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**THE ROLE OF THE FAMILY IN EARLY ADOLESCENCE  
SEXUALITY AND REPRODUCTIVE HEALTH IN  
KISUMU SLUMS**

**BY:**

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**A project paper submitted in partial Fulfillment of the  
requirements for the Degree of masters of Arts in Sociology,  
University of Nairobi.**

UNIVERSITY OF NAIROBI  
EAST AFRICANA COLLECTION

**November 2007**

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## DECLARATION

I, the undersigned, declare that this is my original work and has not been submitted for examination in any other university.

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This project has been submitted for examination with my approval as university supervisor.

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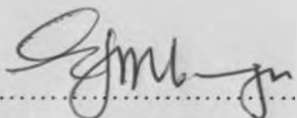
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## **DEDICATION**

This project is dedicated to my Mum, Dad, Okinda's family, my sister Maureen Amore and Moses Ogola

## **ACKNOWLEDGEMENT**

There are many people I would like to thank for assisting me in completing this study. First and foremost are my supervisors, Professor E. Njeru and Prof. Mburugu for their continued advice, counsel and guidance throughout the study.

I also would like to express my gratitude to the Ministry of Education officials for facilitating my data collection exercise. I am indebted to local leaders, teachers, pupils, parents, school management committees, NGOs in Kisumu slums (ADRA) , DEO,DO Kisumu District, for providing the required data. I sincerely thank many others who supported me and without whom I could not have collected data and completed this study.

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## **ABBREVIATIONS AND ACRONYMS**

<b>HIV:</b>	<b>Human, Immunodeficiency Virus that cause AIDS</b>
<b>AIDS:</b>	<b>Acquired Immune Deficiency Syndrome an incurable infectious viral disease that results in damage to the immune system in otherwise healthy individuals.</b>
<b>STD:</b>	<b>Sexually Transmitted Diseases.</b>
<b>WHO:</b>	<b>World Health Organisation</b>
<b>UNICEF:</b>	<b>United Nations Children Education Funds</b>
<b>FLE:</b>	<b>Family Life Education</b>
<b>ASF:</b>	<b>Age Specific Fertility.</b>
<b>KDHS:</b>	<b>Kenya Demographic Health Survey</b>



## ABSTRACT

This study addresses the issues of family communication on sexuality and reproductive health, between the family and adolescents. The need for the study arose from the fact that inspite, of information received by adolescents on sexuality and reproductive health there are still, problems/ challenges on sexuality and reproductive health. This study set out to; assess The role of the family in early adolescents sexuality and reproductive health and specifically, establish the family level of understanding of adolescence, establish the nature or problems faced by adolescents, identify the nature of challenges against effective participation of the family and to establish how families cope with sexuality and reproductive health among early adolescent. During the study the adolescents revealed that they were aware of the dangers of premarital sex (100%) but the level of awareness varied, with some only aware of one or two dangers. They listed unwanted pregnancies, Sexual Transmitted Diseases, majority of the pupils (95.0%) had heard of condoms, of the 22 girls who were interviewed only 31.8% had started undergoing menstruation.

The study revealed that out of 40 respondents 12 had, had sexual intercourse but only 3% indicated that it was a painful experience and therefore unlikely to withstand. 75% however found it an enjoyable experience, 91.7% of the early adolescent who had sexual encounters did not use condoms therefore engaging in irresponsible sexual behaviors.

One pupil admitted to have contracted STD as a result of irresponsible sex.

The study also revealed that majority of parents (73.5%) is not aware of their children needs, only 27.5% talked about sexuality and reproductive health. The level of awareness is low and this is worsened by negative attitudes towards the topic as was suggested by 20% of the respondents. There is an indication that cultural factors promote shyness to both parents and their children to talk about matters of sexuality and reproductive health freely

Moreover the majority of the parents has attained secondary education but is aged above thirty five (60%). The result of this study showed that a majority of parents are not aware of their children's need at the stage of early adolescent. This was corroborated by the pupils who contend that information is inadequate. What is striking is that 67.5% of

respondents are normally not satisfied with the content of information revealed to them by friends, parents and teachers

There is need for dissemination of relevant knowledge and information of relevant knowledge, to not only children at adolescent stage but also their parents and teachers to ensure the cycle of triangular awareness is completed among the school teaches, house, parents and adolescent children

This research aimed at addressing pertinent issues in family communication and information sharing on sexuality and reproductive health. Attempts are made to determine the role of family communication and factors that influence communication in the low-income earners of Kisumu city, Kenya.

This study was both qualitative and quantitative. Data was generated from both secondary and primary sources. Winam division of Kisumu district was purposively selected for the study. The study employed stratified sampling to select schools from each three zones within the division

The study made use of individual interviews, supplemented by Focus Group Discussions (FGD's), case histories and Direct observations, that were guided by observation guide or checklist. Data collected were analyzed by using excel and statistical package of social sciences (SPSS) and further presented using descriptive statistics.

The study, on the basis of its finding recommended that:

- Research should be intensified on family communication, between adults and adolescents concerning sexuality and reproductive health in urban areas
- Devise ways of improving health education to enhance understanding and practices on sex related issues and reproductive health among early adolescents.
- Government should enact laws governing sexual education and reproductive health.
- The role of the media in enhancing adolescent sexuality and reproductive health should be investigated.

- Determine and initiate relevant poverty eradication programmes among commercial sex workers to provide alternative sources of income thereby free families to discuss sexuality and reproductive health matters
- Find out the impact of mass media censure in controlling sex among adolescents in urban areas
- Replicate a similar study on a wider scale to cover urban areas and slums in other cities for effective comparison

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background

Adolescents constitute a distinct population with particular needs and capabilities; they represent a significant proportion of the population, nearly half of world's population is under the age of 15 years. Understanding this sexuality reproductive behaviour is of tremendous policy importance. Currently, 90% or more than one billion adolescents between the ages of 10-19 reside in developing world. Millions of these young people are sexually active. However, they lack reproductive sexual information and resources necessary to protect themselves against unintended pregnancy, HIV/Aids and other sexually transmitted infections. In sub-Saharan Africa half of all the new cases of HIV occur among young people between 15 and 24. Over 50% of Kenyan population is less than 16 years of age and 1/3 of entire population is between 13 and 19.

Adolescents is popularly conceptualized as a period of good health but is also characterised by experimentation with a variety of behaviour choices, partly due to rapid biological and psychological changes, intensive readjustment in the family and school, work and social life and unrelenting process of preparation for adulthood. It little wonders that a significant number of young people get themselves into trouble because of their own risk-taking behaviour.

The World Health Organization (2007) defines a youth as a person aged 10-24 years. This is a period which young people experience physical, psychological changes. Some of the changes experienced by females include development of breasts, broadening of hips, and beginning of menstruation, growth of pubic and armpit hair and development of feeling of attraction to opposite sex.

According to Jerseild (1963), adolescence is defined as a person aged 10-19 years. One of the most sensitive health issues associated with adolescence is sexuality and reproductive health. Sexuality can be looked at as the quality of being sexual, biological and physically fit. Health on the other hand may be comprehensively defined as a state of complete physical, mental and social well being and not merely the absence of diseases or infirmity, in all matters related to the reproductive systems and to its functions and processes. People experiencing good reproductive health are able to have a satisfactory and safe sex life and they have capability to reproduce and freedom to decide if, when and how often to do so. Lack of adequate communication, information and education on this subject constitutes a major public health problem. Addressing adolescent reproductive health problems requires reaching not only youths themselves but also others who influence their lives. Parents and other members of the family can help in promoting the health of young people.

This can be achieved through effective communication, a creative process that involves the transfer of information between people; it includes ideas, emotions, knowledge, skills and motivation. A process that permits expression of ideas and feelings as well as understanding the ideas and feelings of others. In health education and promotion the purpose of communication is to promote or improve health through the modification of the human, social and political factors that influence behaviours. The patterns of behaviour communicated and established during the early adolescent period are likely to continue into adulthood.

Communicating sexuality and reproductive health at a family level is often taken for granted. In modern Kenyan society, adolescence sexuality and related information is often conveniently ignored or ineffectively and casually discussed. The adolescent is often denied complete access to adequate information and services. Parents and other adult relatives do not give them enough information on sex and contraceptives because it is considered culturally inappropriate; hence they turn to their peers who may provide them with inappropriate and incorrect advice. The adolescent may search for information in books, videos and magazines, which may encourage sexual freedom without giving information about the risks involved with sexual intercourse (Lema, 1990; Baker and Rich, 1990; Ajayi et al., Sullivan, 1995). The negative perception associated with providing

contraceptive information and services with promiscuity and increased sexual activity is a major barrier to adolescence contraceptive use

## **1.2 Problem Statement**

Among the plethora of problems that affect the health of adolescents is lack of proper information regarding sexuality and reproductive health of adolescents. Lack of open communication is the cause of many struggles between the young and their parents; sitting down to have an honest discussion on sexuality is so surprisingly hard to everyone. The result is lack of appropriate and accurate information which places young people at the risk of blindly walking into sexual activities with risk of emotional damage as well as the obvious dangers of pregnancy and HIV/AIDS. Girls are further made vulnerable and face higher risks due to their lower educational status and inability to negotiate on issues related to reproductive and sexual health. Studies have revealed that in developing countries, age at menarche is declining, it starts as early as between 12-14 and some start much early as 10-12 years. Some years ago for example, Kenyatta National Hospital shocked the nation with a reported birth at the age of 9 years.

Statistical information suggests that young people across the board become sexually active early and have multiple partners. HIV/AIDS is an epidemic and continues to be a serious concern all over the world. In Kenya it is established that people living with AIDS, a majority of whom are children, adolescents and youths do not use any form of contraception. In Kisumu all the four divisions are seriously plagued by the HIV/AIDS menace, prevalence district stands at 38%, up from 30% in 1999, and is among the highest in the-country. This has impacted negatively the district population since it has affected the most productive age bracket leading to death of persons in their prime age. (Kisumu District plan Development Plan 2007-2008). In Kisumu city which is the headquarters of Kisumu district, 2.25% of girls were infected compared to 4% of the male teenager (NACC, 2000). A considerable percentage of the population in Kisumu is youthful, about 42% of the population is below 15 years, while 73% is below 30 years.

Population Council (1999) multi centre study on factors determining the spread of HIV/AIDS, found that youth in Kenya (Kisumu) started having sex earlier than their counterparts in oilier cities covered in the study {Ndola, Cotunu, Benin and Yaounde} In Kisumu 57% of unmarried girls aged between 15-19 and 72% of the boys in the same age group were sexually active. The median age at first coitus were lowest in Kisumu with girls at 15 and boys at 16 compared to 18 for males in Cotonu and 17 in Yaounde and Ndola The adolescents lack knowledge, which would enable them to make responsible choices to protecting themselves, and are not motivated to practice safe sex behaviour Questions commonly asked by young people on sexuality remains a strong pointer to inadequacy of information. Little attention has however been given to communicating about sexuality to young adolescence particularly of ages 10-15 years, many parents have had a negative attitude towards sharing this as they relate it to promoting promiscuity. Despite the growing awareness of the risk associated with unprotected sexual activity among adolescents, access to reproductive health information for the young people remain severely constrained by laws, policies and bias of the health workers. The young adolescents are unlikely to acknowledge that they are having a problem and usually find it very difficult to seek help.

Considering the health risk posed to the young adolescents because they are sexually active, the society must ensure that the young people have the information, skills and means to protect themselves, timely and accurate information and skills must be provided to empower them to have control over their sexuality. The adult society has not been totally successful in offering solid values and meaning to the youth. Further, there is lack of universally accessible preventive services in contrast to a nearly constant exposure, and sometimes pressure, to abuse alcohol and drugs and to engage in unprotected sex.

### **1.3 Research Questions**

1. How is inadequate family communication in sexuality and reproductive health a major predisposing factor, placing adolescents at risk of unsafe sex and its

consequences?

- 2 What is the role of family in communicating sexuality and reproductive health among early adolescents?

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

### **1.4.1 Broad Objectives**

To investigate the role of the family in early adolescents sexuality and reproductive health.

### **1.4.2 Specific objectives:**

1. To establish the early adolescents and their families level of understanding of sexuality and reproductive health among early adolescents.
2. Establish the nature of problems of sexuality and reproductive health as experienced by early adolescents at the family level.
3. To identify the challenges against effective participation of the family in sexuality and reproductive health among early adolescents
4. Establish how families cope with sexuality and reproductive health problems/challenges among early adolescents.

## **1.5 Limitation and scope of the study**

As an exploratory study it was limited to schools in urban slum areas in Kisumu slums, Kisumu district of Kenya. Although, there is a major problem of sexuality and reproductive health among early adolescence in Kenya. The study focused on adolescence in Kisumu slums, on the basis of it, having higher levels of sexual and reproductive health problems / challenges. The study was also limited to selected indicators, of internal efficiency and participation, lack of essential data from local education offices was another limitation, for example, data on schools enrolment in the division was unreliable and lacked consistency. The proposed study was also limited to 3 schools due to the researcher's time and financial limitation



## **1.6 Rationale for the Study**

Every adolescent should have sufficient knowledge of sexuality and reproductive health as a matter of human right. The young adolescents are also at risk and must therefore get correct information to ensure in future and earlier they receive it as part of their socialization the better for the society. Most studies have focused their attention on late adolescent's sexuality with scanty, if any data concerning young adolescents aged between 10-15 years. There are no specific studies on family communication among adults and children on issues pertaining to sexuality, young adolescent's knowledge on basic concepts and ideas on reproductive health. It is expected that the outcome of this study will contribute significantly to the body of literature and will provide an insight to the policy makers regarding young adolescence reproductive health, interfamily transfer and sharing so that impact oriented reproductive health programmes can be designed and implemented in order to effectively address increasing adolescent health and reproductive health problems. This study is also in line with Kisumu district for health priorities and education namely to develop the district's reproductive health strategies, promote adolescent health, intensify control spread of HIV/wide range of contraceptives, to enhance moral change to stop and control of HIV/AIDS scourge through sensitizations of both the pupils and the community at large on the spread of HIV/AIDS issues. (Kisumu District Development Plan 2002-2008) There are notable absence of literature communication between adolescents and parents regarding sexuality, effective family dialogue is a tool, which taken seriously can translate into safe behaviour. Lack of information is perhaps the most pervasive service least recognized.

## CHAPTER TWO

### 2.0 Literature Review

Related literature has been reviewed under the Following sub-heading;

- Adolescents' sexuality and risk taking behaviour.
- Statistics on adolescent sexuality and reproductive health.
- Involving parents and families.
- Sexuality communication in the traditional setting.
- Mass media and modern society.
- Parent - Child communication - A review.

### 2.1 Adolescents sexuality and sexual risk taking.

Adolescence is a critical period in development of altitude about sex and sexual behaviour. According to Epstein et al 1989, adolescents hold diverse views on health and health problems depending on their development stages, gender, and racial, social economic and educational status. The sexual behaviour of young people may expose them to the risk of sexually transmitted diseases including HIV/Aids, unwanted pregnancy, dale rape and sexual violence. Problems associated with adolescent sexuality are increasing STDs and teenage pregnancy continues to be problems in developed and developing countries. High-risk behaviours characteristics of adolescence can result to significant morbidity and mortality. Premarital sexual contacts are a common phenomenon in many regions worldwide, of course in varied degrees. The breakdown in traditional Family systems, urbanization and rapid erosion of many customs and traditions and the opening up of the society to the outside influence, mixture of traditions and imported culture has brought interesting scenes into reproductive health For example, sex discussion among teenagers is treated with increased openness, talk about girl boy relationship dominate discussions in the adolescents Free limes Factors contributing to increased sexual activity. Several studies have shown that age at first intercourse is declining, suggesting that that today's studies have shown that few adolescents use contraceptives and are at risk of pregnancy (Kiragu, 1991; Me Cauler and Salter, 1996, Kiragu and Zabib 1995).

This result in such unfortunate situations as dropping out of school, poverty, early marriage and contracting sexually transmitted diseases (DHS Chart book, 1995, Kane et al. 1993, Ilinigumbo 1995) young people start childbearing early they are of physiologically mature, a study of Nyeri, Kisii, Kilifi, Meru and former south Nyanza districts 15% of the girls were married before the age of 15 years; among rural adolescent 22% start childbearing early as opposed to 17.5% their urban counterparts. Youri (1993) has shown that among adolescent that got pregnant while in school, 47% had an abortion while 53% gave birth. Rogo (1992) has documented that over 90% of adolescent pregnancy is unwanted consequently the resort to abortion. Early and unwanted pregnancy is a major cause for discontinuity of education among school going female adolescent; according to pregnancy crisis ministries, girls as young as 15 years are procuring a from both professional and back street commercial abortionists. Young people often use crude and dangerous methods and objects to induce abortion. Unsafe abortion among the youth is associated with inaccessibility to contraceptive services and information. A 1999 a study of sexual activity among 15 years old and found that over 50% were sexually active with first intercourse occurring at age 13 to 14 years of age. The study as confirmed that out of the 50%, (89%) of the sexually active, had not used any form of contraceptives. A study of UNICEF also found out that more than 40% of male students aged between 14 to 18 years had multiple sex partners and only (i. 8% at every intercourse reported having used condoms. So while sexual activity among adolescents is high, contraceptives use remains low leading to high levels of teenage pregnancy and related consequences. Studies carried out by WHO show that contraceptives knowledge together with Family Life Education (FLE) encourages safer sexual behaviours among sexually active adolescents. In a related study Turyasingura, 1989, Ageyei et al, 1990 found out that youth in Uganda as early as this time adolescents in Uganda were faced special risks.

The average age of first intercourse then is about 15 years old. Being that is the average then this might imply some youths are starting early even as early as 10-12. Out of school boys and girls were even more vulnerable, non-attendants reported first sexual intercourse at a younger age on average at about 13.6 years (Kaahariuzi, 1991, Turinde-Kibali 1992). Another study carried out by Ilinigumbo 1995 involving 1058 female

adolescents' 9% of them attempted fell ill, and 25% had to be hospitalized. The early sexual debut is a key factor in spread and transmission of HIV/AIDS. Studies conducted in Kisumu indicate that some 18% of adolescents' girls become HIV positive within one year of sexual debut and that by age 19 some 33% (about 3 out of 10) are already infected. Age at marriage has increased over the past two decades, but still remains low in many communities. Women from Nyanza and Coast provinces marry early at around 18 years, while those in Nairobi have the highest age at marriage at about 22 years. A study of six districts (Nyeri, Kisii, Kericho, Kilifi, Meru and South Nyanza) revealed of schooling on South and the level of education, those with more years marrying at later ages than with few years of education. Nyanza district, 15% of girls were married before the age of 15 years. These are variations based on both residences. In many Sub-Saharan countries, the percentage of adolescents getting married before the age of 18 years ranges from 75% in Mali and Niger to around 15% in Botswana, Namibia and Yaounda. In Kenya, early marriage is higher in rural areas and those areas reporting lower levels of education. Marrying at younger ages means that young people start childbearing early before they are physiologically mature. This can have serious social and health consequences. Early marriage is a consequence of several factors key among them being early pregnancy, lack of alternative opportunities for girls and a desire for higher bride wealth for parents. There are variations however based on residence, level of education and socioeconomic status. The youth site curiosity, peer influence, pleasure, expectations of gifts and money and forced sexual intercourse as reasons for indulging in sex. This group of young people must be provided with accurate and timely information and skills that will enable them postpone their initiation of sexual activity.

## **2.2 Statistics on adolescents' sexuality and reproductive health.**

- Currently over 25% of the world's population is made up of young people between the ages of 10-24. 86% of these live in less developed countries.
- According to the latest demographic and health survey data, 34% of Kenyan population consists of young people aged 10 to 24 years, while those between ages of 10 to 19 makes 25%.

- Kenya's adolescent and youth population continues to grow with serious demographic socio-economic implications
- Youth or young people are defined as those in the 10-24 age group, which includes pre-adolescents and (ages 13-19) and young adults [ages 20-24 over 50% of Kenyans population is less than 16 years of age with one third of the entire population being between 13-19 years old.
- Over 50% of Kenya's population is less than 16 years of age with one third of the entire population being between 13-19 years old
- Age Specific Fertility Rate (ASFR) for adolescence aged 15-19 is 111/1000.
- One in five girls reports having been coerced or forced into their first sexual intercourse. 50% of Kenya's adolescents have begun child bearing by age 19, 20% by age 17 and 30% by age 18.
- Over 40% of adolescents with no education are either mothers or have begun childbearing. Of those with primary and secondary education, 26% and 8% respectively had become mothers.
- It is estimated that 60% of new HIV/AIDS infections among women and 40% among men in the next five to six years will occur among those less than 20 years of age.
- Over 80% of Kenyans adolescent age 15-19 do not perceive themselves to be at risks of contracting HIV/AIDS. 70% still engage in high-risk sexual behaviour.
- According to data from the ministry of Education, about 20% of youth aged between 15 and 19 (mainly secondary school students) are infected with HIV virus.
- An estimated 40-60 percent of all reported sexual assault cases are committed against girls 15 years and below.
- According to the KDHS (1998), about 46% of youth in the age group 20-24 are married at the exact age of 20. 11% of girls aged 15-19 who left school before completing primary education did so due to pregnancy.

From the available statistics it can be safely concluded a lot of data exist for the youth above 15 years, this however marked scanty information existing regarding adolescents aged between 10-15 years and this forms my centre of focus

## 2.3 Involving parents and families

The family especially the parents have initial responsibility for sexual education of their children. The role of family in adolescent's well-being is however gaining recognition. The effect of the family functioning and parenting style on adolescent's physical health, mental and rational well-being and employment is the focus of increased research attention (Me far lane et al 1995, Spruijt and de Goedi 1997). Addressing the HIV/AIDS epidemic and other reproductive health related problem in the adolescence requires reaching out not only to the adolescents themselves but also to others who influence there lives. Parents and other family members can help prevent these problems among the young people Families have great influence over a person were in touch with their family are influenced by their absence. Families are a major determinant of adolescence sexual behaviour. Families in this context refers to parents, mothers and fathers and the extended, uncles, aunties cousins, grand parents if present or fosters parents.

Families can help their adolescence refrain from risky sexual behaviour, family connectedness and parent -child communication is therefore key to ensuring healthy behaviour. The family of course greatly influence their children's health behaviour and there is need to build a relationship of trust with the parents, aunties, uncles and parents if they ever this extended chain of relatives exists. In the United States a study that asked students who most influenced their decision about sex, 37% cited their parents while 30% cited their friends. In addition to parents, other adult family members and others in the community influence adolescent health behaviour. Studies also show that young people with a stable, positive and supportive family environment that include parental monitoring engage in less risk-taking Parental affection help deter such adolescents behaviour as violence and delinquency. In a United State school study, sixth and seventh graders with supportive parents were less likely to use drugs or get into fights and more likely to delay sex than classmates who were emotionally detached Parents often said that young people should be taught about HIV/AIDS.

In Brazil, for example the vast majority of women interviewed in the low-income areas said that they did not want their daughters to grow up as uninformed about sex they themselves

were In a study in Kenya over  $\frac{3}{4}$  of parents of children ages 10-14 said that adolescents should be taught in school about HIV and other STIs and family planning and other reproductive health subjects.

According to Jersild 1963, a large proportion of adolescence, particularly girls, would like to start dating before their parents would wish them to do so, in a study published in 1924, G. F. Smith found that girls reported they were first interested "in going out with boys" sometimes in the age from 10-18years; the median age is 14years. From ordinary observation one gets the impression that the more pre-teen-agers are dating now than is true 10-15 years ago. The role of the family is also emphasized to a marked degree when adults view their adolescence in retrospect. The author asked students to write an account of conditions and events which in their judgments, were most helpful or trying during their adolescent years, these accounts have regularly mentioned the home and relationships with parents more than any other single factor

## **2.4 Parent-Child Communication- A Review**

Some adolescents have parents with whom they get along and discuss important things, a majority of them are unfortunate and have trouble getting along with their parents. Their relationship with their parents become more completed as they start struggle and arguing with their parents, labeling them old- fashioned and they think parents do not trust or have confidence in them. Communication between parents and their children is often difficult. Julia, 22 year old, Ghana had this to confess" When I started seeing the changes in me, I found it very difficult to tell my parents about it. But as time went on I felt more relaxed and is able to talk to them I asked them any question that I intend Parents and children alike are often embarrassed to talk about sex and avoid the topic.

Most parents want very much to help their children go through adolescence safely but often they don't know. They are afraid of embarrassing themselves perhaps their own parents didn't talk to them about adolescence and all the changes that one goes through. Thus it becomes very difficult to help their children when they themselves did not get enough help.

In South Africa, adolescent women said they were afraid to talk about sex to their parents' In Zimbabwe young people said that communicating with their parents is often one sided, with parents mainly warning about dangers of sex. In Mexico young people cited such communication barrier as lack of time not getting along with parents and lack of trust in the parent's advice. HIV is particularly a sensitive topic that many parents avoid. In Kenya less than ½ of the parents of teenage children had discussed HIV /AIDS with their children.

Many parents know little about HIV and worry that they do not have enough information to give to their children. In the United States parents said that one reason for poor communication is that their teenage children might ask questions the parents could not answer. In developing countries, especially in rural areas parents are less educated than their children and that they lack the knowledge to talk about sex. When parents talk to their children about sex they do so ineffectively. In Zimbabwe, although many parents said they have discussed AIDS, none of the adolescents interviewed cited parents as an important source of AIDS information. In the US again a study of 90% of mothers said they had spoken to their children about sex but only 2/3 of the children agree. Researchers agree that parents -Child communication about sexuality and reproductive health should begin early so that it can evolve comfortably as the child mature. A serious talk about sex as the child enters puberty is likely to be strained and-awkward. Similar discussions before however provide the groundwork for a successful discussion. Parent-child communication is most likely to be successful, of course in a close and loving relationship. Today the emergence and increase of HIV/AIDS has now influenced family to impart knowledge on sexuality, the dangers of STD's HIV/AIDS information to their children. The extents to which this happens and the intervening factors that either promote or hinder this communication and whether the information provided assist them behave responsibly with respect to promoting good health is not quite clear. There is need for more time to cultivate meaningful relationship with children.



## **2.5 Sexuality communication in the traditional context.**

Customarily in much of the African setting, the family served as a vehicle for socialization. Sex education and preparation of boys and girls for adolescent life is left in the hands of the extended family. Community elders informed boys approaching puberty about sexual matters during rites such as circumcision. Grand parents and elderly, aunts and uncles used traditional and popular media such as drama, dance, song, story and proverb telling about love, marriage, sex and how to keep away from premarital sex as the young boys and girls were being prepared for adulthood. The society and therefore the family had strong values regarding the importance of marriage and child bearing. Premarital sex is strictly forbidden for girls and boys, all the communities in Kenya for example placed high value on virginity. The society looked at a pregnant girl as an insult and the victim's felt stigmatized and cut off from their families. Parents however, traditionally did not talk about sex with their own children. The socializing process created opportunities in specific group for questions, open discussions, advice, participation feedback, clarification and explanations on issues not well understood and development of problem solving skills. This type of communication is able to fit in the needs of the adolescences leading to attitude and behaviour change. Drama has been used and is one of the most exciting and effective ways to share messages and generate discussions. Drama focusing on sexuality staged in local languages in schools, public gatherings such market places; story telling, dance, and songs have played roles in many traditional societies and setting.

The erosion of tradition means of regulating sexuality and contraception due to rural-urban migration and the worsening of the economy have caused waning of many traditional mechanisms (Lema and Njau, 1991; Zenoah, 1993; Lima et al, 1991; Suda, 1993) rural - urban migration has also weakened extended family networks which provided stability and support. Customs such as early marriage and female genital mutilation were used traditionally to curb early sexual practices and avoid adolescent Childbearing out of wedlock (Bledsoe and Cohen, 1993). With increased family mobility and urbanization, the traditional form of sex education have decreased or all but disappeared, more and more parents are progressively surrendering responsibility for their children to various institutions (Gakuru 1997).

This has been replaced by sex education through school health education program and family life education, the media where they transmit information through medium of mass communication such as, the radio television, books, posters, newspaper that have become a significant source of information about sexuality (Nagendo Barton 1992)

## **2.6 Mass Media and Other Sources Information**

Information through the mass media has increased dramatically in the recent years and it has facilitated rapid spread of simple information, increased awareness and knowledge through the use of radio, television, talk showed, brochures and flyers. However, it has been misunderstood and there is often lack of clarification. Mass media has permeated our daily lives Marshall Me Luhan defined media as "an extension of man". Architect Buck minister fuller suggests that television is becoming "a third parent" in many American household and indeed this also the case in the Kenya households. We have become as Marshall Me Luham puts it a global community in the sense that we share the world's bounty via the media myths of falling in love at first sight, idealistic portraits of human relationship. Role models come from media characters, characters in fiction or in television may inspire the thinking of adolescence about communication and relationship. Keny Joseph, predicts that the radio may become the source of a best friend Other adolescents rely on peers who are notorious for unreliability and misinformation. Religious leaders provide a moral perspective on the appropriateness of sexuality education. Healthcare providers also work with the young people and provide specific expertise; Public forums also provide opportunity for an expert talk about sexuality and education for members and opportunity to ask questions.

Despite all these efforts, sex education for children and young adult is still hotly debated and emotive issue today, proponents of sex claims a comprehensive non-judgemental provision of young people such that they can when faced with decisions about sex, they make responsible and health positive choices.

## **2.7 Theoretical Framework**

The study of sexual behaviour in Africa has become a major pre-occupation for social scientists in recent decades. This focus on sexual activity results in part from the evidence that HIV infections in the continent are transmitted through heterosexual intercourse (Rosen Je, Conly Sr 1998). However any review that our knowledge in adolescents sexual behaviour is still very limited. The major theoretical framework for the study will be based on social change with major emphasis on the role of family. With adoption of western life, which removes the youth from parental surveillance. This study uses social cognitive theory which provides the theoretical basis for healthy relationships, emphasizing the importance of building behavioural skills.

### **2.7.1 Social Cognitive Theory**

The threat of HIV has highlighted the need to prepare young people to manage competently the emotional and biological challenges, inherent in informing relationships and living safe and satisfying sexual lives (Mcrobbie, 1996:182, Wellings, 1996: 8).

Three main themes can be drawn from sociological research on young peoples sexuality. First, to a great extent sexuality is learnt and learnt differently according to ones gender. Second, the management of heterosexual relations depends upon culturally maintained and individually learnt. Lastly the perception of health risk is itself culturally defined.

Socio cognition models on theories specify a set of individual cognitions which have been shown to motivate and regulate health behaviour. Social cognitive theory assumes that the environment influences behaviour and is composed of the social environment; family, friends, peers at work or school while physical environment situation refers to the persons perception of the environment, observational. Learning occurs when a person imitates other peoples behaviours and the reinforcements associated with those behaviours if a person is to perform a behaviour he or she must know what the behaviour is and have skills to perform it. This explains the effect of the role of parents on the adolescents.

Reinforcements are applied to reward positive behaviour and sanctions negative behaviour. A person learns that certain outcomes occur when a given situation and expects them to occur when that situation presents itself again and the person performs similarly. If an adolescent is rewarded from abstaining from sex she is likely to repeat the same positive behaviour.

### **2.7.2 Symbolic Interactionism theory**

Focuses on the nature of interactionism, the dynamic patterns of social action and social relationship (Abraham 1992:208). Social interactionism has shown how one's identity emerges from one's own presentation of oneself and one's audience's views of oneself (Berger and Luckman 1966:66). In other words, behaviour is learned through interaction with same sex, peers, which make their identities vulnerable to contact with opposite sex (Wight, 1994:721). Thus if adolescents living in slums interact with peers who are already into sex they are very likely to learn the behaviour. In interactionism theory, Charles Horton Cooley and George Herbert Mead are unquestionably the most prominent.

#### ***Charles Horton Cooley***

Cooley focused his attention upon the complex relationship which exists between the individual and society, he says that 'Man does not stand alone as an individual and that society does not exist without individual'.

The organic view of the society affirms the indispensable reciprocity between the individual and society. They are not empirically separable but are a differentiated coincidence of the same phenomenon. No society without individual and no individual apart from society, if we say that society is an organism, we mean ... that it is a complex of forms of processes of which in living and growing by interaction with others, the whole being so unified that what takes place in one part affects all the rest. It is a vast tissue of reciprocal activity. The society is important in the upbringing of adolescents.

## 2.8 Operationalisation of Variables

### Definition of Terms

The following theoretical definitions will be adopted for the study:

- Adolescence:** Adolescence is a period during which young people experience physical, emotional and psychological changes, normally this experience occur during teenage years of 13-19. (Hubley, 1995)
- Sexuality:** Sexuality is a life long concept that begins at birth and ends at death 'it includes:
- How you feel about yourself as a person
  - How you feel about being a man or woman
  - How you get along with members of the same sex or opposite sex.
- Sexuality is: Much sexual feeling or sex, part of sexuality is sex usually referring to our Reproductive system or our private parts. Sexuality involves our cultural values and religious practices and we are socialized. (Lema, 1987).
- Reproductive Health:** Reproductive health is a State of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters related to reproductive system, its functions and process. That people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. (Jerseild, 1963).
- Communication:** Communication may be defined as a process in which the speaker(s) transmit information (o the receiver / listener through appropriate channel to establish mutual understanding by ascertaining that feedback has been received, a two way exchanging messages, and facts statement with verification of reception, comprehension and acceptance. (Hubley, 1995).
- Household:** A residential unit whose occupants lives together and shares the same resources
- Pubic hair:** The hair that grows in the genital or private parts.

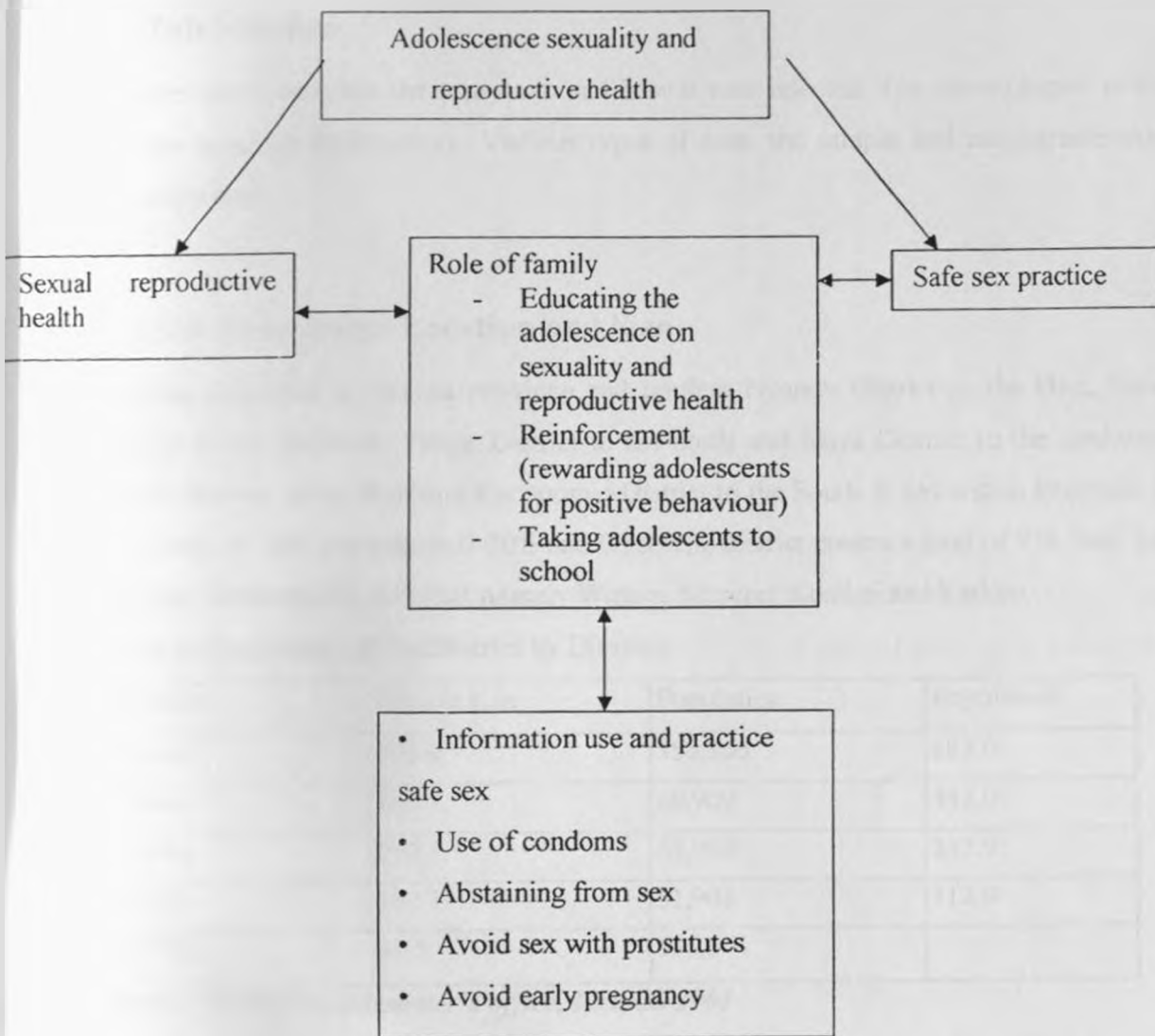
**Menstruation**

Also known as monthly period, the flow of blood from the uterus out of a woman's body usually occurring every 28 days and ends between 45 and 55 years. (Lema, 1987).

VARIABLE STUDY	VARIABLE INDICATORS
<p>Independent variable</p> <p>Role of Family</p> <ul style="list-style-type: none"> <li>- FATHER</li> <li>- MOTHER</li> <li>- SISTERS</li> <li>- BROTHERS</li> <li>- GRANDPARENTS</li> </ul> <p><u>Dependent variable</u></p> <p>Early adolescents sexuality and Reproductive health. Age 10-15 years</p>	<ul style="list-style-type: none"> <li>- Educating the adolescents on sexuality and reproductive health</li> <li>- Reinforcement (Rewarding adolescents for positive behaviour).</li> <li>- Taking adolescents to school etc.</li> </ul> <ul style="list-style-type: none"> <li>• using condom</li> <li>• pregnancies</li> <li>• Diseases (HIV, STIs)</li> <li>• Number of partners</li> <li>• Choice of partners</li> </ul>

## 2.9 Conceptual Framework

The conceptual framework showed the relationship between the role of the family and adolescents sexuality and reproduction health



## CHAPTER THREE

### 3.0 METHODOLOGY

#### 3.1 Introduction

Chapter three describes the study site and how it was selected. The same chapter points out the research methodology. Various types of data, the sample and its characteristics are explained

#### 3.2 Site Description, Location and Size

Kisumu District is in Nyanza province and borders Nyando District to the East, Nandi District to the northeast, Vihiga District to the north and Siaya District to the northwest, Bondo District to the West and Kachuonyo District to the South. It lies within longitude 33 20' E and 35' 20E and latitude 0 20'S and 0.5S. The district covers a total of 918.5km<sup>2</sup> and has four administrative divisions namely Winam, Maseno, Kombei and Kadibo.

Areas and population of The District by Division

Division	Area in Km	Population	Population
Winam	395.0	350,365	887.0
Maseno	168.7	69,969	441.0
Kombei	192.1	63,969	332.9
Kadibo	162.7	51,901	318.9
TOTAL	911.5	535,571	

*Source: District commissioner's office, Kisumu 2001*

The district has three parliamentary constituencies viz: Kisumu Town East, Kisumu town west and Kisumu rural. Kisumu Town East covers Kadibo and part of Winam and a small part of Maseno Division and Kisumu Rural constituency covers Kombei and part of Maseno Division. Winam division, which is the focus of the study, is the largest division in terms of area 395km<sup>2</sup> and has the highest density. It is the division, which holds the provincial and District headquarters. Kisumu City, the largest in Western Kenya is found in this division. The main attraction to the town is the availability of jobs and business opportunities.



colleges and training institutions. There are pockets of poverty in Kisumu city particularly in the slum settlements such as Obunga, Bandani, Nyalenda, Nyawita and Manyatta. This has extended pressure on social amenities such as housing, water and sewerage systems. The town has a ready market for most products thereby promoting the growth and development of agricultural, industrial and the service sectors. However, slum dwellers, street children and orphans and the unemployed youth are a threat to the security. The actual study area refers to the slums settlements including low income residential areas, schools and population this are:

- Rweya
- Otonglo
- Kanyamedha

Kisumu district envisage glaring short term and medium term challenges outstanding among them are Revival or closed factories for cotton, sugar and the molasses plant which stalled, fish processing factories, water and sewerage systems in the city and the growing unemployment and HIV/AIDS pandemic. All the four divisions of Kisumu are seriously plagued by HIV/AIDS menace; prevalence in the district stands at 38% up from 30% in 1999 and is among the highest in the country this has impacted negatively to the district population since it has affected the most productive age bracket leading to death of persons in their prime age.

A considerable percentage of the population in Kisumu is youthful, about 42% of the population is below 15 years, while 73% is below 30 years. Those aged 60 and above account for only 3.4% of the population. 53% of the people who live in Kisumu district live below poverty levels. Poverty in the district is attributed to environmental, economic, HIV/AIDS menace and social cultural factors. An agricultural activity, which is the mainstay of about 90% of the population, has been affected by inadequate and unreliable rainfall patterns. This study will be carried out in a sample schools in the 4 education Divisions /ones, namely Urban, Southern, Eastern and the Western Division.

### **3.3. Data type and sources**

To maximize collection of accurate information, the study generated its data from secondary and primary sources. The secondary sources were literature materials from

local libraries, records and reports from schools, education offices and organizations that focus on adolescents. Primary data was generated from interviews, Questionnaires and FGDs. Structured Questionnaire with closed and open ended questions was administered to selected respondents.

### 3.3.1 Sampling Procedure

Sampling is defined as the process by which a relatively small number of individuals, objects or events are selected and analyzed in order to find out something about the entire population from which it is selected (Singleton et al, 1988). This study used purposive sampling in selecting the study area. This procedure describes a situation where one selects a sample on the basis of one's knowledge of the population, its elements and the nature of research (Babbie, 1995). In this form of sampling the researcher relied on his or her judgment to select units that are representative or typical of the population (Singleton et al 1988). Expert judgment was used to select key informants from Kisumu district to give their views on the factors affecting adolescence on sexuality and reproductive health. Key informants included the DEO, DO, Chiefs, Counselors and Committee Members.

The study used stratified sampling to select the zones. The zones were classified into social economic status. Table below indicates the stratification process.

**Table 1: Distribution of zones according to socio-economic status**

Zones	(socio-economic status)	Sample (n) school
Southern	Moderate	1
Otonglo	Low	1
Rweya	Very Low	1
<b>TOTAL</b>		<b>3</b>

**Table 2: Sample frame for the schools**

Zones	No. of schools	Sample number of schools
Rweya	5	1
Southern	4	1
Otonglo	5	1
<b>TOTAL</b>	<b>14</b>	<b>3</b>

The study employed simple random sampling in selecting the schools to be studied, the researcher wrote the names of the schools in the papers then folded them and picked one from each zone at random.

**Table 3: Sample Frame for Students according to schools and classes**

Schools/classes						Totals
	4	5	6	7	8	
Kanyamedha	5	12	10	6	4	37
Buoye	5	7	10	4	2	28
Nanga	2	5	4	2	2	15
<b>TOTAL</b>	<b>12</b>	<b>24</b>	<b>24</b>	<b>12</b>	<b>8</b>	<b>80</b>

### Sample size and characterized

**Table 4: Sample distribution**

Category of respondents	Male	Female	Total
Government official	3	1	4
Teachers	9	11	20
School management committee	3	0	3
Parents	15	25	40
Counselor	1	0	1
Students	18	22	40
<b>TOTAL</b>	<b>49</b>	<b>59</b>	<b>108</b>

**Table 5: Distribution of pupils according to classes**

<b>Class</b>	<b>Number</b>
Four	6
Five	12
Six	12
Seven	6
Eight	4
<b>Total</b>	<b>40</b>

In Kisumu there are a total of 9 education zones out of the 9 zones three of them namely Southern, Rweya and Otonglo, were purposively chosen because they are the only ones with schools located in the slum areas. The study used multi stage sampling to select from each zone, location, one sub location, one primary school to be included in the sample in Kisumu district. The study used method because sampling schools and household started at a higher level rolling down through locations and sub locations. The other reason for using multi stage sampling was to save costs of covering a larger population.

### **3.3.2 Study population**

Study population consisted of male and female adolescents aged 10-15 yrs and the study will cover sampled public primary schools in the slums

### **3.3.3 Unit of Analysis**

The study was aimed at establishing the role of family in early adolescence sexuality and reproduction health. The unit of analysis is the social entity whose social characteristics are the focus of study (Baker, 1994). The same view is held by Babbie (1995) that a unit of analysis as that which a researcher seeks to understand. That is what or who is to be analyzed (Singleton et al, 1988). The units of analysis in this study is therefore, the family, early adolescences, the school, DEO, DO, NGOs, chief, counselor and community members.

### **3.3.4 Data Collection Methods**

Secondary data was gathered through documents analysis. This entailed review of relevant published and unpublished literature, journals, books such as national policy documents on education sector review report (for Kisumu) Development plans, district education office reports (for Kisumu) data on school enrolment rates.

Qualitative design is adopted to capture human behaviour, thoughts and feelings on the issues addressed by the study. The quantitative design was useful in generating generalisable data and visualizing trends and patterns in adolescence sexuality and reproductive health. The researcher blended both qualitative and quantitative research paradigms to enrich the study.

The main sources of primary data were key informants. Their responses to questions as well as observations the researcher made provided necessary data for this study. Primary data was collected through various approaches as discussed below.

#### **i) Focus Group Discussion**

In addition to the aforementioned methods of data collection, Focus Group Discussions (FGD's) and in depth interviews were also conducted. FGDs were conducted by separating the sexes in each of the schools to encourage freeness and openness. There were 6 Focus Group Discussion, 2 for boys and 2 for girls from each school.

The discussion groups were held separately based on sexes to enable each group freely discuss indepth issues that affect adolescents of Kisumu slums. This arrangement enabled the researcher to investigate experiences and ideas about the possible causes of sexuality and reproductive health in adolescences and strategies that might be adopted to alleviate the situation. Each discussion is held for about one hour each at pre-determined sites and venues in schools. The researcher used FGD interview guide to facilitate discussions. The researcher also moderated the discussions process while the research assistants took notes.

## **ii) Interviews**

In this study, key informants interviews were conducted using discussion/interview guides to obtain explanations and perceptions of adolescents in sexuality and reproductive health. Personal interviews were conducted using, structured Questionnaire which had closed and open ended questions to pupils and teachers.

These questions were given out in advance to allow adequate time for head teachers to provide data on school enrolment, staff establishment. In addition, to the aforementioned an interview guide was administered for in depth interviews with purposively selected samples of literate respondents. This entailed holding one to one interview with key informers namely District Education Officer Kisumu, Counsellor, 3 committee members, 2 chiefs and DOs.

## **iii) Case histories**

More so, the study used the case study approach guidelines were developed and used together with information from adolescents' stories and profiles. These case stories were presented in narrative form to document voices and experiences of girls and boys.

## **iv) Direct observation**

The study also made use of direct observations that were guided by an observation guide or a checklist. Direct observation is the process in which one or more persons observe what is occurring in real life situation and they classify and record pertinent happenings according to some planned scheme (Koul, 1992). School facilitates such as fencing, seating arrangements number of girls versus number of boys in the class teaching forces in the school among other thing.

### **3.3.5 Data analysis**

As indicated in the previous section data collected for this study was both qualitative and quantitative. Qualitative data analysis was used to show the magnitude of the role for the family in early adolescence. Sexuality and reproductive health; quantitative analysis was used to explain details of the situation and also give more insights to the issue under the study. For this purpose collected information was categorized accordingly for the purpose of computerizing.

### **Quantitative data**

Analysis of quantitative data was done using descriptive statistical tool, descriptive statistics involves methods concerned with arranging, summarizing and conveying the characteristics of a range of number (Runyon et al, 1996). This study has used the following descriptive statistics i.e, percentages and frequency distributions, to interpret and present data

These statistical tools were summarizing descriptions of units with regards to measurable characteristics of the respondents and the study variables.

### **Qualitative data**

Since the researcher also collected qualitative data the study thus, extracted data from the research instruments thematically. In addition, presentations of data on field observations, Focus Group Discussion, informal and in depth interviews were presented qualitatively using quotations and documenting the adolescence case stories/profiles. This project has a total of five chapters; appendices include study instruments, and a map of the study area.

## CHAPTER FOUR

### 4.0 DATA PRESENTATION AND ANALYSIS

#### 4.1 Introduction

A qualitative study attempts to understand behavior and institution by getting to know the persons included and their values, rituals, symbols, beliefs, and emotions (Nachmias and Nachmias, 1996). By using qualitative method, researchers are able to collect data and explain phenomena more deeply and exhaustively. In qualitative research data is in the form of text, materials, photographs which describe events and occurrences. Data collection and analysis in qualitative research go hand in hand and are done simultaneously (Mugenda and Mugenda, 1999). In this study, data gathered from in depth interviews with educational officials, observation and informal discussion is presented.

This chapter therefore, presents data obtained from 108 respondents who were either interviewed face to face or engaged in Focus Group Discussions. The collected data are summarized organized, presented, analyzed and interpreted using descriptive and inferential statistics such as percentages, frequency distribution measures of central tendency used in this study is mean.

Data collection and analysis is guided by the objectives of the study. The first objective being to establish the family level of understanding of sexuality and reproductive health among early adolescence. The second objective is to establish the nature of problems of sexuality and reproductive health as experienced by early adolescence at the family level. The third to identify the challenges against effective participation of the family in sexuality and reproductive health among early adolescence

This chapter presents an analysis of the data and the findings under the following sub-headings:

- Early adolescence and their Families level of understanding of sexuality and reproductive health among early adolescents



- Problems of adolescent sexuality and reproductive health at family level
- Challenges hindering effective participation of the family in sexuality and reproductive health
- How families cope with sexuality and reproductive health problems/ challenges

## 4.2 Background information of respondents

This section looks at the distribution of respondents in terms of schools and zones.

The main respondents were 40 primary school pupils of ages between 10 and 15 years. These ages were meant to capture the early adolescence period including the early and late mature. They were drawn from three schools in Kisumu municipality namely Kanyamedha, Buoye and St. Vitallis Nanga. St. Vitallis Nanga primary school is within a moderate socio-economic environment while Kanyamedha and Buoye are from low and very low socio-economic environments respectively. These schools were from separate zones Otonglo, Southern and Rweya. These zones have differences in poverty levels and urbanization levels. Focus Group Discussions were conducted by separating the sexes in each of the schools to encourage freeness and openness.

The researcher also interviewed the main respondents' parents and 20 teachers drawn from the three schools filled in the Questionnaires. The key informants interviewed included the chiefs from the three locations under which the schools fall, the divisional officer (D.O) and the district officer. Other key informants included a committee member from each of the schools.

**Table 4.1: Distribution of respondents in terms of schools and zones of study**

School	Zone	Pupils	Parents	Teachers
Kanyamedha	Otonglo	17 (42.5%)	17 (42.5%)	6 (30.0%)
Nanga	Southern	11 (27.5%)	11 (27.5%)	7 (35.0%)
Buoye	Rweya	12 (30.0%)	12 (30.0%)	7 (35.0%)
Total		40 (100.0%)	40 (100.0%)	20 (100.0%)

The respondents were categorized according to gender as shown in table 4.3.2 below. However, there is no statistically significant difference between the sexes. Averagely the females tend to be more than the males; presenting a national outlook whereby the females tends to be more than males.

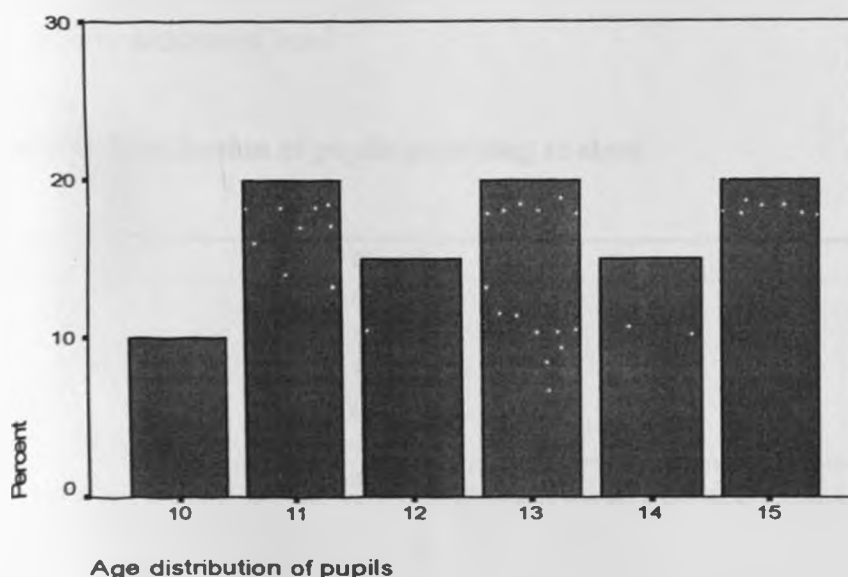
**Table 4.2 Distribution of the respondents according to their sex**

Respondents	Male	Female	Total
Students	18 (44.4%)	22 (55.6%)	40 (100.0%)
Parents	15 (37.5%)	25 (62.5%)	40 (100.0%)
Teachers	9 (45.0%)	11 (62.5%)	20 (100.0%)

**Distribution of the pupils sampled in terms of their age**

The ages of pupils interviewed ranged from 10 to 15 years. These were distributed as shown in figure 1 below. The majority were 11, 13 and 15 years old with 20% each. 12 and 14 years old were 15 % each and the 10 year olds formed 10% of the pupils interviewed. These ages are in line with the rationale of the study which focuses on early adolescents' sexuality and reproductive health.

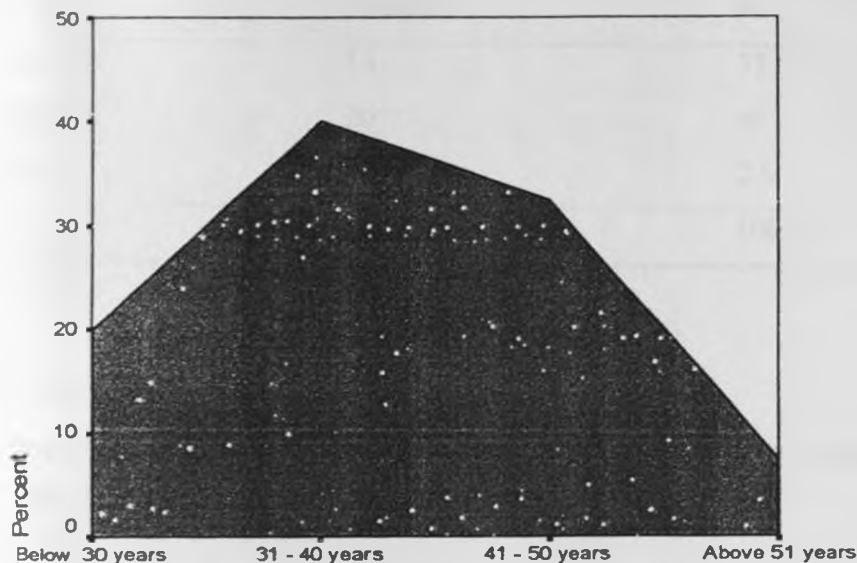
**Figure 1:Age of the respondents**



### Age of the pupils parents

The survey showed a fairly young parental population. Only 7.5% of the parents interviewed were above 51 years old and 32.5% between 41 and 50 years. Majority of the parents were aged between 31 and 40 years; 20% were aged below 30 years.

**Figure 2: Age distribution of pupils parents**



Age distribution of parents

### Distribution of pupils according to class

The interviewed students were from classes' four to eight. This is mainly to capture the ages of early adolescent hood.

**Table 4.3: Distribution of pupils according to class**

Class	Number	%
Four	6	15.0
Five	12	30.0
Six	12	30.0
Seven	6	15.0
Eight	4	10.0
Total	40	100.0

### Religious distribution of respondents

The researcher sought to find out the religious affiliations of the pupils. The study revealed that all the respondents are religious with 97.5% of the population being Christians.

**Table 4.4: Distribution of the respondents according to their faith**

Religion	Number	%
Catholic	13	32.5
Protestant	26	65.0
Muslim	1	2.5
Total	40	100.0

### Type of family

The pupils revealed that a majority of them (87.5%) come from monogamous families with only 12.5% are from polygamous families.

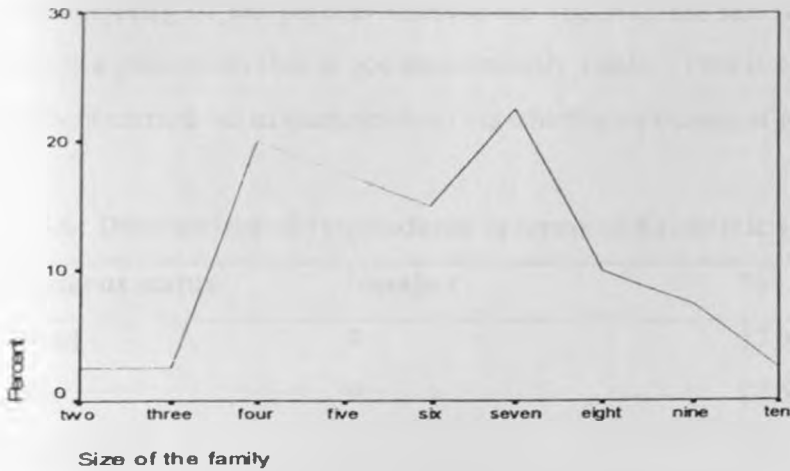
**Table 4.5: Distribution of respondents according to the type of family**

Type of family	Number	%
Monogamous	35	87.5
Polygamous	5	12.5
Total	40	100.0

### Size of the family

The sizes of the families ranged from two to ten people. Majority of the families are large (75%) have more than four members.

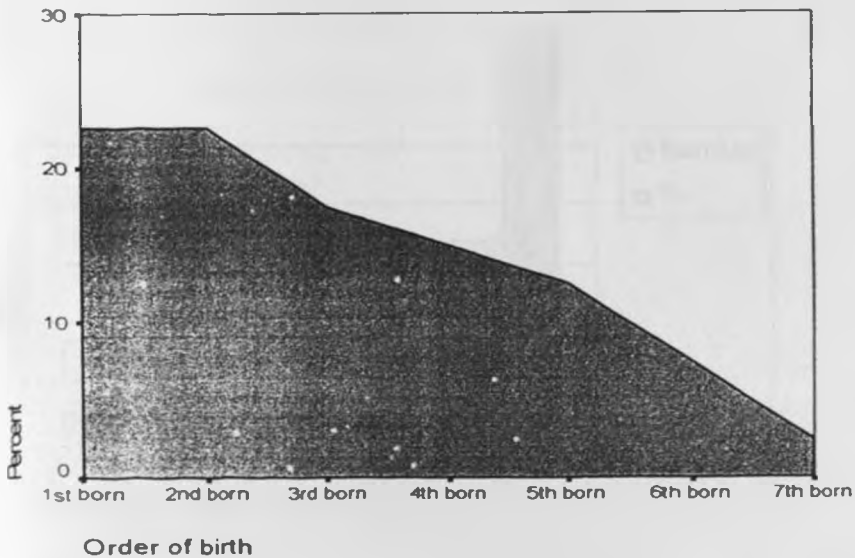
**Figure 3: Distribution of respondents in terms of the size of the family**



**Position of birth**

Majority of the pupils interviewed are either first or second born (50%). There is a general decline from 22.5% (first born), 22.5% (second born), 17.5% (third born), 15.0% (fourth born), 12.5% (fifth born), 7.5% (sixth born) to 2.5% (seventh born).

**Figure 4: Distribution of respondents according to birth**



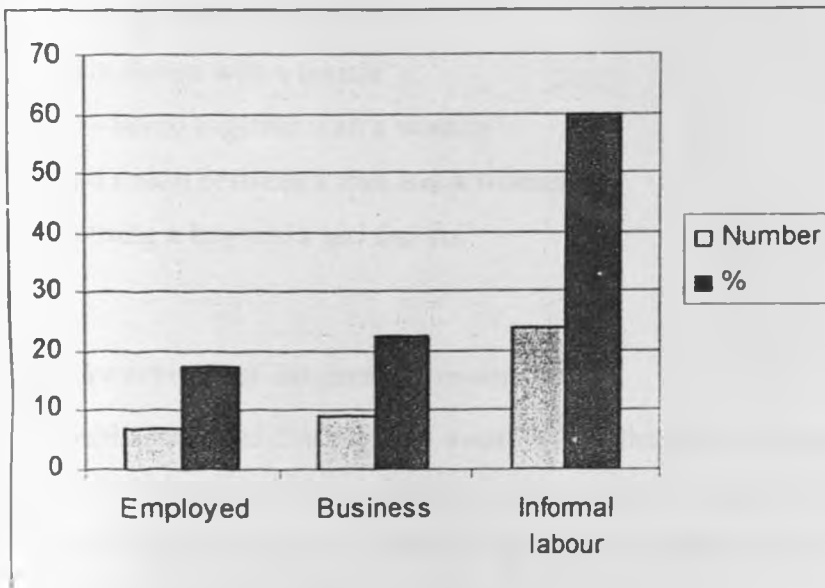
### Economic status

A clear majority of the parents interviewed (82.5%) are not formally employed. This represents a population that is not economically stable. This is explained by the fact that the study is carried out in slum settlements which are pockets of poverty.

**Table 4.6: Distribution of respondents in terms of Economic status**

Employment status	Number	%
Employed	7	17.5
Business	9	22.5
Informal labour	24	60.0
<b>Total</b>	<b>40</b>	<b>100.0</b>

**Figure 5: Distribution of respondents in terms of Economic status**



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### **4.3 To establish early adolescences and their families level of understanding**

This section looks at the level of understanding of adolescences and their families in sexuality and reproductive health

#### **4.3.1 Knowledge, Attitude and practice**

This sub-section looks at the knowledge level of the early adolescents about sexuality; their attitude and practice on the topic.

#### **4.3.2 Understanding of the term sexual intercourse**

Although the pupil respondents could not define exactly the meaning of sexual intercourse; they seemed to understand its meaning. Only three of out of the 40 students (7.5%) interviewed were not aware of its meaning. Asked what they understood by the term sexual intercourse; they gave the following responses:

“Bad things”

“A boy sleeping with a girl”

“Doing bad things”

“Having sex with opposite sex”

“A male sleeps with a female”

“A man being together with a woman”

“Sexual union between a man and a woman”

“Something a boy and a girl can do”

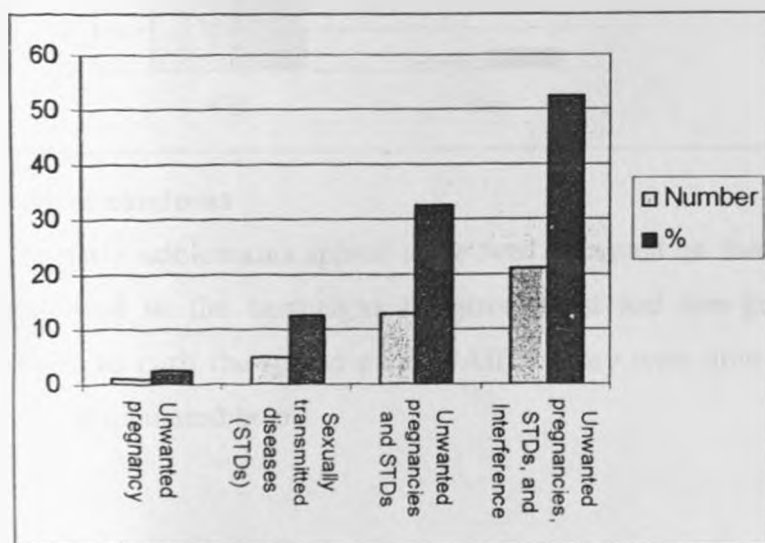
#### **4.3.3 Awareness of dangers of pre-marital sex**

The pupils revealed that they are aware of the dangers of pre-marital sex. However, the level of awareness varies, with some only aware of one or two dangers. They listed unwanted pregnancy and sexually transmitted diseases as the major dangers of pre-marital sex as shown in table 4.7 below:

**Table 4.7: Distribution of respondents according to their knowledge on dangers of dangers of pre-marital sex**

Dangers of pre-marital sex	Number	%
Unwanted pregnancy	1	2.5
Sexually transmitted diseases (STDs)	5	12.5
Unwanted pregnancies and STDs	13	32.5
Unwanted pregnancies, STDs, and Interference with Education	21	52.5
<b>Total</b>	<b>40</b>	<b>100.0</b>

**Figure 6: Distribution of respondents according to their knowledge on dangers of of dangers of pre-marital sex**

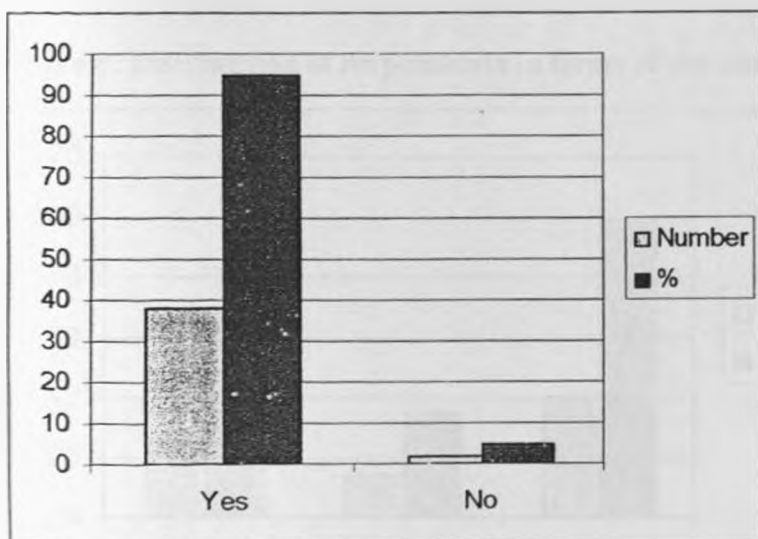




#### 4.3.4 Awareness of Condoms

Majority of the pupils (95.0%) have heard of condoms. They are also aware that they used for family planning and prevention of STDs. They further revealed that condoms can be obtained from hospitals, shops, chemists and VCT centres. Asked who should use a condom, they were in agreement that they are used by males in particular fathers and old men. One pupil said that they are used for sex outside marriage. Another pupil said that condoms should be used by those over 15 years old. Some female students were categorical that they should be used by boys.

Figure 7: Distribution of respondents in terms of awareness of condoms



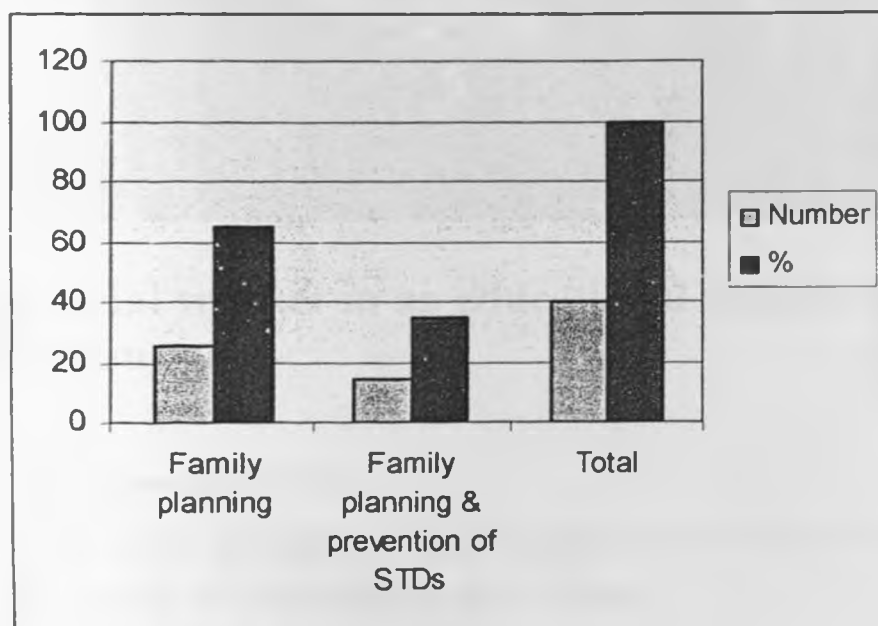
#### Uses of condoms

The early adolescents appear to be well informed on the use of condom. This may be attributed to the campaigns by government and non-governmental organizations on efforts to curb the spread of HIV/AIDS. They were able to indicate why condoms are used as tabulated below

**Table 4.8: Distribution of respondents in terms of the uses of condoms**

Uses of condoms	Number	%
Family planning	26	65.0
Family planning & prevention of STDs	14	35.0
Total	40	100.0

**Figure 8: Distribution of respondents in terms of the uses of condoms**



## Call for free access to the pill



### **A social worker in an educational session with the youth in Kisumu**

#### **4.3.5 Awareness of AIDS**

In order to find out whether the pupils are aware of HIV/AIDS the researcher asked them what AIDS is. The following were their responses:

“A bad disease”

“A disease that weakens the immunity system”

“A killer disease”

“Acquired immune deficiency syndrome”

“A disease caused by HIV”

“A disease that makes people thin”

“An incurable disease”

“A sexually transmitted disease”

The respondents were further asked how they thought people get AIDS. Their responses were summarized as follows: Blood transfusion, Sharing sharp objects, Unprotected sex with infected persons, Circumcision, Deep kissing and Sharing toothbrushes.

In addition the respondents recommended the following methods to avoid HIV/AIDS: Abstinence, Avoid sharing sharp objects, Being faithful to one partner, Blood screening before transfusion, Educating the masses on HIV/AIDS, Advocate for use of condom, HIV testing before engaging in sexual intercourse, Sterilization of blades.

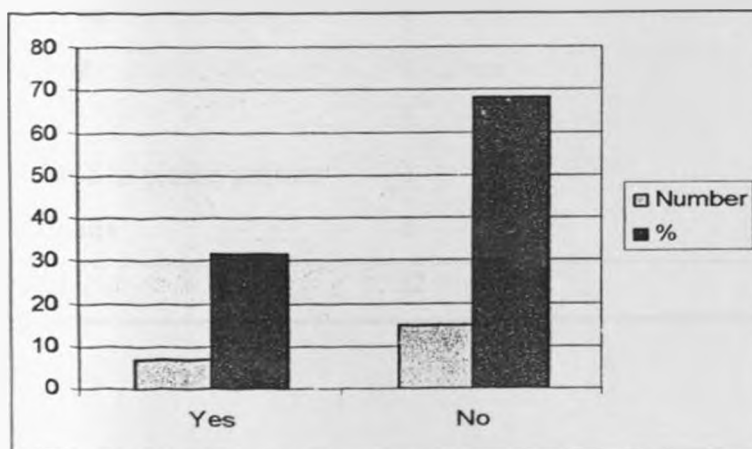
#### 4.3.6 Sex Experience and Practice

This sub-section seeks to find out the actual sexual experiences of the early adolescents.

##### 4.3.6.1 Menstruation

Girls who were interviewed, only 3.8% had started undergoing menstruation. 68.2% had not started menstruating. When they asked what is the cause of menstruation the girls had completely no idea.

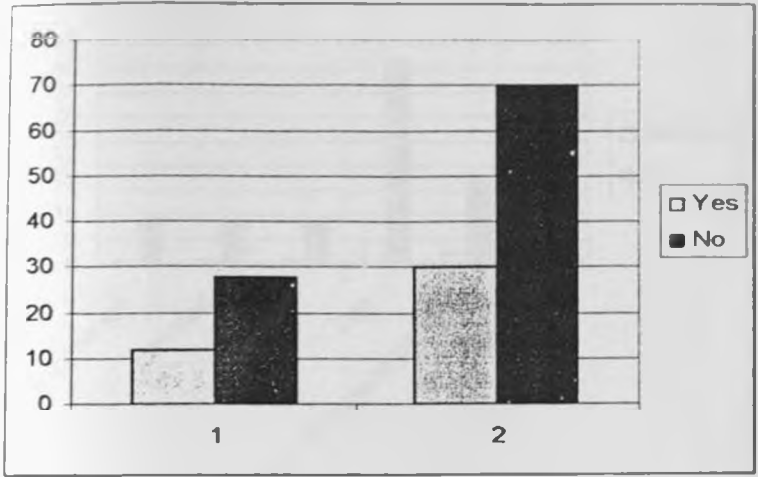
**Figure 9: Distribution of respondents according to their experience in menstruation.**



##### 4.3.6.2 Sexual intercourse

The pupils interviewed only 30.0% admitted to have had sexual intercourse. 70% had not had.

**Figure 10: Distribution of respondents according to their sexual experience**



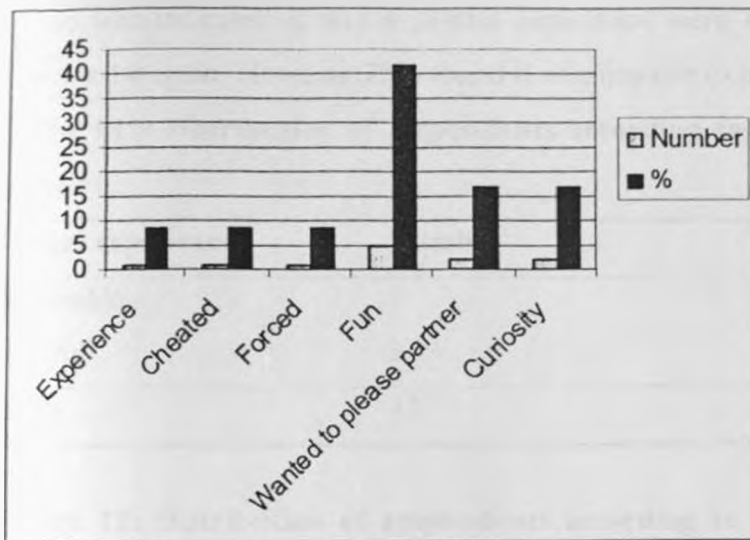
**4.3.6.3 Reasons for engaging in sexual intercourse**

Those who admitted to have had sex gave the following reasons for their pre-marital sex encounter

**Table 4.9: Distribution of respondents in terms of reasons of engaging into sex**

Reason	Number	%
Experience	1	8.3
Cheated	1	8.3
Forced	1	8.3
Fun	5	41.7
Wanted to please partner	2	16.7
Curiosity	2	16.7
<b>Total</b>	<b>12</b>	<b>100.0</b>

**Figure 11: Distribution of respondents in terms of reasons of engaging into sex**



#### 4.3.6.4 Sexual partners

The researcher sought to find out the ages of the respective sexual partners to the interviewed pupils. The study reveals that majority have had sex with their peers as shown in table 4.10

**Table 4.10: Respondents report about the ages of their sexual partners**

Age of sexual partners	Number	%
7	1	8.3
11	2	16.7
13	4	33.3
14	2	16.7
17	1	8.3
20	1	8.3
30	1	8.3
Total	12	100.0

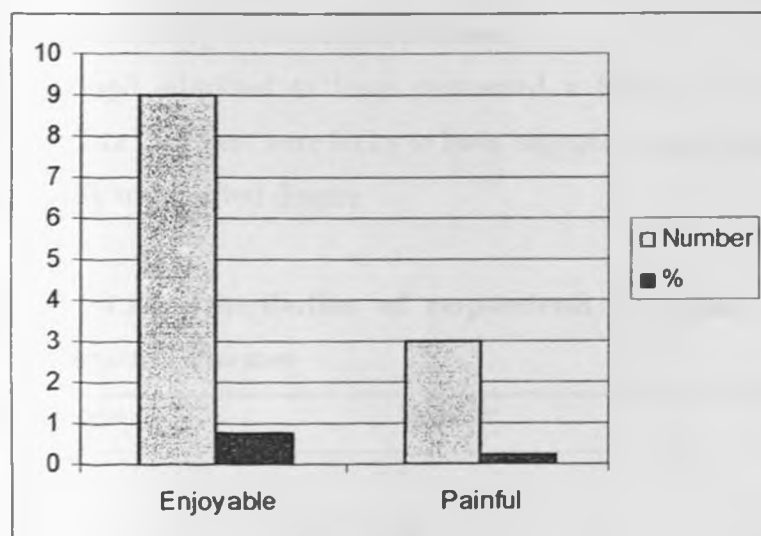
#### 4.3.6.5 Sexual experience

Those who indicated it was a painful experience were only 3% therefore unlikely to withstand it again. However 75% found it an enjoyable experience-

**Table 4.11: Distribution of respondents according to their sexual experience and practice**

Sexual experience	Number	%
Enjoyable	9	75%
Painful	3	25%
Total	12	100.0

**Figure 12: Distribution of respondents according to their sexual experience and practice**



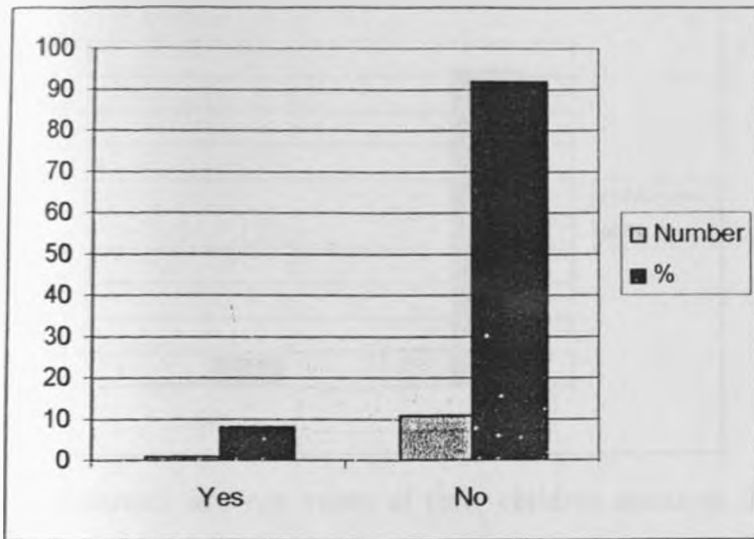
#### 4.3.6.6 Safe sex

Majority of the early adolescents who had sexual encounters (91.7%) did not use condoms therefore engaging in irresponsible sexual behaviour.

**Table 4.12: Respondents report on the use of condoms**

Response	Number	%
Yes	1	8.3
No	11	91.7
Total	12	100.0

**Figure 13: Respondents report on the use of condoms**



#### 4.3.6.7 Sexually Transmitted Diseases

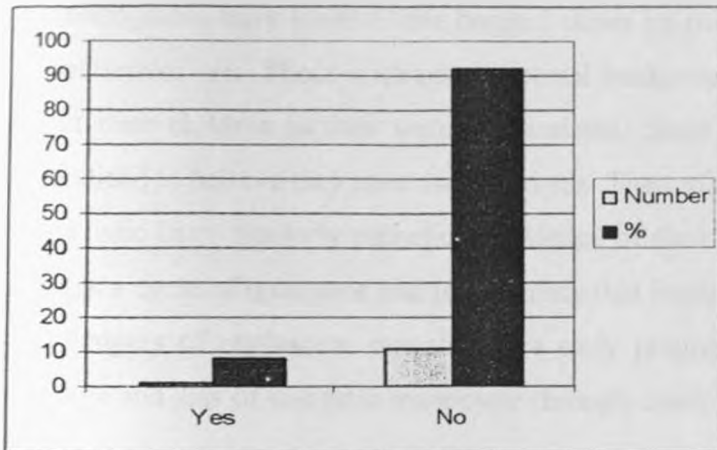
One pupil admitted to have contracted a STD as a result of irresponsible sexual behaviour. The rest were lucky to have engaged in unprotected sex and escaped without a sexually transmitted disease.

**Table 4.13: Distribution of respondents in terms of contraction of Sexually Transmitted Diseases**

Response	Number	%
Yes	1	8.3
No	11	91.7
Total	12	100.0



**Figure 14: Distribution of respondents in terms of contraction of Sexually Transmitted Diseases**



Many parents are not aware of their children needs at the stage of early adolescence. Most children do not know girls can have protected sex using condoms and parental influence is minimal compared to the influence of their peers. Since there is limited time (27.5%) talk about sexuality and reproductive health. The level of awareness is low and this is worsened by negative attitudes towards the topic as suggested by 20.0% of the respondents. There is indication that cultural factors promote shyness by both parents and their children to freely talk about matters of sexuality. Moreover the majorities of the parents have attained secondary education but are aged above thirty five years (60.0%). The HIV/AIDS scourge has assumed prominence recently and these parents may not have been exposed to need for concerted efforts to educate adolescents on sexuality and reproductive health issues.

Furthermore, it is not prudent to assume that a literate population is informed of emerging issues like need for creating awareness among adolescent youth on sexuality issues. This is compounded by not only lack of time but the fact that majority are in business (45%) and self employing jobs like furniture making, blacksmith, driving, fishing and so on which take up all their time toiling to make ends meet. The socio-economic status contributes to their inability to manage their time effectively for the benefit of their adolescent children. A paltry 5% are professionals in knowledgeable domains like teaching.

Consequently, from the foregoing facts, the family level of understanding is perceived to be limited concerning adolescent sexuality and reproductive health. The parents who are knowledgeable have limited time bogged down by cultural factors and negative attitude to matters of sex. Those with poor parental background are not even aware of how to assist their children as they were not assisted. Some of their children feel parents are prejudiced to believe they must have had sex. Their main sources of information are their peers who have similarly pathetic knowledge of their adolescent status and needs. This creates a cycle of ignorance and indifference that impact negatively on the quest to check the dangers of adolescent sexuality like early pregnancies, STI infections, HIV/AIDS scourge and loss of energetic manpower through death.

The majority of respondents think condoms are meant for use by male adults only and their parents. In fact none is referring to the unfaithful youth who have premarital sex. It appears they are oblivious of dangers of having unprotected sex by youth and adults alike. Since there is no mention of female condoms and being faithful to marital partners, this points to a very low level of understanding of sexuality and reproductive health matters.

#### **4.4 Problems of adolescence sexuality and reproductive health of family level**

This section looks at the nature of problems of adolescences sexuality and reproductive health. It covers the counselors point of view, focus group discussions and adolescences views.

The following are some problems of adolescent sexuality and reproductive health as expressed by the respondents: Mass media influence, Shyness of adolescent children to divulge information and seek assistance on sex related problems, Ignorance of parents, teachers and children, Early pregnancies through unprotected sex, Infection with sexually transmitted infections, Peer pressure to involve in love affairs, Sexual harassment by their peers and adults, Distraction from learning, Unprepared ness for the immediate body

changes, Poor relationship with teachers and parents, Parental background, apathy and prejudices, Cultural factors that abhor, ignore, and make sexual matters secret, Problems of physical body changes and lack of protection, Limited time for discussion about sexual related matters, Parents' occupation and socio-economic factors and generally communication barriers between children and their teachers and parents

From a counselor's point of view, the problems adolescents face are: Identity role crisis – The adolescents think and want to be treated like adults, Pressure to relate with opposite sex, Quest for autonomy which the parents cannot provide, Rebellion against parents, Paying more attention to their peers than anybody else for advice, Undergoing rapid physical and emotional changes, Moods swing especially for girls, Many demands which cannot be met by parents and Curiosity to have sexual experience.

The Focus Group Discussions revealed that pre – marital sex is rampant among the early adolescents. The girls cited demand for money to buy cosmetics as a contributory factor and generally curiosity. Peer pressure, pornography and suggestive dressings were fronted by the boys as major factors contributing to pre – marital sex. The age of first sexual encounter varied from 8 – 12 years across the boys and girls. Majority confessed to having many sexual partners (2-5) despite being clearly aware of the implications. All of the respondents were aware of contraceptives but still did not use them during sexual encounter. They are also aware of HIV/AIDS transmission and prevention. The Focus Group Discussions also identified the media and the peers as the major source of information on sexuality. The parents and teachers are not consulted by the respondents due to fear and embarrassment. Most are easily misled for instance a 10year old said, "I is convinced to have sex so that I can be like God "

## 4.5 Challenges against effective participation of the family in sexuality and reproductive health among early adolescence

This section looks at the challenges against effective participation of the family and reproductive health

### 4.5.1 Family information sharing

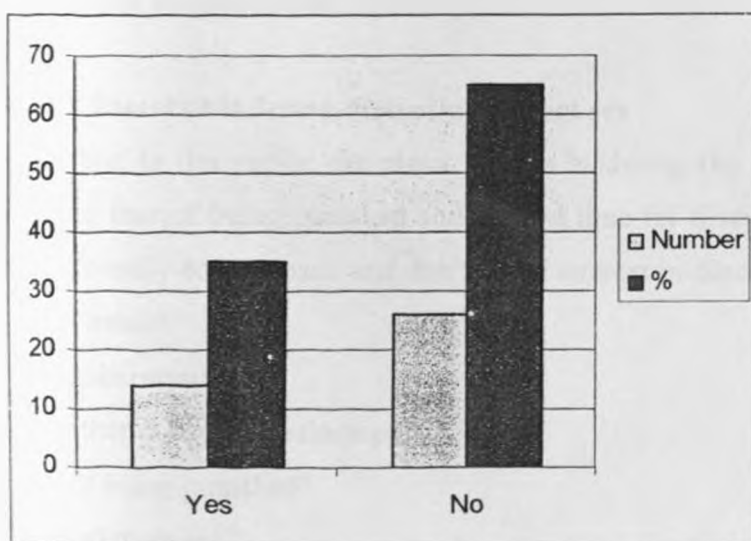
#### 4.5.1.0 Discussion of sex with parents

The respondents who revealed that they discuss about sex with their parents were only 35% while a clear majority (65%) did not discuss. The discussions were initiated by parents in almost all cases (92.9%).

**Table 4.14: Respondents report on discussion of sex with their parents**

Response	Number	%
Yes	14	35.0
No	26	65.0
Total	40	100.0

**Figure 15: Respondents report on discussion of sex with their parents**



According to the pupils and the parents the discussions focused on the following areas: Values of abstinence, HIV/AIDS, Dangers of irresponsible sexual behaviour, Unwanted

teenage pregnancies, Choice of friends, Sexual intercourse, Moral values, Abortion and Drug use

#### **4.5.1.2 Rating of discussions**

Asked what they liked about the discussions, the respondents said

“I like the encouragement to abstain for a bright future”

“I like being told to finish school and not get AIDS”

“I like the message about shunning bad friends”

“They tell me not to have a boy friend”

They were categorical that the discussions are informative and good in promoting moral integrity.

The respondents were further asked to list whatever they did not like about the discussions. They were quoted below:

“bad words”

“Being forced to admit that I have had sex”

“They don’t tell me the dangers of sex”

“They hide some information”

“The warning not be overtaken by peer pressure”

“Being told that sex is bad”

#### **4.5.1.3 Factors hindering discussions about sex**

According to the pupils; the major factors hindering the discussions is embarrassment, shyness, fear of being punished and lack of time for discussions. Others are the parents are unfriendly to approach and don’t have interest in discussions about sex. They were quoted below:

“It is embarrassing”

“My father doesn’t like the topic”

“Fear of being punished”

“It is bad manners”

“Parents can start quarrelling when I initiate the discussion”

“Parents have no time for discussion”

“I am not close to my father”

“The parents feel am too young and that knowledge will spoil me”

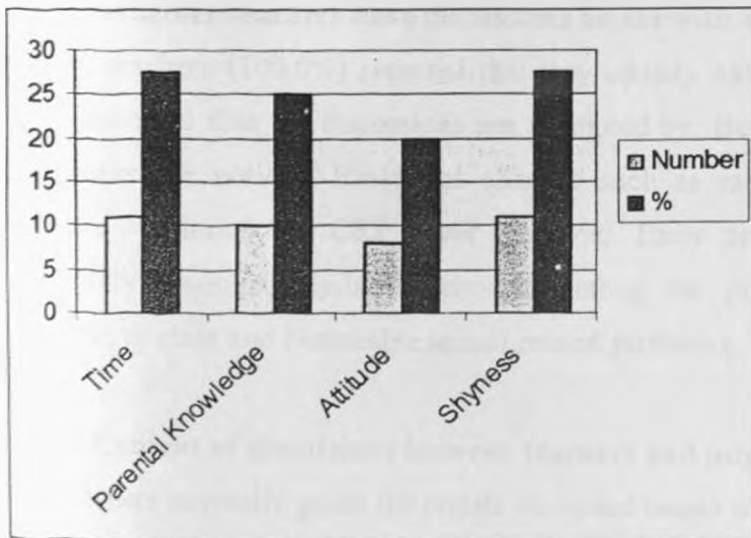
“I feel shy”

However, the parents cited time, parental knowledge, poor attitude and shyness as the major hindrances to discussions on sexuality. These are displayed in table 4.15 below:

**Table 4.15: Factors that hinder discussions of sexuality and reproductive health between parents and pupils**

Factors	Number	%
Time	11	27.5
Parental Knowledge	10	25.0
Attitude	8	20.0
Shyness	11	27.5
Total	40	100.0

**Figure 16: Factors that hinder discussions of sexuality and reproductive health between parents and pupils**



#### **4.5.1.4 Teachers opinions on discussing sexuality and reproductive health with early adolescents**

The teachers were very supportive of discussions with their students (10-15years) on sexuality and reproductive health. The following are their view points:

“It is best to discuss with them because being still an ignorant age, it requires us to guide and counsel them”

“Encourages good behaviour since the pupils are undergoing adolescence”

“It is healthy and useful; helps us to raise awareness to the youths on different functions of parts of their bodies and helps them take precautions.”

“It healthy due to vulnerability of the young adolescents”

“It is necessary to make them aware of STIs, AIDS, sexual problems and how to control themselves”

“It should be done by both teachers and parents because they will learn it somewhere else”

“It is very important since this age bracket is equally affected by AIDS”

“It should be freely and openly discussed for the purpose of awareness creation”

“It is very necessary as it helps them understand themselves sexually and know more about reproductive health.”

#### **4.5.1.5 Whether teachers have discussions on sex with the pupils**

All the teachers (100.0%) reported that they usually have discussions with the pupils. They indicated that the discussions are prompted by: Behaviour changes – some queer behaviours are noticed, Biological changes such as menstruation occurring in class, Syllabus – science and CRE cover the topic, Early pregnancies, Emerging cases of immorality amongst pupils, Misconduct among the pupils, Spillage of relationship problems to class and Noticeable sexual related problems

#### **4.5.1.6 Content of discussions between teachers and pupils**

The teachers normally guide the pupils on varied issues of adolescence; emphasizing on abstinence and generally how to take care of themselves during adolescent hood. The following areas are covered during the discussions as revealed by the teachers’

respondents: Drug abuse, Body and sexual behaviour changes in adolescents, Abstinence, Dangers of pre-marital sex, Preventive and control measures, Boy – girl relationships, Functions of reproductive organs, Menstruation, Masturbation, Sexually transmitted infections including HIV/AIDS, Handling of emotions during adolescence and Virtues and attitudes to develop towards social life.

A counselor noted the following as the challenges faced by the family in effective participation in sexuality and reproductive health: lack of awareness of the early adolescent stage, Parents negative attitude towards the needs of the child, Poor parent – child relationship, Lack of time for parents to talk to their children and do activities like cooking, singing and praying together, Inability by the parents to provide for the physical and socio-emotional needs of the adolescents and Rapid physical and emotional changes experienced by the adolescents at this stage.

The challenges hindering effective participation of the family in sexuality and reproductive health/problems are: Mass media influence, Cultural factors where communities detest discussing sexual matters, Peer influences override family ties, Lack of role models in churches, Occupation of parents and their socio-economic status, Poor relationship between parents and children, Family priorities such that time is not allocated of discussing sexuality and Parental knowledge and understanding of issues of adolescent sexuality.

#### **4.5.2 Mass Media Influence**

There is a high frequency of influence occasioned by the mass media on issues of adolescent sexuality and reproductive health. The radio, television, newspapers and literature including posters play a significant role in disseminating information. This includes the pornographic literature and suggestive adverts which arouse sexual feelings of young adolescents. Role models come from media characters and not from parents or other members of the community like teachers and religious leaders. In the words of Architect Buck minister television for instance has become “a third parent” in many American households and indeed this is a case in Kenyan households. The media in



Kenya is not properly censured and certainly provides information that exacerbates the already volatile problems of adolescent sexuality and reproductive health

#### **4.5.3 Poor relationship with parents and teachers**

According to the respondents, the children are afraid of their parents and fear punishment hence cannot discuss about sex. Many parents start quarrelling if their children initiate discussion on sexual matters. They exhibit general apathy towards the topic "Father doesn't like the topic". Moreover, they have no time for such discussions.

On the other hand some teachers harass pupils and they fear discussing any such matters with their teachers. Teachers explain that pupils are shy and not willing to open up.

This poor relationship portends disaster to the child who is compressed between a hard rock (at home) and a hard surface (at school). Whenever communication is smooth at home and at school, the child definitely benefits and may carry a discussion from school to home and vice versa in a perfect communication setting beneficial to child understanding sexuality and reproductive health.

Parents who subscribe to certain cultures/values will never discuss sexual matters with their children as it is considered a taboo. They are afraid of embarrassing themselves probably because they never got any talk about adolescence from their parents.

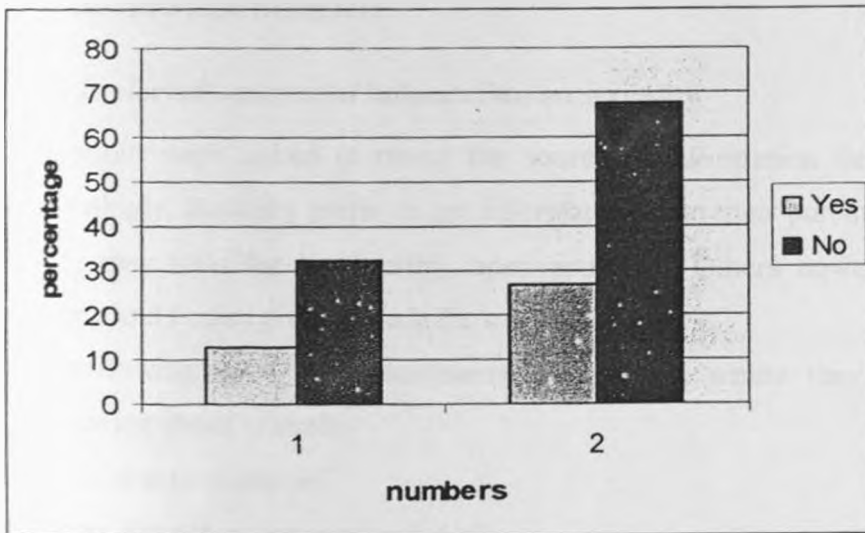
#### **4.5.4 Peer influences override family ties**

Majority have their sources of information as peers (friends) compared to those from family. Since their friends are also their peers, apparently peer influence overrides family ties. They explain that families have not time for them and don't explain well issues of sexuality. The youth decry lack of adequate information not only from parents but also from friends. 67.5% are not satisfied with the content of information they received with only 32.5% are satisfied with this information.

**Table 4.16: Respondents report on their satisfaction on the content of information they receive**

Response	Number	%
Yes	13	32.5
No	27	67.5
Total	40	100.0

**Figure 17: Respondents report on their satisfaction on the content of information they receive**



The respondents sought to explain why they perceive the content of information they receive as inadequate. They are quoted below:

“I am not told the impact of sex”

“The family doesn’t explain well”

“I normally have no time for the peers”

“Parents have never told me and they know more”

“They don’t go into details”

“Sometimes the content is not beneficial; they are just bad words”

### **Factors hindering smooth communication between teachers and pupils**

Age barrier, Unfriendliness of some teachers, Preference for advice from peers, Religious background, The pupils are shy, afraid and feel ashamed, The pupils fear being misinterpreted as engaging in premarital sex, Cultural factors which make sex issues a secret, Lack of proper knowledge by the teachers and parents, Poor approach by teachers and the pupils attitudes towards the teachers and parents

## **4.6 How families cope with sexuality and reproductive health challenges**

According to statistics, extracted from the respondents, families appear to be coping with challenges of sexuality and reproductive health challenges to a small extent and peers play the most significant role.

### **4.6.1 Preferred sources of information on sexuality**

The pupils were asked to reveal the source of information they would most prefer. Interestingly, majority prefer to get information from their parents and family members whom they consider trustworthy, open and wise. Others however, preferred friends, teachers and health professionals for varied reasons.

The following were their comments when asked where they would prefer to get information about sexuality.

“Family due to openness”

“Parents since they are wise and able”

“Parents because they are readily available”

“Parents because they can guide one well”

“Parents since they are trustworthy”

“Teachers and parents because they know about diseases”

“Teachers because they know more”

“School because friends lie”

“Newspapers because they are elaborate”

“Health professionals since they are trained and therefore more knowledgeable”

“Friends since am afraid of my father, they are more open”

#### 4.6.2 How teachers cope with sexuality and reproductive health challenges

Faced with numerous problems of adolescent hood, the teachers devised the following is to address the problems. Offering guidance and counseling, Offering AIDS education and community discussion, Being open to the pupils and facing realities of what affects them sexually, Creating awareness on challenges of adolescent hood, Creating friendly atmospheres with the children, Establishing a counseling team of trained teachers, Promoting formation of health clubs where pupils discuss amongst themselves, Sensitizing parents to be open with their children, Facilitating behaviour change, Infusing counseling measures in lessons and introducing straight talk discussions between teachers and pupils

A counselor proposed the following as the possible solutions to sexuality and reproductive health challenges: offer intensive guidance and counseling to enable the adolescents cope with the challenges, engage the early adolescents in co-curricular activities such as drama, music and church activities, engaging them in debates about sexuality and HIV/AIDS with their peers, parents should take time with their children and share ideas or activities with them, avoid caning unnecessarily but instead correcting them with love and not through coercion or threats, parents should try to make the children comfortable as much as they can afford and listening to their concerns and providing answers to their questions

**Table 4.17: The rating of usefulness of parents, health professionals, religion and family members in helping the adolescents cope with sexuality and reproductive health challenges**

	Very useful	Fairly useful	Not useful	Don't know	Total
Parents	12 (30.0%)	8 (20.0%)	20 (50.0%)	-	40 (100.0%)
Health professionals	8 (20.0%)	8 (20.0%)	24 (60.0%)		40 (100.0%)
Religion	2 (5.0%)	18 (45.0%)	15 (37.5%)	5 (12.5%)	40 (100.0%)
Other members of the family	11 (27.5%)	11 (27.5%)	15 (37.5%)	3 (7.5%)	40 (100.0%)

#### 4.6.3 Suggestions of the Key informants on how to cope with Sexuality and reproductive health challenges amongst the pupils

Some committee members, chiefs and local city education director were interviewed to capture their views on early adolescent sexuality and reproductive health. They noted that high cases of school drop outs in the area are due to teenage pregnancies. They attributed the rising case of pre marital sex on: Bad company the children are getting involved in, Poverty in the area; thus the girls especially engage in commercial sex to get money, Curiosity among the adolescents and parental neglect; the parents are not free to talk to their children about sex.

They gave the following preventive measures to arrest the prevailing situation: parents to act as role models to their children, Massive sensitization on effects of drug abuse, counseling panels should be introduced in schools and introduction of feeding programs in schools to capture the children and also prevent it being abused as an avenue for sex for food.

The peers have the greatest influences on issues of sex related matters. Their limited knowledge is considered more useful than parents input, health professionals and other members of the family. There is need to utilize this influence positively through peer education.

Although peers have the greatest influence, parents also have influences despite the shortcomings already discussed. Not only parents have limited knowledge and time for their adolescent children. The home environment is controlled by parents who act as role models. Parental religious affiliation turns out to be that of their children usually. The impact of religion cannot be overlooked as it includes young and old alike. Faithful strict followers of religion abstain from premarital sex and preach faithfulness in marriage. Multiple sexual partners is also discouraged in Christianity which is dominant (95.6%) and only (4.4%) which condones polygamy up to the fourth wife. None of them encourages premarital sex hence adolescent involvement in sex is condemned. The other members of the family equally play a significant role as models. However it is difficult to

effectively evaluate the percentage influence of the media versus the family peers, religion and significant others

Finally health professional through non – governmental organizations and ministry of health play a significant role in disseminating crucial information to the public concerning sexuality and reproductive health matters. The seminars and public awareness campaigns by health professionals cannot be overlooked. What remains to be done is the censorship of media against proliferation of adverse seductive literature and adverts that arouse young adolescents' sexual feelings. Posters and pornographic literature that portray sexual relationship with opposite sex as symbols of success are flawed and require banning or regulation. Government policies must be geared at providing sound adolescents sexuality and reproductive health.

## CHAPTER FIVE

### 5.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 Discussions and specific conclusions from the research findings

##### 5.1.1 Early adolescence and their families level of understanding in sexuality and reproductive health

The results of this study show that a majority of parents are not aware of their children's needs at the stage of early adolescents. This is corroborated by the pupils who contend that the information is inadequate. They claim whatever content given is not beneficial to them and is not detailed enough. What is striking is that 67.5% of respondents are normally not satisfied with the content of information received from friends, parents and teachers.

Moreover, cultural factors act as a barrier to dissemination of full information to the children. The breakdown of traditional set up has compounded the problem. The majority of the parents are young since (92.5%) were born fifty years ago when the traditional order had broken down. Their level of education of secondary (97.4%) does not provide them with additional knowledge in the fields of children behaviour at varied age levels, a key factor in understanding sexuality and reproductive health among early adolescents.

The family is therefore perceived to have a limited understanding of adolescent sexuality because of social-cultural factors such as traditional taboos against the discussion of sex, being victims to modern age when sex discussions are shameful to parents, time constraints and adolescents over-reliance on their equally ignorant peers for information. This creates a cycle of limited information especially among the literate and semi-literate who have never participated in education at post secondary and college levels. No doubt the grave consequences include HIV/AIDS spread among the slum population, unexpected pregnancy at adolescent, premarital sex (77.3%), STI's and sometimes death of the productive population. There is need for dissemination of relevant knowledge and information to not only children at adolescent stage but also their parents and teachers to ensure the cycle of triangular awareness is completed among the school teachers, home parents and adolescent children.

### 5.1.2 Problems of adolescent sexuality and reproductive health at family level

This study sought to unearth the myriad problems encountered at this stage of adolescent to merit the study and possible solutions. The problem of access to seductive literature at an early age through mass media cannot be overemphasized. The study showed that the adolescent is exposed to radio, television, newspapers and pornographic literature that provoke an early awareness of sex without providing controls and checks. Whereas the parent is shy to explain the dangers of premarital sex due to traditional (cultural) taboos and ignorance, the adolescent friends pass on their limited knowledge and influence to their friends who engage in sexual intercourse even before reaching puberty. Worse still, according to the research adolescents are more likely to listen to their peers than parents, health professionals, religious teachings and other members of the family. Apparently they perceive parents as prejudiced about their sexual matters, have limited information and unconvincing.

They indulge in premarital sex resulting in early pregnancies, STI's, HIV/AIDS and death. There is no mention of use of female condoms and 91.7% of respondents who had sex never used a condom.

Sexual affairs distract the adolescent from pursuing his/her studies. The physical changes in the body catch the adolescent unawares prompting need to suddenly adjust or sail in imminent adolescent confusion. When he/she is aware of potential changes, adjustment becomes easier as opposed to lack of information and total disregard for adolescent plight.

Furthermore poor relationship with parents and teachers dearly costs the adolescents important sources of information. Some parents and teachers are shy to address the topic just like the adolescent pupils. Parental background and apathy denies him/her a relevant source of information at home. The study reveals that some parents derive income from commercial sex and are least bothered explaining dangers of sex and virtues of responsible sex in adult marital stage.

In addition, cultural factors have been cited as a major contributing factor inhibiting access to information. Sexual matters are considered a secret and adolescents fear asking questions lest they are labeled as sexual perverts. In fact, some parents' occupation with seeking for income in self employing jobs that are low paying exacerbates the already



fragile situation for adolescents. All the time is devoted to fending for family basic needs. The majority (7.9%) are involved in informal labour and devote little or no time to counseling. Most of them (51.4%) have never discussed sexual matters with their parents. The adolescents are more satisfied with information received from their friends. In this kind of scenario, they tend to ignore counsel not only from their parents and teachers but also neglect counsel from health professionals, religious leaders and other members of the family.

### **5.1.3 Challenges hindering effective participation of the family in sexuality and reproductive health**

In this study the mass media is cited as playing a significant role in adolescent sexual matters. Since he/she is more exposed to the mass media it effectively replaces the parent and teachers who have limited time. This age of information explosion provides a lot of information to slum dwellers and urban inhabitants alike. The radio, TV, newspapers and posters are the most common sources. These adolescents passively and actively acquire ideas on sex. Their peers who acquire this understanding pass it on to their friends who internalize and practice it. The leaders and health professionals, who rarely approach the adolescents on this important issue, have their efforts ignored by the adolescents. It is not clear from the study why adolescents are not satisfied with the content provided by health professionals. Apparently these youngsters develop a negative attitude to those likely to deny them what they refer to as fun and pleasure. They simply want to have experience and sometimes to please their partner.

Moreover, they lack role models in their teachers and parents who they accuse of high handedness, prejudice and creating fear. Some parents clearly detest discussing the topic while others ply their trade in commercial sex. The family has hardly prioritized the discussion of sexuality and reproductive health as an important issue. This state of indifference and apathy could partly be induced by ignorance or being an ardent subscriber to cultural taboos against discussing sexual matters. The school and home environment do not provide a conducive atmosphere for enabling easy access to information on adolescent sexual status. The child is more at school than home yet

teachers are not playing a significant informative role. Time restrictions and unavailability deals a major blow to ensuring adolescent sexuality and reproductive health issues are comprehensively accorded due attention. The helpless adolescents eventually bear the adverse consequences of contracting diseases, unexpected pregnancies with irresponsible peers and likelihood of drop outs from school.

#### **5.1.4 How Families cope with sexuality and reproductive health challenges**

In this study, the families tend to play a dismal role in helping adolescents to cope with challenges of sexuality and reproductive health. This is attributed to a number of factors including time availability by parents, parental background, their occupation and cultural taboos that consider sex matters as secret.

In this study it becomes clear that adolescents are willing to listen more to their peers and peer education is encouraged. Parents, health professionals and significant other members of the family also provide useful information on sex related matters although adolescents consider their output as little compared to the contribution of their friends.

The teachers tend to play their role of guidance and counseling, formation of health clubs, encouraging pupils to be free, open and face reality, sensitizing parents to be friendly to their children and initiating peer education. Teachers also infuse issues related to adolescent sexuality in their lessons and provide individual counseling when such matters arise. In fact schools also provide HIV/AIDS awareness education and implementation.

Since pupils spend 75% of their valuable time in school, the teachers play a key role on issues of adolescent sexuality and reproductive health challenges. Many families abdicate this noble responsibility to schools and yet it is expected to be a concerted effort between parents, teachers and peer educators. The unfriendly relationship existing between the adolescents and their teachers, adolescents and their parents must first be overcome to enable all these players effectively tackle the challenges of adolescent sexuality and reproductive health.

The health professionals have to step up their campaigns even using mass media which has a significant influence on adolescent sexuality. Literature, posters, radio, television, and newspapers are useful tools in disseminating information and must be utilized by

health professionals, social workers, parents and educators to pass relevant information on adolescent sexuality. In mass media influence on adolescent sexuality has been experienced and recognized.

## **5.2 Summary and Conclusions for this study**

Relevant studies carried out in Kenya have identified the need for families to understand the problems and challenges of early adolescents, on sexuality and reproductive health issues. It has become very clear that girls and boys engage in sexual relationships even before reaching puberty. The majority (61.9%) had not started menstruating at the time of engaging in sexual relationship where 22.7% had started having sexual intercourse. The study also explored how families cope with adolescent sexuality and reproductive health problems

The following research objectives were thus addressed:

- Investigate the family level of understanding of sexuality and reproductive health among early adolescents.
- To find out the nature of problems of sexuality and reproductive health as experienced by early adolescents at the family level
- Examine the challenges hindering effective participation of the family in sexuality and reproductive health
- Determine how families cope with sexuality and reproductive health problems/challenges.

The study is not only a qualitative but also a quantitative study. Data were collected from Focus Group Discussion, a survey by use of questionnaires and content analysis. The focus discussion group provided information about perceptions, feelings, opinions and attitudes concerning issues of adolescent sexuality and reproductive health

Descriptive survey is useful in revealing knowledge and attitudes of not only adolescents towards reproductive health, but also teachers and parents contribution towards adolescent sexuality and reproductive health problems/challenges.

The study targeted early adolescents at 10-15 years in slum areas of Kisumu (Buoye,

Kanyamedha and Nanga) Kisumu is a cosmopolitan city housing almost all social, cultural, economical and religious groups in Kenya. Purposive sampling is used to select that participating schools in the slum settlements.

### Conclusions

It has been noted that the family have inadequate information concerning adolescent sexuality and reproductive health issues due to educational, social, cultural, economic and religious constraints. The information available to them is scanty and they are normally not satisfied with the content. The adolescents appear to dismiss their parents, health professionals, religions and significant others as providing inadequate information that cannot enable them cope with sex related matters. The majority appear to endorse their peers as providing useful information in helping them cope with sex related matters. This information seems inadequate and in helping them to understand and implement the use of condoms for preventing STI and HIV/AIDS. The majority did not use condoms and appear to suggest they are for male adults or married people only.

Adolescents have mentioned the mass media predominantly as sources of information about sex issues, radio, newspapers, television, posters and literature. However, they are dissatisfied with the content. These sources of information including the family and friends do not provide sufficient relevant information to enable them to cope with the problems/challenges of adolescent sexuality. Parents are roundly blamed for passing inadequate information. Some of the parents are too harsh to approach. Poor parent/adolescent relationship is a deterrent to free reception of the message on adolescent sexuality.

Moreover, parental ignorance, social –cultural attitudes and economic status contribute significantly to problems of adolescent sexuality. The young parents are not socialized on issues of adolescent sexuality; hence hardly attempt to tell their children. The nature of their employment in slum areas dictates that they devote all their time in search of income. No time is spared for talking to early adolescents concerning sexual related matters. Many are willing to listen to their parents as a source of information. Sex matters

are also treated as secret in most communities. Teachers similarly view themselves unable to effectively assist the adolescent because of poor teacher/ pupil relationship. They fear harassment by teachers and consider age barrier as blocking smooth communication between the teachers and the pupils. Some teachers have limited knowledge due to unavailability of induction courses. Pupils are shy and unwilling to discuss sex issues. The issue of child upbringing environment is used to explain whether child will communicate freely or shy off.

### **5.3 Implications and Recommendations for the study**

The study findings have vital implications in the different fields of social, cultural, legal, educational and economical domains.

#### **5.3.1 Social Implications to the prescription of Social action**

The results of this study showed that the home and school environment play a significant role in socializing the early adolescent in matters of sexuality and reproductive health. The cordial relationship of the adolescent with his/her parents is inevitable if information on sex related issues is to be internalized and utilized positively. Besides, teachers ought to cultivate smooth communication channels with adolescents in order to instill a sense of responsibility and discipline in the mind of the adolescent as a preventive measure.

Another vital implication of the study is the relatively high esteem bequeathed to friends (peers) in delivering their half baked content to their peers. They show approval of the information on sexuality delivered by their friends.

#### **5.3.2 Cultural implications to proposed remedial measures**

A typical past society regarded sex as a taboo among unmarried young people. Talk about sex is preserved for initiation ceremonies when mature males and females were preparing to take adult roles. The admission of sexual intercourse at early adolescent even before menstruation is a recent phenomenon that surpassed cultural imaginations. The drift to sexual intercourse irrespective of age and gender reflects the breakdown in

traditional family systems and increased risks of STIs including HIV/AIDS among adolescents. Furthermore the study showed that few adolescents use protective gadgets like condoms and are at risk of pregnancy. This view is confirmed in other studies (Kiragu, 1991; Mc Camler and Salter, 1996; Kiragu and Zabib, 1995).

Young people are increasingly usurping the adults preserve and indulging in sex unrestricted due to breakdown of traditional order, media adverts, freedom and family communication. Parents lack time to educate their children on adolescents' sexuality and reproductive health. The adolescents propagate abstinence theoretically but practice sex at an early adolescent stage for various reasons ranging from forced, fun, pleasure, and to please their partners notwithstanding the risks. Social and religious groups should intensify efforts to teach young people moral values because families have played a dismal role in addressing adolescent sexuality and reproductive health issues. Music which is loved by the youth could be used as an important tool of socialization to decry moral decadence and teach vital issues concerning sex related matters among adolescents.

### **5.3.3 Legal Implications on Enforcement of Legislation**

The study reveals that mass media sourced of information like radio, television, newspapers, pornographic literature and posters play a major role in socializing youth to practice sex at early stages. This deterrent measures through acts of legislation regarding pornography and seductive adverts.

The following measures are therefore recommended for action:

- Legislation and enforcement in cases where relevant legislation exist regarding pornographic and seductive adverts, they should be strengthened.
- The media council must be pressurized to self-regulate and censure its own operations to safeguard the morals of the adolescents and youth in general.
- Banning television channels that broadcast seductive literature. The information explosion through internet sources might be hard to ban. However, radio channels, newspapers and television stations can be forced to broadcast favourable ideas

- Establishment of guidance and counseling centers accessible to the public at subsidized rates. It should be a government policy to establish and finance such centers in order to bridge the gap created by poor communication with parents at home and teachers at school.

#### **5.3.4 Educational Implications**

The study revealed that peers of the adolescents played a key role in influencing their understanding of adolescent sexuality and practicing sex at that early stage. This poses great risk to this young age group since their peers don't have substantial adequate information on issues of sexuality and reproductive health. Consequently, there is a need to establish and reinforce peer education programmes.

According to this study, the adolescents conceded that information provided by peers is very useful (55.6%) and not useful (26.7%). The existing mistrust between adolescents and their parents, poor regular communication on adolescent issues and socio-cultural impediments imply that peers should be empowered to influence fellow friends in order to effectively overcome the challenges posed by mass media sources. The health professionals according to this study are only 18.2% considered very useful and not useful (59.1%). This reinforces the need to make greater use of peer education to stem this challenge. This can be initiated in schools and any organized social groups.

Any sex education inclusion in the syllabus programmes should target male and female adolescents alike as both sexes are affected. The relevant information should be incorporated as an integral part of the curriculum. There is a great need of training teachers, social workers, parents and youth on issues of adolescent sexuality and reproductive health matters.

### **5.3.5 Recommendations for further research and Implementation**

- Research should be intensified on family communication between adults and adolescents concerning sexuality and reproductive health in urban areas.
- Devise ways of improving health education to enhance understanding and practices on sex related issues and reproductive health among early adolescents.
- Government should enact laws governing sexual education and reproductive health.
- The role of the media in enhancing adolescent sexuality and reproductive health should be investigated.
- Determine and initiate relevant poverty eradication programmes among commercial sex workers to provide alternative sources of income thereby free families to discuss sexuality and reproductive health matters.
- Find out the impact of mass media censure in controlling sex among adolescents in urban areas.
- Replicate a similar study on a wider scale to cover urban areas and slums in other cities for effective comparison.



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## **APPENDICES**

**Appendix 1: School Questionnaire**

**Appendix 2: Household Questionnaire General Information**

**Appendix 3: Teachers Questionnaire**

## Appendix 1: School Questionnaire

### THE ROLE OF THE FAMILY IN EARLY ADOLESCENCE SEXUALITY AND REPRODUCTIVE HEALTH IN KISUMU SLUMS

#### Identifying variables

Zone	Name	Code
School	_____	_____
Student No.	_____	_____
Respondent Name	_____	_____
Date	_____	_____
Enumerators name	_____	_____

#### Socio-demographic profile

1. Sex of the respondent (observe)

Male

Female

2. How old are you? (list the exact no. of years between 10-15)

3. Where do you live?

4. What classes are you in?

5. what religion affiliation do you belong to

Catholic

Protestant

Muslim

None

Others (specify)

6. Which type of family are you coming from?

Monogamous

Polygamous

7. Are your parents still alive and staying together?

Yes

No

8. If No explain

9. How many are you in the family?

If more than one what born are you?

1<sup>st</sup>

2<sup>nd</sup>

3<sup>rd</sup>

4<sup>th</sup>

5<sup>th</sup>

6<sup>th</sup>

10. What do your parents do for a living?

Employed

Business

Informal labour (jua kali)

**Knowledge, Attitude & Practice**

11. What do you understand by the term sexual intercourse?

12. What are some of the dangers of having sex before marriage?

Unwanted pregnancy

Sexually transmitted diseases

Interference with education

Others specify .....

13. Have you ever heard about condoms?

Yes

No

14. If yes what are they used for?

Family planning

Prevention of STDs including HIV/AIDS

Others specify .....

15. Where can we obtain condoms?

16. Who should use a condom?

17. What is AIDS?

18. How do you think people get AIDS?

19. Can one do anything to avoid AIDS/HIV, what can we do?

Sex Experience and Practice

20. If female ask if she has started menstruating

No

Yes

21. What is the cause of the menstruation?

22. Have you ever had sexual intercourse?

No

Yes

23. Why did you have it?

Forced

Fun

Money

Experience

Wanted to please partner

Cheated

Wanted to know how it feels

Others specify

24. With a person of what age? Give specific age

25. How is it?

Enjoyable

Painful

Others (specify)

26. During the sexual intercourse, did you use a condom?

Yes

No

27. Have you ever suffered from STD?

Yes

No

b) If yes, whom did you seek advise from?

Health personnel

Parents

Friends

Class teacher



**Family information sharing**

28. Do you ever discuss with your parents about sex?

Yes

No

29. If Yes who initiates such kind of discussions?

30. What exactly do you discuss about?

31. What do you like about the discussion?

32. What don't you like about the discussion?

33. If No to Question 27, what hinders you from discussing about sex with your parents?

34. What are your **main sources** of information about sex issues?

Medical practitioner (doctor, nurse)

Radio/TV/Video

Newspaper

Community meeting/chiefs baraza

Poster

Neighbours

Church

- Friends
- Family
- Others (specify)

35. What content do you receive from the sources mentioned?

36. Are you normally satisfied with the content?

- Yes
- No

37. If no, why?

38. Where would you prefer to get information about sexuality & why?

39. How useful are the following in helping you cope with sex related matters?

	Very	Fairly	Not	Don't know
Parents				
Health professionals				
Religion				
Peers				
Other members of the family				

**Appendix 2: Household Questionnaire General Information**

**THE ROLE OF THE FAMILY IN EARLY ADOLESCENCE SEXUALITY AND  
REPRODUCTIVE HEALTH IN KISUMU SLUMS**

Household Questionnaire general information

Questionnaire household code \_\_\_\_\_

Enumerators name \_\_\_\_\_

Date of interview \_\_\_\_\_

Day / Month / Year

Respondent name \_\_\_\_\_

Age \_\_\_\_\_

Gender \_\_\_\_\_

Occupation \_\_\_\_\_

Area of residence \_\_\_\_\_

**Household background information**

Q1. Can you read and write?

Yes

No

Q2 If yes, what is the highest level of education you attained?

Primary

Secondary

Post secondary

Others (specify)

Q3. List the names, ages and gender of all H/H members?

a) Ask if they ever discuss about sex in the family

b) Ask questions and fill in incidences of family discussion about sex in the past 3 months

H/H Member Name	Sex	Age	Has this H/H member been talked to about sex in the past 3 months

Q4. What exactly is discussed?

- Sex
- Teenage pregnancy
- Abortion
- Drug use & Violence
- HIV/AIDs

Q5. If No, what are the hindering discussions between parents and the pupils factors?

- Time
- Parental knowledge
- Space
- Attitude
- Shy

**Appendix 3: Teachers Questionnaire**

**THE ROLE OF THE FAMILY IN EARLY ADOLESCENCE SEXUALITY AND REPRODUCTIVE HEALTH IN KISUMU SLUMS**

**Questionnaire for teachers**

**Background information**

Name of school \_\_\_\_\_

Zone \_\_\_\_\_

Respondent \_\_\_\_\_

Gender \_\_\_\_\_

Date \_\_\_\_\_

Enumerator \_\_\_\_\_

Q1. What is your viewpoint about discussing sexuality and reproductive health to early adolescents of 10-15 years of age?

.....  
.....

Q2 Do you ever have such discussions?

.....  
.....

Q3. If yes, what prompts such discussions?

.....  
.....

Q4 What is normally discussed?

.....

.....

Q5. Do your pupils normally seek advises from you whenever they are faced with sexual related problems? Please explain nature of problems.

.....

.....

Q6. What are some of the factors hindering smooth communication between the teachers and the pupils on this subject?

.....

.....

Q7. How have these problems been addressed?

.....

.....

## Appendix 4: OBSERVATION GUIDE

### THE ROLE OF THE FAMILY IN EARLY ADOLESCENCE SEXUALITY AND REPRODUCTIVE HEALTH IN KISUMU SLUMS

1. Name of school .....
2. Availability and quality of buildings and facilities
  - a) Classrooms: number available ..... condition/state (temporary, permanent, falling walls).
  - b) Toilets/Ablution block
  - c) Administration block
  - d) Staff houses
  - e) Store
  - f) Library
  - g) Playing field
3. Other facilities in the school: play field for boys and girls – games and sports available in the school.
4. Toilets – state of toilets greatly affect girls education. number of toilets for girls and number for boys and their orientation i.e. where are girls toilets facing and how far from the boys. Do they have a shutter? If no toilets, where do they go?
5. Water – source? Safety, storage
6. Describe the state of floor, materials used to construct, describe classrooms roof – hall? Does it leak during rainy seasons?
7. Windows – if any, shutters?
8. blackboard – is it there, type/condition
9. Availability of teaching aids/charts and other displays on the wall to make it learner friendly environment – if blank its not stimulating
10. availability of textbooks, pupil: textbook ration
11. Sitting arrangement – how many number on share sit, are girls sharing desks with boys.
12. Number of pupils present i.e. boys and girls.

13. Number of pupils on register (spot check, look at register)
14. Get average attendance for week (1-5) for boys and girls. See whether register is marked, if so, up to when?
15. Average pupil's age in standard 1 for boys and girls. Get the oldest and the youngest for boarding, and youngest-oldest in nursery/ECD.
16. General pupil appearance- clean, neat, well groomed?
17. Note pupil's health – well nourished? Are they happy?
18. Observe pupil teacher interact.
19. Security – is the school fenced? State/ type of fence.
20. Surrounding – is it well kept, safe?



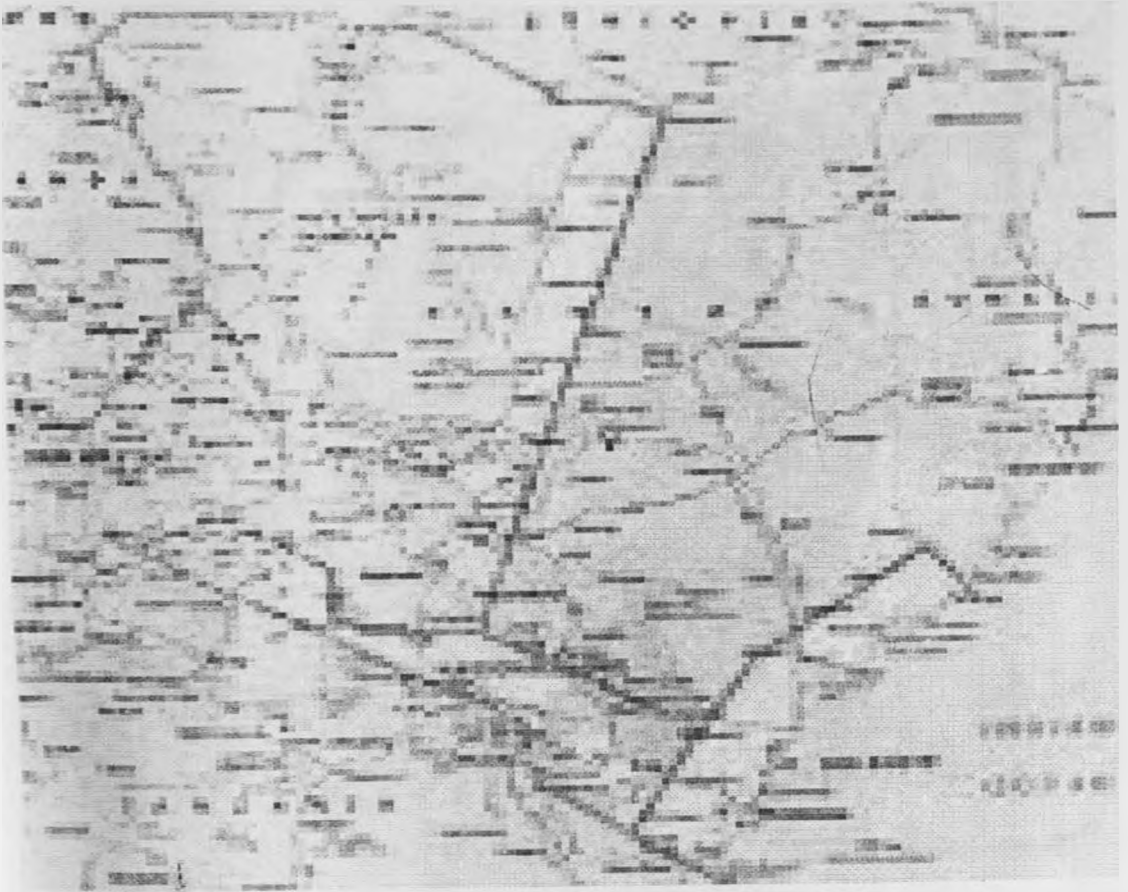
## **APPENDIX 5: INTERVIEW GUIDE FOR COUNSELOR**

1. What are the some of the problems of adolescent in the family
  
2. What are the possible solutions?
  
3. what challenges does the family face against effective participation in sexual and reproductive health among adolescents?

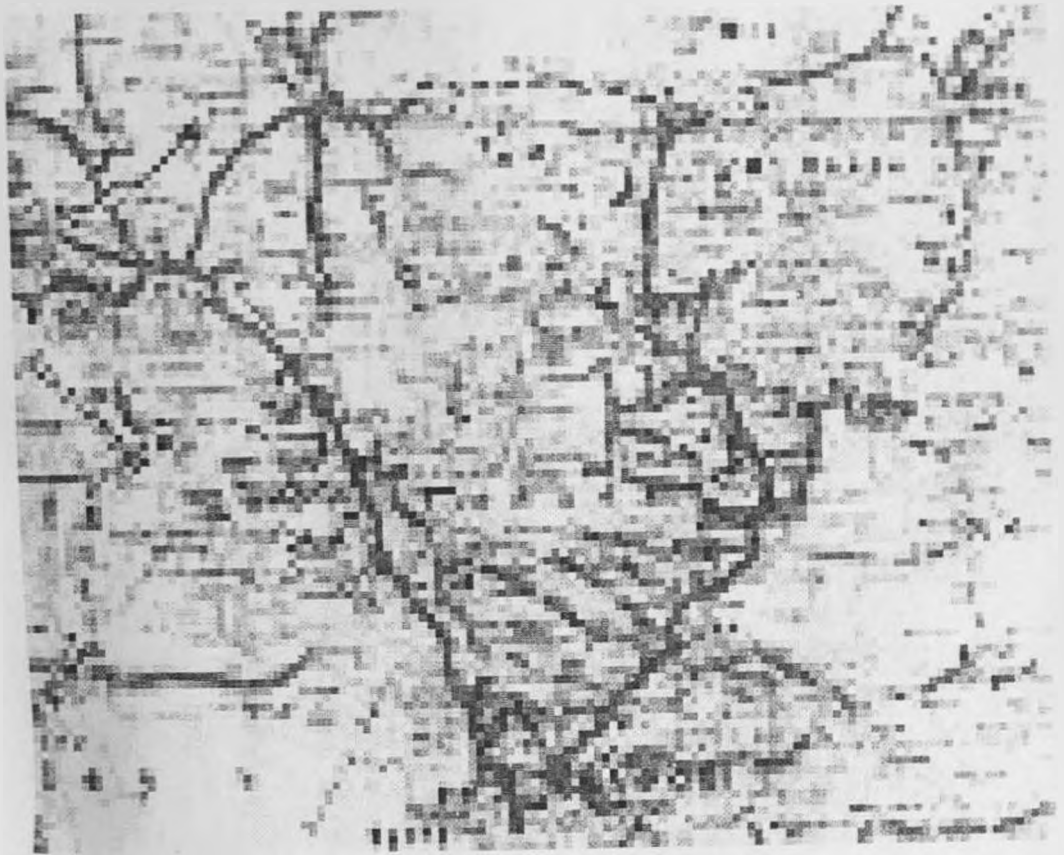
## **APPENDIX 6: FOCUS GROUP DISCUSSION GUIDE**

1. what are the factors contributing to pre-marital sex
2. age of first sexual intercourse
3. use of contraceptives /types
4. number of sexual partners
5. awareness of HIV/AIDs
6. Parents and family involvement in sexual education/parent -child communication?
7. When did you start dating?
8. sex education
9. role of mass media and other source of information
10. Role of society and customs in sexuality?
11. Problems experienced by adolescent.

**Appendix 7: MAP OF KENYA**



Appendix 8: Map of Kisumu



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JOM

NYATTA MEMORIAL  
LIBRARY