THE STRATEGIES THAT SECONDARY SCHOOL ADOLESCENT BOYS UTILIZE IN MANAGING SEXUALLY TRANSMITTED INFECTIONS INCLUDING HIV/AIDS:

THE CASE OF OL'JORO-OROK DIVISION NYANDARUA DISTRICT.

By

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DECLARATION

This thesis is my original work and has not been presented for a degree award in any other University.

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This thesis has been submitted for examination with our approval as University Supervisors.

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DEDICATION

To my Jesus, for ever renewing my strength and vision.

Also to my dear wife Esther Muthingu and my beloved son Victor Nguura.

for their constant love and encouragement.

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However, I remain personally responsible for any shortcomings in this thesis.

ABSTRACT

This study was carried out as a population based survey conducted among secondary school boys aged 13 to 19 in Ol'Joro-orok division, Nyandarua District. The objectives of the study were: to investigate the factors that influence adolescent boys' sexual behaviours and practices; explore the role of sexual perceptions and attitudes on boys' risk management practices; identify the various risk management techniques that boys employ against the risks of STI and HIV infection and to examine boys' illness and treatment seeking behaviours upon infection with an STI. The research was carried out in May and June 1997. The study presents the findings from 120 adolescent boys who filled the survey questionnaires as well as 54 others who provided supplementary qualitative data as FGD participants and key informants. Stratified and random sampling procedures were used in the selection of the respondents while purposive sampling was used to select the FGD participants and key informants. The data was analysed using quantitative and qualitative methods.

The findings revealed that individual and family background characteristics, peer group associations and the male sexual norms prevailing in the respondents' communities did influence the boys' sexual behaviours and practices.

The adolescent boys were found to have sexual attitudes and opinions that were not compatible with wholesome sexual and reproductive health and practice. Most of the respondents had a non-accepting attitude towards condom use, while significant proportions approved multiple sexual partner relationships, casual sex, rape and premarital sexual intercourse for boys. The results of the study showed that these negative sexual attitudes and opinions hindered adolescent boys from adopting effective risk management or safer sex practices. The study also noted that while the boys reported using various strategies in managing the risks of STI and HIV infection, they mainly depended on lay techniques and resources that offered them little or no protection.

Finally, the results of the study showed that adolescent boys have generally poor STI illness and treatment-seeking behaviours. A substantial proportion of those with STI experience ignored or did nothing about their symptoms while the majority of those who sought some kind of treatment only did so after lengthy delays (between 14 to 21 days). Moreover, of those who sought STI treatment most depended on self-medication, mainly herbal regimens and OTC drugs. Lack of money, embarrassment, adult hostility and physical distance mainly constrained boys from accessing STI treatment when they felt they needed it.

The study recommends that STI and HIV prevention and control intervention programmes targeting young people should not only aim at changing their sexual behaviours but also their faulty attitudes which are precedents to risky practices. Further, for AIDS information, to translate into modified sexual behaviours, programmes need to present the information in ways that are attractive and acceptable to adolescents. Involving the adolescents in programme design, delivery and evaluation is one effective way, that could also lead to positive peer pressure in modified sexual behaviour change.

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ABBREVIATIONS:

S.T.I./S.T.D	:	Sexually Transmitted Infections /Sexually Transmitted Diseases
R.H.	:	Reproductive Health
F.L.E.	:	Family Life Education
O.T.C.	:	Over-the-Counter Drugs
A.A.A.S	:	American Association For the Advancement of Science
A.M.R.E.F.	:	African Medical and Research Foundation
G.O.K.	:	Government of Kenya
C.B.S.	:	Central Bureau of Statistics
N.C.P.D	:	Kenya National Council of Population and Development
N.A.S.C.O.P.	:	Kenya National AIDS and STD Control Programme
G.U.D.	:	Genital Ulcer Disease
P.C.	:	Population Council
P.R.B.	:	Population Reference Bureau
U.N.A.I.D.	:	United Nations Agency for International Development
K.I.E.	:	Kenya Institute of Education
C.A.H.	:	Department of Child and Adolescent Health
A.I.D.S.	:	Acquired Immune Deficiency Syndrome
H.I.V.	:	Human Immunodeficiency Virus
H.B.M.	:	The Health Beliefs Model
G.T.A.	:	The Grounded Theory of Adolescence
I.E.C.	:	Information, Education and Communition
K.D.H.S.	:	Kenya Demographic and Health Survey
M.T.P.	:	Medium Term Plan
F.G.D.	:	Focus Group Discussion
H.T.L.V.-III	:	Lymphotropic Virus III
W.H.O.	:	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE PROBLEM

Young people constitute a large and rapidly growing proportion of many country populations, yet their sexual and reproductive health needs remain largely ignored. (Population Reference Bureau, (PRB), 1996; Goliber, 1997). The importance of adolescents' reproductive health is particularly crucial in Sub-Saharan Africa, a continent that has over 70% of all HIV/AIDS cases worldwide, and where 50 to 80 percent of those aged 15 to 19 have experienced sexual intercourse as compared to countries like U S.A. where only 33% of unmarried 19 year old women have had sexual intercourse. (WHO, 1989; 1995). However, in many Sub-Saharan countries, including Kenya, there is no explicit policy, legislation or reproductive health programs for adolescents. As a result the risks related to sexual activity and childbearing are among the most serious health risks that adolescents face. With the advent of AIDS these risks are multiplied (Lema, 1987; PRB, 1996).

In Kenya, where about 60 percent of the population is less than 20 years old, including over 6.5 million adolescents aged 10-19, early sexual exposure mostly at tender ages of 12 years continues to lead to increased pre-marital pregnancies, abortions and high incidence of sexually transmitted diseases. Consequently, complications of pregnancy, child birth and unsafe abortions are the major causes of death among adolescents girls aged 15 to 19. Young people aged 15 to 24 also, have the highest infection rates of STI including HIV (Lema, 1987; Republic of Kenya, 1994; Toroitich-Ruto, 1997; NASCOP, 1999).

While there has been a keen interest in Kenya on expanding what is known about adolescent sexuality and health, research to date has largely focussed on reproductive health and the situation of the adolescent girls. With the emergence of HIV/AIDS, the need to focus attention on the sexual behaviour of young men as well has emerged. This is due to the facts that they are at risk and because both their sexual and reproductive behaviour invariably impacts on that of young women as well. Since in this predominantly patriarchal setting men control the circumstances under which most women are exposed to the risk of HIV infections as it is typically males who

are the key decision-makers on the timing of sexual activity and contraception usage (Kamau, 1996; Tunju, 1996; Nzioka, 2000). The need to focus on boys sexual and reproductive behaviour intensifies in the light that despite a high knowledge of sexual risks, fear of HIV, and awareness of the protective value of condoms, boys exhibit high risk behaviour. They feel the need to conform to social prescriptions of male prowess, early sexual experience and having more than one partner. They also consider getting girls pregnant and having had treated STI as marks of masculinity (Nzioka, 2001). Further, research reveals that compared with girls more boys report being sexually active, have more sexual partners and start sex at an earlier age. The Kenya Demographic and Health Survey (KDHS) 1998 found that about 32 per cent of unmarried adolescent boys aged 15-19 had had sexual debut by age 15, as compared to 15 per cent of girls. In the 12 months proceeding the survey, 22.9 per cent of the boys had had sexual intercourse with two or more partners as compared to only 3.1 per cent of girls of the same age. Overall, almost half (45 per cent) of all boys aged 15-19 had one or more sexual partners. (National Council of Population and Development (NCPD), 1999). Condom use among boys, however, tends to be infrequent and erratic. It has been observed that while 60-70 per cent of adolescents in Kenya are at risk of contracting HIV, about 80 per cent have at one time or another engaged in unprotected sexual intercourse. As a result, research has found that as high as 25 per cent boys aged 15-19 with STI were also HIV positive in some areas of the country such as Western Kenya and South Nyanza. (Nyamongo, 1996; Johnstone, 2000). Yet, boys are reluctant to seek STI treatment as they may view mother and child health clinics and family planning centres as "female" spaces or fear the disapproval and stigmatization they may encounter from health care providers. Boys are therefore most likely to consult unqualified treatment sources. Improper and incomplete STI treatment thus makes it more likely that STI including HIV will be transmitted to others and complications such as infertility will occur, (Gyepi-Garbrah, et al, 1985; WHO, 2000). Studying the STI management strategies that boys utilize will therefore accrue benefits not only to adolescent boys and young men, but also to adolescent girls, women, children, men and communities.

1.2 STATEMENT OF THE PROBLEM

Millions of the young adults around the world become infected with STI every year (WHO, 1995). In Kenya national health data suggest that STI and HIV are increasing among the youth. A survey of 1058 adolescents in four rural districts found that 25% of the males and 16% of the females had experienced an STI at least once in the 12 months proceeding the survey. Community based studies in some areas of the country, such as Western Kenya and South Nyanza have further shown that as high as 25 % of boys aged 15-19 with STI were also HIV positive (Williams et al, 1997; Johnson, 2000). This shows that, like girls, boys face great risks of contracting STI including HIV and therefore need relevant information, skills and health services, just as girls do. Boys' need however, becomes urgent in the light that infection with an STI may increase a boy's prestige among peers and having a treated-STI be considered as a mark of masculinity (Gachuhi, 1986; Nzioka, 2001) Unfortunately, however STI actually increase susceptibility to HIV infection and untreated STI enhance transmission of HIV (Bloor, 1995). However, while there has been a keen interest in Kenya on expanding what is known about adolescent health sexuality, research to date has largely focussed on the reproductive health and the situation of adolescent girls. Girls also receive most attention in the form of programs and services and get information from their mothers and aunts after their first menstruation, while boys are less likely to talk to family members about their sexuality (Ajayi et. al, 1997, WHO, 1995). Consequently, boys often face the risks of STI and HIV infection on their own and with little factual information, too little guidance and too little access to healthcare. (IPPF, 1995). This study therefore sought to investigate the coping strategies that boys utilized in the absence of supportive programs, to manage constant risk of STI including HIV/AIDS infection by generating answers to the following research questions:-

1. What are the various variables that influence the sexual behaviour and practices of the adolescent boys?
2. How do boys perceive risky behaviour and how does this impact on their health-seeking behaviour?

3. What strategies do adolescent boys utilize in the management of the risks of STI and HIV infection?
4. How do boys manage their STI illnesses?

1.3 OBJECTIVES OF THE STUDY

1.3.1 Broad Objective

The broad objective of this study was to examine the strategies that secondary school boys utilized in managing the risks of STI and HIV infections.

1.3.2 Specific Objectives

1. To investigate the factors that influence sexual behaviour and practices of adolescent boys
2. To explore the impact of sexual perceptions and attitudes on boy's risk management practices.
3. To identify the various safer sex or risk management techniques that boys employ.
4. To examine boys' illness and treatment-seeking behaviour patterns on infection with an STI.

1.4 STUDY HYPOTHESES

The study was guided by the following hypotheses:

1. That the sexual behaviour and practices of adolescent boys were largely influenced by their individual and family background characteristics, the peer group associations and the male sexual norms prevailing in their communities.
2. That the sexual perceptions and attitudes of the adolescent boys hindered their successful adoption of effective risk management practices.
3. That adolescent boys frequently ignored STI symptoms or resorted to self treatment upon making self-diagnosis
4. That there was high tendency among adolescent boys to utilize lay techniques and resources in the management of the risks of STI and HIV infection.

1.5 JUSTIFICATION OF THE STUDY

This study found justification on the following grounds:

One, adolescent boys' sexual and reproductive health behaviours are directly related to the health of adolescent girls as in Kenya's patriarchal setting, it is typically males who are the key decision-makers on the timing of sexual activity and conception usage (Kamau, 1996, WHO, 2000). Male adolescents sexuality research therefore, qualifies as an aspect of preventive health agenda for successful AIDS intervention planning because adolescent boys as well as adult men contribute to many of the health risks that adolescent girls face, including reproductive tract and sexually transmitted infections, pregnancy-related complications, and violence and abuse Therefore, protecting boys from acquiring STI and HIV is an important way of protecting girls.

Two, research on early sexual activity of adolescent males suggests that patterns of viewing women as sexual objects, viewing sex as performance-oriented and using pressure or force to obtain sex begin in adolescence and often continue into adulthood. This provides a strong argument for working with boys as they form attitudes towards women and develop ways of interacting in intimate relationships as adolescence is the optimum time to prevent high risk behaviour from becoming routine. (Balmer, 1994; WHO, 2000). Three, alcohol and other substance use often accompany the early sexual experiences of young men and increase the risk of STI, including HIV/AIDS and unwanted pregnancy. (WHO, 2000). Male adolescent sexuality therefore constitute a social problem and a behavioural risk. Research on boys' sexuality is therefore both necessary and timely. Four, the HIV pandemic, much of it related to the sexual behaviour of adolescent and adult men, is having a major impact on the economic capacity and development of many Sub-saharan African countries. From an economic perspective, therefore, ignoring the specific health needs and health-related practices of adolescent boys represents tremendous costs to societies. (WHO, 2000).

Five, improving and safeguarding the health and well being of boys is a matter of human rights. The Convention on the Rights of the Child clearly states that boys need relevant information, skills and health services, just as girls do (WHO, 1995).

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 LITERATURE REVIEW

2.1.1 INTRODUCTION

This section reviews the available literature on social and behavioural prevention and control of STI including HIV/AIDS. The review however adopts a general perspective due to the scarcity of specific data on boys and STI including HIV/AIDS.

2.1.2 THE NATURE OF STI AND HIV/AIDS

2.1.2.1 Nature of STI

Sexually transmitted infections occur in various types. Some of these are urethritis, chlamydia, gonorrhea, syphilis, vaginitis, candidasis, trichomonas, cervicitis, pelvic inflammatory disease (P.I.D.), Genital Ulcer Disease (G.U.D.), Herpes 1 and 2, Chancroid and pediculosis. (Population Media, 1996). The World Health Organisation (WHO) generally classifies STI into two broad categories - viral and non-viral STI. Viral STI are uncurable while non-viral STI are curable. (WHO, 1989). Fortunately, viral STI are few, as WHO (1989) observes that except for Genital Ulcer Disease (G.U.D.) and Herpes 1 and 2 which are viral, all other STI which are mostly caused by bacteria, protozoa, fungi or yeast are curable. This means that one characteristic of STI is that they are largely manageable illnesses as most can be treated effectively through known remedies. Secondly, the symptoms of many STI are difficult to recognise. Some infections produce no obvious symptoms, for instance 20 % of men and 55% of women do not notice symptoms of gonorrhoea. (WHO,1995). This implies that STI infections are mostly not diagnosed and the spread increases. Thirdly, untreated STI could lead to severe health conse-

quences such as sterility, infertility, blindness, insanity, still birth, loss of pregnancy, paralysis, heart disease, increased susceptibility to HIV/AIDS infection and death (WHO, 1995) This shows that STI are severe illnesses if not treated or well treated.

2.1.2.2 Nature of HIV/AIDS.

AIDS stands for Acquired Immuno Deficiency Syndrome. AIDS is seen as a syndrome or a collectivity of many illnesses. Most researchers agree that AIDS is caused by HIV which stands for Human Immunodeficiency Virus. There are two types of HIV, that is, HIV 1 and HIV 2. HIV 1 is made up of 8 strains :- A,B,C,D,E,F,G,H. The worst strains are A,C, and E which are found in Sub-Saharan Africa and are often associated with heterosexual transmission. Strains B and D are mostly found in homosexual and lesbians, while F,G and H are largely with drug addicts. HIV 1 is the most common in Kenya. HIV 2 has no known strains and is predominantly found in West Africa and has mild symptoms. (Bloor, 1995). The HIV attacks the white blood cells which offer the body's immunity against a variety of disease organisms. The destruction of infected cells leads to many bacterial, and protozoa infections, like pneumonia and tuberculosis which further weaken the body. Symptoms associated with HIV/AIDS infection are: breakdown in the central nervous system, dementia, confusion, disorientation, deficient memories, general weakness, blurred vision, chronic diarrhoea for more than a month, eventual loss of more than 10% of the body weight, persistent cough for more than four weeks, generalized skin infection and inflamed lymphonodes. (Weber, 1988; WHO, 1995). HIV/AIDS could be said to have three main characteristics. One, is that it has no known cure. Two, as explained above HIV/AIDS has fatal health consequences. Three, HIV/AIDS has a long incubation period, ranging from one to ten years for a HIV positive status to develop into full-brown AIDS (WHO, 1995). This means that HIV infection takes a long time to be diagnosed and therefore its transmission increases.

2.1.3 A Sociological Perspective on STI and HIV/AIDS

While the study acknowledged the bio-medical nature of STI and HIV/AIDS as explained above, it however, sought to understand the social transmission of STI and HIV which entailed the locating of the illnesses in their social context. This means that the study's main issues of concern and interest were not the biological mechanisms of transmission but rather the social and sexual relationships and practices of the adolescent boys which amplify the risks of STI and HIV infection. This is because the transmission of STI and HIV, occurs through intimate social activities and successful intervention strategies are based on changing the behaviour of large groups of people which require detailed knowledge of their social world(Abrecht, 1992).Besides,

> In the later stages of the epidemic (AIDS), when knowledge of the biology transmission is substantial and widespread, the danger lies not in dying of ignorance, but dying of say, intimacy or embarrassment, or powerlessness or even ambiguity (Bloor, 1995;101).

2.1.4 The Lay Perceptions about STI and HIV/AIDS.

Perceptions are peoples' worldviews, knowledge and meanings that they may attach to phenomena and the definitions they offer. More importantly, the perceptions that an individual has about a situation normally guides the actions the person takes regarding the situation. (Knutson, 1965; Brown, 1989)

2.1.4.1 Lay Perceptions about STI

According to Mechanic (1982), perceptions take a central role in health and illness behaviour as the likelihood of taking a particular action is a function of perceived threat and perceived benefit. Perceived threat is a function of perceived seriousness. It is therefore important to understand the lay perceptions that people have about STI and HIV/AIDS and further, because as Nzioka (1996) argues these socially meaningful ways of making sense of risk of STI and HIV infection inform some of the prevailing sexual practices.

Studies in Africa reveal that STI are not perceived favourably as most people do not "see" STI as illnesses that could lead to fatal health consequences. Larson (1989) found that in Rwanda, no stigma is attached to STI when they occur to men as they are an expected occurrence In Uganda there is a general attitude which links STI with sexual prowess, which is normally prescribed for men. (Larson, 1989). This shows that STI are largely considered as routine illnesses for men. In Kenya, a study conducted in urban Kisumu revealed that Genital Ulcer Disease (G.U D.) and other STI are commonly neglected by people in the region until symptoms become unbearable. (Onditi and Hongo, 1994). This shows that frequently STI may be taken as mild or less serious diseases until and unless progression of symptoms prove otherwise. Among boys, infection with an STI may increase a boy's prestige among peers and boys may consider having been treated for an STI a mark of masculinity. (Gachuhi, 1986; Nzioka, 2001). The fact that STI are generally perceived as common and less serious diseases may hinder their viable control by these populations since as Cockerham (1992) notes , those diseases which people perceive as common are usually defined as routine illnesses such that they do not bother about them.

2.1.4.2 Perceptions about HIV/AIDS

Social perceptions to AIDS are largely fearful, moralistic and emotive, (Nzioka, 1994) for the following reasons:

One, AIDS has no known cure, has fatal consequences, and HIV positive diagnosis translates into death sentences, and more importantly it kills people at the 'wrong' time. (Brandt, 1985). This means that AIDS is rightly perceived as a severe illness and therefore a disease which one seriously needs to avoid.

Two, in Kenya as in much of East Africa, AIDS is experienced as a shameful disease, a construction that attaches stigma to the disease, and produces a dominant view that AIDS is a disease for immoral, promiscuous and irresponsible people. Indeed, the view that AIDS is a disease of particular socio-sexual categories still dominates public HIV/AIDS discourses. (Seidel. 1990; Nzioka, 1996). This implies that certain sections of the population may wrongly habour

feelings of invulnerability toward AIDS as they may not perceive themselves to belong to the socio-sexual categories socially associated with the disease. It was the interest of this study therefore, to investigate how adolescent boys rated their HIV vulnerability at group and individual levels, and how this rating influenced their sexual practices

2.2 National Control Efforts on STI and HIV/AIDS

The information on exact magnitude of STD in Kenya is scanty but it is among the 5 top diseases for which patients seek medical attention at our out-patient health facilities where over 50,000 cases of STDs are being treated each month. Sydromic management approach to STDs is thought to be the answer to many of the problems to efficient STD case management as recommended by WHO. This is widely used in Kenya. The approach seeks to successfully integrate STD treatment with primary health care services, where STD screening and treatment and condom distribution are done along normal antenatal and family planning services. However, primary health care services in Kenya, face several constraints with regard to the management of STDs. These are lack of access to the laboratory technology necessary for making etiologic diagnosis of STDs, shortage of well-trained staff, high work load and limited staff time available per patient. (Nyanganyi, 1996; NASCOP, 1999). Further, cultural and social barriers such as stigma and beliefs that STDs are not severe illnesses hinder the successful STD case management. In urban Kisumu, for instance G.U.D. and other STDs are commonly neglected until symptoms become unbearable. Partner notification method, which is a main pillar in syndromic management of STD was also largely hindered by stigma and gender feelings, since infected partners, males especially were reluctant to notify or accompany their partners for treatment. (Onditi and Hongo, 1994).

Given the limited equipping and number of public health facilities in Kenya, health workers in the private sector see over 50% of STD patients. (NASCOP, 1990). Most of these however, are more likely to receive improper treatment, since profit motives may lead to underdosage of proper medication or issue of expired drugs or wrong prescription by the often under-qualified health care staff in private clinics. (Tunju, 1996).

Traditional medicine claims to have made significant progress in STD treatment including HIV/AIDS and it has a widespread perceived efficacy and use among most Kenyan Communities, and for most illnesses.(Nyamwaga, 1982; Sindiga, 1994). However, little scientific research and recognition has been accorded this domain. Moreover, there is lack of proper policy, qualification and integration of traditional medical practice into the national health sector. (NASCOP, 1996b). As a result traditional medicine remains largely undeveloped in Kenya and unutilized in the management of STI despite its great potential in the light of WHO's (1995) observation that traditional medicine remains the most accessible and affordable treatment option in developing countries.

2.2.1 HIV/AIDS Control Efforts.

The AIDS epidemic has been described as the single most important challenge that Kenya has faced in post-independence. (NASCOP, 1998). By the end of 1998 it was estimated that some 1.9 million people were infected with HIV 2 representing an adult prevalence of around 14%. In urban areas prevalence is estimated to be 17-18% or 430,000 HIV infected adults as compared to 12-13% or 1.4 million HIV infected adults living in rural areas. It is projected that 3 million people will be infected with HIV by the year 2005. About 75% of reported AIDS cases occur among adults between ages 20 and 45. In 1999 alone, 200,000 people are estimated to have died of AIDS which is about 500 AIDS deaths daily or approximately 20 deaths per hour. The cumulative number of AIDS is estimated to increase from 700,000 in 1999 to 2.7 million by 2005 which is over 740 deaths per day. (NASCOP, 1999 a; 1999 b).

Although significant resources are being devoted globally to research the prospect of developing a cure or an effective vaccine for HIV which is safe and affordable worldwide is still apparently remote. Prevention or modification of sexual behaviour therefore remains the only effective way to controlling the spread of HIV infection. And it may always remain the most cost-effective option. (Bloor, 1995).

Various methods have been employed by the government in the control of HIV/AIDS in Kenya. These include: policy instruments, advocacy and promotion of behaviour change, research, condom distribution and STD treatment and control as discussed below

2.2.2 Policy Measures

Three strategic plans for HIV/AIDS/STDs prevention have been formulated since 1984 when the first AIDS case was reported. The need for a natural response was recognised and the First Medium Term Plan (MTP1) of 1987 to 1991 developed to provide a framework for addressing HIV/AIDS related issues. By 1991, AIDS was recognised as not just a health issue but a development problem requiring the participation of all other sectors. Thus MTP II of 1992 to 1996 focused on multi-sectoral response towards fighting against HIV/AIDS. MTP III 1999-2004, acknowledged the fact that poverty, ignorance and ill-health including AIDS are inter-related and that the government alone has neither the means nor adequate resources to tackle the problem. The plan therefore recognises the important role played by NGOs, religious organisations, the community and private sector and donors in health care delivery. Other policy instruments include the Sessional Paper No. 4 of 1997 on AIDS in Kenya which provides policy guidelines on how to address critical issues on AIDS over the next 15 years and beyond and Economic Policy Framework Papers of 1996, 1998 and 1999-2001 which identified HIV/AIDS as a priority issue which should be tackled urgently since it threatens poverty alleviation and economy recovery strategies. (NASCOP, 1999 b).

2.2.3 Advocacy and Promotion of Behaviour Change.

Public health education programmes have led to high levels of awareness among Kenyans about nature and transmission modes of HIV/AIDS epidemic. This achievement was mirrored in the 1998 Kenya Demographic and Health Survey (KDHS) which found that 99% of men and 99% of women were aware of sexual transmission of HIV/AIDS irrespective of urban-rural residence, level of education or province of residence (NCPD, 1999). However, several obstacles and challenges militate against successful Information, Education and Communication (IEC) interventions, such as resource limitations, poverty, socio-cultural sexual practices that are high risk such as different types of marital unions like polygamy, woman to woman marriage, reunion, polyandrous, hypodermic, leveritic (wife inheritance), endogamous and exogamous relationships. Other non-sexual cultural practices that are high-risk include, circumcision, ear pierc-

ing, ritual bathing of the dead, scarification and tattooing as they are mostly done with unsterilized or contaminated instruments Gender challenges are other important social barriers in HIV/AIDS prevention as the predominantly patriarchal Kenyan communities prescribe a high status for men which at times involves risk taking and perpetuates sexual norms that glorify male sexual prowess and virility, pressuring men to demonstrate these virtues through sexual experimentation, conquests and multiple sexual relationships. On the other hand the low status of women in society reduces their capacity for decision making in sexual matters and their lives in general leading to lack of bargaining power and inability to negotiate desirable and safe relationships. This then may largely explain why the high HIV/AIDS awareness in Kenya has not been successful in bringing about behaviour change. (GOK, 1997; NASCOP, 1999 b).

2.2.4 Research

National medical research has taken significant efforts towards the HIV/AIDS pandemic. Under the umbrella of Kenya Institute of Medical Research (KEMRI), efforts to discover an AIDS cure and vaccine have been marked by the presence of some AIDS drugs such as 'Kemron' Institutional efforts have likewise been noted such as the recent development of an AIDS trial vaccine under the joint efforts of the University of Nairobi Faculty of Medicine and London based medical researchers. (Daily Nation, February 5, 2001). National epidemiological research on HIV/AIDS prevalence and incidence is also undertaken through sentinel surveillance sites countrywide, by the National AIDS and STD control Programme (NASCOP) and the Ministry of health. However, it is apparent that, as Tunju (1996) observes little attention and co-ordination has gone towards social research in the fight against HIV/AIDS in Kenya. Trivializing the role of social research is however, counter-productive as shown in a recent U S.A. Congressional Staff Report which clearly states that :

> A sociological perspective on AIDS is critical for research and policy because the transmission of HIV infection occurs through intimate social activities, successful intervention strategies are based on changing the behaviour of large groups of people, and effective treatment program require detailed knowledge on the social worlds of persons with AIDS (Albrecht, 1992: 1)

2.2.5 Promotion and availability of condoms.

This intervention promotes condoms through mass media, counseling and education and increases the availability of condoms through expanded public distribution, social marketing programmes with high risk populations and programmes in the workplace. The general assumptions are that through the intervention condom use increases to 60% for commercial sex workers, to 10% in contacts between men and their casual girlfriends and 5% among couples. Under these assumptions, prevalence is reduced by 35% after 10 years. (NASCOP, 1996). However, national sexual data in 1998 KDHS Survey reported that only 20% of men and 6% of women reported 'ever using condoms' with partners, and only 20 9% of the boys aged 15-19 had started using condoms since they had learned of AIDS. (NCPD, 1999).

Social resistance to condoms mostly may explain the low condom use levels amidst high levels of HIV/AIDS awareness. Condoms are rejected for religious reasons and also because they are socially associated with promiscuity and disease. Onditi and Hongo (1994) for instance found that women in Kisumu rejected condoms arguing that they were not prostitutes while men's rejection was as a result of fear that their wives may become unfaithful. Nzioka (1996) also found that condoms were rejected as a result of the belief that they were smeared with HIV by their foreign manufacturers. Further, condoms may be rejected in the view that they reduce sexual gratification and male erectal capacity (WHO, 1995).

2.2.6 Lay Strategies of HIV Prevention

Limited research has been conducted on the non-clinical methods and resources that people utilize in HIV prevention. However, available literature reveal that people employ various methods towards this end. In his study on lay perceptions of HIV infection and social construction of safer sex, Nzioka (1996) found that some adult males avoided sexual intercourse with commercial sex workers, foreigners and urban women whom they perceived as 'polluted' but had unprotected sex with school girls and rural women, perceiving them to be 'unpolluted'. In the same study taking a shower immediately after sex or cleaning the penis with a piece of cloth as well as swapping of positions with 'suspicious' partners during sexual intercourse were per-

ceived as preventive methods against HIV infection.

In Zambia, Larson (1989) found that adult males had started targeting very young girls for sex believing them to be the 'HIV-free generation'. In Cameroon, Cameron (1989) found that some HIV-positive men rape young boys on the understanding that this would cure them of HIV. A similar finding is reported in Kenya. (KIE and UNAIDS, 1999).

Adolescents themselves may also have similar beliefs on safer sex as reported by Okumu and Chege (1994) who found that 6% and 16% of the girls in their sample respectively said having sex with uninfected partner and bathing immediately after sex would prevent STI infection

In the above light therefore this study hypothesized that adolescent boys largely utilized lay techniques and resources in managing the risks of STI and HIV infection. This was also on the consideration that adolescents reported few other sexual behaviour changes in the 1998 KDHS where only 20.9% of boys reported having started using condoms, another 20.4% were restricting themselves to one partner and 13.5% were having fewer partners since they had learned of AIDS (NCPD, 1999).

2.3 Barriers to Preventing STI including HIV among adolescent boys

Various factors make adolescent boys particularly susceptible to infection of STI including HIV. Behavioural factors are among the leading and include: partner selection, rate of partner change, frequency of intercourse, condom use and illness behaviour as explained below.

One, boys are less likely to require commitment to or from a partner before sex. Boys as a result report having frequent sexual intercourse with casual contacts which means that boys are often in multiple partner relationships. Further, boys are less likely to be in stable relationships as they may change sexual partners frequently (Sonestein, 1986; Maggwa, 1987; Kiragu, 1995; Population Council, 1995) and therefore, are highly exposed to STI including HIV, as WHO (1989) identifies casual sex contacts as one of the major means of STI and HIV transmission.

Two, boys experience more intense sexual practice or episodes as compared to girls. Boys' high sexual frequency is explained by the fact that boys rank sex as a higher priority, are more likely to see sexual activity as acceptable at young ages or before marriage and are more likely to be

proud of their sexual experience unlike girls who encounter guilt feelings (Sonenstein, 1986, Maggwa, 1987, IPPF, 1995). Boys' high sexual frequency therefore leads to high exposure to STI and HIV infection.

Three, boys frequently engage in unprotected sex as condom use among boys tends to be infrequent and erratic (Nyamongo, 1996). This may be due to embarrassment of carrying a condom or due to the social and symbolic meanings of the condom which associate it with prostitution and disease. Boys may also reject condoms on the perception that they reduce sexual enjoyment. (Schoepf, 1990; WHO, 1995). Low condom use or non-use therefore carry high risks for boys.

Four, boys have poor illness behaviour as they are less likely to seek or comply with appropriate STI treatment for various reasons. One, boys may be reluctant to ask parents for money to go to clinic for treatment as they may fear being asked why they need the money. Two, boys may also consider child health clinic and family planning clinics as "female" spaces. Three, boys may also fear the disapproval and stigmatization they may encounter from the health care providers at the public health facility. Finally, feelings of guilt, anger, denial and shame can be powerful barriers to seeking STI treatment. (WHO, 1989; IPPF, 1995, Population Council, 1995; WHO, 2000). This means that boys may be reluctant to seek STI treatment and therefore, are more likely to ignore or accommodate symptoms or result to self-treatment. This further means that STI among boys may mostly remain untreated or poorly treated with the result that boys remain vulnerable to HIV infection.

Five, the early sexual experiences of boys are often accompanied by alcohol and drug use which increase the risk of STI and HIV infections. (WHO, 2000).

Six, boys regard STI lightly, as they may not consider them as serious illnesses as they consider untreated STI as a mark of masculinity (Nzioka, 2001). Boys may therefore not appreciate the need to seek prompt STI treatment or strictly comply with appropriate treatment, making them more vulnerable to HIV infection.

Seven, other barriers to STI treatment among boys are structural such as lack of free or low-cost services targeting the adolescents. Boys may therefore not readily access condoms and lack

the appropriate information on sexual and reproduction health to enable them detect abnormal sexual functions and make a timely self-diagnosis, thus making them more prone to HIV infection.

2.4 SOME IMPORTANT FACTORS THAT INFLUENCE ADOLESCENT SEXUALITY

2.4.1 Biology

Immediately adolescence sets in, sexuality becomes the greatest single factor in play vis-à-vis the total developmental process of both mind and body; physical and mental. Human and adolescent sexuality in particular involves an inevitable and irresistible biological drive that always demands gratification. For boys the onset of spermache often marks the initiation into sexual activities in an attempt to satisfy the newly discovered sexual urges and curiosity. (Mitchell, 1971). Indeed, sexual curiosity and desire are among the main reasons adolescents give for their involvement in first coitus (Lema, 1987; Maggwa, 1987; Khasiani; 1985; Njau and Radeny, 1988; Kiragu, 1995).

2.4.2 Age

Most studies report that most adolescents will not have experienced sexual exposure until puberty. (WHO,1995; Population Council, 1995). Kenyan Studies report that most adolescents initiate sexual activity on attaining 15 years of age. (Maggwa, 1987, Njau, 1993; Okumu and Chege, 1994; Kiragu, 1995). This means that the younger the adolescent, the more likely he is to be sexually inexperienced.

2.4.3 Peer Group

Mitchell (1971) observes that male adolescent sexual attitudes, practices and patterns are formed less by the home, school, and church than by the youth's own peers. Caplan, (1987) further observes that where these sexual values which lead boys to strive for sexual intercourse may have been formed several years before their first sexual experience, they find support for their efforts within the peer group.

2.4.4 Religion

Religion plays a vital role in human behaviour, sexuality included. Over the ages moral and religious teaching have controlled the tempo of human sexuality. (Mitchell, 1971). Religious affiliation has been observed to influence sexual activity. For instance, Khasiani (1985) and Okumu and Chege (1994) found that secondary school students affiliated to Catholic faith reported a higher coital involvement than their Protestant counterparts. Different doctrinal emphasis seems to account for this.

2.4.5 Marital Status of Parents

The environment and living conditions of young people are important determinants of their sexual risk behaviours. Young people who live with their parents are less likely to engage in sexual activity as their behaviour is more likely to be under their parents' control. On the contrary orphans or single –parented children are more likely to engage in sexual activity as they are subjected to little or no parental supervision and control. (WHO, 1995).

2.4.6 Type of School attended

Studies on Kenyan adolescents sexuality report the co-ed or mixed schools promote high sexual activity due to the constant close association between girls and boys. Okumu and Chege (1994) and Ferguson (1988) found that students in mixed secondary schools reported higher sexual involvement and frequency than those in single-sex schools.

2.4.7 Alcohol and Drug use

Around the world adolescent boys have higher rates of tobacco, alcohol and other substances use than do adolescent girls. Alcohol and other substance use also often accompany the early sexual experiences of young men and increase the risk of STI, HIV infections and unwanted pregnancy. (WHO, 2000).

2.4.8 Male Sexual norms

Njau (1995) explaining the expressions of sexuality in Africa notes that, besides, their multiplicity, they all have but one underlying common theme - male supremacy. Male and female sexuality are seen as distinctly different, as opposite and with associated dichotomized values. Male sexuality is defined positively as rational, strong, superior and non-emotional, while female sexuality is defined negatively as natural, weak, irrational and emotional. Since women are seen as emotional and lacking in thought and reason, males are supposed to control both their sexuality and that of women. Njau (1995) adds that, the control of women's sexuality is by extension, the control of women. Female sexuality is associated with creation, guardianship and carriers of social boundaries and group identities. Given these special roles, women's sexual freedom is seen as polluting society. Her integrity must therefore be guarded by the enforcement of chastity, virginity and fidelity, since her promiscuity reflects abomination and a sense of death in the flow of social life. Therefore, unlike with men, whose promiscuity have a cultural justification, sexuality for women has more to do with procreation than with pleasure, and more specifically procreation for patrilineage. (Mbiti, 1969; Rogo 1995). A few examples from all over Africa will confirm this. In Nigeria, Caldwell (1990) observed that women had no control over their husband's sexuality. Poewe's (1981) and Sunanda et al, (1989) studies among the Luapala of Zambia show that sexual deprivation is seen as causing emaciation or madness especially for men. This reinforces the view that unlimited sex is a healthy exercise especially for men. In Uganda, Kisseka (1989), found that among the Ankole, men as a rule have extramarital affairs with mistresses and girlfriends, and the more women a man had sex with, the higher was his reputation. Kisseka (1989), adds that among the Acholi and Baganda, women were taught never to deny their husbands sex. In Kenya, Nelson (1987) observed that men are culturally constructed as having insatiable sexual appetite. This legitimizes multiple sexual partner relationships for men. Having many sexual partners is also culturally important for men, as it elevates their social status in their communities. For instance, among the Kikuyu, Nelson (1987) found that male sex drive was believed to be strong, and men were thought to need a lot of sex with a variety of sexual partners. All Kikuyu men and women shared this view. However,

women were expected to have sex with only one person - their husband In Kisumu, Buzzard (1982) found a strongly held ideology that men must have access to constant sex And among the Maasai, Njau (1995) observed that, male sexuality was associated with force, energy and power; the more sex a man had the more prestigious he became. Since the male sexual role is inextricably tied to issues of paternity and self-identify (Nelson, 1987), from an early age a boy learns that being masculine is crucial to his identity and self-esteem and sexual activity may be the clearest measure a boy sees consistently applied. Boys are thus taught to be sexually aggressive and to view sex as a contest in which winning means convincing, perhaps coercing or even forcing a girl to have sex. (WHO, 1995). As a result, boys start sex at an earlier age than girls and report having multiple sexual partners and having intercourse with casual acquitances, while girls' report having their first and subsequent sexual relations with a steady boyfriend or fiance. Unlike girls, boys are less likely to require commitment to or from a partner before sex. Boys are more likely than girls to approve and be proud of sex before marriage, while girls generally report guilt feelings. Additionally, boys are less likely than girls to use contraceptive (use condoms) as they mostly report that it is the girls' responsibility to avoid pregnancy. Further, boys may be encouraged by peers and even family members to become sexually active or to go to prostitutes while girls are admonished to remain chaste. In fact, if a boy does not have sex by an "appropriate age" his friends and family may question his masculinity. (Gyepi 1985, Gachuhi, 1986 IPPF, 1994; Kiragu and Zabin, 1995). Boys sexual behaviour and attitudes generate from the dominant social constructions of sexuality in Africa that advocate a double standard tacitly approving and even encouraging premarital sexual activity for young men and extramarital sexual activity for older men, while disapproving and often punishing such behaviour in girls and women (Rogo, 1995). The above background may therefore largely explain the 1998 Kenya Demographic and Health Survey's findings that about 32 % of unmarried adolescent boys aged 15 – 19 had had sexual debut by age 15 as compared to 15% of the girls. Twenty three per cent (22.9%) of the boys also had had sexual intercourse with two or more sexual partners in the 12 months preceding the survey as compared to only 3.1 % of girls of the same age. Overall, almost half (45%) of the boys aged 15-19 had had one or more sexual partners. (NCPD, 1999).

2.5 THEORETICAL FRAMEWORK

2.5.1 The Health Beliefs Model (HBM)

HBM argues that for individuals to engage in health behaviour, such as safe sex, an individual has to perceive himself or herself as vulnerable or susceptible to a health threat, that health threat has to be perceived as having serious consequences, the protective action that is available has to be perceived as effective, and the benefits of the action have to be perceived as outweighing the perceived costs of the action. However, even when individuals perceive that they could and should adopt a particular course of action, some trigger or cue might be required to nudge them into action. (Rosenstock, 1966; 1974). In managing the risks of STI and HIV infection boys may therefore, practice safe sex if they perceive: one, themselves as vulnerable to STI and HIV infection; two, STI and HIV/AIDS as serious illnesses; three, condom use as effective; and four, safer sex as having more benefits than unprotected sex. Further, the death of a close or known AIDS patient may trigger the quicker adoption of safer sex practices.

Elsewhere, the perceived costs' dimension of the model has been broadened to encompass perceived social constraints on the adoption of protective action, in recognition of the social structures and normative influences which shape and channel individual behaviour. Rosenstock (1966) and Mechanic (1982) for instance stressed structural barriers to the use of American health services and need for such use to be culturally approved by family, friends and peers. Knonenfeld (1988) further found that the 'perceived barriers to action' dimension was the most powerful predictor of health behaviour ahead of 'perceived vulnerability' or 'perceived seriousness'. This means that even when adolescent boys perceive themselves as vulnerable to STI and even HIV/AIDS, and even when they rightly perceive these illnesses as serious, they nevertheless may fail to adopt safer sex practices, for instance condom use if such is culturally disapproved by family, friends and/or peers.

HBM was initially developed to explain health behaviour and was later applied to illness or sickness behaviour (Rosenstock, 1966). The model was therefore, a very suitable and relevant guide to the study as it sought to examine boys STI and HIV risk management practices. How-

ever, the models specific focus in health and illness behaviour, restricted its scope and ability in helping the study obtain comprehensive data on the sexual and reproductive health perceptions and practices of the adolescent boys that predisposed them to sexual risk behaviour. Further, the HBM model has been criticized for being highly abstract and individualistic (Knonenfeld, 1988). The Grounded Theory of Adolescence (GTA) which is more inclusive and concrete was therefore used in this study as a complementary to the HBM model.

2.5.2 The Grounded Theory of Adolescence (GTA).

GTA is based on the adolescents' common sense knowledge. It is observed that adolescent make sense of their environment primarily through the use of a stock of common sense knowledge. This is very significant since:

> common sense is not a simple thing but reflects an enormous amount of information gained from experience, and provides an excellent basis for day-to-day living. (Wolpert, 1992:63).

This common sense knowledge is socially defined and acquired through the formal and informal socialization process. Adolescents do not generate it themselves, but take socially approved knowledge and assess it against their own experiences. They then adopt it, adapt it, so that it becomes a vocabulary that enables them to describe and justify their opinions, experiences and values. (Balmer, 1994).

Within the GTA, the role of the adolescent is seen as confusing and uncertain since the society does not provide a clear and unequivocal model. Adolescents therefore, are left to discover a new set of behaviour which fit the expectations of society but no skill training is provided. Adolescents therefore, learn largely through observation, since little verbal instruction is given they largely depend on themselves and evolve a set of behaviours consistent with the society in which they live. These behaviours are the expression of a set of values which make sense to them and are based upon their common sense knowledge. Many of these values are however,

unattainable due to socio-cultural barriers and lack of an adequate set of behavioural skills. Adolescents therefore resort to the use of coping strategies. For instance, while 'having money' and 'being honest' are values they cherish, 'petty stealing' and 'lying' are often the strategies used to attain the value of 'having money' (Balmer, 1994). By extension it may be argued that it is the value of adolescents to have wholesome sexual and reproductive health but the absence of adolescent sexual and reproductive health programs and services makes this value unattainable and adolescents have to use coping strategies, which this study seeks to investigate. During adolescence individuals come to understand that their environment is not a fixed or concrete reality, but a shifting and changeable pattern of meanings which is in a constant state of re-definition, which they can influence and re-define (Balmer, 1994). The male adolescent will thus be seen as a rational problem-solver, who rather than being simply shaped by his social milieu, interprets, cooperates, takes roles, communicates and aligns his sexual acts, in the face of HIV/AIDS pandemic. (Blumer, 1954).

Besides being more inclusive and concrete as compared to HBM, GTA had the advantage of enabling all adolescent sexual and reproductive health practices be studied as meaningful behaviour, laden with definitions and meanings that society and adolescents attach to them. GTA therefore does not ignore or undermine any sexual or reproductive health experiences of adolescent boys as meaningless, even when such practices do not make any biomedical or clinical sense, GTA appreciates that they do have social sense or meanings. GTA further allowed the male adolescent to be studied where he is and how he is, as it focused on his common sense knowledge which defines his social reality. GTA acknowledges that the environment is not a fixed reality but a shifting and changeable pattern of meanings which is in a constant state or re-definition (Balmer, 1994). Therefore, it allowed adolescent sexuality to be studied anew as a changing phenomenon needing re-definition in the light of HIV/AIDS as a newly emergent, historical, medical and social reality. Finally, GTA was a very practical and resourceful guide to the study as it seeks to explain adolescent experiences and the same adolescents were the study's target population.

2.5.3 A Conceptual Model on Strategies of Managing the Risks of Infection by STI including HIV/AIDS.

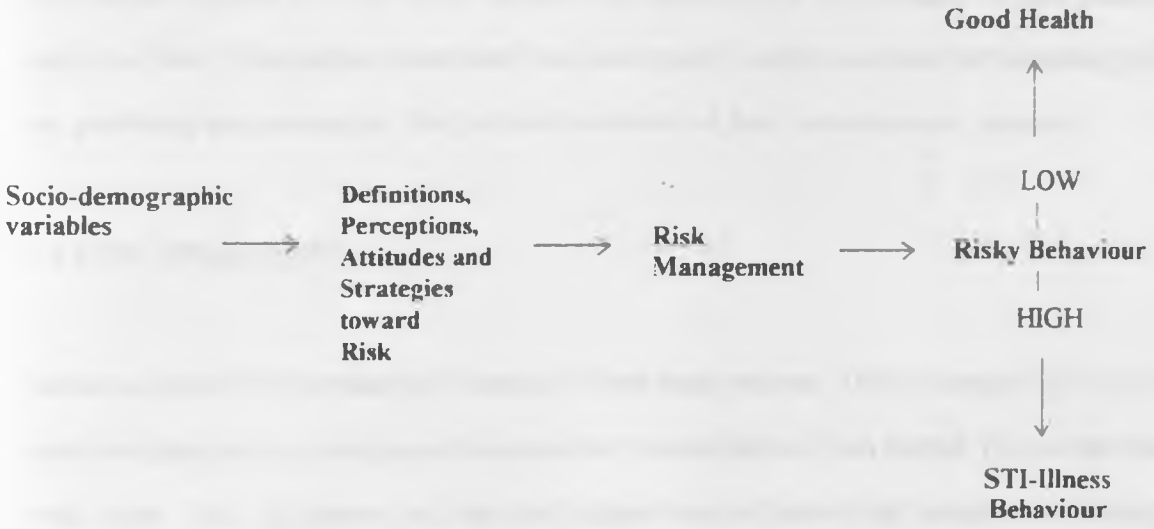
This study hypothesized that individual and family background characteristics such as age, school attended, religious affiliation, peer group associations, sexual desire, alcohol and drug abuse, place of residence and marital status of parents do influence adolescent boys' sexual and reproductive health knowledge and practice. The study further hypothesized that adolescent boys' perceptions and attitudes towards risky sexual practices hindered their successful adoption of effective risk management practices, such as, condom use, abstinence, partner selection, fidelity and negotiation skills. A boy may therefore adopt high or low risk behaviour depending on how he perceived sexual risks. In the right that adult males were avoiding sexual intercourse with commercial sex workers or with foreigners or urban women whom they perceived as 'polluted' or 'unclean' yet seeking and having unprotected sex with school girls or rural women whom they perceived as 'unpolluted' or 'clean', so as to avoid HIV infection (Nzioka, 1996), this study further hypothesized that there was a high tendency among adolescent boys to utilize lay techniques and resources in the management of STI and HIV infection. Boys could therefore be argued to be susceptible to similar social evaluations of sexual risk as adult males and therefore, to hinge safety on such elements as perceived 'familiarity', 'love', 'trust', or 'innocence' of their prospective or actual female sexual partners.

STI and at worst HIV infection is the most likely result of such sexual behaviour. Our next hypothesis thus focused on the STI-illness behaviour of adolescent boys. Gachuhi (1986) found that infection with an STI may increase a boy's prestige among peers and WHO (2000) reports that boys may avoid consulting child health and family planning clinics considering them as "female" spaces or fear the disapproval they may encounter from the health care providers. This study therefore finally hypothesized that adolescent boys largely ignored STI symptoms or resorted to self-treatment after a self-diagnosis. Drawing on the available behaviour on male adolescents sexual and health seeking behaviour on STI illnesses a conceptual framework on strategies for managing the risk of STI infection including HIV, has been formulated for this study (See Fig. 1)

Figure 1

CONCEPTUAL FRAMEWORK

Strategies for Managing the Risk of Infection by STI including HIV.



CHAPTER THREE

SITE SELECTION AND RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter explains how the study sample was selected and the methods of data collection used in the field. The chapter describes: site description; sample size and the sampling procedure; problems encountered in the field and methods of data collection and analysis.

3.1.1 SITE SELECTION

Nyandarua district was purposively selected for two main reasons. One, monetary and time constraints necessitated its coverage as the researcher's home district, thus helped reduce the study's overall costs. Two, the district had the third highest rates of school girl pregnancies, among 42 districts, in a 1988 National Survey on school-girl pregnancy in Kenya (Ferguson, 1988). This indicates that premarital sexual activity among adolescents here was high, thus the study's relevance in trying to investigate the contributing factors to this high adolescent fertility.

3.1.2 SITE DESCRIPTION

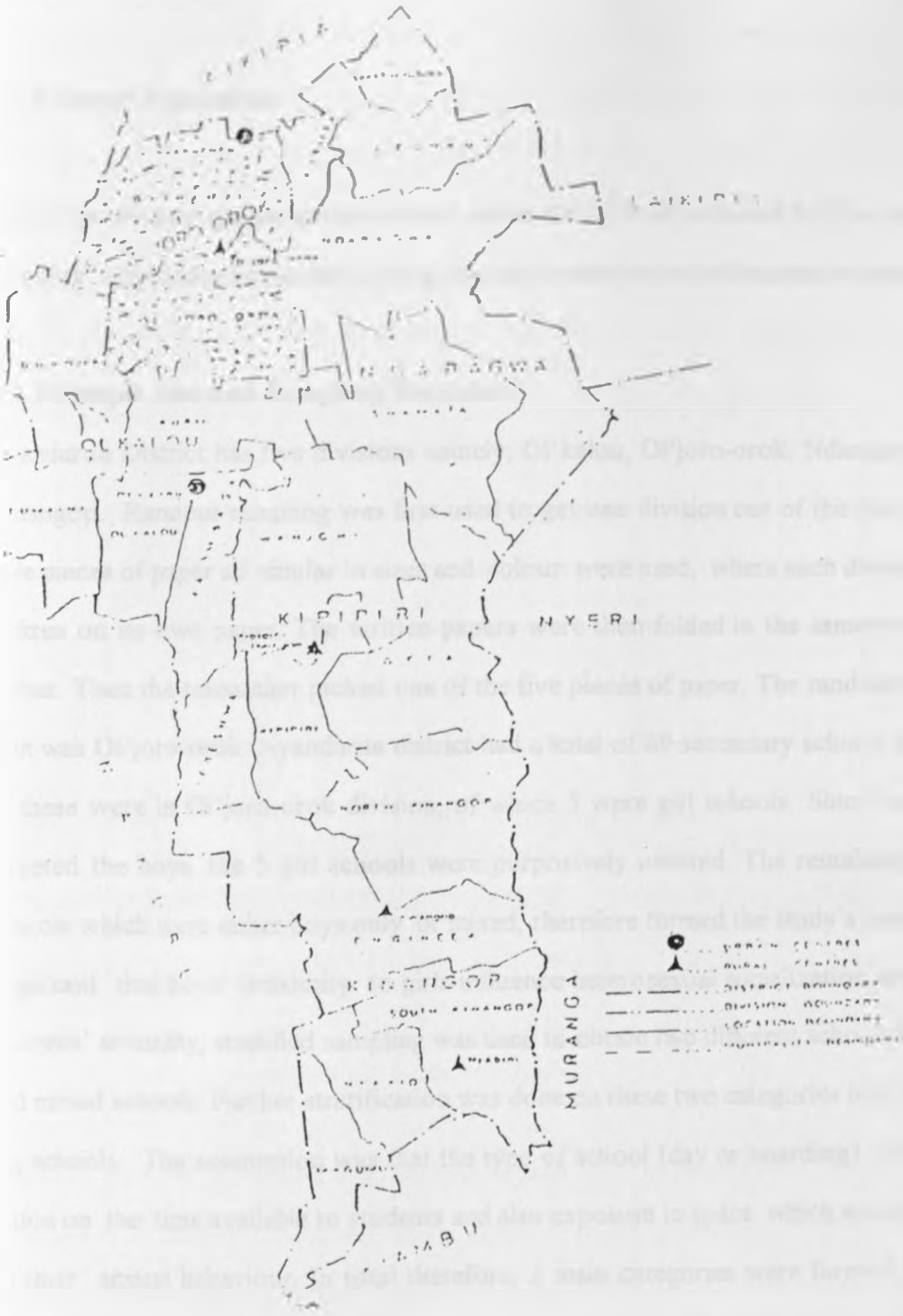
Nyandarua district is one of the 5 districts in Central Province. It lies between 0°08'N and 0°50'S latitude, and between 36° 13E and 36° 42E Longitude. It is bordered to the north by Laikipia district, to the East by Nyeri and Murang'a to the South Kiambu and to the West by Nakuru district. The district lies between 1,828 and 2,437 metres above the sea level and covers an area of 3,528 sq. km which is 0.6% of the republic and 26.7% of Central Province. The annual rainfall received ranges from 750 to 1500mm which falls March – May and August – November. The climate is of low high temperatures with an average mean temperature of 23.1°C. The district is mainly agricultural with upper highland zones majoring in growing wheat,

barley, pyrethrum and sheep rearing. The lower highland zones produce maize, beans, temperate fruits, horticultural crops and livestock. The main mode of agriculture is however, peasant or small-scale farming. This kind of economy may imply that parents may be unable to readily give money to adolescents when they need money for STI treatment. The district has 5 divisions, 22 locations, 63 sub-locations and 3 constituencies. The district headquarters are in Nyahururu town (See maps 1 & 2 in the following pages).

Development of infrastructures, particularly roads, electricity, water supply and health delivery points is very low. There are only 3 district hospitals, with a bed capacity of 504, 6 health centres and 25 dispensaries. This points to a shortage of healthcare services when weighed against the district's total population of about 480,000 persons. This further implies that adolescents may even be in a greater shortage for STI treatment sources. The district has 401 pre-primary units, 261 primary schools with 69 secondary schools with a teacher-student ratio of 1:17; of the 550 teachers, 273 (49.6%) are untrained. The fact that half of the teachers are untrained puts the schooling adolescents at a greater disadvantage as these teachers may be unable to effectively deliver sexual and reproductive health information, since even trained teachers report feeling inadequately trained for the same task or delivery. (Kiragu, 1994). The district has a total population of 479,902 persons of which 235,052 are males and 244,850 are females. The 10 to 14 years age cohort has a total of 64,954 persons with 32,770 males and 32,184 females while the 15 – 19 years age cohort has 58,975 persons, comprising of 29,987 males and 29,488 females. While infant mortality rates are low, the fertility rate stands at 3.2%. (Central Bureau of Statistics (CBS), (1999).

MAP 1: THE LOCATION OF NYANDARUA DISTRICT IN THE NATIONAL CONTEXT

MAP 2: MAP OF OL'JORO-OROK DIVISION IN THE DISTRICT CONTEXT



3.2 RESEARCH METHODOLOGY

3.2.1 Target Population

The 13 to 19 year old secondary school males (boys) were selected for the study as this age category is the secondary-school-going population and the study focused on secondary schools.

3.2.2 Sample Size and Sampling Procedure

Nyandarua District has five divisions namely; Ol'kalou, Ol'joro-orok, Ndaragwa, Kipipiri and Kinangop. Random sampling was first used to get one division out of the five in the District. Five pieces of paper all similar in sizes and colour were used, where each division's name was written on its own paper. The written papers were then folded in the same way and put together. Then the researcher picked one of the five pieces of paper. The randomly selected division was Ol'joro-orok. Nyandarua district had a total of 69 secondary schools and 19 (27.5%) of these were in Ol'joro-orok division, of which 5 were girl schools. Since the study strictly targeted the boys, the 5 girl schools were purposively omitted. The remaining 14 secondary schools which were either boys only or mixed, therefore formed the study's sampling frame. In cognizant that boys' proximity to girls influence heterosexual socialization and consequently students' sexuality, stratified sampling was used to obtain two different school categories- boys and mixed schools. Further stratification was done on these two categories into day and boarding schools. The assumption was that the type of school (day or boarding) would have implication on the time available to students and also exposure to space which would in turn impact on their sexual behaviour. In total therefore, 3 main categories were formed, these were: 3 boys' boarding schools (All boy schools were boarding), 4 mixed boarding schools and 7 mixed day schools. Purposive sampling was finally used to select four schools from the above three categories given limited finances. One school from the 3 in the boys-boarding category, one from the 4 in the mixed-boarding category and 2 schools from the 7 schools in the mixed-day category. The four schools were Kangui (Boys boarding). Gatimu (mixed boarding),

Ol' joro-orok and Passenga (both mixed and day schools). Monetary limitations allowed only for the study of a small sample of 120 students though a larger sample would have been preferred. The number of respondents per school was calculated as the percentage (%) of the respective total on boy-enrolment in each school against the study's sample size (n-120) The total boy enrolment in the four schools was 763 and per respective schools as follows, Kangui 246, Gatimu 186, Passenga 170 and Ol'jo-roko-orok 161. Calculated on respective percentages of study sample, the number of respondents per school was obtained as follows; Kangui 38, Gatimu 29, Passenga 28 and Ol'joro-orok 25. Further, the total number of boys aged 13 to 19 years in every form (one to four) was taken in each school. The total number of boys aged 13 to 19 years in every form was calculated against the respective percentage (%) of the entire study sample in every school, so as to get a proportional percentage of respondents each form would produce of the required school sample as shown on table 3.1, below:

Table 3.1: Distribution of the Respondents by School Type and Form

Name of school	Number of Students per Form				Row Total
	Form I	Form II	Form III	Form IV	
Kangui Boys Boarding	8 (21.1)	9 (25.7)	11 (28.9)	10 (26.3)	38 (100)
Gatimu Mixed Boarding	6 (20.7)	9 (31)	8 (27.6)	6 (20.7)	29 (100)
Passenga Mixed Day	3 (10.7)	8 (28.6)	10 (35.7)	7 (25)	28 (100)
Ol'Joro-orok Mixed Day	3 (12)	5 (20)	7 (28)	10 (40)	25 (100)
Column Total	**20 (16.7)**	**31 (25.8)**	**36 (30)**	**33 (27.5)**	**120 (100)**

Nb: The figures in parenthesis are percentages (%).

When the number of respondents required in each form in each school was got, random sampling was used to pick them using the list of names of the boys aged 13 to 19 years in each form from the class registers. Rotary method was used where 'Yes' was written on the required number of papers equal to the required respondents in each form in each school. All the other pieces of papers were designated 'No'. These papers were uniformly folded, and all the boys aged 13 to 19 years in each school asked to pick one. All the boys who picked a "Yes" qualified to be respondents and were given questionnaires to fill.

3.2.2.1 Selection of FGDs' Participants.

Six FGDs were conducted,two from each school category that was involved in the survey; i e boys boarding, mixed boarding and mixed day schools. The schools that were surveyed on also provided the FGDs. The three schools, Kangui (Boys boarding), Gatimu (Mixed boarding), and Ol'joro-orok were randomly selected from their categories and 2 FGDs from each school were selected. Each group comprised of 8 respondents. This number was preferred so as to enhance good control over the group. The target population was male adolescents aged 13 to 19 years. As such, there was need to create homogeneity in the groups and to control the effects of age differences that could lead to domination of discussion by the seniors.TheFGDs were thus conducted in two different age clusters,that is,ages 13-15 and 16-19 together. These respondents were randomly selected from the above three schools. To avoid respondent bias, the students who had filled the survey questionnaires were omitted. Each school produced two groups from each age cluster (ages 13 to 15 and 16 to 19). The class registers were used to identify the students in the age clusters, their names were listed down and they were assembled after classes. The researcher explained the study's objective and placed a request for willing participants. Those who were unwilling were allowed to leave. The willing students were again regrouped into the required two age clusters and 2 respondents, one in each age cluster were randomly selected from each form in every school.

There were 6 FGDs in total each with 8 respondents and thus a total of 48 boys participated in FGDs. The discussions were held in unoccupied classrooms and took one and a half hours each. The researcher was the sole facilitator.

3.2.2.2 Selection of Key Informants.

Eight respondents were interviewed in-depth. The key informants were purposively selected on the basis of their own reported sexual behaviour and attitudes. The 'highest' risk taker was selected from each school after examining the respondents with the contribution of the follow-

ing: Highest number of sexual partners, highest frequency of sexual intercourse, highest number of times of unplanned and unprotected sexual intercourse. The 'lowest risk' taker from each school was identified and selected by examining respondents with the lowest number of the same indicators. The key informants, were interviewed in open-air or selected places under trees far away from the interference of others. These settings offered the privacy and ease required by the informants to reveal their private sexual experiences. The interviews took a maximum of 35 minutes each. To get an all rounded view on the boys strategies of managing STI, including HIV, other key informants were selected from the Health Care Sector. Purposive sampling which was most convenient was used to select 3 other key informants. These were 2 nurses, one from a local dispensary and the other from a private clinic and a herbal practitioner.

3.2.3 METHODS OF DATA COLLECTION

3.2.4 The Questionnaire

The questionnaire was the principal research instrument for the study. It was administered to the 120 adolescent boys aged 13 to 19 years who formed the study's main sample. The study needed both quantitative and qualitative data and the questionnaire was the most efficient data collection method that met that requirement. The questionnaire comprised of both closed and open-ended questions. The questions sought to elicit data, on the following areas:

(i) Personal and social demographic characteristics: age, sex, religion, class, type of school attended, residential area, and parents' marital status.

(ii) sexual experiences:- age at first intercourse, reason for intercourse, place of intercourse,

(iii) Rating of first intercourse, time of subsequent intercourse, reason for sex, further frequency of sexual intercourse.

(iii) Perceptions and attitudes on STI and HIV/AIDS and on risky sexual practices such as

multiple sexual partners, lack of condom use and pre-marital sex

(iv) Coping strategies in avoiding the risk of STI/HIV infection: known medical, cultural and peer methods.

(v) STI-illness behaviour of respondents or techniques and the treatment sources they used in treating STI illnesses.

Besides the questionnaire's efficiency, its use had other additional advantages. One, given that the study was conducted in schools where there was tight schedules and programmes, it was convenient and flexible enough to be squeezed in between the school breaks as it did not need much time to fill. Two, the questionnaire achieved a high response rate given that the study's population was literate, and hence understood the questions and easily wrote down their responses. Three, sexuality is a highly private domain that is not readily discussed and in this regard the questionnaire offered the privacy and anonymity required to elicit truthful personal responses. Four, as the researcher did not have research assistants the questionnaire was the easiest field tool to administer in terms of time, finance and efficiency. However, the use of the questionnaire had the following disadvantages. The questionnaire was rigid in that it did not allow free reaction from the respondents. It also did not give room for rephrasing or clarification of questions to the respondent as might have been necessary. Two, the questionnaire did not allow the researcher to validate the respondents' responses e.g. through questions. Three, the questionnaire did not allow for sufficient researcher- respondent contact to develop the required rapport so as to easily report some 'protected' sexual experiences in the lives of the respondents. In the face of these disadvantages of the questionnaire, Focus Group Discussions (FGDs) were used as a complementary data collection method.

3.2.5 **Focus Group Discussions (FGDs)**

Six FGDs were conducted. For easier data collection and analysis, the three FGDs in the 13-15 year old category were numbered 1,2, and 3, while the other three in the 16-19 year old category were given numbers 4,5, and 6. The FGDs sought to collect qualitative data and the

questions touched on the following:

(i) Peer influence on sexual behaviour- how age-mates, both boys and girls perceived a boy who had no girlfriend and had had no sexual experience.

(ii) Sexual experience –whether the majority of boys engaged in sex, its frequency, reasons for sex, and circumstances.

(iii) Negotiation for sex – methods used to negotiate and the reasons for them. the content of negotiation discussions.

(iv) STI – perceptions to STI and their justifications, and known ways of preventing STI including HIV/AIDS.

(v) STI treatment – perceived problems in seeking treatment, preferred sources of and known methods of treatment.

The FGDs were a suitable complement to the questionnaire as they had the following advantages. One, they helped to validate the data collected in the questionnaires. Two, FGDs allowed various clarifications on responses of the respondents in the questionnaires to be made. Hence they helped illuminate and refine the raw data for easier analysis. Three, the groups helped access some psychologically, 'protected' sexual practices and beliefs since respondents were encouraged to discuss *'How boys generally behaved or believed'* and not what they personally did or believed. Thus the groups helped in the collection of additional and quality data. However, the FGDs had the following disadvantages. One, since the researcher did not use a tape recorder, recording in the midst of discussion was difficult and only the important points were noted down on the researcher's notebook in shorthand. Two, unlike in the questionnaire where every respondent actively and equally participated, some respondents in the FGDs did not do so. Although every respondent was encouraged to talk and was given a chance to do so, some were shy and talked little. Three, the environment in the FGDs did not allow the adequate probing of some deep private sexual experiences since members, required utmost privacy. Given

the above disadvantages the FGDs needed a complementary method of data collection which was found in the use of key informants.

3.2.6 Key Informants

This method had the following advantages which enabled it to complement the FGDs very well One, it offered the respondents the ultimate privacy they required to reveal in depth-details on their sexual behaviour. Two, it was able to capture the specific personal and socio-cultural factors that predispose adolescent males to risky behaviour. This method however, had the following disadvantages. One, it was uneconomical in terms of time, since it only covered one respondent per a particular time period and also needed deep details. This took a lot of time and hence could only allow a few informants to be interviewed. Two, recording of the responses was difficult since it was done manually and thus only the most important responses were recorded. All the same sufficient and quality data managed to be collected.

The data obtained from key informants was qualitative and the questions sought to get detailed and deep information on following: -

(i) Sexual intercourse and reasons for it, number of sexual partners and reasons for it, negotiation methods used and why.

(ii) Perceptions and attitudes towards STI and HIV and risky sexual practices.

(iii) The coping strategies used in avoiding the risk of STI/HIV infection.

(iv) Treatment seeking behaviour for STI and problems encountered.

3.2.7 Documentary sources.

This study obtained important data through literature research from textbooks, journals, magazines, newspapers, pamphlets and other relevant publications on the study subject.

3.2.8 Observation.

Observation was minimally used in this study but it assisted the researcher to confirm certain

data for instance, the physical accessibility of the respondents to treatment sources and the various sources available for treatment.

3.3 OPERATIONAL DEFINATIONS OF KEY CONCEPTS AND VARIABLES

3.3.1 CONCEPTS

Adolescent male

Referred to young boys aged 13 to 19 years

Sexuality

This referred to the total set of ideas, activities and expectations based upon one's sex i.e. female or male

Sexually transmitted infections (STI)

Was used interchangeably with sexually transmitted diseases (STD) and denoted any infections defined biomedically or socially that adversely affected the reproductive health of the adolescent males.

Social constructions

Referred to the common sense or day to day interpretations, definitions or meanings that boys had on their sexuality and STI including HIV/AIDS.

Reproductive health

Referred to the ability to have a responsible, satisfying and safe sexual life.

Reproductive health care

Referred to family planning, counseling, information, education, communication and other services

Awareness

Referred to knowledge about a piece of information

Biomedical

Referred to the modern or scientific forms of medicine and medical beliefs about diseases and their control.

Health behaviour

This referred to preventive health services or the practices undertaken by people who are well so as to avoid illness.

Illness behaviour

Referred to the use of curative health services or the activities engaged in by people who feel unwell so as to get proper remedy for their illness.

Self-diagnosis

Denoted the personal discovery and interpretation of experienced symptoms to be a certain disease, which was yet to be clinically confirmed.

Ignoring STI symptoms

Referred to the situation where nothing was done about or no attention given to illness symptoms detected and interpreted to be STI infection.

Safer sex

Was used in the study to mean any sexual activity including cultural and peer practices which reduced the exposure to the risk of STI and HIV infections

Lay strategies

Denoted the ideas, activities and techniques used in avoiding STI/HIV infection including treatment sources for STI's which were not clinical or founded on biomedicine

3.3.2 VARIABLES

The study had five major independent and two dependent variables. Independent variables included: Perceptions, attitudes, peer group associations, individual and family background characteristics. Dependent variables were sexual behaviours and practices and effective risk management practices.

3.3.2.1 Independent Variables

Perceptions

Referred to respondents' views and understandings.

Attitudes

Referred to the positive, or negative feelings. The respondents for instance, were asked to state whether they approved or disapproved condom use and premarital sex for adolescent boys. Those stating approval were judged to have positive attitudes and those who disapproved were judged to have negative attitudes.

Risky Sexual Practices

Referred to high risk sexual activities such as multiplicity of sexual partners, unprotected sexual intercourse, high sexual frequency, involvement in rape and alcohol and other substance use.

Peer Group Associations

Referred to respondents own playmates or friends of or about like age. Peer influence was

measured by the respondents choice of ordinal measurements such as 'I wanted to be like my friends'. 'I did not want to look odd' or 'Everyone does it' when explaining their own sexual behaviours.

Individual Characteristics

These referred to the variables of age, religious affiliation, level of formal education, type of school attended, and place of residence.

Male Sexual Norms

Referred to the sexual notions or views that advocate for intensive sexual involvement for males such as multiple sexual partner relationships, high frequency of coitus, and engagement in pre-marital sexual activity.

Family background characteristics

Referred to marital status of parents.

3.3.2.2 Dependent Variables

Sexual behaviours and practices

Sexual behaviours referred to the boys' mannerisms, showings or signs and actual doings connected with and or including sexual intercourse. Sexual practices referred here were sexual experience, frequency of coitus, number of sexual partners, age at first coitus, engagement in unprotected sex and rape, manner of sexual proposition and communication on sexual and reproductive health information.

Effective Risk Management Practices

Referred to the use of procedures, methods, skills, habits and resources utilized to avoid contracting STI including HIV/AIDS. These included, abstinence, condom use, sticking to one

sexual partner, negotiating with partner and other lay activities and techniques they used in avoiding the risk of STI/HIV infection.

3.4. METHODS OF DATA ANALYSIS

3.4.1 Unit of analysis

Hagood (1969) defines the unit of analysis as the object of the study's assumptions and the entity around which the researcher gathers information. This study gathered information mainly from and on male adolescents. These therefore formed the study's basic unit of analysis.

3.4.2 Methods of Data analysis

As the study collected both qualitative and quantitative data, accordingly qualitative and quantitative analysis were used. Qualitative analysis used descriptive statistics such as the mean range, simple frequencies, percentages, logical deductions, comparison of different findings and excerpts from Focus Group Discussions (FGDs) in describing, discussing and interpreting qualitative data. The same tools largely helped to condense and summarize the raw data as well as justify the hypotheses that did not call for inferential statistical testing .

The social constructionist approach was further used in the analysis of respondents qualitative responses from FGDs and key informants. The social constructionist argue that truth is dynamic, changing and situationally determined. There is therefore no 'inner self' and 'public self' but a repertoire of faces ,each activated in front of a different audience. Therefore, sudden changes of opinion in the course of conversation or holding of opinions that are inconsistent does not invalidate the truthfulness of these responses. (Berger and Luckman, 1984; Tseelon, 1997). For instance, a boy may disapprove premarital sex arguing it may lead to poor academic performance and increased risks of infecting STI and HIV/AIDS. At the same time however, he may still feel sex to be important in a boy/girlfriend relationship when he considers its accompanying advantages of peer prestige and feelings of sexual prowess. This therefore does not mean 'confusion' or 'cheating' but revelation of different 'truths'. The social constructionist theory

thus helped explain inconsistencies and contradictions found in the responses of the participants in the course of the study

Quantitative analysis used cross tabulations, chi-square (x^2)contingency co-efficient(c) and the Pearson product Moment correlation coefficient (r). The former two tools of statistical inference were employed in testing the hypotheses of the study by way of drawing conclusions about the study sample while the two later tools were the measures of association based on chi-square (x^2) that were found needful. Contingency coefficient (c) was used to measure the strength of relationships between variables measured at nominal level. Pearson product-moment correlation coefficient(r) was used to measure both the strength and direction of relationships between variables measured at interval scales.

Contingency coefficient (c) can be used with a table of any size, has a minimum value of zero but the maximum value it can take depends on the size of the table. The correlation coefficient (r) can take values ranging from −1 to +1. When the value is positive, the relationship is positive and vice versa. Values close to 1 (negative or positive) indicate a very close association, while values close to zero indicate lack of association. (Nie et al, 1970).

3.5 PROBLEMS ENCOUNTERED IN THE FIELD

Although the research was carried out successfully, the researcher encountered some problems which eventually affected the study in some ways. One, limited funds led to the scaling down of the study sample and also delayed the commencement of field research. Field research had been initially scheduled to start in February but actually took off in May 1997, thus disrupting the study's timetable.

Two, given the sensitivity of the topic of sex, one school principal declined to allow the research to be conducted in his school. The researcher therefore, had to redo sampling procedures so as fill the gap.

Three, given a tight school programme, the research was squeezed in after school, i.e. after 5 o'clock. Investigations were therefore, extended late into the evenings, inconveniencing the respondents and the researcher. This led to the extension of the research time and increased study costs.

However, despite the above problems and challenges the study was completed successfully.

CHAPTER FOUR

RESPONDENTS' BACKGROUND CHARACTERISTICS, SEXUAL ATTITUDES AND PRACTICES

4.1 INTRODUCTION

This Chapter presents the respondents' background characteristics, sexual perceptions and attitudes and actual sexual practices. Its major aim is to provide a background to more specific findings of the survey's report. Background characteristics examined include: ethnicity; age; religious affiliation; marital status of parents; place of residence; type and gender composition of school attended, level of formal education, awareness on STIs and HIV/AIDS, sexual experience, condom use, alcohol and drug abuse and sexual and reproductive health characteristics such as characteristics of first coitus, condom use, and number of sexual partners.

4.2 BACKGROUND CHARACTERISTICS OF THE RESPONDENTS

4.2.1: Age and Level of Formal Education.

The age range of the respondents was between 13 and 19 years with a mean age of 17 53 years Thirteen percent (12.5%) of the respondents were aged 14 years and below, 47.5% were in the 15-17 years and 40% in the 18-19 years age category. Seventeen percent (16.7%) of the respondents were in form one, 25.8% in form two, 30% in form three and 27.5% in form four.

Majority of the respondents were therefore over 15years of age and had attained at least two years of secondary school education.

4.2.2: Ethnicity and Marital status of Parents.

A majority (80%) of the sample were Kikuyus. The rest of the respondents were Embu (6.7%) Luo (4.2%); Kalenjins (2.5%), Luhyia (1.7%), Meru's (0.8%) and Kisiis (0.8%). This shows that the

study's sample was multi-ethnic with a dominance of the Kikuyu's. This is because the Kikuyus form a majority population in Nyandarua district and the secondary school enrollment is based on a majority intake of students from home district.

About eighty-one percent (80.8%) of the boys' parents were currently married, 3.3% were widowed, 9.2% were divorced and 6.7% of the parents had never married. This means that majority of the respondents came from stable homes.

4.2.3: Religious affiliation

Over half (55%) of the respondents were Catholics, 37.5% Protestants and 7.5% reported being members of the "Mungiki" or "Thaai" sect. 'Mungiki' is a Kikuyu translation for the term "The masses". The sect advocates for a return to the traditional African religious worship and rituals among the Kikuyu; for instance worshipping under 'Mugumo' (fig tree) while facing Mt Kenya, offering animal sacrifices and circumcision of females. The sect is popularly known for its militancy as seen in their forceful circumcision of women, stripping of women in trousers or mini-skirts and constant confrontations with the police. (The Daily Nation, 17th November, 2000).

4.2.4: Type and Gender Composition of school attended and place of residence.

About forty-four percent (44.2%) of the respondents were in day secondary schools while 55.8% were in boarding schools. Sixty-eight percent (68.3%) were in mixed secondary schools while 31.7% came from a boy school. On the other hand, three-quarters (74.2%) of the sample came from the rural areas while 25.8% lived in urban places. The majority of the respondents were therefore day scholars in mixed secondary schools and who lived in the rural areas.

4.3 RESPONDENTS' REPRODUCTIVE HEALTH KNOWLEDGE

The respondents were asked a series of questions to assess their knowledge on reproductive health. Table 4.1 displays the proportion of respondents who had correct knowledge on specific reproductive health related issues.

Table 4.1 Proportion of Respondents with Correct Reproductive Health Knowledge by Topic.

Characteristic	Frequency n=120	Percentage (%)
Knew the fertile period during a girls' cycle	*35*	*29.2*
Knew that if a man pulls out before ejaculation, he can still make a woman pregnant	*38*	*31.7*
Knew that contraceptive pills do not cause infertility	*40*	*33.3*
Knew that condoms do not have small holes that allow HIV to pass through.	*72*	*60*
Knew that condoms cannot get lost in a woman's body	*71*	*59.2*
Knew that condoms are effective in preventing transmission of HIV	*73*	*60.8*
Knew that one cannot get AIDS from mosquito bites	*73*	*60.8*
Knew that one cannot always tell if someone has an STI	*82*	*68.3*
Knew that if signs of an STI disappear, it does not necessarily mean that one no longer has the STI	*76*	*63.3*
Knew that one can get pregnant the first time they have sex	*90*	*75*
Knew that one can get pregnant if they have sex standing up	*87*	*72.5*
Knew that boys who have wet dreams can make a girl pregnant	*93*	*77.5*
Knew that there was no cure for AIDS	*118*	*98.3*
Knew that a healthy looking person can have AIDS	*106*	*88.3*
Knew that one can protect themselves from AIDS	*113*	*94.2*
Knew that anal sexual intercourse can transmit STI and HIV	*68*	*56.7*
Knew that urinating after sex does not prevent STD and HIV transmission	*77*	*64.2*
Knew that having sex with young girls does not cure STI	*84*	*70*
Knew that untreated STI could lead to severe health consequences	*26*	*21.7*
Knew an AIDS patient or someone who had died of AIDS	*88*	*73.3*

NB: The findings in this table are discussed under the following four subheadings.

4.3.1 Respondents' awareness of HIV/AIDS

Table 4.1 shows that most respondents were well knowledgeable on various issues regarding HIV/AIDS. The respondents had high HIV/AIDS awareness levels as 98.3% of them knew that AIDS has no cure, 94.2% knew that one can protect themselves from AIDS and 88.3% knew that a healthy looking person can have AIDS. Over sixty percent of the respondents also knew that condoms can prevent HIV transmission (60.8%), condoms do not have small holes for HIV to pass through (60%) and that mosquito bites do not transmit HIV (60.8%). Further, 73.3% of the respondents said they knew someone who had AIDS or who had died of AIDS. These findings corroborate those of the 1988 Kenya Demographic and Health Survey (KDHS), that practically everyone has heard of

AIDS i.e. 99% of women and 99% of men and that 71% of Kenyans personally knew someone who had AIDS or had died of AIDS (NCPD, 1999).

4.3.2: Respondents Awareness on STIs.

Table 4.1 shows that the respondents had good knowledge of STIs. Their majority knew that one cannot tell if someone has an STI (68.3%), that disappearance of STI symptoms does not necessarily mean one is healed (63.3%), and that having sex with young girls does not cure STI (70%). However, only twenty-two percent (21.7%) of the respondents knew that untreated STI could lead to severe health consequences. This shows that STIs were not considered by the boys as severe illnesses, a finding also noted by several studies (Gichuhi, 1986; Larson, 1989; WHO, 1989; Nzioka, 2001).

Qualitative data further revealed that severity of STIs was regarded even more lightly as one FGD participant observed in Sheng:

Participant: *Masinaa ni poa, si huwa ni homa ya wazee tuu?*

Besty tena huyahandle easy,

Noma ni AIDS, juu haina dose

Na humdestroy besty sana, hata mob yake humuepa.(Group 4)

This means that:

STIs are okey, aren't they simply men's fever?

Again young men easily handle them

The problem is AIDS as it has no cure

And it destroys one's health seriously making even friends to ran away.

Kibe, a 17 year old key informant who confided having been treated for STI asserted that:

Kibe: *I don't care how many times I get gonorrhoea or syphilis as long as I see a doctor, but I have to be very careful not to get AIDS.*

Researcher: *Don't you feel that these STDs may lead one to get AIDS easily?*

Kibe: *No, unless you get an STD and AIDS at the same time, and this when you go to prostitutes who are the source of AIDS. Otherwise AIDS is very different from other STDs as it*

brings death while these others come and go

Researcher: *You mean they just heal on their own?*

Kibe: *Yes, they mostly do, but if after waiting for the pains to go they don't, then 'maumivu yakizidi muone daktari'*

The above instances reveal that male adolescents may not only regard an STI infection of no serious health consequence since they feel that they can easily handle it or that it will soon go, but that it may also be positively perceived as a mark of masculinity as shown by their machismic reference to STIs as *'simply men's fever'*, a finding similarly reported by Gichuhi (1986). More importantly, it is clear that the respondents were largely unaware of the role of STIs as 'co-factors' in the transmissibility of HIV as they mostly felt that AIDS is the problem. This finding affirms that of WHO (1989) that young people are often ignorant of the facts that: STIs increase the risk of HIV acquisition; HIV increases susceptibility to STIs; and that both STIs and HIV are markers for high-risk behaviour. On the other hand, almost the entire sample or (96.7%) said that AIDS is a 'severe' illness pointing that it had debilitating health consequences and social stigma. This differed with earlier findings where adolescents largely denied the severity and even the existence of AIDS (Balmer, 1994, Okumu and Chege, 1994). This change of perception may be attributed to the raised national awareness on AIDS as a result of intensive advocacy and the fact that most (73.3%) of the respondents had seen an AIDS patient or known of his death.

4.3.3 Respondents' Knowledge on Fertility and Family Planning.

This was the respondents' weakest area of knowledge. Despite the fact that rhythm or safe days is one of the most popular strategies that adolescents use in controlling fertility less that a third (29.2%) of all the respondents had the correct knowledge on fertile period during a girls cycle. Only a third of the respondents further knew that pulling out before ejaculation can still make a woman pregnant (31.7%) and that contraceptive pills do no not cause infertility (33.3%). Population Council and Family Planning Association of Kenya (1988) similarly found boys to have very little knowledge on issues of fertility and family planning.

4.3.4: Perceived effectiveness of condoms against STI and HIV.

The study sought to establish whether the respondents perceived condoms as effective against STI and HIV infections. Over all, 73 (60.8%) of the respondents said that condoms are effective against STI and HIV infection, 41 (34.2%) said that they are not effective and 6 (5%) said they were not sure on this issue. This shows that majority of the male adolescents are aware that condoms can effectively prevent them from contracting STI and HIV infections. Other studies report a similar finding (Mati, 1989; Oniango and Rogo, 1989; Kiragu and Zabin, 1995). The main reasons why 39.2% of the respondents felt that condoms were not effective in the prevention of STI and HIV were that condoms break or burst easily during sexual intercourse and that they have tiny pores through which STI and HIV pathogens could pass. The two reasons are similarly reported in previous Kenyan adolescent studies for the opinion that condom are not effective against STI and HIV (Balmer, 1994; Becker and Rich, 1996). However, these reasons point more to the disadvantaged position of the Kenyan adolescents than to that of the condom. This is because studies on condom breakage reveal that breakage of condoms largely result from difficulty in usage which is associated with lack of experience or little knowledge on condom use. (WHO, 1999). The misconception that condoms have pores further reveals lack of clear and detailed knowledge on condoms which notes that condoms have a thickness (of 0.03 to 0.09mm) which rules out the possibility of holes and that they are extensively tested to meet WHO standards. (NASCOP, 1999).

4.4 Perceived Sources of Sexual and Reproductive Health Information.

The respondents identified various sources from which they had heard of STI and HIV/AIDS information in the past three months as shown on table 4.2 below.

Table 4.2: Perceived sources of Reproduction Health Information

Sources	Frequency n=120	Percentage (%)
Magazines, Newspapers and Books	79	65.8
Friends	65	54.2
Television (TV)	63	52.5
School	60	50.0
Radio	38	31.7
Family	11	9.2

Most respondents as table 4.2 shows had mainly got information from the print media (65 8%) and friends (54.2%) and television (52.5%) This finding differed with that of Lemma (1987) and Maggwa (1987) that the school mainly informed adolescents on sexual and reproductive health matters. It was however, similar to more recent findings, which report media and friends as the main sources of information for adolescents (Rukaria et.al, 1992; Balmer, 1994, Kiragu and Zabin, 1995). This shows that male adolescents usually do not get sexual and reproductive health information from parents or guardians.

4.5 COMMUNICATION ON REPRODUCTIVE HEALTH TOPICS

The study wanted to assess the communication on RH between the respondents and their parents, and among the peers (same and different sex friends). Different topics were presented and the respondents asked to identify anybody whom they had discussed any of the topics with in the previous six months. The topics were namely: body changes, wet dreams, sexual urges, boy/girl relationships, whether to have sex, pressure to have sex, unwanted pregnancy, HIV/AIDS and STIs, condoms, alcohol and drug use, school work and future career. Teachers and friends (mainly same sex) were found to be the main discussants of RH topics with the respondents as shown below

Fig.2: Percentage of Respondents who Discussed Various Topics By their Discussion Partners

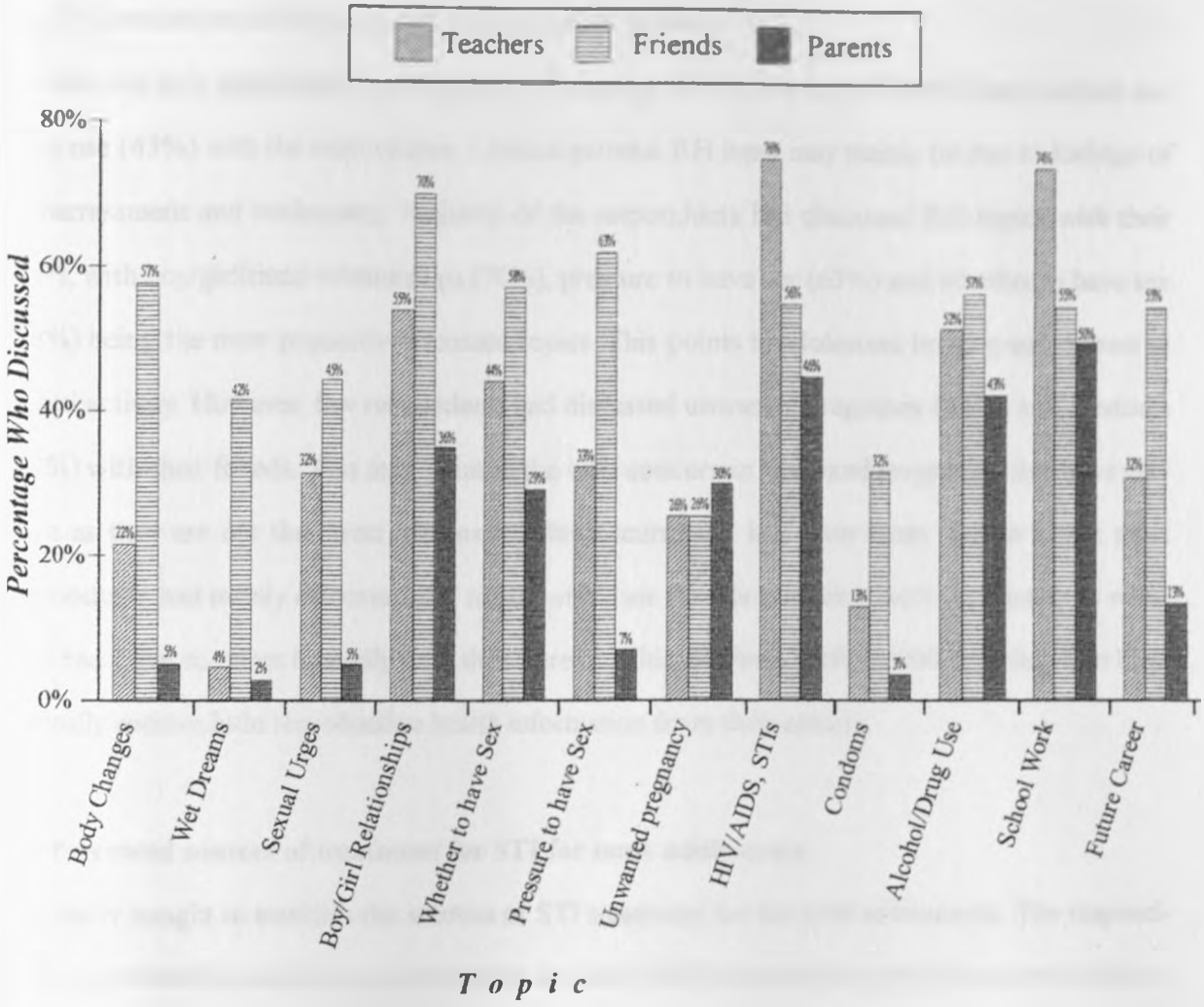


Figure 2 shows that HIV/AIDS and STIs, Alcohol and drug use and boy/girl friend relationships as the respondents' most discussed RH topics in the previous six months to the study. School work was also a frequently discussed topic. Teachers were the leading discussants on HIV/AIDS and STIs. Over three quarters (76%) of the respondents said they had discussed HIV/AIDS and STIs with their teachers. This may be explained by the recent introduction of AIDS education in the school curriculum. It is also important to note that significant proportions of the respondents had also discussed boy/girlfriend relationships (52%), whether to have sex (44%) and alcohol and drug use (52%) with their teachers. This underscores the fact that teachers are important sources of RH information. However, few adolescents had discussed wet dreams (4%) and condoms (13%) with their teachers. This may suggest that the respondents found wet dreams a rather embarrassing topic

to discuss with seniors. Limited condom use discussions may point to the teachers hesitancy to qualify condom use for boys against popular public opinion

Parents had only significantly participated in discussing HIV/AIDS and STI (46%) and alcohol and drug use (43%) with the respondents. Limited parental RH input may mainly be due to feelings of embarrassment and inadequacy. Majority of the respondents had discussed RH topics with their peers; with boy/girlfriend relationships (70%), pressure to have sex (63%) and whether to have sex (58%) being the most popularly discussed topics. This points to adolescent boys' great interest in sexual activity. However, few respondents had discussed unwanted pregnancy (26%) and condoms (32%) with their friends. This may point to the little concern in unwanted pregnancy that boys may have as they are not the direct victims of this occurrence. It is clear from figure 2 that most respondents had mainly discussed RH topics with their friends and fairly with their teachers while they had done so rather limitedly with their parents. This confirms WHO's (2000) finding that boys normally receive little reproductive health information from their parents.

4.6 Perceived sources of treatment for STI for most adolescents.

The study sought to establish the sources of STI treatment for the male adolescents. The respondents were therefore asked to mention various sources of STI treatment sought by most male adolescents.

Table 4.3 below shows the respondents' perceived sources of STI treatment for most male adolescents.

Table 4.3: Perceived sources for STI treatment for most adolescents.

Source	Frequency n=120	Percentage (%)
Herbs	56	46.7
Private Clinic	48	40.0
Public health facility	38	31.7
Purchase of drugs at chemist	32	26.7
Traditional healer	11	9.2
Borrowed or shared drugs	23	19.2
Sex with young girls	26	21.7

Table 4.3 shows that the four commonly perceived sources of STI treatment for most male adolescents were the herbs, private clinic, purchase of drugs and the public health facility. The use of herbs was however, perceived as the therapeutic source that most adolescents commonly sought for STI treatment. Most male adolescents were also more prone to herbal self-medication other than seek the services of a traditional healer. This could be due to the fact that the herbs were locally and easily available and that herbal practitioners used locally available herbs in treating STIs which were similarly known to the male adolescents to be efficacious in STI treatment. The researcher in a personal interview with a local herbal practitioner confirmed that 'Murubaine' and 'Mucatha' herbs which were mentioned by the respondents were some of the herbs he also used in the preparation of herbal medication for STI treatment. The herbs mentioned by the respondents were: 'Murubaine' which had a cross-ethnic mention by the Kikuyu, Embu and Meru respondents. 'Mucatha' herb was solely mentioned by the Kikuyu, 'Ogaka' by the Luo and 'Omnkhumbera'by the Luhya respondents. The herb was said to be obtained by boiling the leaves of these herbs. Their barks and roots could likewise be used.

It is significant to note that as table 4.2 shows, borrowed or shared drugs were also perceived to be sources of STI treatment for a significant number of the respondents. This means that male adolescents may share their purchased or prescribed STI drugs and thus sometimes end up taking only half of the supposed medication. This amounts to misuse or abuse of STI drugs, a practice that could largely lead to STI drug resistance.

4.6.1 Perceived accessibility to treatment sources.

The majority (55.4%) of the respondents came from homes located more than 3 kilometres from the nearest private clinic, while 44.6% of them resided 1 to 2 kilometres to the nearest private clinic. Fifty-nine percent (58.5%) of the respondents lived 3 to 5 kilometres from the nearest public health facility and 63.2% of them lived in households situated over 5 kilometres from the nearest chemist. Over half (52%) of the respondents' homes were at least 3 kilometres away from a known traditional healer. None of the schools from which the respondents came had a school clinic or a nurse.

All schools were within 3 kilometres to a private clinic and a chemist, and at most within 5 kilometres from a public health facility. The public clinic was therefore, the most physically accessible treatment source for the respondents when both at home and at school. However, over half (55.4%) of the respondents were located more than 3 kilometres from the nearest private clinic when both at home and school. This implies that majority of the respondents could not readily access an STD treatment source when they felt that they needed it. This finding concurs with that of a recent Poverty Report in Kenya which found that majority of the poor take over one hour to reach the nearest doctor or hospital (CBS, 2000).

4.6.2 Perceived Problems faced by the Male adolescents in accessing STI Treatment.

The respondents mentioned four major problems that male adolescents face in seeking STD treatment. These were: lack of money (55%), embarrassment (49.2%), hostility from adults (45%) and physical distance (41.7%). Other problems mentioned were lack of time (21.7%) and inability to share personal problems (15%). The above shows that lack of money was perceived to be the main problem that hindered adolescents in accessing STI treatment.

This finding is similar to that of the above recent Poverty Report in Kenya which found that over 40% of the poor who do not access medical sources when sick as they feel it is too expensive (C.B.S. 2000).

4.6.3 Perceived own action in case of STI infection

The study aimed at establishing the possible illness and treatment seeking behaviours by male adolescents in case of infection with an STI. The respondents were therefore asked to state their perceived own action in the case of contracting an STI.

Table 4.4 Percentage Distribution of Respondents' Perception on Own Action in case of STI Infection.

Own Action	Frequency n=120	Percentage(%)
Wait for Symptoms to heal on their own	36	30.0
Use herbs	25	20.8
Consult a private clinic	21	17.5
Purchase drugs at Chemist	16	13.3
Consult a public health facility	11	9.2
Consult a traditional healer	6	4.2
Have sex with an infected girl	5	5.0
Total	**120**	**100**

Table 4.4 shows that the respondents felt that they were more likely to wait for symptoms to heal on their own or use herbs on discovering that they had an STI infection. It is important to note that having sex with uninfected girls was said to be a way of curing an STI infection by 5% of the respondents. Similarly, 6% of girls in Okumu's and Chege's (1994) sample said that having sex with a different man would cure an STI.

4.6.4 Perceived own action on discovery of a girl friend STI infection.

Majority of the respondents said they were more likely to drop (25%), avoid meeting (20%) or avoid sex (27.5%) with their girlfriends if they discovered they had STI Only 13.3% of the respondents said that they would advice or help their girlfriends to seek treatment. This means that most respondents do not jointly work with their sexual partners in seeking treatment for emerging STIs in their relationships. Worse, they were more likely to abandon or avoid their infected partners leaving them without support or advice.

Table 4.5: Percentage distribution of the respondents' responses on perceived own risk, reaction and actions to possible HIV infections.

Characteristics	Frequency n=120	Percentage(%)
Perceived own risk of HIV infection		
Great	06	5.0
Moderate	21	17.5
Low	93	77.5
Own willingness to take a voluntary HIV-test		
Willing	32	26.7
Not willing	88	73.3
Perceived own reaction on discovery of being HIV-positive		
Commit suicide	38	31.7
Run away from home	29	24
Get saved/ pray God for help	19	15.8
Consult an AIDS counsellor	11	9.2
Try to live with AIDS	7	5.8
Not sure what to do	16	13.3
Total	**120**	**100.0**

Table 4.5 shows only 5%of the respondents felt that they were at 'high' risk of HIV infection, a finding that is similar to that of the 1998 KDHS report where only 3.8% of the boys aged 15-19 felt the same.(NCPD, 1999). This low rating of own-HIV risk by the respondents could be explained by the fact that they did not perceive their sexual practices to be risky as they mainly cited non-sexual reasons. Most of the respondents for instance who felt to be at 'high' risk explained that they were likely to be infected by contaminated shaving machines during hair cuts or from infected needles set up in public places by HIV infected people. WHO (1995), however, observes that explanation of STDs that are non-sexual in nature are likely to be common and perpetrated among adolescents, while Bloor (1995) found that the unexamined assumption that HIV infection is knowingly transmitted by persons with HIV/AIDS predominates public AIDS discourses against research evidence which indicates that those who know themselves to be infected are more likely to reduce their risk behaviour than increase it.

Majority (73.3%) of the respondents as table 4.6 shows, said that they would not be willing to take a voluntary HIV-test, while only 26.7% of them would be willing to do so. Over half (52%) of the 88 respondents who were unwilling to take HIV test gave their main reason as the 'fear of being told' that they were HIV-positive. The remaining 36 said they did not need the test as they were certain

they were not infected. HIV-testing was thus mostly perceived as unnecessary or a risky exercise where one risked being given a false report indicating that he was infected. This shows that most respondents were unable to assent to even the probability of personal risk of HIV infection and hence the use of complex denials

The same reason may explain why over half of the sample (55.7%) felt that their most likely reactions on discovery of being HIV-positive was either committing suicide (31.7%) or running away from home (24%). These feelings however, show that the respondents lacked necessary knowledge and skills to enable them to reasonably and responsibly handle a likely own HIV infection. This knowledge gap could be traced to HIV/AIDS Information, Education and Communication (IEC) Programmes, which have largely dwelled on HIV prevention, transmission and symptomology and mostly lack a post-infection counseling component. Therefore, most people could be argued to know that 'AIDS KILLS' and 'AIDS HAS NO CURE' but not to know what to do when they become infected with HIV or how to live with AIDS.

4.7 RESPONDENTS SEXUAL ATTITUDES AND OPINIONS

The study sought to establish respondents' attitudes towards some sexual practices especially those that are high risk, for instance, lack of condom use, having multiple concurrent sex partners and casual sexual intercourse. Table 4.6 shows the respondents responses

Table 4.6 Some sexual Attitudes and Opinions of the Respondents

Characteristic	Frequency n=120	Percentage (%)
Adolescent boys' use of condoms		
Approved	48	40.0
Disapproved	72	60.0
Adolescent boys' engagement in pre-marital sex		
Approved	57	47.5
Disapproved	63	52.5
Ideal age for boys' to start sexual intercourse n=57		
10 –12 years	3	5.3
13 – 15 years	8	14
16 – 18 years	35	61.4
19 + years	11	19.3
Ideal number of sexual partners n=57		
1	6	10.5
2-3	32	56.2
4+	19	33.3
Importance of Sexual intercourse in Boy-Girlfriend Relationship		
Very important	46	38.4
Fairly important	55	45.8
Not important	19	15.8
Adolescent boys' right to have sex with girls they don't love n=57		
Yes	18	31.6
No	39	68.4
Plan for Sex n=103		
Planned to continue with sex	99	96.1
Planned to obstain from sex	04	3.9
Perceived Peer (Boyfriends') Sexual Activity		
All of them engage in sex	36	30.0
Most of them engage in sex	72	60.0
Few engage in sex	8	6.7
None engages in sex	4	3.3
Boys engagement in Rape		
Approved	46	38.3
Disapproved	74	61.7

Nb: The findings on this table are discussed under the titles below.

4.7.1 Attitude to condom use.

As table 4.6 illustrates, 40% of the respondents approved condom use by adolescent boys while their majority (60%) disapproved it. Most of the respondents therefore, had negative or non-accepting attitude towards condom use. Four main reasons were given for this attitude. These were: that condoms use is sinful; spoils sexual enjoyment; meant for married people to space children; and is meant for prostitutes to prevent them from STDs in their promiscuity. This finding is congruent to that of previous adolescent studies (Khasiani, 1985, Gichuhi, 1986; Kiragu and Zabin, 1995) which

have found that condom use non-acceptance among adolescents mainly bears on religious sentiments, sexual pleasure and misconception that condoms are exclusively for family planning needs. Buzzard (1982) and Schoef (1990) also report non-accepting attitudes towards condom use due to their symbolic and social meanings which associate them with promiscuity and disease. Over half (52.5%) of the respondents disapproved boys engagement in premarital sex for the reasons that it often led to poor academic performance and carried risks of HIV infection. Kiragu (1994) similarly noted that most boys disapproved of premarital sexual activity. The age of 16-18 years was felt to be the most ideal for boys to initiate sexual activity by the majority (61.4%) of those respondents who approved premarital sex . Majority (84.2%) of the respondents felt sexual intercourse to be either 'fairly' (45.8%) or 'very' (38.4%) important in boy/girlfriend relationships. The fact that most respondents felt sexual intercourse to be of importance in boy/girlfriend relationships, even when their majority (60%) disapproved of it, shows that heterosexual intercourse carried important social and sexual meanings for the boys as Willie, a 19 year old key informant observed:

Researcher: *But must a boy, have sex with his girlfriend?*

Willie: *Yes, don't they say that love without sex is like tea without sugar?*

Researcher: *That is what they say, what do you personally think?*

Willie: *Sex is the only way to show your girlfriend you love her, and that she is special and the only one who is yours. Otherwise she would say that you do it with other girls out there. It is also the only way to make a girl truly happy.*

The above instance shows that sexual intercourse was treasured in heterosexual relationships as an avenue for expressing satisfactorily, the strong feelings of love, intimacy and trust. It was also perceived as the most pleasurable mutual undertaking in these relationships. However, it is important to note that most respondents disapproved of the act of having sex with a girl one did not love (68.4%) or engaging in forceful sex or rape (61.7%). This suggests that most boys do not engage in premarital sex merely for enjoyment but mainly for social reasons.

4.7.2 Attitude to Premarital Sex

As table 4.6 illustrates fifty-three percent (52.5%) of the respondents' disapproved premarital sexual intercourse for male adolescents. These respondents argued that premarital sex was, sinful as it went against Christian principles; led to poor academic performance thus destroying one's lifetime opportunities; and caused suffering to girls who got pregnant while a few of them said it was risky as it increased ones exposure to STDs and HIV infection

A significant proportion (47.5%) of the respondents however, approved premarital sex for adolescent boys for various reasons as seen below from FGD discussions

Participant: *Yes, I also agree with them. To me it is even more than important for a boy to have sex before marriage.*

Researcher: *Would we then, look at these reasons. I mean are those boys who avoid sex before marriage disadvantaged in any way?*

Participant: *I want to say that these boys have very short things.*

Researcher: *Which things?*

Participant: *Aaah, 'Buffalo' seema, tomboa*

Participant: *Okey, they have very short penises, because they do not erect very much.(Group 1)*

Participant: *Sex also helps to remove face pimples and even back pains because backbone is not over-loaded with sperms.*

Participant: *Tena mtu hamwagi (ejaculate) ovyo ovyo. One always has clean underware and beddings. (Group 2)*

Researcher: *You mean these are the only reasons why ... ... ?*

Participant: *But sex is fun, it is sweet and one feels refreshed, and you also get experience that is needed in marriage. (Group 6)*

The following sexual misconceptions emerge from the above FGD excerpt: One, that the exercise of one's sexual functions in sexual intercourse may develop genital size, increase one's erectal capacity and improve sexual performance. Two, that abstinence for a long period of time may lead to occurrence of illness. While these misconceptions which lack scientific proof and may be said to result from the respondents' lack of proper sexual and reproductive knowledge, they could also be argued to derive from the social and sexual opinions prevailing in most communities where male sexual activity is associated with prowess, prestige, and wholesome health (Buzzard, 1982; Caplan, 1995, Larson, 1989; Njau, 1995).

4.7.3 Ideal Number of of sexual partners.

By stating their ideal or recommended number of sex partners for adolescent boys, the respondents attitude towards multiple concurrent sexual partners was established As table 4.6 shows, only eleven percent (10.5%) of the respondents who approved premarital sex for boys felt that a boy should stick to one sexual partner while their majority (89.5%) felt that boys should keep at least two or more sexual partners. However, a range of two to three partners was the best ideal for most boys This shows that the respondents approved having multiple concurrent sex partners and that they were largely inclined towards risky behaviour. Boys did this for various reasons as Charles a 16 year old key informant who reported having had more than five sexual partners argued:

Charles: *The easiest way to make a girl pregnant is to have frequent sex with her. Alternating between two or more girls who you can trust helps prevent pregnancy. This also helps when one girl is away.*

Researcher: *Is there anything more you would add on that?*

Charles: *And again you can't ran away if a girl is really attracted to you and keeps on disturbing you. You have to be a man and proof that you can do it*

Willie, a 19 year old key informant who had more than six sexual partners, had more to say:

Willie: *It is not possible to have sex with only one girl. When you are in school you need a girl and at home you also need one*

Researcher: *But Willie, a school term is only three months long and there is the mid-term break?*

Willie: *Well you know, one also wants to taste what other girls are like.*

Researcher: *Isn't a girl just like any other girl?*

Willie: *No, some look so beautiful and everyone wants them, so you really feel good to have sex with them .. Other girls also know how to do it very well.*

Researcher: *what does that mean?*

Willie: *It means that they don't bore you by lying there and waiting for you to finish, they touch you and move their waists.*

From the above instances it is clear that the need to have constant sex experience led the respondents to have multiple concurrent partners. This has been similarly observed among adult males (Buz-

zard, 1982; Caplan, 1985, Njau, 1995). The need for sexual adventure also led the respondents to seek variety in sexual experience. Further the need for social prestige and recognition as when the respondents seek and have sexual intercourse with those girls considered beautiful and wanted by other boys may as well lead boys to multiple sexual relationships as Willie argued

4.7.4 Importance of Sexual Intercourse in Boy-Girl Relationship.

As table 4.6 shows, over thirty-eight percent (38.4%) of the respondents were of the opinion that sex is 'very important' in a boy-girlfriend relationship as compared to 45.8% and 15.8% who respectively felt it to be 'fairly important' and 'not important'. Most of the respondents who felt sex to be 'very important' in boy-girl relationships explained their opinion in that one would be risking to lose his girlfriend to those boys who were sexually active as his girlfriend might consider him unmanly by not asking for and having sexual intercourse and that sex was great fun. Those who said sex was 'not important' cited the dangers of HIV infection and the fact that true love could best be expressed in mutually harmless ways.

4.7.5 Attitude towards Rape

Rape is a forceful sexual penetration which may be perpetrated by an individual or a group. According to table 4.6 the majority (61.7%) of the respondents were opposed to rape pointing that it brought great psychological pain and trauma to innocent women and girls. In the present of HIV/AIDS, rape, they said exposed its victims to high risk of infection. Rape also was seen to bring great pain to relatives of the victims. However, thirty-eight percent (38.3%) of the respondents considered rape as acceptable. Three reasons were mainly given for approving rape. One, rape was said to be a justifiable retaliation to girls who reject the advances of boys or those who appeared proud or aloof. Rape was then done intentionally to humiliate these girls. Two, rape was considered as the only way of satisfying peer expectation by the boys who did not know how to court girls or who were rejected for various reasons, for instance, physical or other disabilities. Three, rape was described as the unintended consequence or uncontrollable male sexual desire. This was said to mostly occur after intense sexual foreplay with provocative girls who then declined to proceed to sexual

intercourse. The FGD participants however, classified rape into two categories – 'brutal' and 'friendly' rape. 'Brutal' rape was when a gang or a stranger were the perpetrators. Most participants felt that 'brutal' rape was both unacceptable and illegal and that the rapists deserved to be punished. 'Friendly' rape on the other hand was said to occur where a girl invited the advances of a boy but would not agree to have sex. In this case the boy could get confused, not knowing if the girl was genuinely resisting him or whether she was engaging in a game. The participants therefore felt that in this case rape was justified since even when the girls actually wanted sex, they still said 'No'. Rape was thus felt to be inevitable even in boy-girlfriend relationships. Balmer (1994) also found that 5 participants out of 6 in his FGDs approved of rape.

4.8 RESPONDENTS SEXUAL CHARACTERISTICS AND EXPERIENCES.

4.8.1: Respondents' Characteristics of First Sexual Experience

Table 4.7: Percentage Distribution of the Respondents' by characteristics of First Sexual Experience

Characteristic	Frequency n=103	Percentage (%)
Sexual experience		
Experienced	103	85.8
Not experienced	17	14.2
Age at first Sex		
<10	12	11.7
11-15	46	44.7
16-18	42	40.8
19+	3	2.9
Age of first partner		
Same Age	34	33
Younger	54	52.7
Older	15	14.3
Rating of first sexual experience		
Enjoyable	83	80.6
Not enjoyable	20	19.4
Motivation of first sexual experience		
Forced to have sex	3	2.9
Curiosity	28	27.2
Urging of friends	36	35.4
Desire to test sexual prowess	35	34.5
Total	**103**	**100.0**

As table 4.7 shows that over eighty-six percent (85.8%) of the respondents were sexually experienced and most (56.4%) had their first coitus before they were 16 years old. These findings confirm those of Gichuhi (1986), Lema (1987) and Nzioka (2001) who noted respectively, that 50-80% of Kenyan male adolescents were sexually experienced and that most of this sexual activity occurred at tender ages.

Over, eighty percent (80.6%) of the respondents rated their first sexual experience as enjoyable and that their sexual partners were mainly younger girls (52.7%). Three main factors were identified by the respondents as being the motivation behind their engagement in first coitus. These were Curiosity (27.2%), desire to test sexual prowess (34.5%) and the urging of friends (35.4%). This means peer pressure was the most significant influence in the respondents' involvement in first sexual intercourse, a finding that is echoed in earlier studies (Maggwa, 1987, Gichuhi, 1986; Balmer, 1994).

4.8.2 Respondents' Sexual Negotiation

In order to investigate the methods male adolescents utilized in heterosexual relationships to obtain sex, the respondents were asked whether they had sweet-talked, touched, offered money or attempted to force their partners into sex during the most recent proposition. Table 4.10 shows the proportion of respondents who utilized any of these the last time they asked for sex.

Table 4.8 Respondents' Manner of Sexual Negotiation During Last Proposition

Manner of Sexual Negotiation	Frequency n=103	Percentage(%)
Sweet talked partner	84	81.6
Touched partner	66	64.1
Subjected partner to attempted force	23	22.3
Threatened partner	10	9.7
Offered money or gift to partner	19	18.4

As shown in the table above, the majority of the boys either sweet talked their partners (81.6%) or touched (64.1%) them during the last sexual proposition. At the same time, considerable proportions of the boys had tried force (22.3%), threats (9.7%) or offers of money or gifts (18.4%). This seems to suggest that boys initially engage in mutual sexual negotiation with their partners, but also

readily resort to force or pressure where their wishes are not met. This further points to the boys poor or lack of life skills.

Seventy-two percent (71.7%) of the respondents felt that their partners during the last proposition never actually wanted to have sex, while only less than a third (28.3%) said that their partners were willing to have sex. The respondents were asked about the outcome of the encounter. Sixty-three percent (63.1%) of the boys said that they ended up having sex. This shows that most boys convinced, coerced or forced their partners into sex during their last or recent encounter. This also means that boys mostly do not respect the perceived wishes of girls regarding sex.

4.8.3 Some Sexual Practices and Characteristics of the Respondents.

4.8.3.1: Respondents' Characteristics of First Sexual Experience

Table 4.9: Percentage Distribution of the Respondents' Sexual Experience by Selected Characteristics

Characteristic	Frequency [n=103]	Percentage(%)
Number of lifetime female sexual partners		
1	12	11.7
2-3	21	20.4
4-5	47	45.6
6+	23	23.3
Frequency of sexual episodes in the previous six months		
1	11	10.8
2-3	28	27.2
≥ 4	60	58.6
No response	4	3.4
Condom use		
Ever used	36	34.9
Never used	67	65.1
Planned for Sex		
Always	13	12.6
Sometimes	41	39.8
Never	49	47.6
Discussed safer sex with partner before sex		
Yes	16	15.5
No	87	84.5
Ever practised masturbation		
Yes	117	97.5
No	03	2.5
Experience of Anal sexual intercourse		
Yes	32	31.1
No	71	68.9
Involvement in Rape		
Yes	29	28.2
No	74	71.8
Ever Caused pregnancy		
At least once	19	18.4
None	74	61.7
Not aware	10	9.7
STI-immune status		
Had had a self-diagnosis	68	66.0
No STI experience	35	34.0
STI treatment seeking bahaviour [n=68]		
Sought treatment of some kind	38	55.9
Sought no kind of treatment	30	44.1
Time taken to seek STI Treatment [n=38]		
A day or less	0	0
Within 7 days (one week)	3	7.9
Within 14 days (two weeks)	16	42.1
Within 21 days (three weeks)	19	50.0
Total	**103**	**100.0**

Table 4.9 shows that most (88.3%) of the respondents who were sexually experienced had had more than one sexual partners and 68.9% had had more than three. This finding resonates with that of Maggwa (1987) where 72% and 51% of the sexually experienced boys in his study had had one and three or more sexual partners, respectively. Additionally the respondents had high rates of sexual frequency as sixty percent (58.6%) had had more than four sexual episodes in the six months preceding the study. Only 34.9% of the respondents in this study had ever used condoms or always planned for sex. This shows that most of the sexual activity of these respondents was both unprotected and unplanned. This then may largely explain why over half of the sexually experienced respondents had made an STI self-diagnosis, though only (55.9%) of them reported having sought treatment of some kind. However, most (92.1%) of the respondents only sought treatment after long delays. This shows that seeking STI treatment was mainly the consequence of progressively disturbing symptoms. This finding is congruent with those of other studies (Ajayi, 1999; WHO, 2000) that STI treatment is often sought when symptoms become unbearable.Almost all (97.5%) of the respondents had practised masturbation. The high masturbatory practices could be understood in the light of IFPP's (1995) observation that masturbation is an integral part of a boys' manhood development and also a way for a boy to learn his intercourse cycle.

A third (31.3%) of the sexually experienced boys said that they had had anal sexual intercourse while about one in every four of the respondents had been involved in rape.

These practices however, seem to have been under-reported on the questionnaire in the light of qualitative data where 5 in 8 of FGD participants admitted that these were regular and 'normal' practices. Earlier Kenyan FGD studies similarly report that anal sexual intercourse, masturbation and rape are widespread among male adolescents (Balmer, 1994; Becker and Rich, 1996).

Eighteen percent (18.4%) of the sexually exposed respondents reported that they had caused a pregnancy at least once, while their majority (71.9%) said they had not, and ten percent (9.7%) of them said they were not aware. This rating was a little higher than that of Oniang'o and Rogo (1989) who found that 14% of boys in their sample had impregnated at least one girl. This difference however, may result from the increased sexual activity among adolescents(Toroitich-Ruto, 1997).

4.8.4 Respondents' Therapeutic Resources In STI Treatment.

The respondents utilized various treatment resources and methods in managing their last perceived STI illness as shown below.

Table 4.10 Respondents' treatment resources and techniques used inthe last perceived STI illness.

Treatment Behaviour	Frequency	Percentage (%)
Sought Clinical medication only	08	21.0
Used herbs only	04	10.5
Used herb, clinical medication	06	15.8
Used herbs and OTC drugs	03	7.9
Used herbs, then OTC drugs and lastly sought clinical medication	03	7.9
Used OTC drugs only (Purchased or borrowed)	03	7.9
Used OTC drugs & then sought clinical medication	02	5.3
Used Dettol and Salty water	01	2.6
Had sex with a young girl	02	5.3
Had sex with young girl, herbs, then sought clinical medication	02	5.3
Consulted traditional healing services	02	5.3
Prayed for healing	01	2.6
Total	**38**	**100.0**

From the table above, the respondents used various therapeutic resources and techniques in the managing of their last perceived STI illness. Treatment resources included, medical clinics or health facilities, herbs, OTC drugs, sterilizers such as dettol and salt, prayers and traditional healing services. The techniques mentioned included applying sterilizers on infected genitals and having sex with 'young' girls.

Different treatment resources were utilized together or in series depending on whether the symptoms were judged by the patients as healed or not. The use of a variety of resources in the treatment of STI echoes the finding of previous studies that lay people in non-western societies with pluralistic medical systems often use various treatment resources available to them to treat their illnesses (Nyamwaga ,1996).

Herbal self-medication was found to be the first choice therapy for most respondents. The high

popularity of herbal medicine as an initial source of therapy may be attributed to its easy accessibility both physically and financially. However, the fact that those who used it initially had to further seek clinical medication or OTC drugs suggests that herbal self-medication was not found to be quite efficacious and hence the need to recourse to the other therapies. This situation may be partly explained by the observation of a traditional healer who was interviewed as a key informant.

Traditional healer: *Knowing 'Mucatha' and 'Mugwanugu' as medicinal herbs for STI treatment does not help anything. These are merely small portions of a rich mixture of herbs. My son, curing the sick is no different from the schools you attend for years. It calls for good training and long experience.*

The respondents treatment patterns seemed to confirm this observation as all the respondent-patients (two) who had consulted a traditional healer as the initial therapeutic resource did not seek any further treatment which suggests that they perceived their STI illnesses as healed. This goes along with WHO's warning that:

> 'The practice of traditional medicine in the third world should not be looked down as inferior but should be seen as a necessary complement to modern medicine and equally deserving of rigorous scientific research input' (WHO, 1999: P 43).

4.9 Sexual Behaviour Changes with regard to HIV/AIDS.

The study asked the sexually experienced respondents to state any sexual behaviour changes they might have made so as to reduce the risk of HIV infection. By so doing the study sought to establish any sexual behaviour modifications the respondents had made.

Table 4.10 shows the respondents responses to this.

Table 4.11 Respondents' Sexual Behaviour Changes with Regard to HIV/AIDS.

Sexual Behaviour Change	Frequency	Percentage (%)
Have sex after long periods	7	9.5
Have started using condoms	25	33.8
Sticking to one sexual partner	11	14.9
Have reduced the number of sexual partners	6	8.1
Stopped sex with people who they are not very sure of	25	33.8

Table 4.10 shows that the respondents had tried or actually made various modifications in their sexual behaviour, in an attempt to reduce their risk of HIV infection. This shows that although the respondents, as already seen, verbally denied own likelihood of HIV infection, they actually were concerned about possible HIV infection. It is significant however, that no respondent reported having absolutely abstained from sex, a situation that studies on harm reduction explain by noting that absolute abstinence is unattainable to most people as it has severe requirements and because harm reduction usually takes small steps to reduce (Baer, et.al.1993) This is important in the light that most socio-cultural advocates of HIV/AIDS prevention in Kenya, such as the family, religious organisations and the community may often solely advocate absolute abstinence for adolescents without realising that:

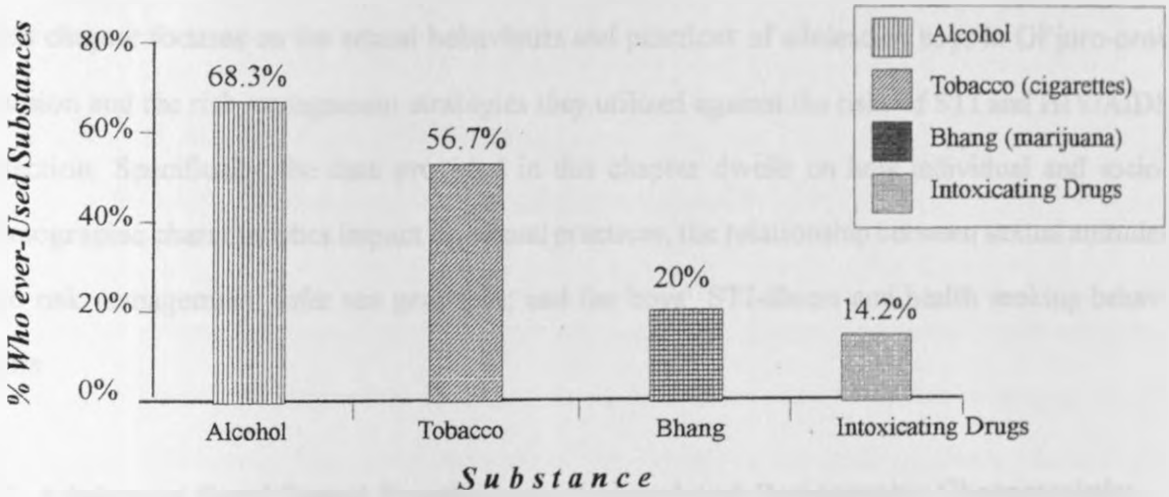
> Harm reduction approaches offer at risk population simple behaviour changes that reduce the harm of high risk activities, often with abstinence as the end point, but accepting that abstinence is not a realistic goal for all people. (Baer, et al, 1993: 258).

The most attempted sexual behaviour changes by the respondents were: starting to use condoms (24.3%), avoiding casual sex or sexual partners one was not sure of (24.3%) and sticking to one sexual partner (23.3%). The 1998 Kenya Demographic and Health Survey (KDHS) similarly found that 20.9%, 20.4% and 13.5% of the boys aged 15-19 had started using condoms, were respectively restricting themselves to one sexual partner and were having fewer sexual partners in an attempt to avoid HIV infection. (NCPD, 1999). The fact that few boys report having modified their sexual behaviour may then largely be explained by lack of a set of socially approved options on sexual behaviour change.

4.10 Alcohol and other substance use

The study sought to establish the prevalence of abuse of alcohol, tobacco, cannabis and other intoxicating drugs among the respondents. The figure below shows the respondents responses on these.

Figure 3: Proportion of Respondents Who Have Tried Various Substances



Over all, eighty-six of the respondents or 71.7% reported having tried substance use of one kind or another. Only thirty-four (28.3%) of them had never used any substance. Alcohol was the most used drug with sixty-eight percent (68.3%) of the respondents having tried it. This finding confirms that of Yambo (1983) which similarly reported alcohol as the mostly abused drug where about seventy percent (69%) male youths had tried alcohol. At the same time this study's finding that 56.7% of the boys had tried tobacco differed with Yambo's who found a larger proportion (63%) of his respondents on tobacco use. This difference may be explained by the intensified campaigns against tobacco use that are taking place nationwide. Bhang or marijuana (20%) and intoxicating drugs (14.2%) were the least tried drugs. Nevertheless, the trends still represent high rates of substance abuse and thus high risks of STI and HIV infection since drug use is associated with risky behaviours (WHO, 2000).

CHAPTER FIVE

ADOLESCENT BOYS' SEXUAL PRACTICES AND MANAGEMENT OF THE RISKS OF SEXUALLY TRANSMITTED INFECTIONS (STI) INCLUDING HIV AND AIDS

5.1 Introduction.

This chapter focuses on the sexual behaviours and practices of adolescent boys in Ol'joro-orok division and the risk management strategies they utilized against the risks of STI and HIV/AIDS infection. Specifically; the data provided in this chapter dwells on how individual and socio-demographic characteristics impact on sexual practices, the relationship between sexual attitudes and risk management; safer sex practices; and the boys' STI-illness and health seeking behaviours.

5.2 Adolescent Boys' Sexual Practices and Personal and Demographic Characteristics.

Personal or individual and socio-demographic characteristics have been found to influence human sexuality significantly. (See literature review). This study therefore, sought to establish the specific impact of these variables on the sexual practices of adolescent boys in Ol'joro-orok division. The personal characteristics investigated were: age, religious affiliation, place of residence, type of school attended and level of formal education. On the other hand, marital status of parents, peer group association and adherence to male sexual norms were the socio-demographic variables investigated.

Sections 5.3 and 5.4 below, presents the tests of the first hypothesis that stated that the sexual behaviour and practice of adolescent boys are largely influenced by their individual and family background characteristics, the peer group associations and the male sexual norms prevailing in their communities.

5.3 Personal Characteristics and Boys' Sexual Practices.

5.3.1 Age

Age was found to be associated with sexual experience as table 5.1 below shows.

Table 5.1 Respondents Age by Sexual Experience

Sexual Experience	Age (Years)			Row Total
	≤14	15-17	18-19	
Experienced	6(40)	51 (89.5)	46 (95 8)	103 (85 8)
Inexperienced	9 (60)	6 (10.5)	2 (4.2)	17 (14.2)
Column Total	**15 (100)**	**57 (100)**	**48 (100)**	**120 (100)**

Nb: Figures in parenthesis are percentages (%).

$x^2 = 30.9441$ with 2df. Significant at 95% confidence level. r=0.59079

As table 5.1 shows that only forty percent of the boys aged 14 years and below reported having sexual intercourse as compared to 89.5% of those aged 15-17, and 95.8% of boys aged 18-19. This suggests that most male adolescents initiate sexual activity on attaining fifteen years of age The relationship between age and sexual experience was found to be statistically significant at 95% confidence level. (x^2=30.9441). Moreover, the association between age and sexual experience was found to be both strong and positive (r=0.59079). This means that age is positively related to boys' sexual experience, a finding which confirms WHO's (1995) observation that most adolescents will not have experienced sexual intercourse at puberty.

Age was also found to be associated with the number of lifetime female sexual partners as table 5.2 shows below:

Table 5.2 Respondents' Number of Lifetime Female sexual Partners By Age.

Age (Years)	No. of Lifetime Females Sexual Partners				Row Total
	1	2-3	4-5	6+	
≤14	4 (66.7)	2 (33.3)	0 (0)	0 (0)	6(100)
15-17	5 (9.8)	14 (27.5)	24 (47)	8(15.7)	51 (100)
18-19	3 (6.5)	5 (10.7)	23 (50)	15(32.6)	46(100)
Column Total	**12 (11.7)**	**21 (20.4)**	**47 (45.6)**	**23 (22.3)**	**103 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=28.0393 with 6 df. Significant at 95% confidence level r=0.8846

Table 5.2 demonstrates that sixty-seven (66.7%) of the boys aged 14 years and below reported having had only one female sexual partner as compared to 9.8% of those aged 15-17, and 6.5% of those aged 18-19. On the other hand, none (0%) of those aged 14 years and below had had more than 3 sexual partners as compared to 62.7% of those aged 15-17, and 82.6% of those aged 18-19 who had had more than 3 female life sexual partners. This shows that majority (88.3%)of the sexually experienced boys had had more than one sexual partner. Age was found to be statistically associated with the number of lifetime female sexual partners. (x^2=28.0393) at 95% confidence level. Further, the high positive value of r(0.8846) shows a strong association and a perfect positive co-relation between age and the number of lifetime female sexual partners. This means that the number of sexual partners for boys increased with age. This could be because increased age is likely to lead to increased heterosexual association and improved sexual negotiation skills leading to sexual involvement with many sexual partners. This is more so in the light that adolescents are often in unstable relationships which change regularly (WHO, 2000).

5.3.2 Religious Affiliation

Religious Affiliation was not seen to significantly influence sexual experience as shown below

Table 5.3 Respondents' Sexual Experience by Religious Affiliation.

Sexual Experience	Religious Affiliation			Row Total
	Catholics	Protestants	Traditionalists	
Experienced	59 (89.4)	35 (77.8)	9 (100.0)	103 (85.8)
Inexperienced	7 (10.6)	10(22.2)	0 (0)	17 (14.2)
Column Total	**66 (100.0)**	**45 (100.0)**	**9 (100)**	**120 (100)**

Nb: Figures in parenthesis are percentages.

x^2=4.575 with 2 df. Not Significant at 95% confidence level. c=0.1916

Table 5.3 above shows that none (0%) of the traditionalists and only 10.6% of the catholic respondents had not engaged in sexual activity as compared to 22.2% of the protestants. Apparently, Catholics and traditionalists were therefore much more likely than the protestants to engage in premarital sex. However , and contrary to expected results statistical association between sexual experience and religious affiliation was found to be significant (x^2=4.575) only at 90% confidence level - below the study's acceptance level and the association between them was also found to be weak as indicated by the small value of c(0.1916). This could be explained by Tuju's (1996) finding that sexual experimentation has a universal appeal to all adolescents regardless of religious commitments, upbringing or future aspirations.

Religious affiliation was however, found to influence condom use as shown in table 5.4 below

Table 5.4 Percentage Distribution of Respondents' Condom Use by Religious Affilliation.

Condom use	Religious Affiliation			Row Total
	Catholics	Protestants	Traditionalists	
Ever used	11 (30.6)	25 (69.4)	0 (0)	36 (100)
Never used	48 (71.6)	11 (16.4)	8 (12.0)	67 (100)
Column Total	**59 (57.3)**	**36 (34.9)**	**8 (7.8)**	**103 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=30.039 with 2 df. Significant at 95% confidence level. c=0.4474

From the above table, it is clear that seventy percent (69.4%) of the sexually active respondents who had ever used condoms were protestants as compared to only 30.6% of the catholics, and 0% of the traditionalists. Majority of the protestants had therefore used condoms as compared to the traditionalist or catholic respondents. The study found significant association (x^2=30.039) in the relationship between religious affiliation and condom use. The association was further found to be strong as indicated by the high value of c(0.4474). This means that affiliation to traditional or catholic faith led to non-use or low use of condoms while affiliation to protestant faith translated to high condom use rates among adolescent boys. The boys affiliated to catholic or traditional faith were therefore more likely to engage in unprotected sexual intercourse than did their protestant counterparts. This may be explained by the opposition to condom use by the two faiths; by catholics as artificial conception and by "Mungiki" sect as a foreign or un-african practice. Protestants on the other hand accept condom use as a reasonable way to successful family planning and STI/HIV prevention and control.

5.3.3 Place Of Residence

Table 5.5 Respondents' Sexual Experience by Place of Residence.

Sexual Experience	Place of Residence		Row Total
	Rural	Urban	
Experienced	82 (92.1)	21 (67.7)	103 (85.8)
Inexperienced	7 (7.9)	10(32.3)	17 (14.2)
Column Total	**89 (100.0)**	**31 (100.0)**	**120 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=11.2503 with 1 df. Significant at 95% level of confidence. c=0.2928

As shown on the table 5.5 above most (92.1%) of the boys who resided in the rural areas were sexually experienced as compared to 67.7% of those from urban areas. On the other hand, only 7.9% of the rural respondents had not had sexual exposure as compared to 32.3% of the urban ones. Most boys who resided in rural areas were therefore sexually experienced. The association

between place of residence and sexual experience was also found to be statistically significant (x^2=11.2503) at the confidence level of 95%. The association was further found to be strong (c=0.2928). Residing in rural areas thus carried higher chances of sexual exposure, a finding echoed by earlier studies. (Khasiani, 1985, Maggwa, 1987; Okumu and Chege, 1994). This finding may be accounted by the fact that unlike in rural areas where boys have a lot of time and freedom with their friends and agemates, in urban areas there is little social time outside school time and mostly parental watch is intensified by urban circumstances eg. little freedom to move at night due to security reasons and lack of a separate houses or 'cubicles' for boys due to high rent rates. Further, as FGD participants revealed as seen below, the lack of suitable venues for coitus in towns hindered many boys from having sex when they felt they needed it.

Participant: *But for us in Nairobi, we have no 'green lodge' (open air space) to take your girl. Doing it (sex) at home is also difficult, as visits may easily be reported by neighbours next door, or prove dangerous as one may easily be mistaken for a thug in the estates. Best days are Sundays but even then one may have to pay for a room.* (Group 1)

Participant: *Still the problem is that one does not have enough money to buy chips and soda or take her for a movie as she expects and then pay for a room. Such times one has to be satisfied with grooving (petting) and wait for the best time to come. (Group 3)*

The above reasons could largely explain why coital frequency of the respondents was similarly found to be associated with the place of residence as shown on table 5.6 below

Table 5.6 Respondents' Frequency of sexual Episodes in the previous six months by Place of Residence.

Frequency of Sexual Episodes	Place of Residence		Row Total
	Rural	Urban	
1	5 (6.1)	6 (28.6)	11 (10.6)
2-3	23 (28)	5(23.8)	28 (27.2)
>4	51 (62.2)	9 (42.9)	60 (58 3)
N/R	3 (3.7)	1 (4.8)	4 (3.9)
Column Total	**82 (100.0)**	**21 (100.0)**	**103 (100)**

Nb: N/R = No Response; figures in parenthesis are percentages (%).

x^2=9.143 with 3 df. Significant at 95% confidence level. c=0.2855.

The table above shows that generally the majority of the sexually experienced boys frequently engaged in sexual intercourse as most (58.3%) had had four or more sexual episodes in the previous six months proceeding the study. Maggwa (1987) similarly found that a significant proportion (48.9%) of the boys in his sample, also had had four or more sexual contacts in the six months before the survey. These findings confirm Toroitich-Ruto's (1997) observation that adolescents are sexually hyperactive.

Further, the table demonstrates that over sixty percent (62.2%) of the boys who resided in rural areas had had four or more sexual episodes as compared to 42.9% of their urban counterparts. Conversely, only 34.1% of the rural boys had had one to three sexual episodes in the previous six months unlike 52.4% of the boys from urban areas who did the same. This shows that the boys residing in rural areas had a higher sexual frequency than their urban counterparts. The study further found significant association (x^2=9.143) in the relationship between place of residence and frequency of sexual episodes. This association was found to be strong (c=0.2855).

Table 5.7: Respondents' Perception on the Effectiveness of Condoms against STI and HIV by Place of Residence.

Place of Residence	Perception on effectiveness of condoms against STI/HIV			Row total
	Effectiveness	Not effective	Not sure	
Urban	25 (80.6)	6 (19.4)	0 (0)	31 (100)
Rural	48 (53.9)	35 (39.3)	6 (6.7)	89 (100)
Column Total	**73 (60.8)**	**41 (34.2)**	**6 (5.0)**	**120 (100)**

Nb: Figures in parenthesis are percentages (%)

x^2=7.4708 with 2 d.f. Significant at 95% lever of confidence. c=0.2421

Table 5.7 shows that the relationship between place of residence and perception on effectiveness of condoms was found to be significant (x^2 = 7.4708) and the association between the two variables was found to be strong (c = 0.2421). This means that male adolescents from urban areas are more likely to perceive condoms as effective against STI and HIV than their rural counterparts. Kiragu and Zabin (1995), report a similar finding. This could be explained by the more positive and accom-

modating social environment to new information and social changes that prevails in urban areas unlike in rural areas as Pido (1997) found in his study in rural Kisumu on *Cultural factors contradicting behaviour modification messages* that

> The multifaceted and densely webbed messages delivered in home, family and social contexts proved a formidable obstacle as they blocked or contradicted the unilaterally presented messages delivered through unfamiliar channels and often suspect sources. (Pido, 1997; P.27).

Actual condom use was also seen to be influenced by place of residence.

Table 5.8 Respondents' Condom Use by Place of Residence.

Condom Use	**Place of Residence**		**Row Total**
	Rural	**Urban**	
Ever used	23(28.1)	13 (61.9)	36 (35.0)
Never used	59 (71.9)	5(38.1)	67 (65.0)
Column Total	**82 (100.0)**	**21 (100.0)**	**103 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=8.4288 with 3 df. Significant at 95% confidence level. c=0.3178

As table 5.8 shows sixty two percent (61.9%) of the respondents from the urban areas who were sexually active reported ever using condoms as compared to only twenty eight percent (28.1%) of their rural counterparts. Most urban boys had therefore engaged in condom use unlike their rural peers. The place of residence was found to significantly influence condom use (x^2=8.4288) in a strong way (c=0.3178). Residing in rural areas therefore increased a boy's likelihood that he would often engage in unprotected sex. The following reasons may explain this. One, physical availability of condoms is higher in towns as they are many places where condoms could be obtained freely for example, the respondents from urban areas unlike the rural ones identified clinics and bars as places where they could obtain free condoms anonymously from condom dispensers. Two, urban boys are also more likely to have higher purchasing power and are therefore more able to buy condoms when they feel they need them. Three, urban boys live in metro-

politan regions saturated with positive condom use messages, hence are more likely to have higher levels of condom acceptance and therefore higher condom use rates

5.3.4 Type of School Attended

5.9 Respondents' Sexual Experience by Type of School.

Sexual Experience	Type of school		Row Total
	Boarding	Day	
Experienced	61 (91.1)	42 (79.2)	103 (85.8)
Inexperienced	6 (8.9)	11 (20.8)	17 (14.2)
Column Total	**67 (100.0)**	**53 (100.0)**	**120 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=3.3883 with 1 df. Not Significant at 95% confidence level. c=1.1657

As seen above only six (8.9%) of the sixty-seven boarders were not sexually experienced as compared to eleven (20.8%) of the forty-three boys who were day scholars. Importantly, over eighty percent of both boarders (91.1%) and day scholars (79.2%) were sexually experienced. Not surprisingly therefore, that the study found no statistical significance between type of school and sexual experience (x^2=3.3883). The association between the two variables was also weak (c=1.1657). This finding was rather unexpected since students in day schools are less supervised by the teachers and are exposed to non-schooling influences which may lead them to easily engage in sexual activity. However, the finding may be explained by the fact that most of the respondents (56.3%) who were sexually experienced had had their first coitus by age 15. This means that most of the boys thus initiated sexual activity while still in primary school.

The study also found association between the respondents frequency of coitus by the gender composition of the school as shown below.

Table 5.10 Respondents' Frequency of Coitus by School Gender Composition.

Frequency of Sexual Episodes	School Gender Composition		Row Total
	Boys only	Mixed	
1	6(24)	5 (6.4)	11 (10.6)
2-3	8(32)	20 (25.6)	28 (27.2)
>4	11 (44)	49 (62.8)	60 (58.3)
N/R	0 (0)	4 (5.2)	4 (3.9)
Column Total	**25 (100)**	**78 (100)**	**103 (100)**

Nb: N/R = No Recorded Response; Figures in parenthesis are percentages (%).

x^2=8.3608 with 3 df. Significant at 95% confidence level c=0.0751

As demonstrated above the majority (81.7%) of the sixty boys who had had four or more sexual episodes in the previous six months preceding the study were enrolled in mixed schools as compared to 63.9% of the eighty-six boys enrolled in mixed schools with similar experience. Enrollment in a mixed school therefore seemed to increase the likelihood of boys' involvement in frequent sexual intercourse. Statistical analysis confirmed this, as school gender composition was found to significantly influence frequency of sexual episodes (x^2=8.3608). The association between school gender and frequency of sexual episodes was however found to be weak as indicated by the low value of c(0.0751). This underscores the fact that other factors exist that influence coitus, as shown elsewhere in this same chapter. Qualitative data revealed that even where school administration was very strict, students who wanted sex could still have it. Weekends were the best times since teacher-supervision was relaxed and minimal. Collusion with other students, prefects included offered sufficient cover that made sex to be easily achievable.

5.3.5 Level of Formal Education.

Table 5.11 below shows that the level of formal education was not found to be associated with condom use.

Table 5.11 Respondents Level of Formal Education by Condom Use.

Condom use	Level of Formal Education				Row Total
	Form I	Form II	Form III	Form IV	
Ever used	3 (27.3)	8 (29.6)	11 (32.4)	14 (45.2)	36 (35)
Never used	8 (72.7)	19 (70.4)	23 (67.6)	17 (54.8)	67 (65)
Column Total	**20 (100)**	**27 (100)**	**34 (100)**	**31 (100)**	**103 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=6.0656 with 3 df. Significant at 95% confidence level. c=0.02358

Table 5.11 shows that twenty seven percent (27.3%) of the Form one, 29.6% of the Form two, 32.4% of the Form three, and 45.2% of the Form four boys who were sexually experienced had ever used condoms. Condom use among the boys therefore, apparently seemed to increase with the number of years of formal education. However, against expected results the level of formal education was not found to have a significant influence on condom use (x^2=6.0656). The relationship was only significant at 90% level of condidence which was below the study's acceptance level of 95%. Moreover, the low level of c(0.02358) indicated a weak association between level of formal education and condom use. This suggests that other factors beside level of formal education significantly influenced condom use.

5.4. SOCIO-DEMOGRAPIC CHARACTERISTICS AND BOYS' SEXUAL PRACTICES

5.4.1 Marital Status of Parents

Table 5.12 Respondents' sexual Experience by Marital Status of Parents.

Sexual Experience	Marital Status of Parents				Row Total
	Married	Widowed	Divorced	Never married	
Experienced	81 (83.5)	3 (75)	11 (100.0	8 (100.0)	103 (85.8)
Inexperienced	16 (16.5)	1 (25)	0 (0)	0 (0)	17 (14.2)
Column Total	**97 (100)**	**4 (100)**	**11 (100)**	**8 (100)**	**120 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=8.9541 with 3 df. Significant at 95% confidence level. c=0.2635

As table 5.12 shows, only seventeen percent (16.5%) of the boys with married parents or from stable families had not experienced sexual intercourse compared to 75%, 100% and 100% of those with widowed, divorced and never married parents, respectively. Marital status of parents was significantly found to influence sexual experience (x^2=8 9541) at the confidence level of 95%.This means that adolescent boys who lived with both parents were more likely to abstain from premarital sexual activity than those with single parents or from unstable families Njau (1993) similarly, found that over 78.6% of the teenage girls who came from unstable families were sexually experienced. This could be explained by the emotional instability and frustrations that often accompany unstable families and could lead adolescents to seek comfort in premarital sexual activity. Little or lack of firm parental control in unstable families may likewise lead to lack of sexual restraint. The same reasons may also, explain why the association between marital status of parents and sexual experience was found to be strong (c=0.2635).

The same reasons may largely explain why marital status of parents was similarly found to influence age at first coitus as seen in the table below.

Table 5.13 Respondents' Age at First Coitus by Marital Status of Parents.

Marital Status	**Age at First Coitus (Years)**				**Row Total**
of Parents	**< 10**	**11-15**	**16-18**	**19+**	
Married	0 (0)	38 (46.9)	40 (49.4)	3 (3.7)	81 (100)
Widowed	3(100)	0 (0)	0 (0)	0 (0)	3 (100)
Divorced	7(63.6)	3 (27.3)	1 (9.1)	0 (0)	11 (100)
Never married	2 (25)	5 (62.5)	1 (12.5)	0 (0)	8 (100)
Column Total	**12 (11.6)**	**46 (44.7)**	**42 (40.8)**	**3 (2.9)**	**103 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=66.8087 with 9 df. Significant at 95% confidence level. r=0.4658

From the table 5.13, none (0%) of the respondents with married parents had engaged in precocious (pre-mature) sexual intercourse as compared to 100%, 63.6% and 25% of those whose parents were respectively, Widowed, divorced or never married. It is note worthy that all the

three (100%) of the respondents who reported engaging in first sex at the age of 19 had married parents. Further, a large proportion of the respondents from unstable families that is, 100%, 90.9% and 87.5% of those with widowed, divorced or unmarried parents had already experienced first coitus by the age of 15 as compared to only 46.9% of those with married parents. The study found marital status of parents to significantly influence age at first coitus (x^2=66 8087). This suggests that boys with parents in unstable marriages are more likely to initiate sexual activity earlier than those whose parents enjoy marital stability. Successful parental modeling and control over adolescents could largely account for this. The association between marital status of parents and first coitus was further found to be positive although the low value of r (0.4658) negated a close association between the two variables. The low value of r(0.4658) points to the fact that other factors exist which mainly influence first coitus as will be seen shortly.

5.4.2 Respondents' Alcohol and other Substance Use

The study noted a significant relationship between respondents' drug and alcohol use and sexual experience as seen in the table below.

Table 5.14 Respondents' Alcohol and Substance Use by Sexual Experience

Sexual Experience	Alcohol and Substance Use		Row Total
	Ever Used	Never Used	
Experienced	81(78.6)	22(21.4)	103(100)
Not Experienced	5(29.4)	12(70.6)	17(100)
Column Total	**86(71.7)**	**34(28.3)**	**120(100)**

NB: Figures in parenthesis are percentages (%)

x^2=17.4151 with 1 df. Significant at 95% confidence level. c=0.3560

Table 5.14 shows that about eighty-percent (78.6%) of the respondents who were sexually experienced had ever tried the use of drugs or alcohol while 70.6% of those who were sexually inexperienced had never tried their use. Drug and alcohol use thus had a significant influence on sexual experience (x^2=17.4151) and the association between the two variables was found to be

strong (c=0.3560). This finding agrees with that of WHO (2000), that alcohol and other substance abuse often accompany the early sexual experience of young men and increase the risk of STI, HIV infections and unwanted pregnancy. This may be mainly because alcohol and drug use hinder rational decision making due to intoxication and also lead to excitement that could easily lead to sexual activity.

5.4.3 The Peer Group and the Respondents' Sexual Practices.

Balmer (1994) observes that the peer group is a formidable force during adolescence and more so for males for whom it is the main source of sexual information. This observation was confirmed by the findings shown below.

Table 5.15 Respondents' Involvement in First Coitus by Primary Reason.

Primary Reasonsfor First Coitus	Frequency n=103	Percentage (%)
Forced to have sex	3	2.9
Curiosity	28	27.2
Urging of friends/To be like my friends	41	39.8
Desire to test sexual prowess	30	29.1
Total	**103**	**100.0**

The table above demonstrates that the primary motivation for involvement in first sexual intercourse for most (39.8%) of the boys, was either the urging of friends or the need to be like them. Peer influence was therefore found to be the main reason behind the boys' involvement in first coitus. Qualitative data seemed to confirm the above, as Maina (not his real name) a 17 year old key informant who reported being sexually inexperienced, warned the researcher against revealing the truth.

Maina: *They (school mates) must not be told that I have never done it (sex) even when I'm this old. The whole school, even the girls would laugh at me, calling me 'softie'*

Researcher: *Rest assured that I won't talk with anyone about your life, but tell me how you have managed to keep it a secret all along.*

Maina: *One has to keep lying. Every term I have to come with my stories also of how I had sex with girls during the holiday.*

FGD data also generated similar sentiments as seen below

Researcher: *What happens to the boys who refuse to give in to peer pressure to engage in sex?*

Participant: *This is serious, the boys may refuse to discuss sexual issues in your presence or chase you away. Yet one always wants to hear what other boys are doing or know about sex even when one is not interested in having sex.*

Participant: *Even girls will avoid a boy who does not fit with the others. (Group 5)*

Participant: *Everybody, including the girls tease you.*

Participant: *The agemates see you as a fool and avoid you. (Group 3)*

Participant: *Unless you are known as a serious christian, people may say that you are abnormal (foolish), infertile or that you may still be uncircumcised. (group 2)*

Participant: *Funnily, others may think that you are a coward, that you fear girls or that you are still uncircumcised.*

Researcher: *Shouldn't one fear AIDS which may come from these girls?*

Participant:: *Boys should fear AIDS but, not girls, not all girls have AIDS, so boys should be wise in choosing those girls they have sex with (Group 4).*

The above excerpts show that peer pressure (both from boy and girl peers) is a formidable force that pressurises male adolescents toward sexual activity. Unfortunately, it is also clear that most boys readily succumb to peer pressure as few of them would dare to stand alone given the loss of peer prestige and intense ridicule.

The study further found association between sexual experience and respondents' perception of peers' sexual experience.

Table 5.16 Perceived Peer Sexual Activity by Own Sexual Experience.

Perceived Peer Sexual Activity	Own Sexual Experience		Row Total
	Experienced	Inexperienced	
All of them engage in sex	34 (94.4)	2 (5.6)	36 (100)
Most of them engage in sex	66 (91.7)	6 (8.3)	72 (100)
Only a few engage in sex	3 (37.5)	5 (62.5)	8 (100)
None of them engage in sex	0 (0)	4 (100)	4 (100)
Column Total	**103 (85.8)**	**17 (14.2)**	**120 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=43.7142 with 3 df. Significant at 95% confidence level. c=0.7113

Table 5.16 shows that while in reality, seventeen (14.2%) of all of the respondents reported being sexually inexperienced, none (0%) of their colleagues perceived this to be the case. On the contrary majority (90%) felt that 'all' or 'most' of their peers were engaging in sex. This suggests that boys were more likely to over-estimate their peers' sexual activity.

Further, almost all (97.1%) of the respondents who perceived 'all' or 'most' of their peers to be sexually active, were themselves sexually experienced as compared to only three (25%) of the twelve respondents who felt that 'none' or 'only' a few of their peers were engaging in sex. A boy's perception of sexual activity among peers was therefore an accurate predictor of his own sexual experience as the relationship between the two variables was found to be significant (x^2=43.7142). The association was also seen to be strong as indicated by the high value of c(0.7113). This means that the more likely the boys perceived their peers to be sexually experienced, the more likely they were to engage in sex. This confirms WHO's (1989), that the urgency with which adolescent males seek heterosexual activity is mainly the function of their peer group association.

5.4.4 Male Sexual Norms and the Respondents' Sexual Practices.

5.4.4.1 Involvement in Premarital Sex.

Gooren (1993) observes that:

> There is multiformity of sexual behaviour and its meanings in different cultures .....
> A sexual act does not carry with it a universal social meaning; physically identical acts may have varying social significance and subjective meanings depending on how they are perceived, interpreted and constructed.
> (Gooren, 1993, P.216).

It is therefore important to acknolwedge that while the larger society (adults especially) mainly view premarital sex as risky and deviant behaviour, it may nevertheless carry different social and sexual meanings to the adolescents depending on how they perceive, interpret and construct it Investigating these sexual constructions and meanings is therefore essential in understanding male adolescent sexuality.

Table 5.17 below shows that the sexual and social meanings that the respondents attached to premarital sex mainly accounted for their need to continue engaging in sex even when their first sexual experience was not enjoyable.

Table 5.17 Respondents' Main Reasons for Planning to continue Engaging in Premarital Sex.

Main Reasons for Planning to Continue with Sex	Frequency n=99	Percentage (%)
To gain enough Sexual Experience (Prowess)	15	15.2
To retain the respect of others/ Avoid being odd among the age mates	29	29.3
I am old enough/No longer a boy/ I am circumcised	26	26.2
For Enjoyment	8	8.1
To show love to my girl	11	11.1
Need to satisfy sexual desire/Sexual desire is unbearable	10	10.1
Total	**99**	**100.0**

From the above, premarital sex for boys carried three important social meanings: gaining of social and peer prestige, portrayal of maturity or manhood and an avenue for expressing intimacy. It also had the sexual meanings or functions of enhancing sexual prowess, satisfaction of sexual desire and giving of pleasure. Boys therefore, mainly felt the need to continue with premarital sex in pursuit of its social and sexual meanings and not merely for enjoyment.

Qualitative data revealed that these social and sexual meanings of premarital sex were not the domain of the male adolescent subculture alone but were contained in the socio-cultural sexual scripts held by all in the society. Kimani, an 18 year old key informant who confessed being a born-again christian and having not engaged in sexual intercourse lamented that:

Kimani: *The problem is that even girls really laugh at you saying that you cannot do anything to them (sexually impotent) simply because you don't ask them for sex. One is really tempted to prove that he is a normal man like others ... ...*

An FGD discussion further revealed that:

Participant: *Parents are really worried when boys even after they have been circumcised remain around the fire place like girls, instead of going out to look for girls.*

Participant: *Not only parents, all the villagers really doubt whether a boy who sticks to their home is really normal ... ...*

Participant: *If they don't call you infertile, they may call you a girl. (Group 3)*

The above excerpts reveal that images of masculinity are closely tied to sexual prowess, a finding echoed in most sexual studies in Kenyan and East African communities where males are portrayed as needing constant sex. (Poewe, 1981; Buzzard, 1982; Nelson, 1987; Kisseka, 1989). It may be argued then that this close tie between masculinity and sexual prowess increases a boy's need for premarital sex as being masculine is crucial to his identity and self-esteem.

It is important to note from the above excerpts that male circumcision though seen as a cultural rite among practicing communities also carried important sexual meanings for the boys and thus influenced their sexual behaviour. In the above instance, the FGD participants felt that the social

expectations on boys' sexual behaviour changed with circumcision. The circumcised boys were now expected to 'walk around' with girls. Circumcision was thus seen to avail the social license for boys to engage in sexual activity.

Jeremiah, a 14 year old Key informant, who confided having had first coitus after his circumcision observed that:

Jeremiah: *Sex is a must after circumcision, others want to know whether you have 'wiped off the suit' of boyhood after becoming a man.*

The above findings suggest that male circumcision besides being a socio-cultural practice is also a male sexual norm whose meanings pressurise boys to engage in premarital sexual intercourse. This phenomenon could further be understood in the light of Population Council's (1994) observation that first sexual intercourse often serves as initiation into adulthood for boys.

5.4.4.2 Involvement in Rape.

Table 5.18 Respondents' Reasons for Involvement in Rape.

Reason for Rape	Frequency ""	Percentage %)
To humiliate a proud or abusive girl	18	62.1
Could not control myself after petting	11	37.9
I just joined others	04	13.8
Their school and ours were enemies	03	10.3
No response recorded	03	10.3

From table 5.18, the reason why the majority (62.1%) of the respondents who reported having ever been involved in rape was mainly to humiliate girls who they perceived as proud or abusive. Qualitative data revealed that by 'proud or abusive' girls the respondents meant girls who had continously rejected their sexual advances. They said that they felt greatly humiliated to have a girl let them down and thus had to settle the score. This means that the boys greatly valued sexual conquest which is a dominant trait of the machismo norm. This is because as Ellis (1913) ob-

serves, the sexual role of the male in this tradition is perceived to be that of the 'Wooer' 'the hunter' 'the chaser' and the 'conqueror' as against that of the female who is the 'wooed' 'the hunted', 'the chased' and 'the conquered'. The other main justification why about fourty percent (37.9%) of those respondents have been involved in rape was inability to control their sexual urges. Mitchel (1971) and Njau (1995) observe that males are generally believed to have strong sexual urges that are often uncontrollable. The justification of uncontrollable sexual urges by the respondents therefore may be seen to reflect their compliance to this popular male sexual norm.

CONCLUSION

As discussed above respondents individual characteristics were found to influence sexual behaviour. Age was found to positively influence sexual experience and the number of lifetime sexual partners. Religious affiliation was not found to significantly influence a boy's likelihood to have experienced sexual intercourse though it influenced their engagement in unprotected sex as it led to very low rates of condom use. Affiliation to protestanism unlike Catholicism or traditionalism on the other hand positively influenced sexual experience as it led to high condom use rates. Residing in rural areas was found to be associated with high sexual experience, increased sexual frequency and low condom use or unprotected sex. Enrolment in a day school was not found to significantly influence sexual experience while enrolment in a mixed school increased frequency of sexual intercourse. The level of formal education was however found to have no significant influence on condom use. These findings qualified to the larger extent the study's first hypothesis that stated in part that male adolescents' individual background factors largely influenced their sexual behaviour. Living in a socially unstable home was found to increase the likelihood that a boy would be sexually experienced and initiate sexual activity early. The urging of friends or the desire to be like them was found to be the main motivation behind engagement in first coitus. Further, alcohol and drug use was found to significantly influence one's sexual experience. Involvement in premarital sex and the respondents' plan to continue with it were mainly seen as bringing respect from others, being signs of manhood and being an avenue of gaining sexual

prowess. The above findings therefore, qualify the second part of study's first hypothesis that stated that the sexual behaviour and practices of adolescent boys were largely influenced by their family background characteristics, the peer group associations and the prevailing male sexual norms. In conclusion therefore, the first hypothesis of the study was found to be true in stating that adolescent boys' sexual behaviour and practices are largely influenced by their individual and family background characteristics, the peer group associations and prevailing male sexual norms. The hypothesis was therefore, accepted.

5.5 RESPONDENTS' SEXUAL ATTITUDES , PERCEPTIONS AND RISK MANAGEMENT PRACTICES.

Risk management strategies may be called safer sex methods and include any sexual practices geared to reduce the risk of STI and HIV infection. These mainly include sexual abstinence, condom use and faithfulness to a single sexual partner. Analyzed below are the respondents' sexual attitudes and perceptions and their impact on adoption of safer sex methods.

Section 5.5 therefore, presents the tests of the second hypothesis of the study that stated that the sexual perceptions and attitudes of adolescent boys' hindered their successful adoption of effective risk management practices.

5.5.1 Sexual Attitudes and Risky Behaviours.

Table 5.19 Respondents' Attitude Towards Premarital Sex by Sexual Experience.

Sexual Experience	Attitude Towards Premarital Sex		Row Total
	Approved	Disapproved	
Experienced	49 (47.6)	54 (52.4)	103 (100)
Not Experienced	8 (47.1)	9 (52.9)	17 (100)
Column Total	**57 (47.5)**	**63 (52.5)**	**120 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=0.0156 with 1 df. Not significant at 95% confidence level. c=0.0035.

From table 5.19, sixty-three (over half) of the one hundred and twenty respondents had a negative or non-accepting attitude towards premarital sexual intercourse. However, their majority (52.4%) had all the same engaged in sexual intercourse On the same note, no significant relationship was found to exist between attitude toward premarital sex and sexual experience (x^2=0.0156) at 95% level of confidence. Moreover, the association between the two variables was likewise found to be quite weak (c=0 0035). This underscores the fact that a negative attitude towards premarital sex per se is not a sufficient deterrent to engagement in premarital sexual intercourse for adolescents. However, respondents' attitude toward condom seemed to have a compelling influence on condom use as shown in the table below

Table 5.20 Respondents' Attitude Towards Condom use by Boys own use of Condom.

Attitude toward Condom use by Boys	**Condom Use**		**Row Total**
	Ever Used	**Never Used**	
Approved	33 (84.6)	6 (15.4)	39 (100)
Disapproved	3 (4.7)	61 (95.3)	64 (100)
Column Total	**36 (35)**	**67 (65)**	**103 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=6.6109 with 1 df. Significant at 95% confidence level. c=0.2455

From table 5.20, thirty-three (84.6%) of the thirty-nine respondents who had an accepting attitude toward condom had actually used condom at one time or the other as compared to only 4.7% of those with a negative attitude who reported ever using condom. The relationship between attitude to condom use and actual use was found to be significant (x^2=6.6109) at 95% level of confidence. Further, the association was found to be strong as indicated by the high value of c(0.2455). Boys' attitude towards condom therefore, greatly influenced their use or non-use of condoms. This confirms Mauro's (1995) observation that sexual attitudes comprise strong antecedents to sexual practices. In our case it is clear that a boys' negative attitude towards condom use was a strong antecedent to the practice of unsafe or unprotected sex.

Table 5.21 Respondents' perception on Importance of Sexual Intercourse in a Boy-girlfriend Relationship by Frequency of Sexual Episodes

Sexual Episodes Six Months Previously	Perception on Importance of Sexual Intercourse in a Boy-girlfriend Relationship			Row Total
	Very Important	Fairly Important	Not Important	
1	3 (7)	3 (6.1)	5 (45.5)	11 (10.7)
2-3	3(7)	22 (44.9)	3 (27.3)	28 (27.1)
>4	37 (86)	22 (44.9)	1 (9 1)	60 (58 3)
N/R	0 (0)	2 (4 1)	2 (18.2)	4 (3.9)
Column Total	**43 (100)**	**49 (100)**	**11 (100)**	**103 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=45.3071 with 6 df. Significant at 95% confidence level c=0.5527

Table 5.21 demonstrates that thirty-seven (86%) of the forty-three respondents who perceived sex in a boy-girlfriend relationship to be 'very important' had had four or more sexual episodes in the six months preceeding the survey, compared to twenty-two (44.9%) of the forty-nine respondents who felt sex to be 'fairly important' and only one (9.1%) of the eleven respondents who said that sex is 'not important' in a boy-girlfriend relationship. This shows the majority of these boys who regarded sex as either 'very' or 'fairly' important had high rates of sexual frequency than those who felt sex to be 'not important' in adolescent relationships. Similarly the study noted a statistically significant relationship between perception on importance of sexual intercourse in a boy/ girlfriend relationships and sexual frequency (x^2=45.3071) at 95% confidence level. The association was moreover found to be strong (c=0.5527). A boy's high opinion or regard on the importance of sex in a boy-girlfriend relationship therefore, led to a high frequency of sexual intercourse which in turn increased his chances, of STI and HIV infection.

As the table below shows respondents' opinion on ideal number of sexual partners influenced actual number of lifetime female sex partners.

Table 5.22 Respondents' Opinion on Ideal Number of Sexual Partners for Adolescent Boys by own Number of Lifetime Female Sexual Partners.

Opinion on Ideal	Number of Lifetime Female Sexual Partners				
No. of sexual partners	1	2-3	4-5	6+	Row Total
1	3(50)	2(33.3)	1(16.7)	0(0)	6(100)
2-3	0(0)	4(12.5)	23(71.9)	5(15.6)	32(100)
4+	0(0)	2(10.5)	8(42.1)	9(47.4)	19(100)
Column Total	**3(5.3)**	**8(14)**	**32(56.1)**	**14(24.6)**	**57(100)**

NB: Figures in parenthesis are percentages (%).

x^2=37.5915 with 6 df. Significant at 95% confidence level. r=0.6398

The table above shows that all (100%) of the respondents who were of the opinion that boys should have two and above sexual partners had actually had had more that two sexual partners. On the other hand however, half (50%) of those who felt that boys should stick to a single sexual partner reported having only one lifetime female sexual partner. Further, respondents' opinion on ideal number of sexual partners was found to significantly influence the number of sexual partners (x^2=37.5915). The two variables had a positive perfect correlation (r=0.6398). This means that a boy's likelihood of having multiple sexual partners increased with his having the opinion that a boy should have more than one sexual partner. In this case the boys' sexual opinion on the ideal number of sexual partners hindered their practice of sexual fidelity or single sexual partner relationships.

5.5.2 Attitude Toward Rape.

Rape was considered as a risky sexual behaviour in that it exposes its victims to intense physical and psychological harm and carries high risks of STI and HIV infection as it largely involves unprotected sex. However, contrary to the study's expectations there was no association found between attitude towards rape and involvement in it as shown below.

Table 5.23 Respondents' Attitude Toward Rape By Involvement in Rape.

Attitude Toward Rape	Involvement in Rape		Row Total
	Yes	No	
Approved	11 (28.9)	27 (71.1)	38 (100)
Dissaproved	18 (27.7)	47 (72.3)	65 (100)
Column Total	**29 (28.2)**	**74 (71.8)**	**103 (100)**

Nb: Figures in parenthesis are percentages (%).

x^2=0.0187 with 1 df. Not Significant at 95% confidence level. c=0 0135

Table 5.23 illustrates that about similar proportions of those respondents who either approved (28.9%) or disapproved (27.7%) of rape had actually been involved in it. Attitude toward rape was not therefore a compelling influence in a boy's involvement in rape since there was no significant relationship between attitude toward rape and actual engagement in rape (x^2=0.0187) at 95% level of confidence. The association was also found to be weak as indicated by the low value of c(0.0135). This suggests that rape could be more of a situational activity or phenomenon of the male adolescent group culture.

CONCLUSION

While attitude towards premarital sex and rape was not found to have a compelling influence on engagement in these practices, attitude towards condom use was found to positively influence actual use. Further, positive perceptions toward the need for sexual intercourse in a boy-girlfriend relationship and on ideal number of sexual partners were found to increase the likelihood of being sexually experienced, thus qualifying the study's second hypothesis that perceptions and attitudes of the adolescent boys toward risky sexual practices hindered their successful adoption of effective risk management practices.

5.6 RESPONDENTS' STI ILLNESS AND TREATMENT- SEEKING BEHAVIOUR

Maintaining a normal health status is a universal human concern. The search for a remedy is therefore the normal human response in the event of an illness. Research however observes that response to sexually transmitted illnesses is often in the contrary as STI are highly stigmatized and thus provoke great embarrasment and shame. For adolescents whose sexual activity is frowned upon, the embarrassment is even greater. (Tunju, 1996). The respondents were therefore expected to mainly ignore or accommodate STI symptoms as the study had hypothesized in the fourth hypothesis, that adolescent boys frequently ignore STI symptoms or resort to self-treatment upon self-diagnosis of an STI. However, contrary to expected result, as shown in the table below, majority of the respondents who reported having had experienced symptoms which they perceived or interpreted to be those of an STI had at least sought treatment of some kind

5.6.1 Respondents' Time-lag in seeking STI Treatment

The search for STI treatment was however never prompt as seen in the table below

Table 5.24 Time taken between the Respondents' Recognition of STI symptoms and Treatment Action for the last Perceived STI Illness.

Time Taken	Frequency	Percentage (%)
A day or less	0	0
Within 7 days (One week)	3	7.9
Within 14 days (Two Weeks)	16	42.1
Within 21 days (Three weeks or more)	19	50.0
Total	**38**	**100.0**

From the above table none of the thirty-eight respondents who sought STI treatment did so immediately and only three (7.9%) of them sought treatment within seven days of recognizing STI symptoms. Thirty-five (92.1%) of the respondents sought STI treatment within the second or third of experiencing the symptoms. This suggests that majority of adolescent boys may accommodate perceived STI symptoms for great periods of time before seeking treatment. Three

main reasons were given by the respondents for the delay in seeking STI treatment. These were the feeling that the symptoms were not severe (54.3%), the feeling that symptoms would soon disappear on their own (40%), and the feelings of embarrassment and fear (31.4%). This suggests that male adolescents, mostly seek STI treatment only when the symptoms become unbearable. A nurse from a public health dispensary confirmed this when she lamented

Nurse: *Boys only come to us when it is too late, most don't report minor STD symptoms like urinary tract pains, itchiness or sores. They often come on serious discharge or when the sores become wounds. Ironically, everyone who sees them at this stage can guess their illness since their walking is problematic.*

However, similar treatment seeking behaviour for STI has been observed among women with genital ulcer disease (GUD) in Kisumu who sought treatment only when the symptoms became too severe to bear. (Ajaji, 1999).

5.6.2 Respondents' Utilization of STI Treatment Resources

Table 5.25 below shows the variousSTI treatment resources the respondents utilized during the last perceived STI infection by the order of utilization.

Table 5.25 Respondents' Utilization of STI Treatment Resources during the last Perceived STI Infection by Order of Utilization.

Resource	Resource Utilization		
	1st Source	2nd Source	3rd Source
Health facility	08(21.1)	12(70.6)	02(100)
Herbs	16(42.1)	02(11.8)	0(0)
OTC drugs	03(7.9)	03(17.6)	0(0)
OTC drugs and herbs combined	03(7.9)	0(0)	0(0)
Dettol and salty water	02(5.3)	0(0)	0(0)
Sex with young girls	04(10.5)	0(0)	0(0)
Traditional healer	01(2.6)	0(0)	0(0)
Prayers	01(2.6)	0(0)	0(0)
Total	**38(100)**	**17(100)**	**02(100)**

NB: Figures in parenthesis are percentages (%)

The table above shows that the majority (42.1%) of the thirty-eight respondents who did something about their last perceived STI illness used herbs as their initial therapy. The herbs popularity as an initial therapeutic resource was because they were relatively the most available, accessible and affordable remedy to most respondents as compaired to the other treatment resources. The health facility was the second most utilised (21.1%) resource. The health facility was however the leading or the most popular second source and the only third source of treatment for the respondents. This means that the respondents recognise the proficiency of the health facilities in STI treatment as they mainly referred their uncured STI cases there.

The STI treatment resources used by the respondents were seen to fall into three broad classifications depending on whether a particular resource was essentially based on self or proffesional treatment or both as seen below.

Table 5.26 Classification of Respondents' Therapeutic Resource Utilization for the last Perceived STI illness.

Resource used	Resource Classification		
	Self-treatment only	Professional treatment only	Self and Professional treatment combined
Clinical treatment only	0(0)	08(80)	0(0)
Herbs only	04(26.6)	0(0)	0(0)
OTC drugs only	03(20)	0(0)	0(0)
Herbs then clinical treatment	0(0)	0(0)	06(46.2)
OTC drugs & herbs	03(20)	0(0)	0(0)
OTC drugs & clinical treatment	0(0)	0(0)	02(15.4)
OTC drugs, herbs & clinical treatment combined	0(0)	0(0)	03(23)
Sterilizers (Dettol and Salty water)	01(6.7)	0(0)	0(0)
Young girls	03(20)	0(0)	0(0)
Young girls, herbs then clinical treatment	0(0)	0(0)	02(15.4)
Traditional healing services	0(0)	02(20)	0(0)
Prayers	01(6.7)	0(0)	0(0)
Total	**15(100)**	**10(100)**	**13(100)**

Nb: Figures in parenthesis are percentages (%).

As table 5.26 shows fifteen (39.5%) of the thirty-eight respondents who had sought some form of STI treatment relied strictly on self-treatment, mainly herbal regimens and OTC drugs. On the other hand ten (26.3%) of the respondents stuck strictly to professional treatment while thirteen (34.2%) of the respondents combined both self and professional treatment. As the study had hypothesized therefore, most of the respondents resorted to self-medication upon STI self-diagnosis. The third hypothesis is therefore true, leading to its acceptance. This confirms WHO's (2000) observation that male adolescents are more likely to use self-treatment in the event of an STI infection.

CONCLUSION

In the light of the above most respondents sought STI treatment on experiencing a self diagnosis. This was contrary to the expected results and also partly contrary to the study hypothesis that adolescent boys frequently ignored STI symptoms or resulted to self treatment upon making self diagnosis. However, a significant proportion (44.1%) of the boys who had experienced STI symptoms actually did nothing about them, proving the third hypothesis of the study to be correct to some considerable extent,in stating that boys frequently ignored STI symptoms. The latter part of the hypothesis was however qualified by the findings that the respondents mainly utilised self medication in the management of their STI illnesses.Conclusively therefore,the third hypothesis of the study was true to the larger extent and was therefore accepted.

5.7 RESPONDENTS' RISK MANAGEMENT PRACTICES

This section consists largely of qualitative data showing strategies with which adolescent boys managed the risk of STI and HIV/AIDS infection.Qualitative data has been used below to test the validity of the fourth hypothesis of the study which stated that there is high tendency among adolescent boys to utilize lay techniques and resources in the management of the risks of STI and HIV infections.

5.7.1 Condom Use

Safer sex in the context of HIV/AIDS control in Kenya has mainly been promoted through the encouragement of condom use (Nzioka, 1996). Apart from being sold in major stores, condoms in Kenya are also distributed freely in most public and private health care institutions. By also waiving excise duty on condom imports the government ensures that they remain cheap and therefore easily affordable to most Kenyans (Gok, 1997). However, only seventeen (21%) of the eighty-one respondents who reported change of sexual behaviour so as to avoid HIV infection, had started using condoms.

Probing the low rate of condom use, qualitative data revealed that condom use was regarded unnecessary where sexual partners were familiar or regular as FGD participants argued that:

Participant: *Condoms are only useful in times when one is not very sure of a girl or with prostitutes and these times are few. But with a girlfriend or a girl one knows to be well behaved, there is no need to use condoms.*

Researcher: *Why don't you feel that they too may be infected with STD of HIV?*

Participant: *But with a girlfriend one is sure she can be trusted. (Group 4)*

Participant: *And with a girl one knows well, one can always tell whether she has been moving carelessly with many men or not.*

Participant: *Girls also don't trust boys who use condoms. They always think they are sick (have STD) or are having sex with other girls. (Group 6)*

From the above excerpt condom use was felt necessary only in casual sex encounters where partners could not be trusted or with commercial sex workers. With girlfriends or girls perceived as well behaved, condom use was felt unnecessary and at times a betrayal of the shared love and trust or a sign of infidelity. This shows that unsafe sex among male adolescent mainly occurs within close social or sexual relationships as with 'girlfriends' or 'trusted' girls as argued above and where these relationships carry particular social meanings such as trust, familiarity, intimacy, care and love.

The above finding on reluctance to use condoms in regular relationships concides with that of Buzzard (1982) in Kisumu, where Luo women feared introducing condoms to their partners because of potential accusations of being promiscuous Schoepf (1990), also found that since condoms are associated with prostitution and disease, proposing a condom to a partner signifies mistrust and can be experienced as an insult

5.7.2 Petting

Petting without coitus was said to be preventive against the infection of STI and HIV Petting was variously described as touching each other everywhere, kissing, hugging, massaging and rubbing against each other. Essentially these descriptions comprised a sense of intimate touching and kissing. FGDs revealed that the manner of petting could range from 'light' to 'heavy' 'Light' petting was where adolescents would touch and kiss their partners while they were still dressed up and only limitedly on the face, hair, lips and breasts. 'Heavy' petting would go further to have the partners half or fully undressed and touching and kissing would be extended to the uncovered breasts, sexual organs and even the inserting of fingers into the female genitals, a practice which was referred to as 'fingering'. This was described as often leading to ejaculation and only stopped short of penile penetration as Laikuru (not his real name) a 19 year old key informant confided:

Laikuru: *I always enjoy gloving (petting). it is always fun and also helps prevent AIDS as I avoid kissing and use the fingers to get to climax with the girls I don't know well or trust ... but with a girlfriend I don't have to punish myself this way.*

From the above instance petting was perceived as a safer sex method besides being a source of fun and sexual relief.

5.7.3 Urinating immediately after sex

Most of the FGD participants observed that urinating immediately after sex helps prevent STI and HIV infection. Infact, all the sexually experienced key informants said that they mostly tried

to urinate immediately after a sexual encounter. Urine was seen to 'carry out' or 'wash down' the urethra of any STI and HIV pathogens. Tunju (1996) similary, reports a strong belief among adult men that if one drinks a lot of beer after sexual intercourse, he urinates more and all the germs are passed out eliminating the risk of STI infection. Earlier studies also have reported the same notions and practice. Gichuhi (1986), Oniango and Rogo, (1989). Larson (1989) also observed the same belief and practice in Rwanda. While urinating immediately after sex may be seen as a lay construction of safer sex, founded merely on social sense or logic some scientific studies give it authenticity and support. IPPF (1994) and Mauro (1995) argue that the act of urinating after sex actually reduces the viral and bacterial 'load' along the urethra thus reducing the degree of STI infectivity. Urinating after sex may therefore in a way be termed as a safer sex though it does not eliminate infectivity. Explaining such instances, Homans and Aggleton (1987) observe that in some cases lay beliefs about disease overlap with those of health professionals.

5.7.4 Taking a bath or washing the penis after sex

About five in every eight FGD group perceived the act of bathing or washing the penis after sexual intercourse as preventive against STI/HIV infection. Further, two key informants agreed that if urine was not forthcoming immediately after sex then they took a quick bath or wiped the penis clean. By washing the penis, taking a bath or even wiping the penis against the underpants or using a piece of cloth or toilet paper, physical cleanliness was perceived as eliminating 'dirt' or STI and HIV pathogens thus preventing an infection. Similar findings where washing was seen as a preventive method against STI and HIV have been observed in Okumu and Chege (1994) where 16% of the secondary school girls in their sample reported that taking a bath after sexual intercourse would prevent an STI infection. Nzioka (1994) also reports the same practice as a lay construction of safer sex among HIV-positive patients in Nairobi. Elsewhere, other studies have reported the same belief and practice as in Kinshasa (Nzila, et. al, 1991) and in Lusaka (Nyiyenda-Meya, 1992). Physical cleanliness however, does not offer any protection against the infection of STI and HIV since the exchange of seminal fluid which causes the infection takes place internally in the reproductive system.

5.7.5 'Quick' sex

FGD participants said that 'quick' sex was a viable method of protection against STI and HIV. By 'quick' sex the participants referred to fewer rounds or stands of sexual intercourse, as one participant argued:

> *Participant:* *You don't get STDs and AIDS when you're quick in it (sex). One or two shots are safe enough. The problem is when you spend all your time there. Yes, too much of something is poison. (Group 1)*

Another participant had similar opinion asserting that:

> *Participant:* *A quickie (one stand) does it. It is convenient for any place and saves you time and trouble! (Group 3)*

In these instances adolescents seemed to equate the risk of STI and HIV infection with the number of 'shots' or rounds or actual exposure one takes in a sexual encounter. That argument seems to find support from biomedicine where STI and HIV transmissibility is measured per single sexual exposure. For instance James Chin, an epidemiologist at WHO's Global Programme on AIDS suggests a mean transmission rate of HIV to range between 0.1% and 1% per a single exposure. (Chin 1991)

Nevertheless, 'quick' sex among adolescents could still be seen as safer sex in that it reduces the vaginal-genital trauma that is characteristic of most adolescent sexual activity as a result of the intense force, energy and aggressiveness often employed by the male adolescents (Caplan, 1987) and also basically because of its nature as dry sex, as it has inadequate vaginal mucus due to immature reproductive systems and genitalia (Mauro, 1995). In 'quick' sex this vaginal-genital trauma is therefore greatly reduced, due to reduced exposure which leads to reduced genital laceration thereby reducing the risk of STI and HIV transmission. 'Quick' sex by the male adolescents may thus be termed as safer sex as it reduces the number and duration of sexual exposures, which may lead to reduced STI transmission rates.

The safety of 'quick' sex is however, not guaranteed since as Bloor (1995) observes, STI/HIV infectiousness is also associated with 'viral or 'bacterial' load. (the levels of infectious virus or bacteria in bodily fluids). So infectiousness is high when the index case is first infected because of the initial absence of antibodies. Therefore a 'quickie' or a 'shot' that a male adolescent may take with a sexual partner who is *newly infected* with an STI or HIV would most certainly lead to an infection as the seminal fluid and blood of the sexual partner would be carrying a high viral or bacterial 'load'.

5.7.6 'Shallow' sex

Qualitative data revealed that 'shallow' sex was seen to be preventive against STI and HIV infection. 'Shallow' sex was described as shallow vaginal penetration as opposed to deep penetration. It was also described as 'light sexual thrusts' implying a minimal application of physical force in penetration. Ben, a 17 year old key informant reasoned as follows:

> Ben: *I'm always very careful with the girls that I do not trust. I don't allow myself to go deep into them. Otherwise I can easily catch a disease.*

In the above instance Ben seemed to construct the risk of STI and HIV infection as being determined by the depth of vaginal penetration in sexual intercourse. The vagina thus was seen to be merely a pathway which is free from infection since the penis penetrates deep through it and ejaculation takes place deep inside it. Therefore, the cervix and the womb which happen to be the receptors of the seminal fluid are the ones which carry the STI and HIV microbes if any. Shallow vaginal penetration of the sexual partners suspected to be infected with an STI would thus be seen to be protective against the infection. This perception however, is fallacious in that any vaginal-genital contact at whatever depth that leads to exchange of seminal fluids carries the risk of STI infection. 'Shallow' sex therefore does not offer male adolescents any protection against the infection of STI.

5.7.7 Periodic Abstinence

Twenty-five (24.3%) of the one hundred and three respondents who reported being sexually experienced said that they avoided frequent sexual intercourse and only had sex after long periods of time. The abstinence period was mostly said to be three months long which seemed more of sexual adaptation as it coincided with the normal three months school term. Periodic abstinence would be considered safer sex in the sense that it reduces sexual frequency which means reduced vaginal-genital contact and thus reduced likelihood of STI and HIV transmission. However, STI and HIV pathogens may still be transmitted during the few or infrequent episodes of unprotected sex. The respondents seemed unaware that it is not the long abstinence period that determines the STI or HIV contagion but the potential risk engendered in a single episode of unprotected vaginal-genital contact.

5.7.8 Reduction of Sexual Partners

One in five (22.3%) of the sexually experienced respondents reported having reduced the number of their sexual partners so as to avoid STI and HIV contagion. While having fewer sexual partners is a recommended safer sex method as it is a positive step towards risk reduction and has the ultimate goal of sticking to one sexual partner, it nevertheless comprises a substantial risk element. For the same reason Bloor (1995) argues that having fewer sexual partners is to be considered a lay safer sex method as it remains highly relative and ambiguous since to one person two partners may be few and to another six may still be considered few. The same reason however may explain why the method was popular with the respondents as they found it convenient and not demanding a radical change of sexual behaviour.

However, it may be argued that while most of the respondents who reported sexual behaviour change were having fewer sexual partners (who qualitative data revealed to be mostly two or three) they still remained significantly exposed to STI and HIV infection.

5.7.9 Sticking to One Sexual Partner

Only sixteen percent (15.5%) of the sexually experienced respondents who had modified their sexual behaviour were practicing sexual fidelity as a safer sex method against STI and HIV infection. In fact, sticking to one sexual partner was the least practiced safer sex method. This means that sexual faithfulness or sticking to a single sexual partner is not popular or readily acceptable sexual behaviour to the male adolescents. This underscores the fact that the male sexual norm of having multiple sexual partners as a sign of sexual prowess remains deeply ingrained in the male adolescent culture. The few respondents who practiced sexual fidelity may however, be said to be at a low risk of infecting STI or HIV/AIDS.

5.7.10 Having sex with young girls

Twenty-four percent (23.8%) of the respondents said that having sex with a young girl is an important way of both preventing oneself and curing of an STI infection. Three respondents (7.9%) of the thirty-eight respondents who sought STI treatment after a self diagnosis said that they had sex with young girls. Qualitative data revealed that by 'young girls' the respondents meant girls who are starting to grow their breasts. This means those in late puberty or early adolescence and thus who were perceived as not being sexually exposed. These were perceived to be an 'AIDS-free generation' and thus having sex with them was considered safe. Larson (1989) reports a similar finding in Rwanda where old men target the young girls for sex perceiving them as HIV-free. Young girls may however be a source of STI and HIV infection to the male adolescents as they may be already be sexually exposed in spite of their young age

5.7.11 Anal sexual intercourse

Thirty-two (31.1%) of the one hundred and three sexually active respondents had had heterosexual anal sexual intercourse. Qualitative data revealed that most key informants and FGD participants perceived that anal sexual intercourse with girls could help prevent HIV infection. A small proportion of the participants especially those from the FGDs in the boys school also felt that homosexual intercourse between boys could also serve the same purpose. A similar finding is reported by Barker and Rich (1992) in their FGDs study on influences on adolescent sexuality

in Kenya and Nigeria where adolescents said that heterosexual anal intercourse could help prevent both pregnancy and HIV infection among adolescents. Anal sexual intercourse however actually exposes male adolescents to a higher risk of infection as HIV is more readily transmitted via unprotected anal intercourse than via unprotected vaginal intercourse (Bloor, 1999).

5.7.12 Masturbation

Sixty-eight percent (68.3%) of the respondents mentioned masturbation as a known method, which could prevent STI and HIV infection. Most FGD participants and key informants freely expressed similar opinion further revealing that masturbation could be done by self or mutually. Masturbation was seen to have a double advantage of offering sexual relief and safety. Its safety was said to lie in its non-penetrative nature. Importantly, almost all (97.5%) of the respondents had practiced masturbation. Earlier adolescents' studies similarly report masturbation as a common practice especially among males (Gachuhi, 1986, Oniango and Rogo 1989, Okumu and Chege, 1994). IFPP (1995) accounts for this behaviour by observing that learning to masturbate is an integral part of a boy's development to becoming a man and also a way for a boy to learn his intercourse cycle. In the fight against HIV/AIDS masturbation among male adolescents then seems to take up a new meaning as safer sex. Tunju (1996) however notes that the use of mutual heterosexual masturbation as a safer sex method prevailed in the African traditional societies with the value of protecting pre-marital sex and teenage pregnancy.

5.7.13 Avoidance

Avoidance of ones' girlfriend or withdrawal from the relationship were reported by the majority (87%) of the respondents as perceived own action if they discovered that a girlfriend had an STI. Three key informants said that they had dropped at least one girlfriend in the past for suspecting them to be sexually unfaithful. Further qualitative data also revealed that the participants and informants would avoid to have sexual relations with the girl they suspected to be more at risk of STI and HIV infection, for instance, girls who were talkative, brown, had enlarged breast, and who wore trousers, lipstick and funny hairstyles. Avoiding bad company or habits such as alcohol and drug use, pornographic entertainment such as romantic movies, literature and music were also seen as reducing the risk of STI and HIV infection. While the above avoidance may lower

the risk of STI/HIV infection, avoidance of unprotected sex would significantly offer male adolescents reliable health and sexual safety.

5.7.14 Sublimation

Freud (1924) defines sublimation as a mode of adjustment where somebody uses a substitute activity to gratify a motive. Freud, gives examples where the sexual urge (an unaccepted motive for the youth) may find expression by channelling the urge into activities such as art, the practice of religion, music or some aesthetic activity that is socially acceptable While, "adolescence centrally rotates around sexual interests and motivations" (Schiller, 1973), some respondents however suggested a shift of interest from sexual matters to other areas as a strategy to cope with the risk of STI and HIV infection. Getting saved and seriously involved in studies, clubs, sports, religious activities and sticking at home and helping parents or watching the television during holidays or weekends were said to be viable ways in which male adolescents could reduce the risk of HIV infection. About three-quarters of FGD participants in 13-15 year age groups said they now spent more time at home rather than go 'hunting' for girls. However, it could be argued that while active involvement in sports and other social activities offer adolescents an avenue to release their sexual energy in useful and harmless activities, it is to be seen that the same activities may provide the chance of heterosexual contact and intimacy development that ultimately leads to sexual activity. An adolescent's choice to practice safer sex or total abstinence may therefore be considered the most important factor.

CONCLUSION

The above discussions revealed that the study respondents, key informants and FGD participants had all used different strategies of safer sex in an attempt to manage the risks of STI and HIV infection. These includes: condom use, sticking to a single sexual partner, periodic abstinence, having fewer sexual partners, petting without coitus, 'shallow' sex, 'quick' sex, masturbation, anal sexual intercourse, urinating after sex, bathing or washing the penis after sex, having sex with young girls, displacement of sexual interests and avoidance of persons, places and practices perceived as risky. As already argued only two of the above would qualify as clinical or biomedi-

cal methods of sexual health safety, namely condom use and sticking to a single sexual partner. Therefore, the fourth hypothesis, of the study is true in observing that male adolescents mainly utilise lay methods and techniques in managing the risks of STI and HIV infection. The hypothesis is therefore accepted. These methods seemed to be founded on a mixture of common sense and biomedical knowledge as already discussed. However, they do not offer the required safety against STI and HIV infection. Nzioka (1996) in his Nairobi study on HIV-Positive patients similarly found that they had widely utilised lay safer sex methods. Becker and Rich (1992) in their FGD study on Kenyan and Nigerian adolescents found that adolescents reported using more of safer sex methods which made sense to them though largely lacking in clinical value. This reinforces the fact that:

> People have built-in principle of economically allowing the smallest possible adjustment in our beliefs and plans to accommodate any new idea; if it requires great changes, we generally won't accept it. (Hubbard, 1988, p. 103).

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter provides a brief summary and discussion of the research findings and the study's conclusions and recommendations. The findings are summarized under the four hypotheses of the study

6.2 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Boys' Sexual Risk Management Strategies

The major objective of the study was to investigate the strategies that adolescent boys utilized in managing the risks of STI and HIV infections. The findings of the study revealed that boys employed a wide range of coping strategies in an attempt to avoid STI/HIV contagion. These include: condom use, sticking to a single sexual partner, petting without coitus, 'shallow' sex, 'quick' sex, masturbation, and sexual intercourse, urinating after sexual intercourse and avoidance of persons, places and practices perceived as risky. As already discussed (see Chapter 5) these coping strategies comprised a blending of common sense, biomedical knowledge, cultural stereotypes and lived experiences. The result of the study therefore, agreeably support the third hypothesis that there is a high tendency among adolescent boys to utilize lay techniques and resources in the management of the risks of STI and HIV infection. This hypothesis is therefore accepted

Further, the above findings validated the suppositions of the Grounded Theory of Adolescence (GTA) - that adolescents use common sense and taken-for-granted knowledge to make sense of their everyday life and to produce explanations or accounts for their actions (Maticka - Tyndale, 1992). The GTA was therefore proved to be a relevant and valuable theoretical guide for this study. Further investigations revealed that the management strategies that the boys utilized emanated from their definitions, attitudes and perceptions toward sexual risk. For instance, majority (60%) of the

respondents were opposed to condom use, over half (52.5%) of them approved boys' engagement in premarital sex, and 78.3% perceived STI as a mostly mild illnesses which are even capable of healing naturally, without any medical intervention. These findings therefore qualified the predicted causal relations between definitions, perceptions and attitudes toward risk and the particular risk management strategies used. The studys' conceptual framework thus stood the test

Various skills, techniques, and resources were utilized by the adolescent boys in dealing with the risks of STI and HIV infection. However, it is concluded that their management behaviours are largely inadequate as they mainly lack in clinical or protective value. Any effective prevention and control of STI and HIV transmission among adolescent boys therefore, calls for change of their current risk management behaviours.

On the basis of this conclusion the study makes the following recommendations. One, that for more effective prevention strategies against heterosexual transmission of HIV to be developed for adolescents, it is essential to understand their lay coping strategies and the lay beliefs and attitudes that are behind them. To have biomedical information target and reveal the loopholes and inherent risks engendered in these lay strategies which are founded on popular 'social sense' and understandings is an effective way of empowering the youth to make informed sexual and reproductive health choices.

Two, to acheive increased acceptance and user rates of the recommended clinical or safer sex methods among adolescents, it is important to involve young people in programme design, delivery and evaluation. This will give them a sense of 'ownership' and belonging toward the clinical safer sex methods. Such positive feelings will translate to higher user rates.

Sexual Behaviour and Practices

The study also sought to investigate the factors that influence sexual behaviour and practices of adolescent boys. Eighty-six percent of the boys in the sample had had penetrative sex. Most (56.4%) of the respondents initiated this sexual activity at tender ages of below 10years (11.7%) and 11 to 15

years (44.7%). Most (80.6%) of the sexually experienced respondents rated their first sexual experience as 'enjoyable' and identified the main motivations for it to be the urging of friends (35.4%), desire to test sexual prowess (34.5%) and curiosity (27.2%). Most (67.9%) of the sexually experienced boys had had more than four sexual partners. The respondents had high sexual frequency with most (60%) of the sexually experienced having had more than four sexual episodes in the previous six months.

Sexual experience increased with age (x^2=30.9441), and so did the number of lifetime female sexual partners (x^2 = 28.0393). Factors associated with increased chances of sexual activity were found to be place of residence (x^2 = 11.2503), marital status for parents (x^2 = 8.9541), and alcohol and substance use (x^2 = 17.4151). Multiple sexual partner relationships among the respondents were significantly influenced by age (x^2 = 28.0393) and the opinion on the ideal number of sexual partners that a boy should have (x^2 = 37.5715).

Factors associated with high sexual frequency among boys were place of residence (x^2 = 9.143), school gender composition (x^2 = 8.3608) and perception on importance of sexual intercourse in a boy/girlfriend relationship (x^2 = 45.3037). Condom use among the boys was significantly influenced by religious affiliation (x^2 = 30.039), place of residence (x^2 = 8.4288) and attitude towards condom use (x^2 = 6.6109). Sexual experience was also influenced by perceived peer sexual activity (x^2 =43.7142). The two, showed a strong association (r=0.7113). Further, the main reasons why the majority of the sexually experienced boys had engaged in first coitus were the urging of friends or need to be like friends (29.1%), moreover the three reasons why most (96.1%) boys planned to go on with sex were to retain the respect of others (29.3%), because they felt old enough or were circumcised (26.2%) and to gain enough sexual experience (15.2%).

The above findings lead to the acceptance of the study's first hypothesis that the sexual behaviour and practices of adolescent boys are largely influenced by their individual and family background characteristics, the peer group associations and the male sexual norms prevailing in their communities. The study therefore, concludes that successful STI/HIV intervention programmes for adolescents require a comprehensive understanding and consideration of the these factors.

Based on the above conclusion the following recommendations are made. One, since the study's findings suggest that non-cohabitation by parents and conjugal instability may raise the risk that adolescent boys will engage in risky sexual behaviour. Consequently, it is recommended that sensitization of parents about these problems should be also part and parcel of the AIDS prevention programmes.

Two, reproductive health programmes for adolescents and society in general need to create and promote images of masculinity that are not tied to sexual prowess or fatherhood. Such images will influence not just the way boys perceive masculinity, but also the ways in which society, including parents, girlfriends and children define masculinity

Three, educators should facilitate better communication on sexual and reproductive health matters between parents and adolescents. Parental programs for instance should be put in place which equip the parents with the necessary information and skills to enable them to effectively communicate with and guide adolescents in sexual matters.

Four, programmes should encourage adolescent boys to act responsibly in sexual matters, for their own sake and that of others. In sexual situations they should respect the rights, wishes and concerns of their partners, including the use of contraceptives to avoid unwanted pregnancies and of condoms for STI and HIV protection.

Five, adolescent programmes need to emphasize communication and negotiation skills. A significant proportion of the respondents had used pressure to obtain sex. Boys also generally did not respect the wishes of their sexual partners. Adolescent boys thus, need confidence and communication skills to ensure that they do not have sex when it is unwanted, and to ensure that they negotiate safer sex practices.

Sexual Attitudes and Opinions

The study also sought to explore the impact of sexual perceptions and attitudes on boys' risk management practices. Over half of the respondents were opposed to or had non-accepting attitudes

toward boys' condom use (60%), engagement in premarital sex (52.5%), rape (61.7%) and sexual intercourse with a girl one did not love (68.4%). For the fifty-seven respondents who approved premarital sex for boys, majority (61.4%) said that the ideal age to start sexual activity was between 16-18 years and with two to three as the most mentioned number of ideal sexual partners (56.2%). Boys seemed to over-estimate peer sexual activity as only three percent (3.3%) of them felt that 'none' of his friends engaged in sex, while ninety percent said that 'all' (30%) or 'most' (60%) of their peers engaged in sex. Only seven percent (6.7%) of the respondents felt that 'few' of their peers engaged in sex.

Only six (5.8%) of the one hundred and three respondents who were sexually experienced were planning to abstain from sex. Ninety seven (94.2%), who planned to go on with sex mainly did so to retain respect from peers (29.3%), because they felt mature enough (26.2%), or to gain enough sexual experience (15.2%).

Attitude towards condom use influenced actual condom use (x^2=6.6109). The two factors were strongly associated (c=0.2455). Perception on the importance of sexual intercourse in boy/girlfriend relationship significantly influenced sexual frequency (x^2=45.3071) with a strong association (c=0.5527). Opinion on ideal number of sexual partners similarly influenced the number of lifetime female sexual partners (x^2=37.5915). The two were positively co-related (r=0.6398). Further, the main reasons why most of the sexually experienced boys planned to go on with sex was to avoid being odd among age mates (29.3%), because they felt old enough or had been circumcised (26.2%), and because they wanted to gain enough sexual experience (15.2%).

These findings agree with the second hypothesis of the study that the sexual perceptions and attitudes of adolescent boys hinder their successful adoption of effective risk management practices. Consequently, the hypothesis is accepted. The study therefore, concludes that sexual attitudes and perceptions are important antecedents to risky sexual behaviour among adolescent boys.

Consequently, the following recommendations are made:

One, that activism on sexual attitude change be an important component of adolescent STI/HIV prevention programmes.

Two, that the community at large should condemn a double standard that encourages boys' sexual activity while punishing girls'

Three, the study also recommends the enactment and enforcement of sex laws which do not exclude young sexual offenders for reason of being under age. Rather, laws should be tailored that justly and relevantly punish and deter young people from engaging in sexual crimes. Such laws will encourage male adolescents to cultivate responsible sexual behaviour toward girls and women.

STI Illness and Treatment Behaviour

The study also sought to examine boys' illness and treatment-seeking behaviour patterns upon perceived/actual infection with an STI. Sixty-eight of the one hundred and three sexually active respondents had experienced symptoms which they suspected to be STI infection. However, thirty (44.1%) of them did nothing about the symptoms while thirty-eight (55.9%) sought treatment of some kind but only after considerable delay. None of the respondents sought immediate STI treatment while the majority (92.1%) took two to three weeks to do so as they mainly thought that the symptoms would disappear on their own.

Herbal medicine and the health facility were generally the most utilized therapeutic resources. Herbal medicine was the most (42.1%) utilized first or initial resource. The health facility was the leading STI- referral resource as it was the leading (70.6%) second resource and the only third health resource. Of the respondents who sought STI treatment, 39.5% relied purely on self-treatment. 26.3% used professional treatment only and 34.2% used a combination of both professional and self-treatment. Four main barriers hindered the respondents from readily accessing STI treatment. These were: lack of money (55%), embarrassment (49.2%), perceived hostility from healthcare providers (45%), and physical distance (41.7%). In effect, the above findings lead to the fourth hypothesis of the study that "adolescent boys frequently ignore STI symptoms or resort to self-treatment upon making self-diagnosis" being accepted.

Based on the above findings, this study therefore concludes that boys did not seek STI treatment with the required promptness and when they did, they largely embarked on self-treatment, a situa-

tion mainly caused by financial limitations and poor provision of health services. It is further concluded that current health facilities are thus not suited to, nor serving the special needs of adolescents.

The study therefore makes three important recommendations. One, since the results of the study show that current health facilities do not provide the confidence and privacy that would make young people feel at ease when visiting them, the need exists therefore, for the establishment of health care services that cater for the special needs of adolescents. Special adolescent clinics would meet this need adequately.

Two, the study recommends that health care providers be trained to offer high-quality care to adolescents in a non-judgemental and confidential manner. It should also be made clear to both staff and public that adolescents are welcome and that their sexual and reproductive health care has high priority. The removal of other unnecessary barriers to services should be effected, for instance limits on access to contraceptives for reasons of age or marital status.

Three, to overcome adolescents' monetary barriers to healthcare, consideration to offer them free or affordable sexual and reproductive healthcare should be made. Parents should also be enlightened on the need to provide adolescents with money for medical consultation without being too inquisitive or suspicious. This will enable the adolescents to access healthcare when they feel they need it.

6.3 Recommendations for further Research

1. There is need for more qualitative research on sexual behaviour change by boys and adolescents in general. Such research should identify behavioural norms and delineate the complex interactions for motivating and sustaining behaviour change.

2. The study recommends increased qualitative assessments at varied sites so as to provide information that would be helpful in developing interventions that promote sexual risk reduction and take account of the social context in which such behaviours occur.

3. Significant proportions of the sexually experienced boys had pressurized their partners into sex. There is need for more research on sexual coercion among adolescents. So as to investigate its prevalence, its social and sexual context and determine how it is experienced by both offenders and victims. The links between early sexual experiences and coercive behaviour during adolescence should be also investigated.

4. A more comprehensive research on alcohol and substance use among adolescents and its influence on risky sexual behaviour is recommended.

5. In the light that herbal medicine was dominantly used by the respondents in STI treatment, more research is recommended so as to identify, document and test the curative value of these indigenous health resources. This scientific validation of ethnomedicine would promote its effective use as a complimentary to biomedicine in STI treatment and also ensure that its use has no harmful health effects.

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APPENDIX 1: SURVEY QUESTIONNAIRE

THE MANAGEMENT OF THE RISKS OF STI AND HIV INFECTION

Questionnaire No. ..... *Date of Interview* .....

INTRODUCTION

Hallow. My name is Peter Ngatia. I am a student from the University of Nairobi. I am interested in knowing how boys in this area protect themselves from the risks of sexually transmitted infections including HIV/AIDS. I will ask you some questions on this subject. The information you give will be strictly kept confidential. Feel free to answer the questions truthfully and accurately. Thank you in advance.

RESPONDENTS GENERAL BACKGROUND

NAME OF SCHOOL: .....

DATE OF BIRTH: ...../ ..AGE ..... YEARS:

1. In what form are you now? (Circle the answer).
   1. Form I 2. Form II 3. Form III 4. Form IV
2. Which is ethnic group do you come from? .....
3. Which is your denomination (Church)? .....
4. What type of School is your current school?
   1. Mixed 2. Boys
5. Is your school day or boarding?
   1. Day 2. Boarding
6. During the last 10 years, where have you lived during your school holidays?
   1. Mostly urban 2. Mostly rural
7. Which is the current marital status of your parent(s)?
   1. Currently married 2. Divorced 3. Separated 4. Never married
8. What is the total number of children your parents have including yourself?
   .....
9. How far is it from your home to the nearest.

i) Health facility of any kind? ..... kms
ii) Human drug chemist? ..... kms
iii) Traditional healer/medicine man? .....kms

SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE

10. What does the starting of menstruation mean in a girl? .....

11. For a girl who is menstruating, when is she most likely to become pregnant? *(circle the answer)*
    1. During periods
    2. Immediately after periods
    3. immediately before periods
    4. Halfway between the end of the one period and the beginning of the next
    5. Don't know
    6. Other (specify) .....

12. If a girl engages in sex before she starts having the first periods, can she become pregnant?

13. To fill the table below show your opinion by writing the word *'True'* or *'False'* after each statement.

STATEMENT	TRUE OR FALSE?
Contraceptive pills may cause infertility	
If a man pulls out before ejaculation he can still make a woman pregnant.	
Condoms do not have small holes that allow HIV to pass through.	
Condoms don not get lost in a woman's body	
Condoms are effective in preventing the transmission of sexually transmitted diseases (STD's) including HIV.	
One cannot get AIDS from mosquito bites	
One cannot always tell if someone has an STD.	
If the signs of an STD disappear, it does not necessarily mean that one no longer has the STD.	
One can get pregnant the first time they have sex.	
One can still get pregnant if they have sex standing up.	
Boys who have wet dreams can make a girl pregnant.	
There is no cure for AIDS.	
A healthy looking person can have AIDS.	
It is possible to protect oneself from AIDS.	
Having anal sexual intercourse can transmit STD and HIV	
Urinating after sex does not prevent STD and HIV infection	
Having sex with young girls does not cure STD infection.	
Untreated STD could lead to severe health consequences.	

14. Do you personally know an AIDS patient or someone who has died of AIDS?
1. Yes 2. No

COMMUNICATION ON SEXUAL AND REPRODUCTIVE HEALTH

15. For the topics listed below, circle any topics you have discussed in the last 3 months and name the person or persons that you have mainly discussed with
i) Body changes .....
ii) Wet dreams .....
iii) Sexual urges .....
iv) Boy/girl relationships .....
v) Whether to have sex .....
vi) Pressure to have sex .....
vii) Unwanted pregnancy .....
viii) HIV/AIDS and STD's .....
ix) Condoms .....
x) Alcohol and drug use .....
xi) School work .....
xii) Future career .....

16. Circle any FOUR sources among the ones given below where you have mostly got sexual and AIDS information in the last 6 months.
1. Radio
2. Television (T.V.)
3. Family
4. Friends
5. Magazines, Newspapers and books
6. School
7. Other (specify) .....

SEXUAL ATTITUDES AND OPINIONS

17. i) In your opinion, it is important for a boy to have a girlfriend?
1. Yes 2. No
ii) Explain your answer in the above question. .....

18. In your opinion, which is the best way for boys to express their love to their girlfriends?
.....

19. How important is sex in a boy-girlfriend relationship?
1. very important 2. Fairly or somehow important 3. Not important

20. i) In your opinion is it right for adolescent boys to have sex?
1. Yes 2. No
ii) Explain your answer. .....

NB: If your answer to question 20 is YES, answer question 21-24 below. If NO, proceed to question 25.

21. i) In your opinion, how many sexual partners do you think a boy should have?
1. one only 2. 2-3 3. 4 and above
ii) Explain your answer .....

22. i) In your opinion, is it right for boys to have sex with girls they are not in love with?
1. Yes 2. No
ii) Explain the reasons for your answer .....

23. i) In your opinion , is it right for boys to use condoms?
1. Yes 2. No

ii) If your opinion is NO, give reasons .....

24. i) In your opinion, is it right for boys to engage in rape?
1. Yes 2. No

ii) If your answer is YES, give reasons .....

SEXUAL EXPERIENCE

25. Have you ever had sexual intercourse?
1. Yes 2. No

NB: If YES to question 25 answer the following questions. If NO go to question 43.

26. How old were you when you first had sex?
1. below 10 years 2. 10-15 years 3. 16-18 years 4. 19 years and above

27. What class were you when first had sex?
1. Lower primary
2. Upper primary
3. Form I
4. Form II
5. Form III
6. Form IV

28. What was the main reason for your first sexual intercourse? .....

29. Which of the following best describes your opinion of your first sexual intercourse?
1. Enjoyable
2. Not enjoyable
3. Disappointing
4. Nothing special about it.

30. Regardless of your first sexual experience, do you now enjoy sex?
1. Always 2. Sometimes 3. Never

31 With whom did you have your first sexual intercourse?
1. Girl younger than myself
2. Girl about my age
3. Girl older than myself
4. Adult woman
5. Other (specify) .....

32. How many female partners have you had sex with in your life?
    1. One partner only 3. 4-5 partners
    2. 2-3 partner 4. 6 and above partners

33. How many times have you had sex in the last six months?
    1. Once 2. 2-3 times 3. 4-5 times 4. Over 6 times

34. In how many days or weeks do you plan to have sex again?
    .....

35. Do you usually plan to have sex or it just happens?
    1. I plan every time 2. I plan sometimes 3. I never plan

36. i) Have you ever used condoms?
    1. Yes 2. No
    ii) If YES, how do you use condoms?
    1. Always 2. Sometimes

37. i) Have you ever been involved in rape?
    1. Yes 2. No
    ii) If YES explain how did you get involved? .....

38. During your last or most recent proposal for sex which of the methods below did you use to try to obtain sex?
    1. Sweet-talked partner 4. Threatened partner
    2. Touched partner 5. Offered money or gifts to partner
    3. Attempted to or forced partner 6. Other (specify) .....

39. i) Do you discuss pregnancy, STD or HIV/AIDS or condom use with your sexual partner(s) before having sex?
    1. Always 2. Sometimes 3. Never
    ii) If your answer is 'Sometimes' or 'Never' give reasons.
    .....

40. Have you ever practiced mastarbation?
    1. Yes 2. No

41. i) What is you plan for sex?
    1. I plan to continue having sex 2. I plan to stop having sex
    ii) If you plan to continue with sex, give reasons. .....

42. What would you say about your friends' sexual activity.
    1. All engage in sex 3. Few engage in sex
    2. Most engage in sex 4. None engage in sex

STD AND HIV MANAGEMENT

43. Are STDs common in this area?
    1. Yes 2. No

44. i) Where do most boys, in this area go for STD treatment? .....
    ii) What problems do you think most boys face when seeking STD treatment?
    .....

45. What would you do if you discovered you have an STD? .....

46. What would you do if you discovered your girlfriend had an STD? .....

47. i) Have you ever experienced symptoms which you suspected to be an STD?
    1. Yes 2. No
    ii) If Yes, did you seek any treatment?
    1. Yes 2. No

    iii) If YES, fill the treatment sources you used and the order in which you used them if you did not get well after the first treatment.

First Source	Second Source	Third Source
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

48. List down below ALL methods you know (traditional and modern) of treating an STD.
    .....
    .....

49. i) Would you be willing to take a voluntary HIV test?
    1. Yes 2. No
    ii) If NO, why? .....

50. If you discovered you were infected with HIV, what would you do?
    .....

51. i) Have you done any changes in your behaviour so as to avoid contracting HIV/AIDS?
    1. Yes 2. No
    ii) If YES, list down the changes you have made. .....

52. In your opinion, what is the probability that you may infect HIV?
    1. High 2. Low 3. None

53. List down any ways you think boys could use to avoid HIV/AIDS infection.

.....

54. What do you think should be done to help adolescent boys in this area best deal with the risks of STD and HIV?

.....

55. Kindly give any comment or additional information on boys' management of STD and HIV risks if you have any.

.....

ALCOHOL AND SUBSTANCE USE

57. Which of the substances below have you ever used?
    i) Alcohol
    ii) Cigarettes (tobacco)
    iii) Bhang (Marijuana)
    iv) Intoxicating drugs
    v) Other (specify) .....

Thank you for your cooperation. I wish you the very best in your studies.

APPENDIX 2:

QUESTIONNAIRE GUIDE FOR FOCUS GROUP DISCUSSIONS.

Greetings

My name is Peter Ngatia. I come from the University of Nairobi. I am interested in understanding the techniques and resources adolescent boys in this area use so as to avoid the risk of STD and HIV infection. We ascertain to you that all the information you give will be treated as private and confidential, meaning that it will not be revealed to anybody, but will strictly be used for the needs of the study only. Feel free to discuss the questions of the study.

1. Don most young people in this area engage in sexual activity?
2. If they do, which factors push young people into sex?
3. At what age do most young people (boys / girls) first engage in sex?
4. Are adolescent pregnancies common in this area?
5. Are sexually transmitted diseases (STDs) common in this area?
6. Which are the sources of treatment that most adolescents use, to get STD treatment?
7. What are the main problems that adolescents face when they are seeking STD treatment and how do they deal with them?
8. Do you know of any traditional methods of preventing STD?
9. How effective are these methods?
10. Suppose you discover you had an STD, what would you do?
11. What would you do, incase you discovered your girlfriend has an STD?
12. Suppose, both you and your girlfriend contracted an STD, what would you do?
13. Would you say that young people in this area are likely to infect HIV/AIDS?
14. Do you know any young people in this area who area HIV-positive or who have died of AIDS?
15. Would you be willing to take a voluntary HIV-test?
16. If no, why would you find it difficult?
17. What would you do, if you discovered you are HIV-positive?

18. Are there any places in this area which offer sexual and reproductive health information and services to young people and if so what services do they offer?

19. Are there places around here where you could obtain condoms if you wanted and if so on what terms are these condoms available?

20. As a boy, which methods would you advice the sexually active boys to use so as to avoid contracting HIV/AIDS?

21. What do you feel youth programmes and the government should do so as to take best care of the reproductive health needs of young people?

Thank you for your participation. Best wishes in your studies.

APPENDIX 3:

INTERVIEW GUIDE FOR KEY INFORMANTS.

SECTION A: For all Informants

1. Do most young people in this area engage in sex and if so what factors pushes them into sex?

2. Would you say these are the same reasons why boys also engage in sexual activity?

3. Are STD common among young people in this area and if so where do most adolescents get treated?

4. How do boys in this area generally view STDs?

5. Why do they view STDs this way?

6. Do boys in this area view STDs and HIV/AIDS the same way?

7. Have you ever had symptoms which you suspected to be STD and if so what did you do about them?

8. What problems do you think young people in this area face when seeking STD treatment?

SECTION B: For LOW-RISK-TAKERS only

9. What reasons have made you abstain from sex or engage in sex only once in your lifetime?

10. What reasons have made you keep only one sex partner in your lifetime?

11. How have you managed to always use condoms when having sexual intercourse?

12. Which other methods do you use to avoid infecting HIV/AIDS?

SECTION C: For High-Risk-Takers only

13. What reasons have made you engage with sex with over six female partners in your lifetime?

14. What keeps you from using condoms every time you have sex?

15. Do you feel that you are likely to catch HIV/AIDS?

16. How do you ensure that you do not catch HIV/AIDS every time you have sex?

17. Would you be willing to take a voluntary HIV test and if not so why not?

18. What would you do if you discovered you were HIV-positive?