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DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK

CONDOM USE AMONG ADOLESCENTS: A CASE OF NYERI NORTH
DISTRICT, CENTRAL KENYA. //

UNIVERSITY OF NAIROBI
EAST AFRICANA COLLECTION

BY:

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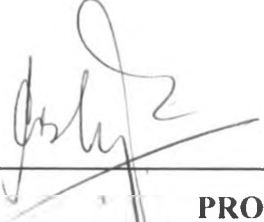
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DECLARATION

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This research report has been submitted for examination with my approval as the university supervisor.

Signature  Date 21.11.08
PROF C. NZIOKA

DEDICATION

I dedicate this research project to the Lord Almighty for his grace that enabled me to go through the course successfully, and my beloved daughter Mercy Waihuini, my ever supportive mother, my late dad and all family members for their understanding, moral support and encouragement throughout the course and preparation of writing this research paper.

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I wish to record my sincere gratitude to my employer, The Center for Disease Control and Prevention (CDC) for sponsorship, sincere thanks to Raymond Nyoka, John Nderitu for his efforts in statistical interpretation, and all my friends who assisted in editing the research paper and correcting the grammar.

ABSTRACT

Unprotected sexual intercourse among Kenyan's teenagers has many serious public health and societal consequences, particularly the transmission of HIV and other STIs. The risk of STD transmission among youths may be reduced by encouraging safer sexual behaviors, such as the use of condoms and abstinence. However, consistent and correct condom use among teenagers has remained unachieved. This research paper will look at the factors effecting condom use among teenagers in Kamariki Sub-location, Nyeri North District in central province, Kenya.

The main objective of this research is to identify the background factors that promote use and non-use of condom among adolescents in terms of, personal, behaviors, social cultural factors and attitudes among teenagers 15-19 years old. Data was collected from a sample of 204 respondents adolescents aged 15–19 recruited using purposive and snow-balling sampling techniques. The data collected was on knowledge, attitudes and practices of condom use. Key informants interviews were also conducted. Survey data was analyzed using Statistical Package for Social Science SPSS software, while the qualitative data was analyzed manually.

The condom use among teenagers was inconsistent, and sexual activities were unplanned. Age, sex, risk perceptions and the type of relationship a teenager is involved were found to determines if a teenager will use or not use a condom. Majority of the sexually active teenagers were boys compared to the girls and use of condom was more with the teenage boys. The study also found that in this rural area, HIV/AIDS knowledge was high and nearly universal. Teenagers were also well conversant with prevention methods but despite this knowledge condom utilization and uptake was inconsistent and slightly above 50%.

The following are the reasons for low condom use

- Social disapproval and negative symbolic meaning translating into embarrassment
- Lack of access to condom
- High cost of condom compared to income levels.

This study recommends that to realize consistency in condom use among teenagers, there is dire need for positive behavior reinforcement, access to information on condom use, peer education and counseling in primary school and review of policy that creates an enabling environment regarding sexual reproduction health and condom use.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACPR	Association for Community and Population Research
AIDS	Acquired Immune Deficiency Syndrome
ARH&D	Adolescents Reproductive Health and Development
CHPA	Culture and Health Program for Africa
CWS	Commercial Sex Workers
F.P	Family Planning
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
HIV	Human Immunodeficiency Virus
HTC	HIV/AIDS Testing and Counseling
ICPD	International Conference on Population and Development
IPS	International press Service
KAIS	Kenya Aids indicator Survey
KDHS	Kenya Demographic Health Survey
MOH	Ministry of Health
PGH	Provincial General Hospital
PRHS	Preventive Reproductive Health Services
PSI	Population Service International
RHS	Reproductive Health Services
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
UNFPA	United Nation Population Fund Programmes
VCT	Voluntary Counseling and Testing of HIV/AIDS.
WHO	World Health Organization

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CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND OF THE STUDY

WHO defines adolescence as a period between 10 and 19 years of age. Adolescence also refers to the time of transition that begins with onset of puberty and ends at the culturally determined point of adulthood. Adulthood is often marked by reproductive and socioeconomic maturity, although it is understood in different context (Mmari & Magnani, 2003). Adolescents consist of heterogeneous groups and their nature varies remarkably in terms of age, gender, social class, education, marital status and socio-cultural context and beliefs (Senanayake *et al.*, 2001). Another key determinant is economic and cultural globalization which has significantly influenced adolescent's value and lifestyles worldwide (Blum and Nelson-Mmari, 2004). It is a dynamic period characterized by both great opportunities and great risks. It is also the time when boys and girls gradually get more autonomy and make more of the decisions that affect their future (Friedman, 1990; Dehne & Riedner 2005). This stage is characterized by major changes in sexuality exposure to; new challenges, roles, behaviors, responsibilities and relationships. Some of the risks during this time come with increased exposure to the world, peer pressure, sexual experimentation and may result to unwanted pregnancies, sexually transmitted infections HIV/AIDS and the consequences are enormous; unsafe abortions STIs and HIV/AIDS.

In 1994 the International Conference on Population and Development (ICPD) held at Cairo identified adolescent's boys and girls as a particular vulnerable group, and governments agreed to commit themselves to a universal agenda on rights and improvements of adolescents reproductive health services. In line with this recommendation, the government of Kenya developed a National Adolescence Reproductive Health and Development (ARH&D) policy in 2003. The policy established the relationship between the nation's development and the health of its youth, recognized the critical role young people themselves play in promoting their own

good health. It also emphasized on a multi-sector, interdisciplinary approach to the provision of integrated and quality reproductive health services.

The principles spelt out in the Adolescent Reproductive Health and Development Policy (ARD& H) thus provided a conceptual guide to the development of the plan of action which further distinguishes four strategic areas: advocacy; health awareness and behavior change communication; access to and utilization of sustainable youth- friendly services; and management. For each of the strategic areas, the expected outcomes were as follows.

- Advocacy: Improved policy environment for effective implementation of adolescent reproductive health and development programmes.
- Health awareness and behavior change communication: Empowered young people able to develop, adopt and sustain healthy attitudes and behaviors towards reproductive health and development.
- Access to and utilization of sustainable youth friendly services: Quality and sustainable youth friendly reproductive health and development services provided.
- Management: Capacities of the key national coordinating agencies for effective management of the ARH& D programme enhanced.

Over 40 percent of the Kenyan population is under 15 years and only about 4 percent are aged 65 years and above (GoK, 2005). This means that over half of Kenya's population of about 31 million is aged below 24 years, with the larger proportion being adolescents. Indeed more than one-quarter. However, pervasive social, economic and health problems mean that circumstances for Africa's and Kenya's adolescents are often especially difficult even though these young people comprise a formidable force that can no longer be ignored. Thus Africa, and Kenya included must rise to the massive challenge of providing its adolescents with opportunities for a safe, healthy and economically productive future (ARH & D, 2003)

Improving young people's reproductive health in terms of access and utilization of condom among the young people is improving the world's future economic and social well being.

Kenya has put in place an adolescent reproductive and development policy to enhance the implementation and coordination of programmes that address the reproductive health needs of young people. The policy recognizes the importance of information and education on sexual and reproductive health for adolescents. The policy also emphasizes on the need to accurate, appropriate information to help young people understand their sexuality and the reproductive process as they grow. This would enable them make sound choices, enjoy healthy and positive lifestyles and avoid undesired consequences like unwanted pregnancies, STIs, and HIV/AIDS.

There are several factors that have been associated with poor access, use and non use of condom and other contraceptive methods. These include cultural beliefs, level of information, family influence and religion/spirituality, sexual behaviors and attitudes (WHO, 2005). It is also not unusual for health providers to request for parental or spousal consent before providing services to adolescents below the age of 18 years. There are other situations where by provision of both male and female condom and education on use are prohibited by the law, religious teachings and cultural beliefs. For example the Catholic Church does not advocate for condom use.

Adolescents and young people who are sexually active besides face policy barriers to accessing services, thereby reducing their ability to protect themselves. Guidelines for provision of reproductive health services, and especially on contraceptives and condom, to unmarried adolescents are deliberately ambiguous and open to conflicting interpretation. For example in the protocol published by the Government of Kenya draft copy it states that, (MOH, 2008)

“Comprehensive reproductive health information and counseling freely available for health reasons in good faith to adolescents and youth seeking this information”. In addition the guideline stresses. “Adolescents/youth who are sexually active, especially those who have been pregnant, have had a miscarriage or have been treated for STIs, need special attention in terms of reproductive health care must be accompanied by their parents or guardians.

This includes appropriate treatment for existing conditions and counseling and provision of a full range of RHS.”

To be able to reach the majority of adolescents and be sustainable over time, these strategies will have to be developed and implemented by government ministries that already have some responsibilities for serving its youth. This is an additional challenge for adolescents since they may not wish to involve their parents/ guardians in matters relating to their sexuality.

While lack of sex education is "blamed" for many teen pregnancies in Kenya, traditions that inhibit discussions between parents and children about sex also play a role. Schools in Kenya lack sex education curricula despite "growing campaigns" to curb HIV/AIDS transmission and sexually transmitted infections. Only 12% of the country's health facilities have "youth-friendly" policies. In addition, religious edicts made by the Catholic Church to suppress the "openness in matters of sexuality" in schools and churches also have contributed to the teen pregnancy rate in Kenya.

1.2 PROBLEM STATEMENT

Despite the proven effectiveness of condom use, different groups understand the use of the condom very differently. Informing adolescents and young people to appropriately use condom and accept behaviors and ways to protect themselves against unwanted pregnancies and sexually transmitted infections has proved problematic in Kenya. Education programmes for in and out of school going adolescents and young people have remained elusive, and there is a pervasive concern that sexuality education and contraceptives services leads to promiscuity. It is from this, that the need for unbiased and accurate information and services must be provided if adolescents are to delay becoming sexually active, to resist pressure to engage in non-consensual sex, and to protect themselves against unwanted pregnancies and infections if they do have sex. Moreover, strategies for providing such information and services need to be acceptable to the community and sustainable over time.

The traditional societies existed and there were mechanism that the expression of youth teenage sexuality and reproductive capacities were socially acceptable. Among the Kikuyu culture young boys and girls interacted with their grandparents and there were sessions where by both the boys and girls interacted sexually. They were allowed to hold hands, careless each other, express their emotions with out necessarily having sexual intercourse and their sexual urges were met (Worthman, 1973). The current society has completely discouraged young people and teenagers not to express their sexual urges until they complete school, become adults and get married.

It becomes unclear as to why adolescents in Kenya despite the wide knowledge on positive and negative implications on condom use, uptake of condom has remained low at 23.4% women aged 15-19 , and 41.3% men aged 15-19 respectively, (KDHS, 2003). In central province, condom use among risky groups was at 20.8% women and 33.1% men (KDHS, 2003). This was third lowest nationally among women and lowest among the men at national level.

It is therefore important to understand the relation between teenage sexual and use of condom with practice. The relationship between teenage sexual practice in the rural areas and behavior is not clear particularly when teenagers are said to believe that premarital sexual activities are wrong and yet they engage in them. The other question relates to the social family and societal roles in provision of sexual information and shaping of appropriate sexual attitudes, what role is society playing in ensuring that teenagers who are sexually active are engaging in safe sex.

This study therefore will be guided by the following research question:

- What is the relationship between teenage sexual practice and knowledge?
- What is the level of condom use by teenagers in Kamariki Sub-Location?
- What are the attitudes and perception regarding condom use among teenagers in Kamariki sublocation?
- What is the role of society in ensuring teenagers who are sexually active in ensuring that they use condom?

1.3 MAIN OBJECTIVES OF THE STUDY

1.3.1 General Objective

Main objective of the study is to determine the factors that influence condom use among teenagers between 15-19 years old.

1.3.2 Specific objectives

1. The study sought to investigate teenage sexual practice and knowledge.
2. Determine levels and patterns of condom use among teenagers
3. Explore attitudes and perceptions regarding condom use among teenagers in Kamariki Sub location.

The findings of this research will inform the policies in seeking ways to improve attitudes and services towards teenagers' access and effective use of condom and other reproductive health services.

1.4 JUSTIFICATION OF THE STUDY

Although there is substantial literature about adolescent-friendly service, few studies have looked at the factors determining the extent to which adolescents access and utilize condom for both preventing unwanted pregnancies and STIs. Youth friendly clinics are seemingly a global concept but are lacking in the developing world. The rural areas are marginalized further creating challenges for adolescent wishing to utilize this service. Attempts to provide adolescents with reproductive health services have focused mainly in urban areas leaving out the rural areas. However, even in the urban areas where youth friendly clinics are operational, the service is offered parallel to the adults' clinic that makes it unappealing to adolescents. Thus the global concept of adolescent youth friendly clinics in developing world and more especially in sub-Saharan Africa is yet to be localized.

1.5 The Scope of the study and Limitations

The study ~~will~~ looked at teenage boys and girls, from ages 15 to 19 and exclude married teenagers. This is because teenagers experience barriers when accessing information on condom use and other reproductive health services. Both boys and girls were studied in order to understand the roles each sex play in the sexual activity and their understanding on condom use.

The study used that particular age group 15-19 years because it was comparable age group to the national health survey and therefore the definition of an adolescent for the sake of this study was guided by the same age limits.

The study was carried out at a time when the youth constituency development funds recruitment exercise was going on and this created confusion among the teenagers who thought that they the study was part of the recruitment process. Some teenagers were demanding some handouts and this caused delay on day one as scheduled. The local administrator managed to rescue the situation and research proceeded on subsequent days effectively.

The key informants were involved in this recruitment of the youth development funds. This affected research study since they were in a hurry to attend to the constituency development funds office. But with all this research assistants worked late in the evening interviewing the key informants.

Due to limitations in terms of resource, the research could not cover the sub-location. Some neighboring community felt left out of the study.

CHAPTER TWO

2.0 LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 A global concern

Global estimates indicate that young adults of age 15-19 often have high rates of STD and present a particularly important problem because of their lack of easy access to STD services and condom, and their frequent and multiple casual sex partners. The highest rates of Chlamydia are among the 15-19 years olds girls, mainly adolescent women (Brain et al, 1995). In many developing countries, more than half all-new HIV infections are among young people 15-24 (UNFPA, 200a). Early sexual debut and the prevalence of STIs in Africa are seen as some of the factors driving the spread of HIV infection. The WHO estimates indicate that STI rates are highest in sub-Saharan Africa with 69 million new cases in a population of 269 million adults aged 15-49 years (Corbett et. al.2002).

Adolescent's sexuality remains a global challenge and more particularly in developing countries. It is evident that adolescents become sexually active before the age of 20, and the sexual contact is generally unprotected (WHO, 1998). This extends further to say that 4.4 million girls aged 15-19 undergo unsafe abortions every year. About half of the world population is under the age of 25 and one in every five people in the world is an adolescent (UNFPA, 2005a; WHO, 1998). About 85% of the adolescents live in developing countries and the remainder in industrialized countries. Sixteen percent of adolescents living in developing countries live in Africa (WHO, 2000a). Sexual activity among young people is not always consented and this exposes them to greater risks. Thus adolescents are more vulnerable to rape, harassment and sexual exploitation, and physical and verbal abuse because they are less able to prevent or stop such manifestation of power (UNFPA, 2000a)

Adolescence is described as a period of increased risk taking because adolescents are susceptible to behavioral problems during puberty (UNFPA, 1997). At this period they try to

make their own decision and choices and actions. According to (Dehne L. Karl & Riendier Gabriel, 2005) adolescents considered to be relatively healthy age group, one without a heavy Burden of disease, compared to the newborn infants and elderly adults. This perception creates the tendency among adolescents to engage in risk-taking behavior that exposes them to health risks which adversely affect their present and future health. Most adolescents engage in early and unplanned sexual activity which incurs the risk of unwanted pregnancies, transmission of sexual infections, and the consequences have social, economic, and physical health implications like illegal abortions, dropping out of school, out of wedlock births as well as contracting sexually transmitted diseases (STDs) and HIV (Wilbon, 2005).

Approximately, 2/3 of the world's population lives in countries where abortion is available on demand and psychosocial factors are accepted as a valid indication. The remaining 1/3 lives in countries where abortion is illegal (Dahlback E., 2006). In countries where abortion is illegal and restricted by law for example in Kenya, girls/women most likely have to resort to an illegal and unsafely termination of unwanted or untimely pregnancy. According to the law abortion can thus either be safe and legal, or unsafe and illegal and this is in many African countries. Induced abortion may be stigmatizing, women are often reluctant to admit induced abortions and depends on the prevailing legislations of the country.

Public health perspective shows that more than 2.5 million or almost 14% of all unsafe abortions in developing world are among young women less than 20 years. Although the age pattern of unsafe abortion of girls aged 15-19 in Africa who have had unsafe abortion is higher than any other region among developing world (Olukoya *et al.*, 2001; WHO, 2004; Shah & Ahman, 2004). WHO, (2004) defines unsafe abortions as a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking standards, or both.

2.2 Global Challenges in accessing adolescent's reproductive health services

Adolescents globally continue to face challenges in accessing reproductive health services. They access health services less frequently and more so after the exposure. (Kipke 1999) identifies problems that many adolescents undergo particularly the lack of access to health care services. Kipke further notes that many health issues of adolescents, such as sexuality issues are socially stigmatized or difficult to discuss. (Goodburn and Ross 2000) observed that in developing countries, the health of adolescents has largely been ignored in comparison to that of children under 5 years and adults. In Bangladesh for example the Association for Community and Population Research (ACPR, 2003) while conducting a baseline survey, noted that the lack of adolescent's friendly reproductive health service predisposes adolescents to greater sexual health risks, greater challenges in access to reproductive health services, including preventive care.

2.3 Global Response

The 1994 and 2004 ICPD conferences in Cairo and Dakar made several recommendations for improving adolescents' access to reproductive health services and education. Participating countries affirmed their commitment to intensify efforts to enhance the rights of adolescents to access sexuality information, counseling and youth-friendly services; to safeguard adolescent's right to privacy, confidentiality and informed consent; and to involve them in the design, implementation, monitoring and evaluation of youth programmes (UNFPA, 2005b). ICPD 2004 reiterated the need for provision of sexual and reproductive health information, education and services throughout the lifecycle.

Since then 1994, ICPD attempts have been made globally to address reproductive health challenges of adolescent. An example is the youth friendly clinics particularly in developed countries. Different countries adopt different model. Some countries for example the United States have program maintaining the traditional medical model by offering a drop-in and after

school hours. Others set aside hours in their clinics to attend to the adolescents while others offer reproductive health care as part of school based program (Hocklong *et al.*2003). Critics have urged that a mix-up of models creates confusion about available services, how and where the services can be accessed. Evidence from research shows remarkable achievement in adolescent sexuality in countries where adolescent services are available and offered. For instance the United States, the United Kingdom and other western European countries have recorded significant drop in adolescent pregnancy rates since 1970s. The drop has partly been attributed to the availability of more effective methods of contraceptives and increase in condom use (Hooklong *et al.* 2003). In the United Kingdom the attributes were due to the 1990 health of the Nation initiative, which brought about creation of more effective adolescent pregnancy and STD prevalence strategies at the national level.

For successful adolescent's health care (Haggstrom-Nordin, 2005), mentions that for adolescents and youth centers to yield results there is need to have a multi-professional structure where medical, psychosocial and educational expertise is available. Staff attitude and skills, confidentiality, anonymity, ease of geographical access appropriate opening hours, suitable location and premises are important factors to success health care for adolescents.

2.3.1 Kenyan Response

In Kenya today rights of adolescents have since ICPD gradually gained recognition. Efforts have been made to provide awareness and education programs targeting the youth and young people. Youth clinics and VCT have been set up in many part of the country today. The government has also made attempts to develop reproductive health policies mainly for curbing the spread of HIV/AIDS. In 2000 the government of Kenya declared HIV/AIDS national disasters and passed on the following policies:

- The 1997 Session Paper No. 4 on AIDS in Kenya (GoK-MoH, 1997). The paper stipulates the need to target young people with HIV/AIDS programmes. It also

highlights the government's role in coordinating HIV/AIDS prevention activities and especially programs that would delay the onset of sexual activity among young people.

- The Condom Policy and Strategy" (GoK-MoH, 2001b). This strategy aims at enhancing access to condom by all sexually active Kenyans at affordable prizes and free condom dispensers in the MoH facilities through out the country.
- In 2001 the government developed The National Guidelines for Voluntary Counseling and Testing (GoK-MoH, 2001c) the guideline aimed to ensure standardized and quality counseling and testing of individuals administered by trained VCT counselors using the rapid HIV tests. Over the years the counseling setting has evolved from static facilities, mobile facilities and the concept is moving towards home based HTC.
- In 2003, the government facilitated the development of Adolescent reproductive health and Development Policy (GoK, 2003a). The policy was launched in October 2003 by the National Council for Population and Development (NCPD) of the Ministry of Health.

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Despite all these efforts by the government, Kenya's youth and adolescents have been denied quality reproductive health services for years. This denial is associated with the high HIV prevalence rated among young people aged 15-24 years. KDHS, (2003) indicates that the HIV rates were at 7 % at the time of the survey. The prevalence among women age 15-49 is nearly 9% while that of the men 15-54 is under 5%. 3% of the women aged 15-19 are HIV infected compared to men in the same age category which is less than half of one percent infected with the virus. Also despite the effectiveness of the VCT services the beneficiaries are only mature minors aged 15 and below and adolescents aged 18 years and above. With the introduction of the infant diagnosis of HIV/AIDS, testing and counseling has opened avenue to 15 years and below but with the consent of the guardians or parents. This again denies the teenagers the chance to present their sexual behavior due to lack of confidentiality.

There are also gender variations. Girls face greater reproductive health challenges than boys following puberty. In Kenya, available data show significant period of sexual activity before marriage. KDHS, (1998) showed that the medium age at first sexual intercourse as 16 for men. It also showed increases in the mean age at first sexual intercourse from 16.7 in 1998 to 17.8 years in 2003. It also showed that girls living in rural areas have their first sex almost a year earlier than those living in urban areas. WHO (2003) estimates Kenya's proportion of births from unmarried adolescents as the third highest in Sub-Saharan Africa with an estimated of 10,000 unmarried girls in Kenya dropping out of school every year due to pregnancy (UNFPA, 1999). Also about 5 million girls aged 15 to 19 have abortions every year, 40% of which are performed under unsafe conditions that leads to high rates of mortality.

2.4 ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH CONCEPTS AND BARRIERS TO EFFECTIVE USE OF CONDOM AMONG THE ADOLESCENTS.

2.4.1 Demographic Factors

Age is a major factor that has been associated with teenage pregnancy. Biologically, the teenagers are at a developmental stage at which their potential for pregnancy and child-birth are very high (WHO, 2005). Sub-Saharan Africa has one of the highest levels of teenage pregnancies in the world. Empirical results indicate that girls' education level has significant influence on the probability of teenage birth, with non-schooling adolescents and those with primary school level education being more vulnerable. Among the variables used as proxies for access to sex education, availability of church forums that educate adolescents about sex and family life issues reduce probability of teenage pregnancy (KDHS, 2003). Age is positively related to teenage pregnancies, with older adolescents being more predisposed to pregnancies. Though use of condom as a contraceptive is found to have a positive effect, only a small proportion of adolescents are using modern contraceptive. Other key factors as outlined by the adolescents themselves include peer pressure and social environment-related factors like

inappropriate forms of recreation, which act as rendezvous for pre-marital sex, as well as lack of parental guidance and counseling.

Access to education opportunities, sex education and information regarding contraceptives among the adolescents is also scarce; as well the widespread poverty that predisposes girls to teenage pregnancies. The problem of teenage pregnancies should be viewed within the broader socio-economic and socio-cultural environment in which the adolescents operate. For example, lack of parental guidance on issues of sexuality and sex education was reinforced by cultural taboos that inhibit such discussions. Adolescents should be equipped with the relevant knowledge on how to use a condom to enable them make informed choices regarding sexual relationships with a full understanding of the pros and cons to use and non-use. All these factors are strongly related to the age of the population under investigation.

Biological sexes being male or female also influence the use and non-use of condom and other contraceptives methods, especially in the current scenario of HIV/AIDS. The role of male condom in STIs prevention has popularized it as one of the most frequent used contraceptive methods. This has not been the case for the female condom which is rare to get and expensive posing as a denial of rights to the women and girls who would wish to make use of the device.

2.4.2 Social Economic Factors

In Kenya condoms are distributed by the MoH free and are available in all public hospitals and clinics in the whole country. However, people have painted these services with stereotype like “cheap is expensive” and the notion that the free MoH condom contains small holes that allow passage of the HIV virus, others denote that the MoH condoms are of poor quality and therefore inefficient. Although most of the adolescents do not have an independent income, they shy off from the MoH dispensers others manage to buy from their little pocket money given by parents the “Trust” condom brand while others find themselves engaging in unprotected sex.

Re-use remain a critical issue in the promotion and support for the distribution of the female condom particularly in developing countries (Harrison *A et al*, 2001) Current results of studies on the reuse of the female condom indicate that users dispose it after the single use. Another contentious issue is relevant to the question of reuse is the high cost of the device. However, in test marketing in Bolivia, Guinea, Haiti, South Africa and Zambia, CWS, single career women and female undergraduate students continued to demand the increasingly popular device as an option, despite the difference in price between the male and female condoms (Timyan, Judith *et al*. 1996).

Effective STI treatment is costly, and rarely affordable to adolescents. This should be the entry point to condom use to cut down on treatment cost. One of the reasons that few girls in Nigeria use public STI services was that they were expensive (Brabin *et al*, 1995). In Uganda, even at clinics where STI treatment was supposed to be free of charge, unauthorized charges were substantial. At private clinics, a young person would pay US\$50 or the equivalent of a half-term's school fees for basic treatment for an STI (Katabesi, 1996)

2.4.3 Personal Factors and Condom Use

Adolescents lack knowledge and awareness of seriousness of infections in the reproductive organs. It is common among adolescents not to see reproductive health as an important health issues among other health issues and this has made condom utilization to take a back seat in teenager's lives. STI's other than HIV for example may not be seen as an important disease to treat and may be categorized as of low priority compared to other diseases. Adolescents girls are often far more concerned about preventing unwanted pregnancy and menstrual problems than about STI symptoms. Boys and young men on the other hand view sexual health concerns as a woman's issue. This has recently seen in a study done in Kenya, Sweden and Argentina (Ahlberg *et, al* 2001: Mercer *et al*, 2001)

STIs are not evenly distributed with some, more likely to be found among age-groups and again disaggregated by gender disparities. In most studies girls seem more frequently affected

than boys. Young people including adolescents with regular sexual partners and specific high-risk group (such as sex workers and detainees) are more often likely to be infected than the general population of sexually active categories (KDHS, 2003). Adolescents often experience feelings of guilt, shame, embarrassment that may leads to failure to communicate issues relating to sexual health matters and this also affect their negotiation of condom use with their sexual partners. When adolescents realize that they have contracted an STI and have not acquired the skills needed to break the silence, they end up delaying treatment, seeking health care when it's already too late (Brain, 1998). The lay man understanding of adolescents contracting an STI is something associated with prostitution, promiscuity and immorality whereas it could have been avoided by use of a condom.

Adolescents seen accessing condoms from the MOH dispensers are labeled as defiant and are more likely than not imagined to be prostitutes. Teenagers due to age factor fear being spotted accessing condom from the dispenser's and are characterized by feelings of shame and embarrassment that this service may not be able to guarantee confidentiality. In a study done in Kenya, Nicaragua, Senegal and Zambia confidentiality was the main concern of young people who were asked about barriers to attend, STI services (MSI, 1995). Even when there is assurances that clinic information will stay confidential, anxiety often remains that parent or other adults will find out about their reproductive health problems.

Adolescents and young people also hesitate to use condom because they fear disapproval by their sex partner, of their sexual behavior and unsympathetic attitudes on the part of service providers, rather than to the inaccessibility of services. There are factors that affect the length of time young people wait to seek care including the perceived seriousness of infection, the extent of confidence to seek help, and perceptions of barriers to accessing care, including stigma.

Adolescents wait longer or spend more time than an adult appraising their symptoms before seeking help probably because of embarrassment and guilt this is more evident when the

ailment is inclined towards sexuality. Young women who are less likely to display any symptomatic signs compared to young men are even less likely to seek STI care. In an assessment of reproductive health needs in Bulawayo, Zimbabwe, for instance young people literally stated that they did not know what to do if they realized they are pregnant or have contracted an STI (Dehne L, Karl, Riedner Gabriele, 2005).

It is therefore necessary to build interventions age and gender factors and guiding concepts that promote risk reductions through counseling, capacity building, raising adolescent's confidence level by encouraging adolescents to taking control of their lives. In Kenya today there are numerous advertisements that are targeting teenagers and young people and encouraging them to take control of their sexual lives by using condom as a tool for HIV/AIDS prevention.

2.4.4 Environmental Factors and access to condom

Access to PRHS is characterized by low population coverage of adult reproductive health services available to the majority population and more specifically to the rural majority. Since 1990's syndromic STIs management expand STI coverage by enabling the primary health care workers, even in rural and remote areas, to identify and treat symptomatic STIs. Nevertheless public STIs' clinics remain weak either staff have not been trained, or staff such as nurses are not allowed to prescribe and treat STIs more importantly effective and essential drugs are probably not consistently available. In Zambia for instance a country where adolescent reproductive health programs development is relatively advanced, the shortage of drugs has been identified as an important reasons as to why young as well as older people rarely attend public STI services (Webb, 1997; Fetters *et al*, 1997)

In many countries Kenya included law and policies restrict adolescent access to certain health services and commodities according to age, marital status or both (MoH, 2008 Draft) In Kenya parental consent is required for all the reproductive health services treatment for the age 15-18 years age group. Laws that define the minimum age at which adolescents may consent to sex, like those in Uganda or Zambia (Ndyabangi, 1999), may also have an impact on health care-

seeking behaviors, and especially on partner notification. This has made adolescents either reuse a condom or ignore the protective device all together.

More important to adolescents' access to condom and other contraceptives than outright legal barriers are situations laws and policies that are particularly restrictive or vague, but the health staff and other providers (such as pharmacist) establish their own policies which prevent access for adolescents and young people to buy a condom over the counter. In Kenya for instance, although the MoH policy does not specifically prohibit adolescents accessing reproductive health services, "the younger you look the less likely you are to be attended to". Young people are normally left on the queue since both adults and young people in most scenarios access this service from the same place. Boys who attend the STI clinics are given disciplinary talks and the few pregnant girls who attend antenatal clinics are often punished and told off for getting pregnant at early age. The fact is that many of the staff practicing in F.P clinics are themselves parents and may bring a parental perspective to their work (Brabin *et al*, 1995). They may treat the STIs but fail to promote or supply condoms, encouraging future abstinence instead (Brabin *et al*, 1995). It is therefore necessary to treat the STI's and also encourage the sexually active teens to use protection next time they have exposure, and more preferably train on how to use a condom efficiently and effectively.

The Kenyan policy on youth and adolescents on use of condom and other contraceptives is not explicit, resulting in different institutional and individual policies, ranging from open-door policy for married couples to prohibition of service provision to the more vulnerable unmarried youth. The social context of adolescent fertility varies widely across countries and across continents. An increase in adolescent fertility outside of marriage is only one of many changes that are affecting the lives of young people. Other important trends include rises in formal education, incomes, and urbanization, as well as a general increase in the availability of modern contraceptives. These changes are part of an unfolding social context that not only affects reproductive behavior but also strongly influences the consequences of early childbearing.

In order to make reproductive health programs targeted toward adolescents more effective, program designers must understand how adolescents think. Providing a review of the literature concerning many of the important elements of adolescents' decision making processes, including their perceptions of the costs and benefits of engaging in sexual behavior, their assessment of their own susceptibility to the potentially negative consequences of their behavior, and the roles of families and peers in shaping their reproductive decisions. Although some adolescents appear to weigh the pros and cons of engaging in certain behaviors, not all decisions are made rationally. For example, decisions to engage in unprotected sexual intercourse may be based on insufficient knowledge or on distorted judgments concerning the risks of pregnancy or of acquiring sexually transmitted diseases (STDs). Non-decision making can occur because of ambivalence about pregnancy or STDs, particularly among younger adolescents. Cultural values regarding sexuality and gender roles, the power dimensions of adolescents' intimate relationships, and economic disadvantage exert powerful influences on how adolescents in developing countries make sexual and reproductive decisions.

Research has shown that adolescents may encounter embarrassment inequality and social exclusion if they need reproductive services and this experiences lead to discomfort to teens using the services. This is particularly because of the belief that the services are not intended for adolescents. Adolescents may be ashamed to use services especially if the visit follows coercion or abuse. They may also have fear of medical procedures and contraceptive methods including side effects and get concerned over lack of privacy and confidentiality.

In Africa efforts by government and international organizations to provide sex education or family life education have met resistance particularly from religious circles. The expectations among the religious leaders are divided on issues pertaining top adolescents' sexuality with some openly rejecting the teaching of sex education in schools.

Access to reproductive health service is also considered as essential component in fulfillment of individuals' right to health in all its forms and all levels. Accessibility to health facilities and health services is determined by components such as non-discrimination, physical accessibility, affordability and access to information.

Theoretical models that describe access are a double ended fit between predisposing factors and on the other enabling factors. Predisposing factors includes an individual's perception of illness, population specific cultures, as well as social and epidemiological factors. Enabling factors refers to the means available to individuals for using health services. However the potential for alleviating health problems by targeting young peoples has been largely ignored (Goodburn and Ross, 2000). Regrettably the risk of adolescents tends to increase while their participation in health care tends to decrease (Cohen, 2002).

2.4.5 The Changing Social and Cultural Context

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Adolescents sexuality today is viewed with, much ambiguity in large part of the world. In the developed countries for example, sociology and psychology of adolescents is often situate within a framework of deviant behavior and public discussion about adolescent's sexuality and child bearing describe adolescents as problematic (McCauley et al, 1995). In line with this adolescence access and use of condom is viewed as a defiant behavior by the community.

There has been little focus on what constitutes normal healthy sexual development for young people. Instead, there have been many mistakes generalities about the extent to which young people are sexually active, accompanied by moral judgment as to whether they should be sexually active at all. Social change and its associated factors of modernization, rural urban migration, urbanization and inflation of foreign culture have been seen as a major factor contributing to an increase in teenage sexuality, pregnancies and child bearing and transmission of STIs.

Reviving intergenerational dialogue is one of the ways that the Kenyan community is adopting to educate adolescents on moral issues. The Nyanza community happens to have the highest

HIV infection in Kenya at, 15.3% (KAIS, 2007). A traditionalist Luo teenage girl at puberty learned about sexuality from her grandmother and the boy of the same age learned from his grandfather. In recent years this tradition has faded and elders and young people have become increasingly disconnected. The traditional communication channels have broken down resulting in little or no communication between the older and younger generations. In response to this, some Non-Governmental Organization implementing in Kenya, Nyanza, province in Bondo district, have brought young and older people together for discussions about HIV and AIDS, adolescence, and relationships. Young people who do not know where to access information on sexuality are linked to the NGO's implementing in this region for example "The Mama na Dada NGO" and are enabled in ways of protecting themselves against STI's, use of condom, how its used and when to use. Besides, the NGO is also integrating innovative ways to link the two generations, bridging the gaps and determined to empower teenagers on effective's ways against HIV/AIDS and STI's prevention. Unlike in the past when boys and girls were taught separately by their grandparents and also kept the information they learned separate from each other, this particular NGO brings both boys and girls are brought together with elders and participants are encouraged to speak about sexual and reproductive issues openly and honestly.

Culture has a vital influence on health, shaping definitions of illness and determining how health-related decisions are made. Culture and Health Program for Africa (CHAPS), encourages communities to reflect on cultural practices that affect health both positively and negatively. Through research and dialogue, communities are given the opportunity to evaluate cultural practices. Since 2000, CHAPS, with funding from the Ford Foundation, has awarded grants to 58 projects in Kenya, Nigeria, Egypt and South Africa to increase community involvement in the pursuit of better health.

Social change can occur at a local level through simple, small-scale interventions. It provides community members the opportunity to see that their efforts can have a positive impact on the

lives of others. The condom culture has not yet been fully adopted and especially by teenagers and this has predisposed them to contracting HIV/AIDS, and STI's.

The social cultural context is also likely to influence adolescents' access and use condom as preventive reproductive health services. In African countries and Kenya included sex matters are seen as taboo for adolescents. The prohibitive silence that says no to sex before marriage and the prevailing social-cultural and policy environment affect provision of reproductive health care to this group (Ahlberg, 2000). In Kenya, adverts targeting adolescents focus on fidelity, for example, the coining of the words "nime chill" meaning that they will not have sex until they are married.

Religious groups have also opposed reproductive health care in favor of abstinence only among the unmarried group. The attempts to introduce sex education in Kenya in the early 90's were resisted by the religious organizations, particularly the Muslim and the Catholic (Brockman 1997). The Catholic Church for instance burnt and denounced the use of condom and contraceptives burning the AIDS awareness material and demolishing condom dispensers (IPS, 1996). That same year, the then Bishop of The Archdiocese of Nairobi, Kenya, Cardinal Maurice Otunga, lead Roman Catholic Church official, in burning boxes of condoms and safe sex literature. Family life education programs were also banned (Erulken et al. 2004). This culture of silence has leads to lack of sex information among adolescents and necessary services to help protect themselves from reproductive health challenges.

There is a paradigm shift from cultural traditions to formal education where by the informal education taught the youth about sexuality matters. The introduction of formal education system shifted the roles of education and informing adolescents from the community members to the formal teachers. Further to that there is lack of curriculum to guide the teachers and lack of training skills on sexuality issues. As a result adolescents have very wrong myths for instance they assume that conception can be prevented if one takes a bath immediately after a sexual encounter, condom have tinny holes that allows HIV/AIDS virus to pass through and

even rejecting the whole literature on condom by saying that the ones supplied by the MOH have the virus and that's why they are offered for free. (Kiragu and Zabin, 1995)

2.4.6 Family Pattern and Socialization Process In Relation To Condom Use

Effort to promote condom use by sexually active young people is an important component of the public health strategy to prevent the transmission of STD's and HIV/AIDS. Major attention has focused on peer educators, partners and individuals associated with condom use among the adolescents but few studies have focused on the familiar factors. Given that the family is a primary source of socialization for adolescents, and can exert a strong influence on sexual attitudes and behaviors. The role of the parent therefore becomes a major concern in influencing condom use.

The family patterns and unit has been disrupted and there has been erosion of culture and traditional values, taboos and social rules regulating sexual behavior among young people (Cook, Wilson, 1992). Family opinions and attitudes appear to be given relatively less weight than are those of peers and partners, particularly in settings where traditional cultural values have been eroded. As part of their decision making process, adolescents often look to their teachers, their peers, and to their school environment for clues regarding various aspects of sexual behavior and to evaluate the degree to which their beliefs agree or disagree with group norms.

With breakdown of the traditions and family forum for socialization, the teaching of young people teenagers have been left to institutions that have emerged from western culture e.g institutions of learning, peer educators, casual conversations with friends, relatives and mass media. This information is very superficial and sporadic. The role of moral teaching has shifted base from family to socialization institutions. Socialization is a central concept social theorists use to explain both cultural maintenance and cultural change. Socialization links the individual to collective life by molding members into compliance and cooperation with social requirements. During this modeling, if teenagers are trained and encouraged to use condom

every time they are having an exposure, this can reduce their chance of getting infected (Miller & Kim, 1998).

In the African traditional setting, sex education in the home, family, and community was characterized by procreation, social interaction, cleansing and healing, spirituality control and oppression, and family prosperity (Chilisa, 2005). Curiously, the sex education programs offered in formal schools in Africa are more limited in scope. In Latin America, the Catholic Church has played a significant role in preventing the development of curricula that could expand the understanding of human sexuality (Chilisa, 2005). The engagement against sex education by religious groups in other parts of the world, especially the Middle East and South Asia, has not been studied.

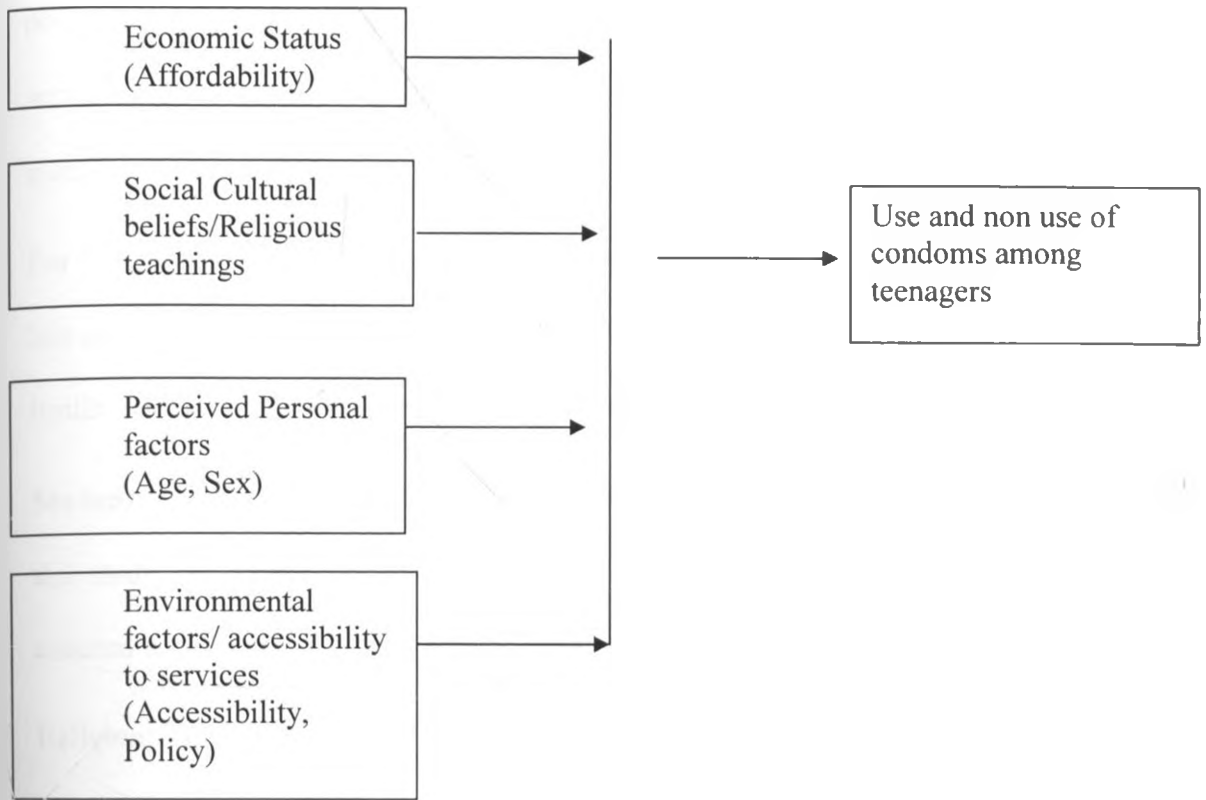
Consequently, schools are a very important arena to empower teenagers on adopting safe sexual behaviors and shun attitudes that deter use of condom. Much of adolescent socialization takes place within the halls and classrooms. Introduction of HIV/AIDS as a subject in the curriculum has improved the level of HIV awareness to attain a universal knowledge of HIV/AIDS at 98% (KDHS, 2003). Pupils are tough on prevention methods focusing on abstinence and being faithful “A, B” and leaving the “C” aspect of condom use. In remote areas, schools accessibility to information about family planning is severely limited and teachers are reluctant because they fear that such education could be disruptive to the school environment.

2.5 Conceptual Framework

- Economic factors are not likely to affect the non use of condom as a method of PRHS among young people in Nyeri District.
- Socio-cultural factors are not likely to affect the non use of female condom by young people in Nyeri District.
- Personal factors, are not likely to affect the non use of condom among the young people in Kenya

- Environmental factors are not likely to affect none use of female condom among the young people in Nyei district

Figure 2.1 The Conceptual Framework



Source: Adapted with modification from Bongaarts, 1993

2.6 Operational Definition of Key Concepts

Adolescent/Teenager: The WHO and UNFPA define adolescents as persons aged 10 and 19 years and classify 'young adult' aged 15-24 in the youth category. It goes a head describing adolescence in developmental terms as a period of transition from childhood to adulthood that takes place between the ages 10-19 years. Adolescent stage is also categorized according to age-sets. These include early adolescence (11-14), middle adolescence 15-17 and late adolescence 18-21. At every stage, the adolescents health goals needs are notably different.

The study will use the WHO classification of adolescent and cover boys and girls aged 15-19 years (i.e. from the first day of 15th year to the last day of 19th year) The inclusion criteria will also be determined by the fact that in Kenya, secondary school education stars at age 15 and

exit at the age of 19 years.. The legal definition of adolescence and mature minors arise due to the issue of guardian consent. Adolescents under the age of 18 years are considered as minors since they have not attained the legal age of consent. In developed countries the state laws do not recognize the legal rights of minors to provide informed consent for general health services. However, mature minors may give consent if they have gone through the legal age of maturity.

For the purpose of this study, adolescents will be classified from the age of 15 years until the last day of the 19th birth day to be able to compare the results with the national demographic health surveys and global age category. Teenager/Adolescence will be used interchangeably.

Students: A person who is studying at secondary school and also primary school. In relation to this study, the term means boys and girls who are in school. The attitudes and perception on condom use, the social circles will be key in this study.

Religion: This refers to adolescent's mode of worship.

2.7 Theoretical Framework

Theory plays a critical role in social science because it generates ideas. These ideas can then be tested empirically by scientific rules of inquiry to see if they are right or wrong. The facts or findings merge from empirical research yield insights help people solve personal problems, and even point toward new pathways to rectify social wrongs. The best theories are those that accurately predict human behavior and suggest how to create more humane ways for people to live their lives.

2.7.1 The Health Belief Model

The conceptual guideline for this study is influenced by the health belief model (Becker 1974) and by rational choice theory. The health belief model is one that is widely used theoretical basic for understanding health behavior. This model was originally developed as a systematic

method to explain and predict preventive health service. It focuses on the relationship between health behavior practice and utilization of health service.

This theory integrates for example when an individual feels that a negative condition can be avoided in this case by use a condom, it also involves an expected recommended action to avoid a negative health condition and individuals can successfully take a recommendation health action comfortably and with confidence.

According to this theory, perceptions determine the likelihood of individuals adopting and maintaining safer sex practice in this case use of condom by teenagers.

2.7.2 Rational Choice Theory

This is an assumption that complex social phenomena can be explained in terms of the elementary individual actions of which they are composed. In rational choice theory individuals are seen as motivated by the wants or goals that express their preference. They act within specific, given constraints and on the basis of the information that they have about the conditions under which they are acting. The relationship between preference and constraints can be seen in the purely technical terms of the relationship of means to an end. Rational choice theory holds that individuals must anticipate the outcomes of alternative course of action and calculate that which will be best for them (Health 1976, Carling 1992, Coleman 1973).

Thus condom is constructed as a form of rationalist behavior, driven by individual's benefits of condom use. Reproductive health services design and provision has been of necessity, predicated on the assumption that individuals are in a position to make rational, informed decisions about their sexual behavior.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter focuses on the research design to be used in this study. Research design is defined as “the plan, structure and strategy of investigation conceived so as to obtain answers to research questions and to control variance.” A research design guides the researcher in collecting, analyzing and interpreting observed facts. This chapter details the approaches that were used in the research project. This includes the study design, study population, sampling techniques, data collection instruments, data collection procedures, data collection methods and data analysis Kerlinger, (1986; 275)

Research method is a process that involves systematic way of gathering information/data, determining relationships and offering explanations of the findings. This research will adopt a survey method using both qualitative and quantitative questionnaires with both close ended and open ended questions. The two methods will be used to increase validity and reliability of the data collected. Qualitative method will be concerned with the process rather than the outcome while quantitative methods will be used to gather quantitative information's.

3.2 Site Description

Nyeri North district is one of the new administrative areas within Central province, in Kenya. It lies, about 200 km north of the capital Nairobi. The area of study lies at the eastern base of the Aberdare (Nyandarua) Range. This forms part of the eastern end of the Great Rift Valley and lies on the western side of Mount Kenya. Nyeri town is the administrative headquarters of Central Province and Chaka is the District Headquarter. The population was is mainly agriculturalist. The area lies at 00°30'S latitudes and 37°30'E longitude. The local scene includes Mount Kenya. The main source of income is farming. Wheat is the main cash crop and maize is the staple food.

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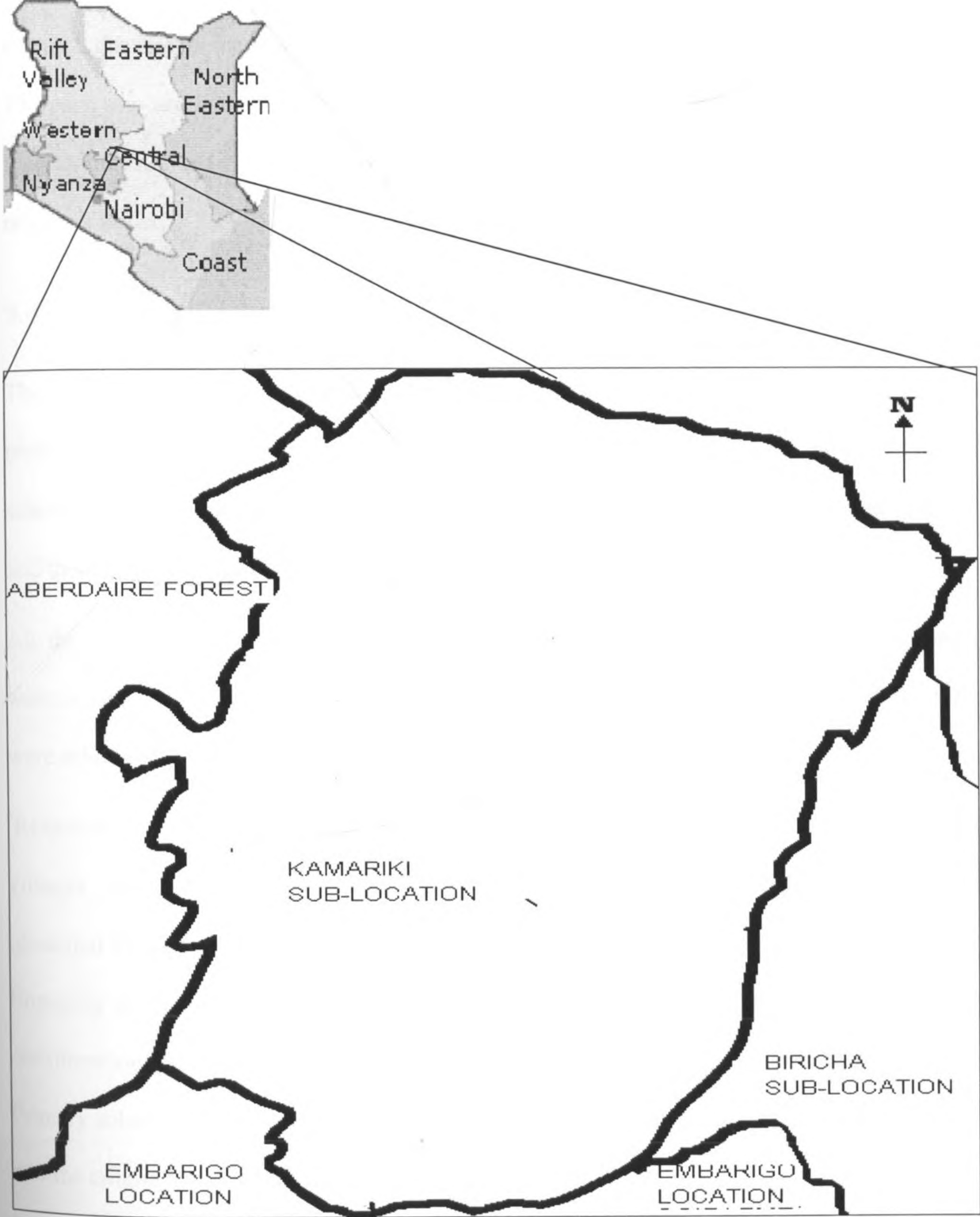
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Choice of Nyeri North District Kamariki Location is purposeful. Bailey (1987) says that an investigator can use his or her own knowledge, research skills and prior knowledge to choose the setting and respondents. The research was interested in the reasons as to why teenagers in Kamariki Sub location are not using preventive reproductive health services in this case condom, and investigate factors that compel these teenagers not to use despite its availability and awareness of the pros and cons to non use.

The other factor determining the choice is the resource and time constrain that has made me not be able to cover larger area. Language barriers, accessibility to this village and familiarity of the region has also contributed to the choice of this setting. I have a passion to unearth the hidden factors that has continued to increase poverty level, and spread of STIs in rural settings.

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Figure 3.1 Map of Kenya showing the Kamariki Sub-Location in Central Province



Source: Government Press, (2004)

3.3 Unit of Analysis

According to Schutt (1996:593), unit of analysis is “the level of social life on which the research question is focused”. The units of observation were the teenagers between the age 15-19 years who are both sexually active and not sexually active. The key informants were the local administrator (sub-chief), clinical officer/nurse at the local health centre, parents and a religious leader.

3.4 Sampling Design and Procedure

The study used multiple techniques purposive sampling and snowball sampling. These techniques were employed with the help of the area, administration to locate the in and out of school teenagers in this sub location. Purposive selection was done to identify the first contacts and there after snowballing.

All the participants who met the eligible criteria (unmarried 15-19 years) and gave consent were conveniently included in the study until the predetermined sample size was met. Recruits were asked to participate on the study but not obligated this was voluntary exercise.

Respondents for both qualitative and quantitative studies were selected from a total of five villages. The four research assistants were facilitated by two locals (youths) who had been identified by the area key informants (with the authority from local administration sub-chief). Engaging research assistants who were not from this village was purposive putting into consideration that this study was sensitive and participants wanted to remain anonymous. Primary school teachers were resourceful through announcing and encouraging teenagers who met the criteria to participate in the study.

The interviews were conducted in favorable surroundings and conditions to ensure openness and privacy. An interview took about 20-30 minutes. During the day, the research assistants conducted door to door interviews. The community guide would introduce the research assistant create a rapport and leave the interview sessions on going for confidentiality.

The researcher and the four research assistant with the help of the village guide went to Kamariki sub location, screening and recruiting respondents. The four research assistants were purposive identified, young slightly above 20 years. This encouraged teenagers interviewed interact freely with the research assistants without fear of intimidation. Research assistants were also gender representative.

The interviews were carried out during the mid-term's holidays and this was purposive in order to tap rich information from the boarding secondary school teenagers. Use of judgment and a deliberate effort to obtain representative samples was used.

Key informants interviews

The key informant's interviews targeted the area administrator, health providers, parents and religious leaders. The objective of this was to get information on the role of the society on condom use among teenagers. The 5 key informants were interviewed one at a time on an agreed day and a check list was used to guide the discussions.

Focus Group Discussions

The 3 FGDs group composition was between 7 and 8 teenagers and they were conducted in the afternoons when the youths were readily available. The objective of the FGD was to get in-depth information on condom use as well as triangulate the information obtained from the main quantitative survey. The researcher using a pre designed check list facilitated the discussions and they research assistants documented the proceedings. The duration of each FDG was about 30minutes.

3.5 Sample Size Determination

The sample size was calculated using the following formula (Fisher, *et al* 2002):

$$N = \frac{z^2 pqd}{d^2}$$

N=desired minimum sample size

Z=Standard normal deviate which is equal to 1.96 and 95% confidence level

P=Proportional of the population estimated to have a particular characteristic (50%) 0.5

Q=1-p i.e. (1-0.5=0.5)

D=degree of accuracy desired at 95% confidence level = 0.05

D=Design effect=1

$$N = 1.96^2 * 0.5 * 0.5 * 1.5 / (0.05)^2$$

$$N = 192$$

10% has been added to the sample size because some of the people may refuse to participate, or fill in the questioners inconsistently. Thus, 10% of 192 is 19. This a final sample size of 211 (192+19=211).

3.6 Data Collection Technique

3.6.1 Methods and Tools of Data Collection

Both quantitative and qualitative methods of research were used to ensure uniformity in the interpretation of concepts. The data was primarily obtained through self administered interviews and focus group discussions. The use of different methods can enhance the validity and reliability of the research findings (Nachmias and Nachmias, 1996).

Quantitative research by definition deals with quantitative and relationships between attributes. This involves the collection and analysis of structured data in a more positivist tradition (Bowling, 2002). The major instruments chosen for the purpose of collecting data for the study

was the self administered questions with a small proportion of face to face interviews for those who were not able to read. Studies suggest that face to face interviews may be biased. The questions were simple and unambiguous to facilitate appropriate responses.

Qualitative technique is a method that is more naturalistic in enquiries and less obstructive than quantitative investigations. This method aims at studying people at their natural social settings.

Focus groups are unstructured interviews with small groups of people 6 to 12 people who interact with each other and the facilitator. FGDs can make group dynamics, stimulates discussions gain insights and generate ideas to peruse in-depth discussions. This is an excellent technique to use for examining groups perception about particular issue.

A total of three FGDs were held and sampling was purposive. The members were recruited progressively from the initial quantitative interviews. Two interviews were same sex and one was mixed group comprising of boys and girls teenagers. The criteria for selection was involvement in local drama on HIV/AIDS awareness, leadership in school (prefects), sexually active and the age criteria was also used a criteria for selection.

3.6.2 Variables used

Independent variables

Source of income/Occupation: This is a combined variable that take to account the source of livelihood, used to measure capability of teenagers.

Sex: This is being male or female and also the aspect of the roles each gender plays in determining condom use.

Dependent variables

Condom use: this will be used to measure the reported use of condom at the last sexual intercourse within the last 12 months

Condom non-use: This term will be used to denote the reported non-use of condom during the last sexual intercourse within the last 12 months.

3.7 Data Collection Schedule

The data was collected from the study population Kamariki sub-location between from 15th September 2008 to 30th October 2008. A total of 230 questioners were administered for quantitative data while 23 participants attended the three FGD. Four research assistants were recruited and trained on how to administer the questioners and conduct FGD. The need to maintain confidentiality was emphasized to the research assistants.

Consenting and initial contracting of eligible respondents before they were given the questioners was done. The questioners required an average of 20 minutes to complete. Those who were selected for FGDs were approached a day before holding the discussion to confirm availability and meetings were held at the most convenient place as specified by the participants.

An introductory letter from University of Nairobi was obtained to enable the researcher to administer questionnaires to the various categories of the study population. Four research assistants were recruited and trained to help in the data collection exercise. They were also instructed to re-assure the respondents about the confidentiality of their feedback. Field work commenced from 16th September to 20th October 2008.

Questionnaires were stored safely in a lockable drawer and confidentiality was ensured by the research assistants.

3.8 Data Management and Analysis

After all the questionnaires were adequately checked for data quality, the information was coded and entered using Epi-Info system and analyzed using SPSS (Statistical Package for Social Sciences). Descriptive statistics namely frequency counts and percentages were generated to capture the distribution of responses on the key issues addressed in the study's questionnaire. Data tabulation using two by two tables were also generated to calculate the chi-square and validate the results. From the variables that the values were less than 5% there was

necessary need to collapse the variables. Later logistic regression was also used to verify the validity of the response by linking the dependant variables with the independent variables.

Qualitative data was analyzed by identifying the key thematic responses from the deep and rich responses from the key informants and focus group discussion.

3.9 Limitation of the Study

Though this study was successful there were challenging situations on the ground where by some teenagers were not available at home. Research assistants had to make follow up visit at least two visit before making conclusion that the prospective respondent cannot be traced.

The study topic being sensitive, some local authorities were persistent wanting to know the turn out and the findings as research was being carried out. Noting that this was the first study to be carried out on adolescent in this area and the nature of sensitivity, teenagers were initially hesitant to share their experience. There was confusion with the recruitment exercise of the Youth development Funds and some teenagers came expecting hand outs. As noted earlier this challenged was resolved with the help of the area sub chief.

CHAPTER FOUR

4.0 RESEARCH FINDINGS

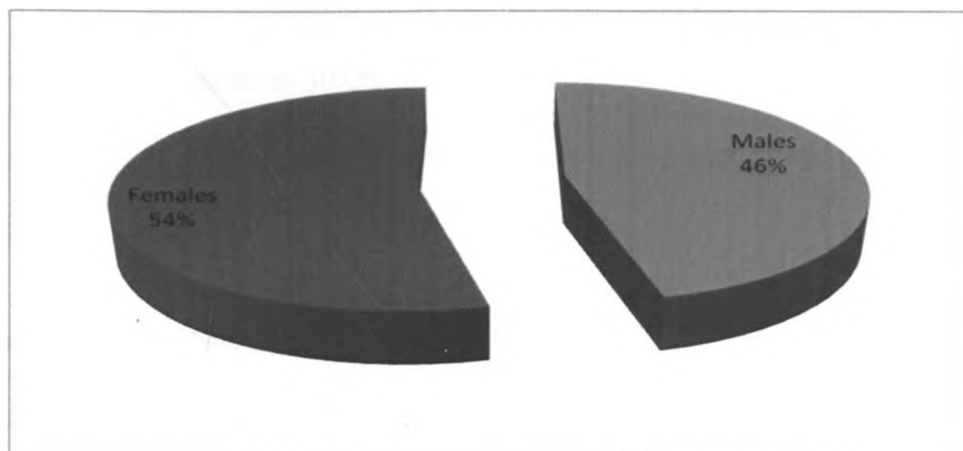
4.1 Introduction

This chapter presents the data analysis, interpretation, and discussion of the research findings from the two categories of respondents. The chapter examines, categorizes, and tabulates the evidence so as to address the initial objectives of the study. The rest of the chapter is organized as follows: section 4.2 presents the demographic characteristics of the sample; and Section 4.3 Characteristics of Sexual Behaviors among Teenagers, section 4.4. Sexual Transmitted Infection and Sexual Behaviors, and the last section 4.5 represent Condom Use among Teenagers. The study targeted a sample of 204 teenagers from sub-location Nyeri North District central province. The residents sample received a response rate of 98% which represents 202 respondents out of possible 204, since 2 questionnaires were inadequately filled, and were therefore insufficient for the analysis. This was performed to eliminate the effects of missing responses.

4.2 Socio-Demographic and Economic Characteristics of the Sample

Figure 4.1 below presents the demographic characteristics of the residents' sample. The gender of the respondents was fairly split with 46% comprising of male respondents and 54% comprising of female respondents. The sample was drawn from teenagers between ages 15-19.

Figure 4.1 Gender of Respondents



Source: Interview data

4.2.1 Highest level of education attained

Given the age range of 15 years to 19 years, 38.1% of the respondents were still undergoing secondary education. This percentage comprised 17.8% males and 20.3% females. Quite some number (56%) of those interviewed had either completed lower primary or lower and upper primary. This was further broken down into 24.8% males having completed only lower primary or have completed both lower and upper primary. This percentage was slightly higher for females who reported 31.2% having attained similar academic profiles. The rest of the respondents comprising 3.5% of males and 2.5 % of females have never had formal education. These figures are slightly lower than those realized in KDHS 2003 survey that had; no education (7.8% females, 5.7% males), Primary incomplete (51.9% females, 61.9% males), Primary complete (18.5% females, 13% males), Secondary incomplete (16.7% females, 14.9% males).

4.2.2 Religion

Religion is predominantly Christian with the biggest proportion comprising of the Roman Catholics at 54%, Protestants at 30.0% and 16% constituting Non Christian African Instituted faiths, Islamic religion and earthiest. This means that a good percentage of those interviewed prophesy to some faith.

4.2.3 Occupation / Source of Income

The community is so much dependent on farming activities, with a small proportion operating small business. The biggest proportion of the youth interviewed were totally dependants on either parents or dependants. Most (47.5%) of females are total dependants. Some 19.8% of males also totally depended on others for their livelihood. The out of school teenagers who were practicing farming constituted 20.8% males and 16.8% females. Small traders comprised of 5.5% males and 9.4% females.

Majority of the teenagers in this area has therefore ever attended some formal education apart from a few individual who have no formal education.

Table 4.1 Socio-Demographic and Economic Characteristics of the Respondents

Variables	Males		Females	
	Frequency	Percentage	Frequency	Percentage
Education Level				
None	4	2.0	2	1.0
Lower Primary	7	3.5	13	6.4
Upper primary	43	21.3	50	24.8
Secondary School	36	17.8	41	20.3
Vocational	3	1.5	3	1.5
Total	93	46.1	109	54.0
Religion				
Islam	1	.5	4	2.0
Catholic	49	24.0	61	30.0
Protestants	28	14.0	32	16.0
African Instituted Churches	14	7.0	11	5.5
Others	1	.5	1	.5
Total	93	46.0	109	54.0
Source of Livelihood				
Farming	42	20.8	34	16.8
Traders	11	5.5	19	9.4
Dependants	40	19.8	56	27.7
Total	93	46.1	109	53.9

Source: Interview data

3. Characteristics of Sexual Behaviors among Teenagers

3.1 Sexual Activities among Teenagers

Overall the mean age at first sexual intercourse was at 17.2. When this was disaggregated by gender, age at first sexual intercourse was at 17.5 and 14.6 for girls and boys respectively. Sex is rare among very young teenagers (15 years) and become more common in later teenage years. Majority of teenagers who have ever had sexual encounter first did so with a partner who was 1 -2 years younger or older depending on gender. Females recorded 18.6% out of 4.1% as having had their first sexual intercourse encounter with a partner 1 – 2 years older. This was the opposite for males who reported 28% out of 55.9% who reported having sexual intercourse with a partner 1 – 2 years younger. A few (12.7 %) respondents had first sexual

encounter with senior partners who were 6 and more years older. A low percentage of 29% of females and 14.4% of males used condom during their encounter.

The interpretation of these data indicates that young men are engaged in sexual relations earlier than the girls with an average of 2 years. There are also rare cases where boys were involved sexually with senior girls. Only a small proportion used condom at first exposure. This is because the first encounter as indicated though willingly they happened sumptuously and therefore unplanned. Only 2.5% used condom at first encounter an indicator of planned sex and they were all teenage girls. The age factors of their partners indicated that they were senior men by age.

Table 4.2 Respondent's gender by age of current partner

	Age of current partner							Total
	1-2 yrs younger	1-2yrs older	3-5 yrs younger	3-5 yrs older	6 and above yrs younger	6 and above yrs older	Don't know	1-2 yrs younger
Male	33	12	10	3	1	7	0	66
	28.0	10.2	8.5	2.5	0.8	5.9	0.0	55.9
Female	0	22	7	11	3	8	1	52
	0.0	18.6	5.9	9.3	2.5	6.8	0.8	44.1
Total	33	34	17	14	4	15	1	118
%	28.0	28.8	14.4	11.9	3.4	12.7	0.8	100.0

Source: Interview data

Out of the total sample of 202, 64.4 % of the teenagers have had sex before this study while 35.6% have never had sex. Of those who have had sexual intercourse, 29.2% were females while 35.1% were males. Despite the lower sample of males in this study as compared to females, the males still emerged more sexually active.

Table 4.3 below considers only those teenagers who have ever had sex at least once.

There was discussion focusing on relationships with boyfriends or girlfriends, older (married) men or women and occasional sex partners. However, young women and men were portrayed differently with respect to initiating sexual relationships.

Table 4.3 Sexual encounters among teenagers

		Ever had sex		Total
		No	Yes	
Male	Count	22	71	93
	%	10.9	35.1	46.0
Female	Count	50	59	109
	%	24.8	29.2	54.0
Total	Count	72	130	202
	%	35.6	64.4	100.0

Source: Interview data

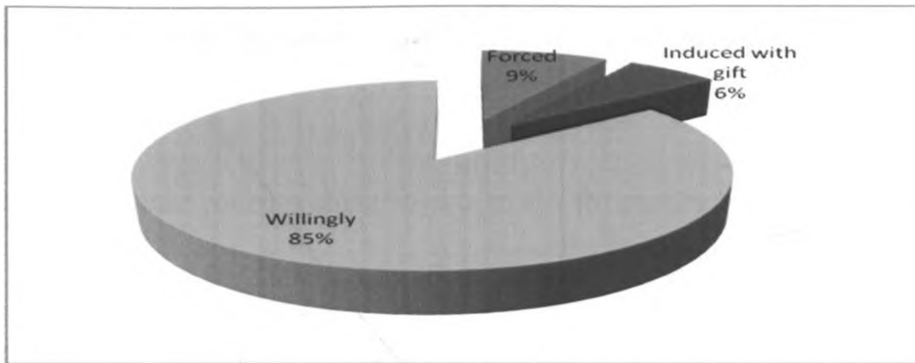
4.3.2 Circumstance under which Teenagers had their First Sexual Encounter

The study investigated the first sexual encounter and the circumstance that lead to this. Of the 130 respondents who have engaged in sex before, 8.5% were forced, 6.2% were induced by gifts while 85.4% had sex willingly. This is shown in Figure 4.2 below.

Young boys and girls are more likely than not be lured into sex by people who know them very well or relatives. This study also shown that 10.1% of the respondents who have had sex were sexually assaulted by their relatives. The remaining 89.9% said they had no blood relations to the person who first engaged them in sexual activities.

The unwillingness by the society to talk or report sexual assault is depicted in the assaulted respondents with only 6 out of the 13 who were assaulted by relatives seeking help from the locally available interventions for social, medical and psychological support (Table 4.4). FGDs indicated that young men were consistently pursuing sexual relationships or “conning” young women into having sex. Young people did express negative judgment to attitudes towards teenage engaging in sexual relations. There were heated debates on the roles of parents who are engaged in illicit brew while their children are conned into sexual debuts by the customers.

Figure 4.2 Circumstance surrounding first sexual encounter



Source: Interview data.

A case was presented of a mentally littered girl who has been raped subsequently by young men in the village. The FGD discussions blamed the local authorities and parents for negligence.

Table 4.4 FGD Interview 1 Sexual abuse among teenagers

Interview 1
During this FGD one of the senior teenage (19 years) shared her experience.
Interviewer: Kindly share with us what happened?
Jane: “I was raped when I was 15 years by my neighbor when my parents were busy selling illicit brew. My neighbor who was a regular customer promised that he will get me a job in Nairobi and that’s how he ended up assaulting me sexually....
<i>(Names used are not the real names of the respondents interviewed).</i>

4.3.3 Sexual Partners in the Last 12 Months

The number of sexual partner’s predisposes individuals into risks of contacting infections like STIS and HIV/AIDS and can also result in unwanted pregnancies. This survey captured information on number of sex partners and type of sexual relationship teenagers engage in. The relationships were categorized into two, steady and non-steady relations (partner 1 and partner 2) respectively. Each category was to specify if this partner was girlfriend/boyfriend living together, girlfriend/boyfriend not living together, someone they paid for sex and the last option was casual acquaintance. 24.4% of the teenagers indicated that they were not married but are living with their sexual partner’s in a form of arranged informal setting. The biggest proportions were in a girl/boyfriend relationship representing 65.6%, 10% represented the paid

and casual sexual encounters. Over all among the sexually active teenagers, 87.4% had a sexual partner at the time of the survey; the rest 12.6% did not have sex partners in the last 12 months

FGDs indicated that some young women engage in sex for money or with men other than their boyfriends. Both male and female teenagers discussed sexual relationships with older, typically married men or women that involved material exchange.

(These relationships were also implicated in the breakdown of protective behaviors as abstinence and condom use). A common expectation was that once a young woman received a gift, she owed something in return—a debt explicitly talked about as sex. Moreover, there was frequent mention that young men give young women money or gifts in exchange for sex or in hopes of having sex in the future. Young women expected money and material goods not only from older partners but also from age-mates, and young men expected to give something for sex. Thus, “transactional sex” is more widely reflective of adolescent relationships than just young women having sex with much older male partners and according the FGDs this category of people should use condom consistently. This is represented by the figure below.

Figure 4.3 Type of sexual partners



Source: Interview data

4.3.4 Teenagers Suspicious of Their Partners Having other Sexual Relationships

Teenagers surveyed indicated that 14.5% were suspicious that their partners may be involved in other sexual relationships but did not use condom in their last sexual encounter. Another 59.4% are not suspicious of their partners' engagement in other sexual relations and did not use condom in their last sexual encounter.

The other group who used condom during their last sexual encounter with partner did so regardless of whether they suspect the partner to be cheating on them or not. This group consists of 16.7% who are suspicious, 50% not suspicious and 33.3% who are not bothered.

Despite the fact that teenagers were suspicious of their partners, teenagers risk perception is low. The teenagers in this case never see themselves to be at risk of infection. This can therefore be postulated that the teenager's risks perceptions is low despite high HIV awareness levels.

Table 4.5 Gender by partner suspicion and use of condom during sexual intercourse with partner

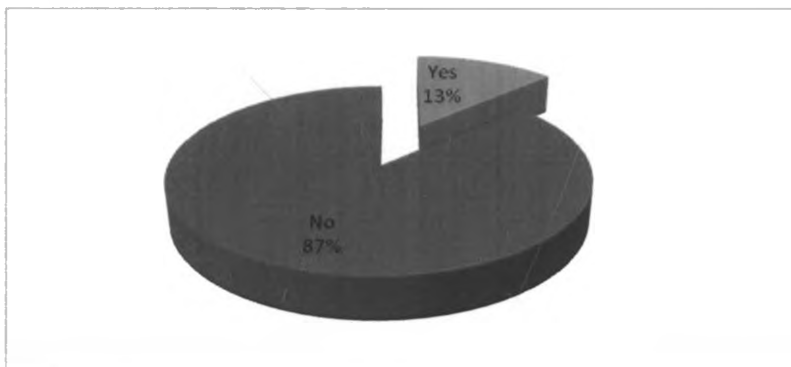
Used condom last time had sex current partner			Do you think partner has other partners?			Total
			Yes	No	Not bothered	
No	Male	Count	9	22	11	42
			13.0	31.9	15.9	60.9
	Female	Count	1	19	7	27
			1.4	27.5	10.1	39.1
	Total		10	41	18	69
		14.5	59.4	26.1	100.0	
Yes	Male	Count	7	13	5	25
			14.6	27.1	10.4	52.1
	Female	Count	1	11	11	23
			2.1	22.9	22.9	47.9
	Total		8	24	16	48
		16.7	50.0	33.3	100.0	

Source: Interview

4.3.5 Teenagers Exchanging Sex for Money

Prostitution in this region is quite low and unexpected being a rural setting with sparse population thus low level of interaction. Despite this, some teenagers did agree that they have been exchanging sex with money as a source of livelihood. This was more prone in areas that were highly populated with informal setting. 13% have ever exchanged sex for money among the sampled population.

Figure 4.4 Exchange of sex for money



Source: Interview data

A common expectation was that once a young woman received a gift she owed something in return- a debt explicitly talked by men as sex. Though the men did not feel the same way when they owed young/older women some cash this was a general understanding among the teenage boys. They also felt that a smile from a girl meant that she is interested. This depicts that there are occurrences of “transactional sex”. This FGD felt that this category of people should use condom at all time.

Table 4.6 Expression on sex and money

Interview 2 FGD
Interviewer: What do you think of teenagers exchanging sex with money?
Respondent Kariuki: Young women will always expect money and material goods chocolate from their boyfriend/s and we boys expect to give something to show that we are in control...
<i>(Names used are not the real names of the respondents interviewed).</i>

4.4 Sexual Transmitted Infection Knowledge and Behavior

4.4.1 Knowledge on STIs

Information about the incidence of STIs is a useful marker of unprotected sexual intercourse. Knowledge of infections other than HIV/AIDS was assessed by asking the teenagers to list some of the signs and symptoms displayed by an infected person. The results as represented by Table 4.7 below showing that 91.4% have heard about STI's before the study. Among the teenagers interviewed, 10.6% have experienced genital discharge or ulcers while the rest (89.7%) have never been infected with genital ulcers in the last 12 months.

Disclosure of STI to sex partner was at 13.3%. This is because of fear of rejection and stigma among the infected by the community and friends. The victims also believe this brings shame to the family of the infected.

Significantly, a number of respondents took various measures to protect themselves and their partners when they had sex after learning that they had genital ulcers. Condom use as a way of protecting the uninfected partner from acquiring the infections showed that 13.3% of those who had genital ulcers or discharge did use a condom during the time they were infected for protection purposes. 26.7% of the teenagers who have had genital discharge stopped having sex with their partners after knowing that they had STI while 13.3% used a condom. Among the ones who went for treatment only 58.3% took all the medicines to the last dose. It is worth noting that a number of the teenagers have acquired skills to protect their partners from infections and re-infections,

Less 50% of the infected cases that were treated and prescribed for drugs did not adhere to the doctor's prescription and dosage. This could be as a result lack of adequate knowledge of how the medication works and the consequences of incomplete dose. Some people also feel cured just because they feel some relief (after taking some drugs) from previous pain that they had and then fail to see the need to complete prescribed dose.

Table 4.7 STI knowledge, access to treatment and behavior of respondents

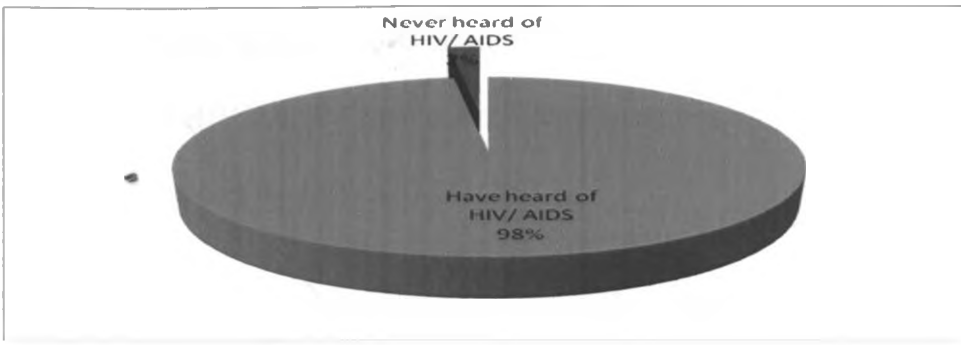
Variables		
Knowledge of STIs	Frequency	Percentage
Heard of STI	181	91.4
Never heard of STI	17	8.6
Ever had a genital ulcers		
Yes had genital ulcers	20	10.6
Not had genital ulcers	175	89.7
Access to medical care for those who had genital ulcers		
Yes accessed medical care	12	57.1
Not accessed medical care	8	42.9
Disclosure of Genital condition		
Yes disclosed	2	13.3
Not disclosed	13	86.7
Stopped having sex		
Yes stopped having sex	4	26.7
Not stop having sex	11	73.3
Used a condom		
Yes used protection	2	13.3
Not use protection	13	86.7
Took medicine		
Yes took medicine	7	58.3
Not take medicine	5	41.7

Source: Interview data

4.4.2 Knowledge about HIV/AIDS

According to the background information, the data shows that knowledge about HIV/AIDS among teenagers is universal at 98%. The data is comparable with KDHS 2003 at 98% among the rural population. At the same time, age, sex and level of education did not influence significantly to knowledge about HIV/AIDS.

Figure 4.5 HIV/ AIDS knowledge among teenagers



Source: Interview data

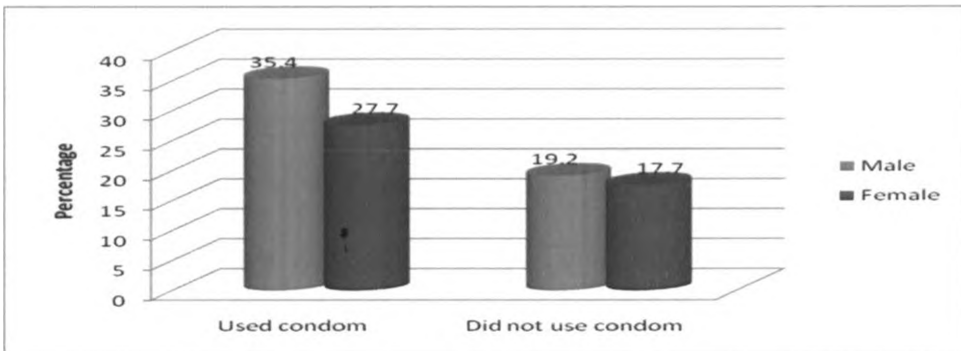
In addition teenagers were for the opinion that HIV/AIDS can be prevented by, abstinence at (75%), being faithful (70%) and with use of condom (45%). The level of education attained was strongly related to the participant’s knowledge of modes of HIV/AIDS transmission.

4.5 Level of Condom Uptake among Teenagers.

4.5.1 Condom Use among Teenagers

Condom use among teenagers who are sexually active was at 63.1% which is comparable to 67.1% that was reflected in KDHS 2003 among the teenagers of the same age group. A total of 36.4% did not use condom in their last sexual encounter. The general percentage (45.4%) of females who used condom is slightly lower than that of males (54.6%) because fewer females reported having never engaged in sexual intercourse as was seen earlier.

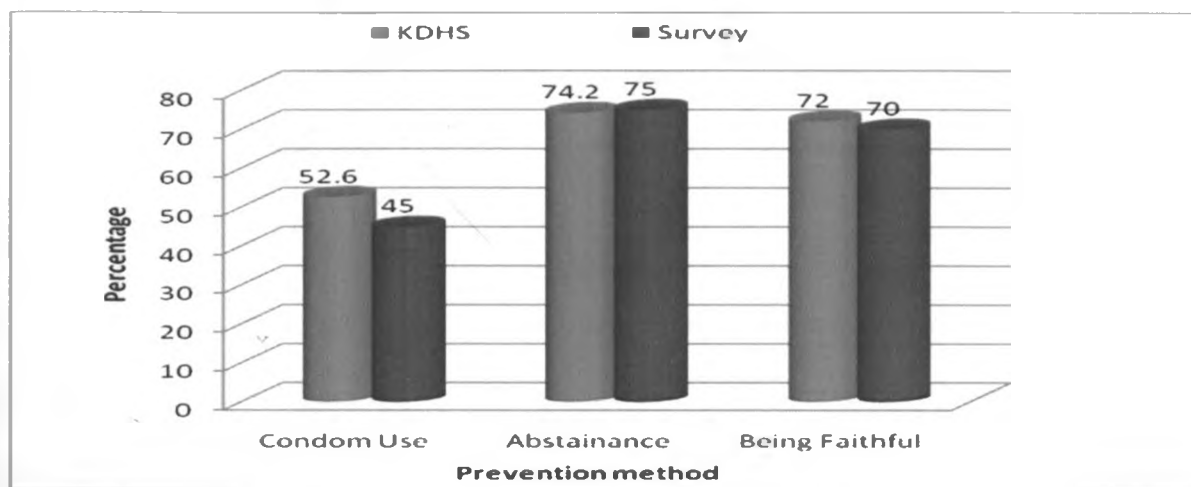
Figure 4.6 Condom use among teenagers



Source: Interview data

Knowledge of ways to reduce AIDS and STI's transmission was also assessed during the survey. Abstinence, being faithful to one uninfected partner and using condom are important ways to curb spread of HIV/AIDS. There were further questions on whether condom use can reduce the chances of getting the HIV/AIDS.

Figure 4.7 Knowledge of HIV Prevention methods indicated by teenagers from Kamariki compared to the KDHS, 2003



Source: Interview data and KDHS 2003

4.5.2 Why Teenagers Use Condom

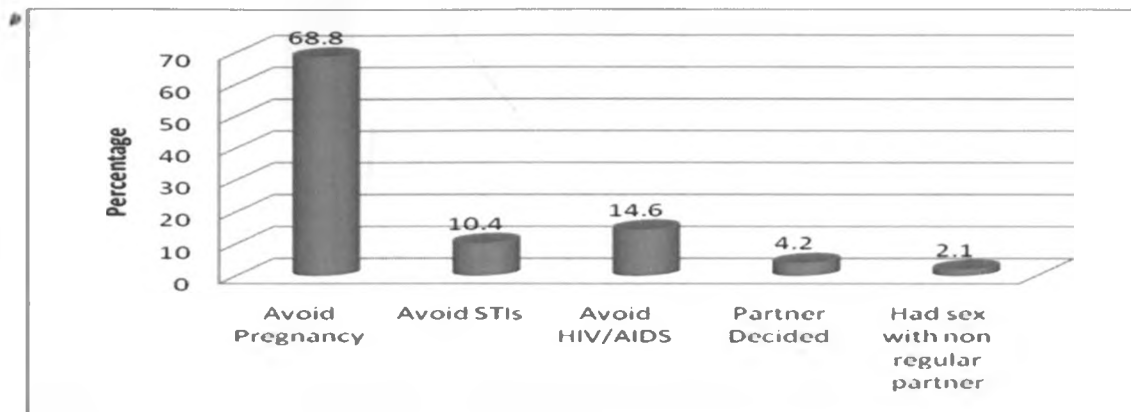
Teenagers use condom for various reasons as an important dual protection in fight to curtail spread of HIV/AIDS, STIs and as a contraceptive. Although for effective dual protection, consistency use of condom is required at every sexual encounter to achieve results. All sexually active women and men who have never married at every sexual exposure is regarded as a higher-risk sex.

Teenagers use condom for a variety of reasons and there is a clear indication that majority fear getting pregnant (68.8%) more than contracting STIs or HIV/AIDS (25%). This means that more teenagers would rather get STI's and treat the infections than get unwanted pregnancies.

Condoms are also seen as a way of cubing STIs when engaging in sex with un-trusted partner.

KDHS 2003 listed attitudes stated by both males and females as diminishing pleasure (29.9%), buying condoms is embarrassing (36.1%), condoms contain HIV (9.2%) and condoms protect against disease (67.1%).

Figure 4.8 Reason for condom use among teenagers



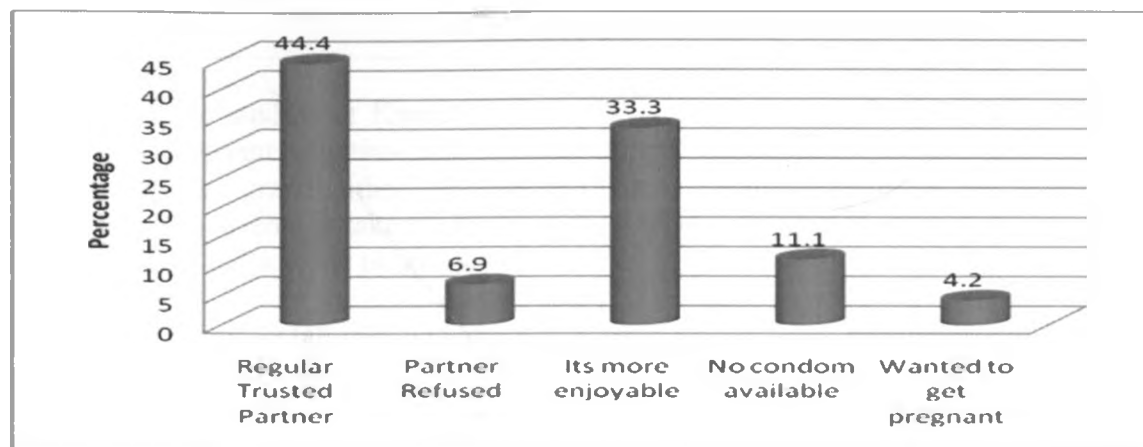
Source: Interview data

At the same time teenagers recognized the dual function of the condom to prevent pregnancy and STIs and when the question ‘condom should be used for preventing pregnancy’ was posed majority of the teenagers agreed with the statement.

Figure 4.10 shows that teenager’s belief that sex is more enjoyable without a condom at 33.3%. This “belief” has continued to increase chances of teenage pregnancy and transmission of STI’s. Other determinant of non use of condom was the “trust” shared by the two partners that was reported by 44.4% of the respondents.

During the FDG teenagers were asked why they think that sex is more enjoyable with out a condom and heated debates on the importance in preventing oneself from STIs, pregnancy emerged from the mixed group 3. Among the sexually experienced boys, they urged that the feeling is different and more enjoyable with out a condom while the ones who have never had sex felt that the feeling is the same. The issue of chewing a sweet in its wrappings emerged. One of the teenage girls who had used a female condom did express that female condoms are usually noisy and uncomfortable. She also expressed the issue of cost being expensive.

Figure 4.9 Reasons for not using condom among teenagers



Source: Interview data

4.5.3 Access to condom

The most preferred source of condom was from the shop with 41%. This could be because they are very accessible and convenient. Of the sexually active, 25% got their condoms from pharmacies. The teenagers interviewed complained the MOH condoms were small and of poor quality but despite all that, these condoms are reportedly used by 22% of the respondents.

Young people were said to typically seek reproductive health services from a variety of sources but after appraising symptoms and trials of home remedies.

Table 4.8 Teenagers access to treatment at the local health centre

Interview Key Informant
<p>Nurse (Joseph)</p> <p>I normally received and treat teenagers with STIs and especially candidiasis where a case is displayed with itching. Though this is not a very serious case they teenagers normally come after many weeks of scratching and when home remedies fail to work. I can tell by the intense of bruises on the genital area. I just hope that these are not genital herpes HSV2. Incase of frequent recurrences I normally send patients to Nyeri PGH for test...</p> <p>We also try to get in touch with the parents obviously by sending the teenager patient to their parents. Yes some of the teenagers come back with their guardians and big sisters and brothers and counsel them accordingly... However this is not perceived well by the teens and most of them end as lost to follow up.</p> <p><i>(Names used are not the real names of the respondents interviewed).</i></p>

One of the teenage girls shared her experiences

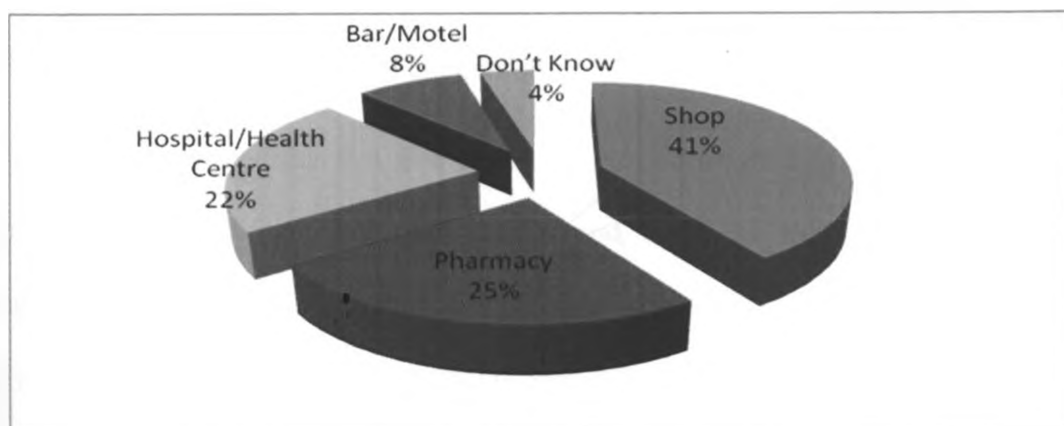
Table 4.9 Level of embarrassment among teenagers and parents in Kamariki

(Group 1)
<p>Respondent Jane I am a form three student at Kamariki Girls Secondary school and my experience is a bit different. I got pregnant sometime last year and dropped out of school for two terms. I live with my mother and my grandmother. My grandmother is a choir member at the local Catholic Church. So... she offered to take me to Nyeri PGH when I developed complications.</p> <p>Interviewer How old was the pregnancy</p> <p>Respondent Jane Ehmmm... I can't really tell may be 6 months or so.</p> <p>Interviewer What happened? A miscarriage I went through HIV Counseling and Testing at PGH and later referred to the family planning clinic.</p> <p><i>(Names used are not the real names of the respondents interviewed).</i></p>

This was a case that indicated that parents/guardians are stigmatized by the entire community and laughed at by the larger community. The secrecy around condom use, teenage sexual behavior is unexhausted program that need intervention at all levels. The same sentiments were expressed by the nurse that in this community teenage pregnancy is characterized with illegal abortions instigated by parents and guardians.

For abortions, young people turn to home remedies, hospitals and traditional healers. Key barriers to access include young people's shyness or shame, distance of providers and cost of services, and negative attitudes from health care workers. Some also were noted fearing that the health care workers may disclose their illness to their parents and guardians

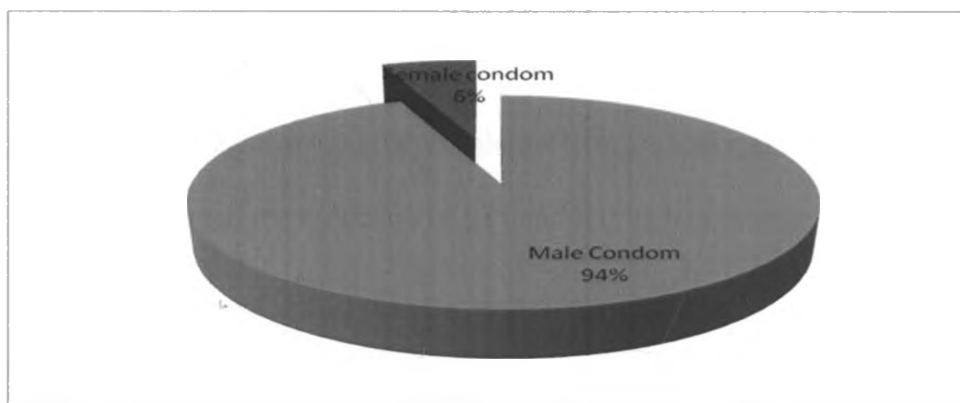
Figure 4.10 Access to condom



Source: Interview data

Majority of the population use the male condom which is easily accessible from the shops, health facilities, local bars and lodgings facilities in this area. The male condom is reportedly used by 94% of the respondents who engage in sexual intercourse. Only a small proportion (6%) used female condom. This is because they are not very accessible in the community and very few people are aware of their existence. The female condom is rarely available in local stores, shops, pharmacy and also in our public hospitals and clinic.

Figure 4.11 Type of condom used



Source: Interview data.

4.5.4 Condom Use Last Time Had Sex by Gender

The results show that 42.9% and 57.1% of sexually active girls and boys were at risk of exposure to infections since they did not use protection when engaging in sexual intercourse. It also shows that more males engage in sexual intercourse. Despite the fact that more male condoms are accessible and affordable, there is no much difference in condom use among the sexes. Figure 4.10 show a low rate of condom use.

The FGDs also confirmed the fact that young people are aware that they may be at risk of contracting STIs, including HIV, the quality and depth of their knowledge vary and misconceptions persist. Additionally their perception of the risk and their chances of acquiring sexually transmitted infections and HIV/AIDS and use of condom were inconsistent.

Table 4.10 Condom use misconception

FGD Group 2

Interviewer: what do you think of condom?

Joe: Sex is more enjoyable with out a condom “the only way is raw” I don’t know what normally happens I forgot to wear a condom at that particular moment.

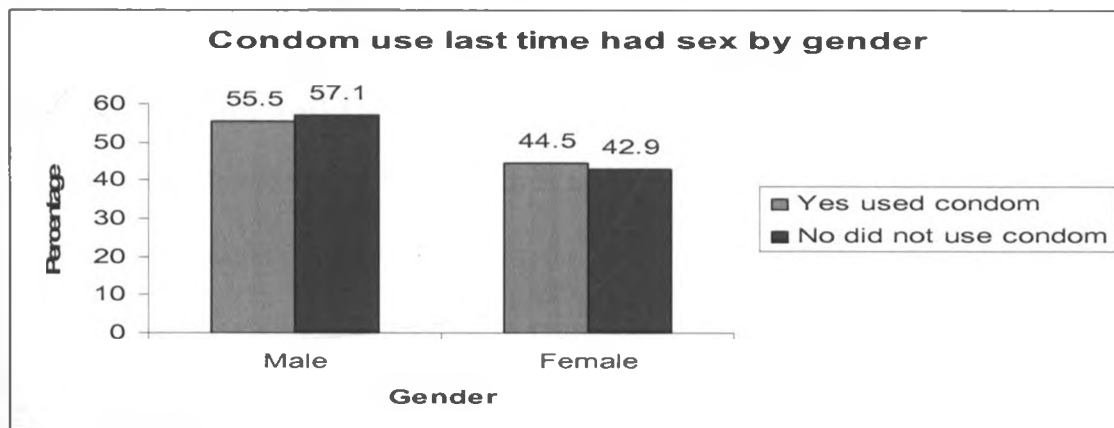
Interviewer: Why did you forget?

Joe: I guess because I only have her alone as my girlfriend... I don’t think she could be infected.

(Names used are not the real names of the respondents interviewed).

Although most participants were aware that a person can have HIV without displaying physical symptoms, they did not hold the same view about other STIs. Instead, they judged whether someone had an STI using visual signs (e.g., walking in a funny way) and did not recognize that many STIs may not cause obvious or visible symptoms. Teenagers interviewed agreed that condom use will facilitate in the reduction of STI and HIV/AIDS as a prevention tool.

Figure 4.12 Condom use at Last Sexual Encounter by Gender



Source: Interview data

4.5.5 Condom Use and alcohol Consumption among Teenagers

The FGD noted that majority of the teenagers normally take alcohol during the functions with family and friends. Condom use among this group was almost equal to non use for the two sexes. Some teenagers described this as happy moment when they interact with their seniors and this facilitates the use of condom among teenage girls. During the FGD boys could not recall all the episodes and they seemed not to recall what actually happened. All the teenagers participating in FGD indicated this as a risky exposure and condom should have been used.

KDHS 2003 indicated that 23.4% of females who are within age group 15 – 19 years used condom at last high risk sex. The percentage was even higher for males (41.3%) within the same age group.

Table 4.11 Alcohol consumption and condom use

Did any of you take alcohol last time you had sex?			Used condom last time had sex current partner		Total
			No	Yes	
No	Male	Count	35	19	54
			36.8	20.0	56.8
	Female	Count	27	14	41
			28.4	14.7	43.2
	Total	Count	62	33	95
			65.3	34.7	100.0
Yes	Male	Count	7	6	13
			30.4	26.1	56.5
	Female	Count	1	9	10
			4.3	39.1	43.5
	Total	Count	8	15	23
			34.8	65.2	100.0

Source: Interview data

4.5.6 Education and Condom Use among Teenagers

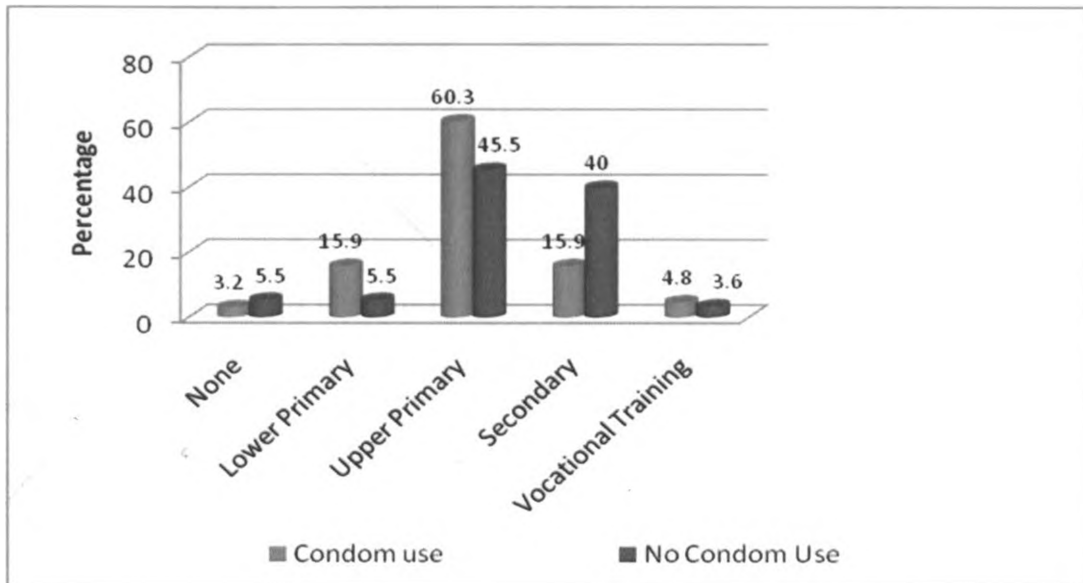
Education was found not to have much bearing on condom use. This could be attributed to exposure the respondent have had during the various walks of life. Apart from that the role of media cannot be underestimated in informing the students on the significance of the condom. The role of media as it is cuts across the religious divide.

Figure 4.14 below shows that condom use is least appreciated by the less educated as is seen with lower primary that registered condom use of 15.9% against 5.5%, Upper primary with 60.3% against 45.5%. This trend was however reversed by those who have attained secondary education with scores of 15.9% against 40%. The introduction of integrated curriculum that covers HIV/AIDS as an element in social ethics has improved significantly knowledge, attitudes and behaviors that prevent the spread of STIs in primary schools.

FGDs indicated that young men and women involved in a premarital pregnancy are treated in radically different ways: Young men who father a child before marriage are pitied, teased or

“gossiped about,” whereas the consequences are more severe for unmarried, pregnant young women, who may have to drop out of school or be chased from their home. Young women who represented the views of teenagers during the study mentioned that young men often deny responsibility for premarital. They suggested that since the family planning pills are not easily accessible, teenagers should use a condom to prevent unwanted pregnancies.

Figure 4.13 Level of education and condom use

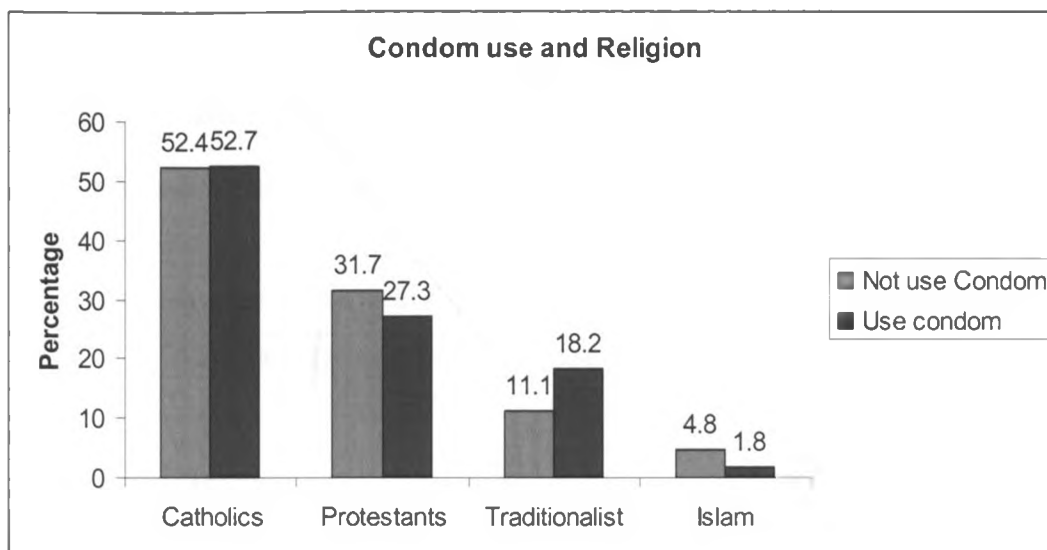


Source: Interview data

4.5.7 Condom Use and Religion

Majority of the population sampled were Christians with Catholics and Protestants dominating the study population. Non Christians namely the African Traditionalists and Muslim represented a small proportion at 12.3%. Traditionalists and Muslims individuals had the lowest uptake of condom with 18.2% and 4.8% uptake. Though the Catholics have strong religious beliefs on condom use and other contraceptives the uptake level was equal (52.4% non use and 52.7% use) among this special population contradicting the religious teachings. Uptake among Protestants is stated at 27.3% for users and 31.7% non-users. Religion is a predominant social factor in exposure to sexual relationship among the teenagers.

Figure 4.14 Condom use and religion



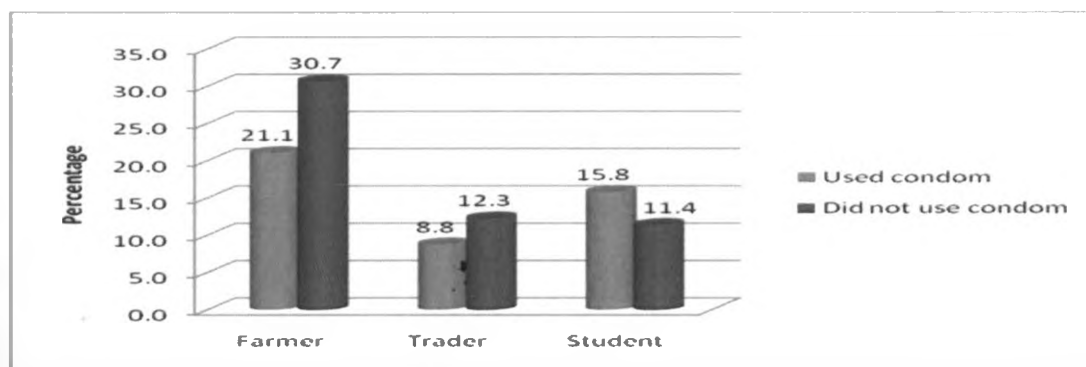
Source: Interview data

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4.5.8 Condom Use and Occupation

Kamariki sub location is predominantly agricultural area with few traders involved in transacting goods and services in this sub location. Of the sampled population, the uptake level was highest among the farmers at 21.1%, students followed closely with 15.8%, while the traders contributed the lowest margin in condom uptake at 8.8%. Adolescent farmers who are regarded in this region as economically stable did not use condom during their last encounter as is reported by 30.7% of the respondents.

Figure 4.15 Condom use and Occupation



Source: Interviews data

4.5.9 Ways of Prevention Oneself from STIs and HIV/AIDS

Adolescents response rates on ways to preventing themselves indicated that 29.8%, agreed with the condom efficiency, 15% indicated being faithful, 39.2% indicated abstinence. 13.2% knew that transmission can occur through contaminated sharp objects and 2% were ignorant

Table 4.12 Response rate on ways of preventing STIs.

Adolescents ways of preventing themselves from STIs		
	Number of counts	Response Rate
Condom Use	104	29.8
Being Faithful	55	15.8
Abstinence	136	39.2
Avoid contaminated needles	66	13.2
Don't Know	7	2.0
Total Response	349	100%

Source: Interview data

Teenagers are familiar with ways of preventing themselves by use of condom but the behaviors are not measuring up to this knowledge. Attitudes towards condom, risk perception, and the urgency of using condom have contributed to the non use of condom among teenagers.

Although abstinence was generally viewed in a favorable light and as an ideal goal to HIV prevention at the FGDs, young people differed as to how realistic they considered this option. Abstinence was viewed as a means of preventing HIV, other STIs and pregnancy.

Most of the discussion groups identified condom use as a way to protect pregnancy but to a lesser extent not effective in protecting HIV and other STIs. Although other studies have highlighted misperceptions about condoms and barriers to access as primary obstacle to condom use, we found that the values young people attach to sexual intercourse also present an important hindrance. Young people talked about enjoying sex without condoms (“the only way is raw”). Other reasons for nonuse were trusting that one’s partner did not have HIV, loving one’s partner and forgetting to use a condom because of the anxiety or excitement involved in having sex. The FDG also brought out the issue on the size of the condom in distribution at the ministry of health outlets as too small and they pointed out one brand from china.

CHAPTER FIVE

5.0 CONCLUSION

5.1 Conclusion and Recommendations

The community has achieved high and nearly universal knowledge on sexually transmitted infections with only a small proportion of less than 10% who indicated that they have never heard of HIV/AIDS or STIs. Besides this knowledge, teenagers have not consistently used condom for protection at every exposure. The community single most source of information on HIV/AIDS was from mass media. This intervention has increased knowledge but the actual use of condom has not reached the universal utilization due to the lack of targeting and there is need for peer education. VCT centre and youth friendly clinic is still far out of reach for teenagers in this community. The family role in enlightening teenagers on behavior inclined to prevention has not been realized with a small percentage of teenagers having discussed of condom use with their family members. The culture of silence between parents or guardians and their teenagers on issues touching sexuality if improved studies have shown that this improves consistency in condom use.

This study realized that there were common factors that influenced use of condom among teenagers these include risk perception, social support, accessibility, acceptability, gender and age. Teenagers, even when aware of HIV risk, often do not consider this risk with steady partners they tend to establish the trustworthiness of their partners as a criteria other than sexual history or the consequence of not using condoms, this was fairly touched during the FDG by key informants. Risk perception is difficult to change. Key informants' recommendations' were inclined toward peer education and school counseling and guidance interventions.

Majority of the teenagers felt that condoms were readily accessible by the fact that they knew where to get a condom from, but they fear being questioned by their friends, parents and health workers why they are using a condom. Low level of knowledge on female condom was a

restricting factor to access and usage. As culture defines a teenager he/she should wait until of age, marry and engage in sexual activities. Thus social disapproval and negative symbolic meanings are barriers to condom use among adolescents. Teenagers were therefore reluctant to get condoms from the public sector, even when free, because they were embarrassed. The alternative was that the private sector poses fewer barriers to accessibility and was generally the most preferred source by teenagers however the high cost was inhibiting accessibility.

Perceived lack of pleasure and loss of spontaneity was noted by the survey as another barrier to condom use. Some respondents agreed with the statement, "Using a condom is a sign of not trusting your partner." This affects the acceptability of condoms among teenagers. Teenagers also believe that condom diminishes pleasure and it should be used by prostitutes. They perceived a teenager having sexual relations as a bad thing and evil.

Personal factors including teenager's irrational choice influence the use and non use of condom. Teenage boys felt caught between expectations to show their masculinity by having sex and impregnating their girl friends. They also expressed feeling of discomfort (embarrassment) getting condoms where they might be recognized. Age was another factor that influenced both sexual activities and the use of condom. Sexual activities increased with the increase in age among teenagers. This is because with age teenagers become more stable in relationships and among the out of school teenagers this is the entry point to marriage among the rural so they are more likely than not to have some form of co-habital arrangement where by they are living in with their partners but not in a formalized marriage.

Lack of condom use is a contributing factor to STIs and disclosure of STIs has remained a big challenge among teenagers with a only a low percentage disclosure. Teenagers feared that disclosure may lead to breakage of their relationships and they also feared being rejected. However some teenagers were comfortable with abstaining when diagnosed with genital ulcers rather than constant to practice safe sex with condom, because they feared infecting their partners and being blamed by their partners too. Girls were more suspicious of their sex partner

compared to the boys because, for the boys were regarded by other teens as heroes with the number of sex partners even though there was low condom usage.

Recommendations:

- This study informs us that there should be redirection of current programs and policies on HIV/AIDS and STIs prevention to the community at large. The study reveals that teenage respondents think that they are safe from infection if they are having sex with their regular steady partner, diminishes the use of condom use in dual protection. It is therefore important for programs to target teenagers who are considered as risky groups and emphasize condom use, consistency, and review of existing policy to include teenagers in reproductive health service access.
- To realize consistent of condom use, there is need for reinforcement of positive behavior change among the teenagers. Introduction of sex education in primary school as a component of social ethics is a good thing. However, the teaching are limiting to abstinence and being faithful. There is dire need for the condom use component as part of the syllabus.
- The condom policy in Kenya is however unclear on the rights of teenagers and minors accessing reproductive health services. There is need for stakeholders, in reproductive health, to improve on the current services and open avenues for the teenagers who are sexually active.
- This study recommends diversified communication channels which localized and enhance information sharing among the adolescents (Drama, Folklore,) promoting behavior change.
- Increase access and affordability of condom in rural areas by diversifying the distribution points and not limiting to health centers, and reviewing the cost as well as exploring the possibilities and use of the female condom.

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6.0 APPENDICES

6.1 BUDGET PLAN

<u>NO.</u>	<u>ITEM</u>	<u>AMOUNT (KSH)</u>
1.	Cost of hiring personnel Research assistants	10,000.00
2.	Stationary	5,000.00
3.	Travel expenses	20,000.00
4.	Subsistence allowances e.g. for lunches for FGDs Participants	5,000.00
5.	10% Contingencies	4,000.00
	TOTAL	<u>44,000.00</u>

6.2 Questionnaire

Good Morning/Afternoon!

My name is _____, I am conducting a survey on behalf of Mary Nduta Nderitu, a student at the University of Nairobi sociology department. The research study will cover Kamariki Sub location on Condom Use among teenagers aged 15-19 years.

This study will help her finish my Masters degree program and can also be used to formulate ways of protecting teenagers and other members of family and community from getting AIDS and other STIs.

I have come to you for assistance. I would be very glad if you could accept to participate by answering questions in this questionnaire.

You have the right to choose whether you want to participate in the study or not. If you choose to participate, I want to assure you that all the information you will give will be held in strict confidence and the information will only be used for this research. Your name will not be written anywhere in the questionnaire and this makes it difficult for anyone to know who gave the information.

Please feel free to ask any question where you feel you require clarification. I would like to thank you sincerely for making a personal decision of participating in this study.

Thank you so much.

Instructions

Circle the answers, which best applies to you and fill in the blank spaces

Section 1.

In this section, I am going to ask you questions about yourself so that we can know each other better.

FOR USE WITH UNMARRIED TEENAGERS POPULATION AGED 15-19

Section 1 Identification

Q001 District _____

Q002 Division _____

Q003 Location _____

Q004 Village/ Sub Location _____

Q006 Date	___/___/___
Q007 Interviewer Name	_____

Q008 Time Interview started _____

Q009 Time Interview ended _____

SECTION 2: Background information on the teenagers

No.	Questions and filters	Coding categories	Skip to
Q201	CIRCLE SEX OF THE RESPONDENT	1. MALE 2. FEMALE	
Q202	How old are you?	AGE IN COMPLETED YEAR __ __	
Q203	Can you read a letter or newspaper easily, with difficulty or not at all?	1. Easily 2. With difficulty 3. Not at all	
Q204	What is the highest level of school attended: primary, secondary, or higher?	0. None (Zero) 2. Lower Primary (1-4) 3. Upper Primary (5-8) 4. Secondary 5. Vocational training	
Q207	Have you ever taken alcohol or any intoxicating substance?	1. Yes 0. No	If no skip to Q209
Q208	In the last 4 weeks, on how many days did you do this?	Number of days: ____	
Q209	What is your MAIN source of livelihood?	1. Farming 2. Trading/Marketing 3. Salaried Employee 4. Artisan 5. Student Other (Specify).....	
Q210	What is your denomination? (ENTER CURRENT RELIGION)	1. Islam 2. Catholic 3. Protestant (Specify)..... 4. African instituted churches Others (Specify).....	
Q211	To which ethnic group do you belong?	1. Kikuyu 2. Meru 3. Embu 4. Maasai Others (Specify) _____	

Section 4. Sexual History and Behavior

NO.	Questions and Filters	Coding categories	Skip to
Q401	Have you ever had sexual intercourse? (PLEASE PROBE FOR ANY RAPE INCIDENTS)	1. Yes 0. No	If no skip to Q501
Q402	What was your age at first sexual intercourse?	Age in years _____	
Q403	Under what circumstance did you have this encounter?	1. Forced sex 2. Induced by gifts 3. Willingly	
Q404	Were you related to the person you had sex with?	1. Yes 0. No	
Q405	If forced (CHECK 403) did you seek support from any where?	1. Yes 0. No	If no skip to Q407
Q406	Where did you seek support?	1. Law enforcement 2. Parents 3. Church 4. Health facility	
Q407	Do you currently have a sexual partner	1. Yes 0. No	
Q408	When was the last time you had sex? (Complete only one of the options.)	Days ago _____ Weeks ago _____ Months ago _____ Years ago _____	
		Partner 1	Partner 2
Q409	IF ANSWER IS 1 OR 2 CHECK Q205 What is your relationship to this partner	1. LIVE IN PARTNER 2. GIRLFRIEND/BOYFRIEND NOT LIVING WITH YOU 3. SOMEONE WHOM YOU PAID OR PAID YOU FOR SEX 4. CASUAL	1. LIVE IN PARTNER 2. GIRLFRIEND/BOYFRIEND NOT LIVING WITH YOU 3. SOMEONE WHOM YOU PAID OR PAID YOU FOR SEX 4. CASUAL

	(partner 1 MOST RECENT PARTNER) (READ OUT)	ACQUAINTANCES OTHERS(SPECIFY _____)	ACQUAINTANCES OTHERS(SPECIFY _____)
Q410	How old is this partner?	1. 1-2 years younger 2. 1-2 years older 3. 3-5 years younger 4. 3-5 years older 5. 6 and above years younger 6. 6 and above years older DON'T KNOW.....	1. 1-2 years younger 2. 1-2 years older 3. 3-5 years younger 4. 3-5 years older 5. 6 and above years younger 6. 6 and above years older DON'T KNOW.....
Q411	At what place or event did you first talk or get to know this partner?	1. OWN FRIENDS HOUSE 2. CHURCH 3. SCHOOL 4. WORK 5. WEDDING, FUNERAL/OTHER FAMILY EVENT 6. SPORTING EVENT 7. BAR/NIGHT CLUB 8. BROTHEL OTHER (SPECIFY).....99	1. OWN FRIENDS HOUSE 2. CHURCH 3. SCHOOL 4. WORK 5. WEDDING, FUNERAL/OTHER FAMILY EVENT 6. SPORTING EVENT 7. BAR/NIGHT CLUB 8. BROTHEL OTHER (SPECIFY).....99
Q412	Where does this partner live? PROBE: Does he/she live in (READ OUT)	1. SAME VILLAGE OR NEIGHBORHOOD 2. OTHER URBAN AREA 3. OTHER RURAL AREA OTHERS(SPECIFY _____)	1. SAME VILLAGE OR NEIGHBORHOOD 2. OTHER URBAN AREA 3. OTHER RURAL AREA OTHERS(SPECIFY _____)
Q413	How long ago did you <u>first</u> have sex with this partner? (COMPLETE ONLY ONE OPTION)	1. DAYS (____) 2. WEEKS (____) 3. MONTHS (____) 4. YEARS (____)	1. DAYS (____) 2. WEEKS (____) 3. MONTHS (____) 4. YEARS (____)
Q414	Did you use a condom the first time you had sex with this partner?	1. Yes 0. No DON'T KNOW 98	1. Yes 0. No DON'T KNOW 98
Q415	How long ago did you have sex with this partner <u>most recently</u> ? (COMPLETE	1. DAYS (____) 2. WEEKS (____) 3. MONTHS (____) 4. YEARS (____)	1. DAYS (____) 2. WEEKS (____) 3. MONTHS (____) 4. YEARS (____)

	ONLY ONE OPTION)		
Q416	The last time you had sex with this partner, did you use a condom?	1. Yes 0. No IF NO, SKIP TO Q418	1. Yes 0. No IF NO, SKIP TO Q418
Q417	Why	1. To avoid pregnancy 2. To avoid sexually transmitted infections 3. To avoid HIV/AIDS infection 4. Partner decided 5. Not regular partner Don't know	1. To avoid pregnancy 2. To avoid sexually transmitted infections 3. To avoid HIV/AIDS infection 4. Partner decided 5. Not regular partner Don't know
Q418	Why not?	1. Regular trusted partner 2. Partner refused 3. It is more enjoyable 4. No condom available 5. Wanted pregnancy Status of both partners known.....F	1. Regular trusted partner 2. Partner refused 3. It is more enjoyable 4. No condom available 5. Wanted pregnancy Status of both partners known.....F
Q419	What type of condom did you use?	1. Male 2. Female	1. Male 2. Female
Q420	Who decided that you use a condom?	1. Myself 2. My partner	1. Myself 2. My partner
Q421	From what place or person did you or this partner get that condom?	1. SHOP 2. PHARMACY 3. HOSPITAL/CLINIC 4. FAMILY PLANNING CENTRE 5. BAR/HOTEL 6. DON'T KNOW Other (SPECIFY).....	1. SHOP 2. PHARMACY 3. HOSPITAL/CLINIC 4. FAMILY PLANNING CENTRE 5. BAR/HOTEL 6. DON'T KNOW Other (SPECIFY).....
Q422	The last time you had sex, did you or this partner drink alcohol?	1. Yes 0. No	1. Yes 0. No UNIVERSITY OF NAIROBI AFRICANA COLLECTION
Q423	The last time you had sex, did you or this partner do anything to delay or avoid	1. Yes 2. No 3. DON'T KNOW IF NO, SKIP TO Q425	1. Yes 2. No 3. DON'T KNOW IF NO, SKIP TO Q425

	pregnancy?		
Q424	What did you do to avoid pregnancy?	USED 1. CONDOMS 2. PILL 3. IUD 4. INJECTION 5. WITHDRAWAL 6. SELF OR PARTNER IS STERILE 7. NOTHING OTHER (SPECIFY	USED 1. CONDOMS 2. PILL 3. IUD 4. INJECTION 5. WITHDRAWAL 6. SELF OR PARTNER IS STERILE 7. NOTHING OTHER (SPECIFY
Q425	Do you think this partner has other partners?	1. Yes 0. No 3. DON'T KNOW	1. Yes 0. No 3. DON'T KNOW

PLEASE PROCEED ONLY AFTER ASKING ABOUT ALL TWO OF THE PARTNERS (INCASE THEY ARE MORE THAN ONE) IN THE LAST 12 MONTHS

No.	Questions and Filters	Coding categories	Skip to
Q426	In the last 12 months with how many people overall have you had sex (including these last partners we've discussed)?	Number ()	
Q427	In the last 12 months have you exchanged or received money / gifts/ favors for sex?	1. Yes 0. No	If No Skip to Q501
Q428	The last time you had sex with someone and exchanged money, did you or this partner use a condom?	1. Yes 0. No	

Section 5: Knowledge assessment on Sexually Transmitted Diseases
Now I would like to ask some questions relating to circumcision and sexually transmitted diseases.

No.	Questions and Filters	Coding Categories	Skip to
Q501	Have you ever heard of disease or infections that can be transmitted through sexual intercourse (STDs)	1. Yes 0. No	
Q502	<p>In a woman, what signs and symptoms would lead you to think that she has such a disease or infection?</p> <p>Any others?</p> <p>(CIRCLE ALL THAT ARE MENTIONED. MORE THAN ONE ANSWER IS POSSIBLE. DO NOT READ OUT THE SYMPTOMS.)</p> <p>UNIVERSITY OF NAIROBI EAST AFRICANA COLLECTION</p>	<p>ABDOMINAL PAIN DISCHARGE FROM VAGINA ITCHING IN GENITAL AREA BURNING PAIN ON URINATION PAIN DURING INTERCOURSE GENITAL ULCERS/OPEN SORES SWELLING IN GENITAL AREA BLOOD IN URINE DIFICULTY IN PASSING URINE LOSS OF FERTILITY NO SYMPTOMS IRREGULAR MENSTRUATION DON'T KNOW OTHERS (SPECIFY)</p> <hr/> <p><i>(Tick all That Apply)</i></p>	
Q 503	<p>In a man, what signs and symptoms would lead you to think that he has such a disease or infection?</p> <p>Any other symptom?</p> <p>(CIRCLE ALL THAT ARE MENTIONED. MORE THAN ONE ANSWER IS POSSIBLE. DO NOT READ OUT THE SYMPTOMS.)</p>	<p>ABDOMINAL PAIN DISCHARGE FROM PENIS ITCHING IN GENITAL AREA BURNING PAIN ON URINATION PAIN DURING INTERCOURSE GENITAL ULCERS/OPEN SORES SWELLING IN GENITAL AREA BLOOD IN URINE DIFFICULTY IN PASSING URINE LOSS OF FERTILITY NO SYMPTOMS OTHERS (SPECIFY) DON'T KNOW <i>Tick all that apply)</i></p>	
Q 504	During the last 12 months, have you had a genital discharge or ulcer?	1. Yes 0. No	If no go to Q601

Q507	When you had a genital discharge or ulcer during the last 12 months, did you seek any kind of advice or treatment?	1. Yes 0. No	If no go to Q601										
Q 508	When you had a genital discharge or ulcer in the last 12 months, did you: A. Tell your sexual partner(s) about the symptoms B. Stop having sex when you had the symptoms C. Use a condom when having sex when you had the symptoms D. Take medicines when you had the symptoms?	<table border="1"> <tr> <td>YES</td> <td>NO</td> </tr> <tr> <td>1</td> <td>0</td> </tr> <tr> <td>1</td> <td>0</td> </tr> <tr> <td>1</td> <td>0</td> </tr> <tr> <td>1</td> <td>0</td> </tr> </table>	YES	NO	1	0	1	0	1	0	1	0	
YES	NO												
1	0												
1	0												
1	0												
1	0												

**Section 6: Knowledge about HIV and level of exposure to interventions.
Now I would like to ask some questions about HIV, the virus that causes AIDS**

No.	Questions and Filters	Coding Categories	Skip to
Q601	Have you ever heard of the virus HIV or an illness called AIDS?	1. Yes 0. No	If no go to Q716
Q602	In the past 4 weeks, have you heard or seen any information about the HIV/AIDS virus?	1. YES 0. NO	
Q603	From what source(s) did you receive this information about the HIV/AIDS virus? Any other source (CIRCLE ALL THAT MENTIONED. MORE THAN ONE ANSWER IS POSSIBLE)	TELEVISION RADIO PARTNER FRIEND FAMILY MEMBER HEALTH CARE WORKER CO-WORKER DON'T KNOW OTHER (SPECIFY)	
Q604	What are some of the locally available interventions that try to address HIV/AIDS	THEATRE DRAMA FOLKLORE MUSIC BILLBOARDS SCHOOL / CHURCH	
Q605	During the past four weeks, have you discussed the HIV/AIDS virus with anyone?.	1. Yes 0. No	If no skip to Skip to Section 7
Q606	With who have you discussed the AIDS virus during the past 4 weeks? Anyone else?	SEX PARTNER FRIEND FAMILY	

	(CIRCLE ALL THAT ARE MENTIONED. MORE THAN ONE ANSWER IS POSSIBLE)	HEALTH CARE WORKER CO-WORKER OTHER (SPECIFY	
Q607	What ways can people protect themselves from getting infected with HIV? Any other ways? (CIRCLE ALL THAT ARE MENTIONED. MORE THAN ONE ANSWER IS POSSIBLE. DO NOT READ OUT THE WAYS.)	USE CONDOMS HAVE ONE UNINFECTED PARTNER NO CASUAL SEX ABSTINANCE NO COMMERCIAL SEX AVOID INJECTIONS WITH CONTAMINATED NEEDLES DON'T KNOW ANY OTHER (SPECIFY)	

Q608	Can a person who looks healthy be carrying the HIV/AIDS virus?	1. Yes 0. No DON'T KNOW	
Q609	Can people reduce their chances of getting the AIDS virus by using a condom correctly every time they have sex? (CHECK Q607: IF CONDOM NOT MENTIONED, ASK Q.609.)	1. Yes 0. No DON'T KNOW	

Key informants and Focus Group Discussion Questioner.

Attitudes towards condom use and non-use

Thanks you very much for the time you have given to participate in this
My name is _____ I would like to ask some questions relating to
condom use among teenagers in this sub location.

1. In general which category of people should use condom?
2. What do you think of young people using condoms?
3. Why should young peoples use condoms?
4. Are condoms easily accessible to young people?
5. Is it is affordable?
6. Where can you physically get the condom?
7. What do you think about young people using condoms?
8. If you were to purchase a condom where would you buy it from?
9. Do you feel embarrassed when purchasing one?
10. Who do you think should use a condom?
11. Do you ever discuss condom use with your sex partner?
12. How often do you discuss?
Always,
Sometimes,
Never.
13. If you discovered that your partner was or is having extramarital sex, will you continue having sex with him? (Probe how by use of condom or not)
14. How often do you agree with sexual partners to use a condom?
15. What are your main reasons for using a condom?
Avoid getting Pregnant
STI's
Both
Don't Know
16. Can you list some of the cultural beliefs that are associated with condom use?
17. What are some of the main barriers to condom use among young people?
18. How can these barriers be circumvented?

19. How can many young people be encouraged to use condoms?
20. Do you think you are at risk of contracting HIV/AIDs and STIS?
21. Why do you think you are at risk?
22. Would you use a condom much more as a protection agent from HIV/STIs, unwanted pregnancy?

HIV,

STIs

Pregnancy

HIV and Aids

All

Thanks you very much for contributing towards the Questioners. Once again the information given will be very confidential and will be used to inform the policy makers on the needs that our young people are facing when going about their sexual and reproductive needs.

Thanks You!!

UNIVERSITY OF NAIROBI
EAST AFRICANA COLLECTION