \_\_\_\_\_

4. This is a similar question as the one above about sources of information on the sexual and reproductive systems of men and women - I mean where eggs and sperm are made and how pregnancy occurs. What has been the most important source of information on this topic? Please tick ONE only.

- Parents [ ]                      Brother/ sister [ ]                      Books/magazines [ ]  
Television programs/movies [ ]                      Internet [ ]  
Medical personnel [ ]                      Friends [ ] (at home or school?) \_\_\_\_\_  
Teachers/school group [ ]                      Church/ religious group [ ] (specify) \_\_\_\_\_  
Other (specify) \_\_\_\_\_

5. a) From whom or where would you prefer as your source of information on sexuality and other sex related issues? Please tick ONE only.

- Parents [ ]                      Brother/ sister [ ]                      Books/magazines [ ]  
Television programs/movies [ ]                      Internet [ ]  
Medical personnel [ ]                      Friends [ ] (at home or school?) \_\_\_\_\_  
Teachers/school group [ ]                      Church/ religious group [ ] (specify) \_\_\_\_\_  
Other (specify) \_\_\_\_\_

b) Why would you prefer them as your source of sexual information?

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**Section C: Knowledge on Sexual and Reproductive health**

**In this section. I would like to ask some questions about the knowledge and information you have on sexual and reproductive health**

1. Have you had any lessons/classes on sexual and reproductive health topics which have given information or discussed the following topics? Please tick ONE box in each row.

<b>Topic</b>	<b>Many Times</b>	<b>A few times</b>	<b>Once</b>	<b>No lesson</b>	<b>Can't remember</b>
Sexual feelings, relationships and emotions					
Puberty					
How girls' bodies develop					
How boys' bodies develop					
Menstruation/periods for girls					
Wet dreams					
Safer sex techniques e.g. use of condoms					
Contraception					
Pregnancy					
Marriage					
HIV and AIDS					
Sexually transmitted Infections					
Sexual violence/ Rape					
Violence against girls/female					

2. For the topics, how useful did you find the information provided to you? Please tick ONE box in each row.

<b>Topic</b>	<b>Very Useful</b>	<b>Useful</b>	<b>Not very useful</b>	<b>Not at all useful</b>
Sexual feelings, relationships and emotions				
Puberty				
How girls' bodies develop				
How boys' bodies develop				
Menstruation/periods for girls				
Wet dreams				
Safer sex techniques e.g. use of condoms				
Contraception				
Pregnancy				
Marriage				
HIV and AIDS				
Sexually transmitted Infections				
Sexual violence/ Rape				
Violence against girls/female				

3. After completing primary school, some young people will not go on to secondary education, so in terms of sexual and reproductive health information, what knowledge (attitude, skills and behaviour) should adolescent males possess/have by Class 8?

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4. Please give your opinion on each of the following statements by placing a cross to indicate if you in the column you think best.

<b>Statement</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Uncertain</b>	<b>Disagree</b>	<b>Strongly disagree</b>
Sexuality education helps in giving accurate information on how best to deal with issues of sex, relationships and HIV					
Sexuality education has a major role to play in enhancing male sexual health and wellness					
Sexuality education for male has a major role to play in enhancing female sexual health and wellness					
Sexuality education helps males make informed decisions about sexual behaviour					
Sexuality needs to be discussed more openly with and among males					
HIV and AIDS is a serious issue for young people					
Teenage pregnancy is a serious issue					

5. Please name as many methods as you know on how to prevent pregnancy.

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6. Please name as many methods as you know that can prevent sexually transmitted infections.

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**Section D: Sexual and Reproductive health Services**

**In this section. I would like to ask some questions about the sexual and reproductive health services provided to male adolescents. These include:**

- **Universal access to accurate sexual and reproductive health information;**
- **A range of safe and affordable contraceptive methods;**
- **Sensitive counseling;**
- **The prevention and management of sexually transmitted infections, including HIV**
- **Quality obstetric and antenatal care for all pregnant women and girls**

1. What do you think are the major sexual and reproductive health concerns/challenges facing male adolescents aged between 18 – 24? List them below.

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2. Are there doctors, hospitals, NGO's, government clinics, VCT centres you know that provide sexual and reproductive health services for adolescent males?

Yes

No

If yes, list below.

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3. In your opinion, do you think that it is necessary for male adolescents like yourself to be provided with sexual and reproductive health services?

Yes

No

Please explain your answer below.

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4. What are some of the sexual and reproductive health services that should be provided to adolescent males and how would it help them better their sexual and reproductive health?

<b>What service?</b>	<b>How would it help them?</b>

**Section E: Current/Most recent sexual relationship**

**Now I would like you to answer the following questions about your own sexual experience and relationships. Again, it is important, that all questions are answered honestly and to the best of your knowledge. You can ask for assistance if you need any.**

1. Have you ever had a girlfriend? By girlfriend, I mean someone to whom you were sexually or emotionally attracted and whom you 'dated' ?  
Yes [ ]  
No [ ]
2. How many girlfriends have you had?(indicate number in the box)
3. During the time you were dating a particular girl, did you 'date'/have you 'dated' anyone else?  
Yes [ ] No [ ]
4. Have you ever had sexual intercourse? (When we say sexual intercourse, we mean when a male inserts his penis into a female's vagina.)  
Yes [ ] - If Yes, go to question 6  
No [ ] - If No, answer question 5, then go to question 13.
5. If no, what are your reasons for abstaining from sexual intercourse? (Tick as appropriate)  
Religious values [ ]  
Fear of pregnancy [ ]  
Wish to wait for marriage [ ]  
Not emotionally ready [ ]  
Fear of HIV/AIDS [ ]  
Fear of other sexually transmitted infections/ diseases [ ]  
Other (specify)  
\_\_\_\_\_
6. If yes, how old were you when you first had sexual intercourse? \_\_\_\_\_
7. How old was your sexual partner when you first had sexual intercourse? (If you do not know exact age, please give an estimated age) \_\_\_\_\_
8. During that first sexual experience, did you have sexual intercourse with the person willingly, pressurize/force or entice this person?
  - i. willing [ ]
  - ii. pressurize/force against their wishes [ ]
  - iii. entice [ ]
  - iv.

9. On that first time did you do anything to avoid a pregnancy?

Yes

No

10. What method did you use the first time? Please tick ONE only.

Condom

Pill

Withdrawal

Safe period

Other (specify) \_\_\_\_\_

11. Looking back to it, which of the following describes best how you feel about your first sexual relationship today? Please tick box that applies.

i) It happened too early

ii) It happened too late

iii) It was about the right time

iv) I didn't want it to happen at all

12. Is there anything, that you now feel you should have known more about when you first had sex? Please state below:

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13. Whose responsibility is it to carry a condom? – the girl's or the boy's responsibility?

Girl's

Boy's

Please provide your reasons why?

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14. Have you been tested for HIV?

Yes

No

If no, why not?

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**Appendix III – Key Informant Interview Questionnaire**  
Key Informant Interview Questionnaire

1. What is your understanding of sexual and reproductive health education?

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2. How did you found out about relationships, sex and contraception?

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3. How knowledgeable do you feel about sexual matters?

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4. Whom or what do you rely on for information? Whom or what are the most important sources to you? How important to you is each source?

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5. Have you at a personal level received any formal/ organized lessons on sexual and reproductive health education geared specifically for males?

Yes

No

If yes, what were some of the topics and content taught?

Topic	Content

If no, do you feel you would have liked to have received such information? Why?

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6. When finding out about relationships, sex and contraception what role have your friends played?

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7. What issues do you talk about with your friends on sexual matters and sexual health?

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8. After completing primary school, some young people will not go on to secondary education, so in terms of sexual and reproductive health information, what knowledge (attitude, skills and behaviour) should they possess/have by Class 8?

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9. Describe a male adolescent's sexual and reproductive health needs.

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10. Do you think sexual and reproductive health for male adolescents is important?

Yes

No

If yes, why?

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If no, why?

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11. Do you think male sexuality education would play a major role in helping to reduce adolescent sexual health problems? Name some specific adolescent sexual health problems and how male sexuality education would play a role.

Problem	Role played by sexuality education

12. What do you see as some key barriers to sexual and reproductive health education for males in schools?

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13. What are some ways you would recommend to promote/improve male sexual and reproductive health education?

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