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# RISKY SEX: How Cultural Norms Regarding Sexuality Inhibit Condom Use Among Kenyan Youth

Collins Kyeremeh  
*University of Windsor*

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**RISKY SEX: HOW CULTURAL NORMS REGARDING SEXUALITY  
INHIBIT CONDOM USE AMONG KENYAN YOUTH**

**By  
Collins Kyeremeh**

A Thesis  
Submitted to the Faculty of Graduate Studies  
through Sociology  
in Partial Fulfillment of the Requirements for  
the Degree of Master of Arts at the  
University of Windsor

Windsor, Ontario, Canada  
2009  
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**RISKY SEX: HOW CULTURAL NORMS REGARDING SEXUALITY  
INHIBIT CONDOM USE AMONG KENYAN YOUTH]**

By

**[Author: Collins Kyeremeh]**

APPROVED BY:

---

[Dr. Wansoo Park]  
[Social work]

---

[Dr. Eleanor Maticka-Tyndale]  
[Sociology and Anthropology]

---

[Dr. Danielle Soulliere]  
[Sociology and Anthropology]

---

[Dr. Karen Engle]  
[Sociology and Anthropology]

## **Author's Declaration of Originality**

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## **Abstract**

Amidst high rates of HIV infection in sub-Saharan African communities, it would seem that most new HIV/AIDS infection cases in Kenya occur among young adults and adolescents. Despite the implementation of numerous AIDS education campaigns and condom distribution programs, it would appear that, for these young people especially, the risk factors are associated primarily with lower levels of AIDS- related knowledge and attitudes towards using condoms. The purpose of this research is to study the way in which cultural norms regarding sexuality and gender might contribute to risky sexual practices among Kenyan youth. To gain a better understanding of these cultural norms, thematic secondary analysis of data collected as part of the evaluation of the Primary School Action for Better Health (PSABH) programme was carried out with particular attention given to focus group discussions among primary school pupils aged 11 to 16 regarding Kenyan socio-sexual scripts and how these scripts may inhibit condom use and thus increase HIV risk. It is anticipated that a better understanding of cultural norms and how they may affect young people's sexuality will allow for the development and implementation of more effective policies and programs to combat HIV in Kenya.

## **Dedication**

This dissertation is dedicated to my wonderful fathers, Mr. Obed Kyeremeh and Mr. A.K Gyamfi, who have been supportive and encouraging of me over the years. Gentlemen, you are the best dads ever. I will also like to dedicate this to my favourite teacher, Dr. Kimberley Ducey. You may never know the impact you have had on me, but I would not be here if you had not encouraged the desire to seek higher education. A great teacher's work goes beyond the classroom and yours definitely went miles beyond University of Windsor campus.

## **Acknowledgment**

As Isaac Newton once said, "if I have seen further, it is because I am standing on the shoulders of giants." If today I have made it this far academically, it is not by virtue of any sharpness of sight on my part, or any physical distinction, but because I am carried high and raised up by the giant size of those on whose shoulders I have been carried thus far. So I will like to take this time to acknowledge the giants in my life who made this dissertation possible. I will like to express a big Hearty thank you to Miss Charity Osei Bonsu for sticking with me through thick and thin. Maame Akua, thank you. To my grandmother, madam Lydia Osei (ante Akua), I say thank you for seeing the speck of light in me when I couldn't see it myself and for nurturing it. To my mothers Comfort Kyeremeh, Grace Gyamfi, and madam Afia, I say well done. Where would I be without you? More importantly, this dissertation could not have been written without Drs. Danielle Soulliere, Eleanor Maticka-Tyndale and Wansoo Park who encouraged and challenged me throughout my academic program. They patiently guided me through the dissertation process, never accepting less than my best efforts. Thank you all ladies for your support.

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## **INTRODUCTION**

New global HIV infections and mortality are declining and the prevalence of HIV levelling. The current estimate of 33.2 million [30.6 – 36.1 million] people living with HIV replaces the 2006 estimate of 39.5 million [24.5 – 47.1 million] (UNAIDS/WHO, 2007, p. 1). In sub-Saharan Africa, an estimated 1.7 million [1.4 – 2.4 million] people were newly infected in 2007; a significant reduction since 2001 (p. 8). Cote d'Ivoire, Kenya and Zimbabwe, among others, have all seen downward trends in their national HIV prevalence (p. 6). In spite of the downward progression of HIV prevalence in the African sub-region, Sub-Saharan Africa remains most heavily affected by HIV, accounting for 67% of all people living with HIV and for 72% of AIDS deaths in 2007 (UNAIDS, 2008, p. 5). Preliminary data also show favourable changes in risk behaviour among young people in a number of countries, such as Botswana, Cameroon, Chad, Haiti, Kenya, Malawi, Togo, Zambia, and Zimbabwe (UNAIDS/WHO, 2007, p. 14). Some credit this changing trend to the HIV education and condom distribution programs that are in place around the World (UNAIDS, 2008, p. 3). For example, UNAIDS believes that “a six fold increase in financing for HIV programmes in low- and middle-income countries 2001–2007 is beginning to bear fruit, as gains in lowering the number of AIDS deaths and preventing new infections are apparent in many countries” (p. 3). They caution however that there is “the need for intensified action to move towards universal access to HIV prevention, treatment, care and support” (p. 3). The idea is that once people are aware of the fatal nature of AIDS and how to protect themselves, they will change their sexual behaviour and adopt safer sex. For instance, in her study on whether education had influence on mother-to-daughter sex education in urban Kenya, Mbugua (2007, p. 1079) argued that “educated” people are highly likely to avoid risky sexual behaviours and to pass on their education to their children, thereby protecting entire

families from the disease. This belief has led to the mushrooming of HIV education programs across Africa. Indeed, results of an extensive research project show a high awareness (97% of respondents) about HIV and AIDS in sub-Saharan Africa (Hartell, 2005, p. 172).

However, numerous studies have revealed that socio-cultural norms, religious doctrines, poverty and lack of education have and continue to hamper the effectiveness of the implemented HIV prevention programs such as condom education, distribution campaigns and HIV education (Bosmans et al, 2006; Luke, 2006; Maticka-Tyndale et al., 2005). It would seem that knowledge does not directly translate into behaviour changes. Numerous studies reveal that, despite a high knowledge of sexual risks, fear of HIV/AIDS and awareness of the protective value of condoms, adults and young people still exhibit high risk sexual behaviour (Dunkle et al., 2004; Maticka-Tyndale et al., 2005; Swidler & Watkins, 2007; Tillotson & Maharaj, 2001; Zellner, 2004). For instance, while it is common knowledge that short of abstinence or playing sex with one uninfected partner who is also monogamous, condoms remain the only proven method that can protect against STIs/HIV (Bosmans et al, 2006), many people still choose unprotected sex rather than using condoms (Nzioka, 2001, p. 114). Multiple sexual partners, transactional sex, and extra-marital affairs are also very common in sub-Saharan Africa despite the looming threat of HIV/AIDS (Maticka-Tyndale et al., 2005; Tillotson & Maharaj, 2001). The puzzling question is why many sub-Saharan Africans continue to engage in risky sexual behaviours despite the abundant knowledge of the fatal nature of HIV/AIDS and exposure to methods of prevention.

In trying to answer this question, Oshi, Nakalema, and Oshi (2005, p. 176) have argued that cultural factors play an important part in the determination of sexual behaviour. They

believe that individuals are active recipients of signals conveyed through continuous interactional processes. So, individuals living in the same home or community and receiving the same message on a particular topic will come to hold the same beliefs, values and meanings on the issue. This means that groups can develop their own systems of significant symbols that are value systems held in common by members (Linden, 2004, p. 347). Looking at the risky sexual behaviour in sub-Saharan Africa, it follows that cultural norms regarding sexuality/gender may be a contributing factor to these risky sexual practices, such as non-use of condom. For example, Mbugua's (2007, p. 1079) findings indicated that most educated mothers in urban Kenya experienced socio-cultural and religious inhibitions which hindered them from providing meaningful sex education to their pre-adolescent and adolescent daughters. This finding further boosts the case that social and cultural norms may have a strong influence on decision making as well as the mundane daily lives of individuals. Cultural standards regarding sexuality, for instance, may influence when to have sex, with whom, with how many people or times and whether or not to use condoms.

Therefore, to understand the low rate of condom usage and the high prevalence of HIV infection in Kenya, it is essential to identify the factors that contribute to high-risk sexual behaviour among Sub-Saharan Africans in general and Kenyans precisely (Bird & Bogart, 2005, p.110). As such, using scripting theory, this study will examine the way in which socio-cultural norms might contribute to risky sexual practices among Kenyan youth. More specifically, it will look at how these norms might inhibit condom use and thus increase risk of exposure to HIV infection. This type of research is needed to more successfully develop and implement effective programs to reduce the HIV/AIDS acquisition rate in Sub-Saharan Africa. Moreover, this

research will bring a better understanding of the sexual practices and experiences of Kenyan youth that may lead to better policy development and prevention programs to address the high rates of HIV/AIDS.

## **THEORETICAL FRAMEWORK**

The AIDS epidemic is increasingly recognized as affecting young people. Globally, the number of children younger than 15 years living with HIV increased from 1.6 million [1.4 million—2.1 million] in 2001 to 2.0 million [1.9 million—2.3 million] in 2007. Almost 90% of these children live in sub-Saharan Africa (UNAIDS, 2008, p. 9). This high rate of HIV infection among young people is evident in Kenya where at the end of 1999, the estimated prevalence of HIV infection for people 15–24 years of age was 11–15% for women and 4–9% for men, with the majority of them infected through sexual contact (Maticka-Tyndale, et al, 2005, p. 27). On the surface, these statistics suggest that young people in Kenya are neither aware of the dangers of HIV nor preventative measures. However, existing literature reveals otherwise. For instance, survey data from 64 countries indicate that 40% of males and 38% of females ages 15–24 had accurate and comprehensive knowledge about HIV and about how to avoid transmission (UNAIDS, 2008, p. 13). The report also states that more than 70% of young men and 55% of young women know that condoms can protect against HIV exposure (p. 14). More specifically, according to Kenya's national report on reproductive health and reproductive rights compiled by Peter Thumbi of Kenya's National Council for Population and Development, knowledge of HIV/AIDS in Kenya is almost universal as almost all women and men (99 percent) know of AIDS. The majority of the people also know that AIDS can be avoided through abstinence, use of condoms, and avoidance of multiple sexual partners (Thumbi, 2002, p. 10). In view of the

fact that most men (*and women*) have the information and the means at their disposal to protect themselves and their sexual partners from the risk of exposure to the HIV virus and yet choose not to do so must be understood within a context where cultural ideologies of sexuality and masculinity put them and their partners at risk in sexual encounters. Unfortunately, social-cognitive theories of HIV risk have traditionally concentrated on individual-level predictors of HIV risk with little or no consideration of the effect of socio-cultural context and social inequality on sexual behavior (Bowleg, 2004, p. 168). Brickell (2006, p. 95) proposes that the best approach is to consider how we come to understand social constructionism sociologically by examining a number of related approaches to gender and sexuality that speak to sociological concerns and might be termed social constructionist: historicism, symbolic interactionism, ethnomethodology and materialist feminism. He believes that using multifarious theories like social constructionist approach offers particular strengths for analysing the complexities of gender and sexuality. As such, this paper will utilize scripting theory which comes from social constructionism perspective in its analysis.

However, before we delve deep into social constructionist theory, it is important to explore the linkage between developments in symbolic interactionist theory over the past thirty years and the sociological study of the social construction of sexualities. Plummer (2003, p. 516) pointed out that sexuality, for humans, is not simply a free floating “desire” but is always grounded in wider material and cultural forces. There is no essential “sexuality” with a strictly biological base that is cut off from the social. As such, any concern with “it” must always harbour wider social issues, for human sexualities have to be socially produced, socially organized, socially maintained and socially transformed. Brickell (2006, p. 95) continues that

sexuality is an aspect of social life like any other and that the meanings granted to it constitute its most important characteristic. Nothing is inherently 'sexual': whether or not particular activities are *considered* sexual is specified in particular locations, times and cultures, as are judgements about the appropriateness of these activities. Where there is a fundamental congruence between the sexual as it is defined by prevailing cultural scenarios and experienced intrapsychically, consequent behavior is essentially symbolic, being entirely dependent upon the shared significant meanings of collective life. In such contexts, the sexual takes a natural air that obscures the fact that virtually all the cues that initiate sexual behavior are embedded in the external environment (Simon and Gagnon, 1986, p. 105-106). Simon and Gagnon called these learned cultural meanings of human sexuality, sexual scripts. Sexual scripts specify with whom people have sex, when and where they should have sex, and what they should do sexually (Maticka-Tyndale and Herold, 1997, p. 318). Scripts are essentially a metaphor for conceptualizing the production of behavior within social life. Most of social life most of the time operates under the guidance of an operating syntax, much as language becomes a precondition for speech (Simon and Gagnon, 1986, p. 98). Scripting theory, developed by Simon and Gagnon (1984), is rooted within the symbolic interactionist and social constructionist perspectives in sociology. Sexual activity is theorized as the end result of a codified sequence of events which is much like the script of a play. Scripts become the templates used to interpret and respond to situations as sexual (Maticka-Tyndale et al, 2005, p. 28).

Simon and Gagnon (1986, p. 98) contend that for behavior to occur something resembling scripting must occur on three distinct levels: cultural scenarios, interpersonal scripts, and intrapsychic scripts. Cultural scenarios provide general guidelines regarding all aspects of

sexual behavior, including who is an appropriate object for sexual desire, the appropriate relationship between sexual actors, the appropriate places and times for sexual activity, and what the participants in the sexual activity are assumed to be feeling. These collectively shared scenarios define the symbolic meaning of behaviors in sexual interactions, and thereby facilitate interpretation of others' intentions and feelings in interactions (Hynie et al, 1998, p. 370).

Interpersonal scripting represents the scripts that the actor negotiates with others. As such, it draws heavily upon cultural scenarios, involving symbolic elements expressive of such scenarios (Simon and Gagnon, 1986, p. 106). They represent our definition of the immediate social context (Simon and Gagnon, 1986, p. 106). At the intrapsychic level the construction of sexual selves involves the routinization and internalisation of wider sexual meanings. For example, Mewhinney, Herold and Maticka-Tyndale (1995) studied university students on Spring Break in Daytona Beach, Florida to gain insight into the sexual perceptions, attitudes, and behaviors of university students on Spring Break. They reported that the feeling of freedom from responsibilities and home constraints, a sense of anonymity, and drinking all contributed to the scripts for behaviour on Spring Break that included engagement in behaviour they would otherwise not do (p. 284). Some students reported having had sexual relations with someone who they knew was involved in a relationship at home. One woman who was interviewed said that in the home environment she would never have been involved with a man who was in a relationship with another woman (p. 283). The spring break sexual script is temporally specific allowing vacationing students to shed it and go back to their conventional selves once they return home. Brickell (2006, p. 95) contends that if the spring break was to be lasting and students were living that culture permanently, their relationship to the scripts generally would stabilise as they attained a sufficient degree of 'socio-sexual competence' and sexual satisfaction. Suffice it to say

that in cultural settings where gender, sexual orientation and the sexual command both importance and attention, it should be easy to conceive of individuals whose identities and very lives substantially resonate around these meanings. This is particularly true in traditional (or paradigmatic) social settings where the stability and apparent seamlessness of social life provide few significant choices and, as a result, prevailing cultural norms and associated meanings are effectively predictive of behaviour (Whittier and Simon, 2001, p. 139-140). In such societies, cultural scenarios and a limited repertoire of what appear to be ritualized improvisations may be all that is required for understanding by either participants or observers (Simon and Gagnon, 1986, p. 102).

It is common knowledge that cultural meanings, values and experiences are socially produced and reproduced within groups. Subsequently, one can anticipate finding the socio-cultural sexual scripts among adults in any society also among the youths of that culture. Based on their review of research literature across sub-Saharan Africa, Maticka-Tyndale and colleagues (2005, p. 37) pointed out that common across cultural groups in a number of African cultures are: certain myths about HIV and condoms, the belief that sexual release is natural and necessary once sexual maturity is reached; a market-like nature of the exchange with a focus on material gain for girls and social and sexual gain for boys; a discourse of force where physical force is intertwined with and undifferentiated from social and biological pressure; and the absence of an overt discourse of sex for pleasure, fulfillment, or emotional bonding. Based on the perspective that experience has a social dimension and that these dimensions are produced and passed on through language to subsequent generations, we can anticipate finding the tribal sexual and gender values and beliefs also among the youths of the community. Adolescent boys and girls

will internalize and respond to cues generated by parents, peers, and other figures within society and thus come to reproduce these same values and beliefs (Ohalete, 2007, p. 739). Thus, an adolescent who is a witness to transactional sex, multiple partners, no condom usage, forced sex, etc, would likely internalize the behaviour as normal and would be more likely to repeat it. Indeed, in Kenya, young people's sexuality tends to resemble aspects of the traditional adult system of sexuality (Maticka-Tyndale et al., 2005, p. 27). In focus group interviews with upper primary school pupils in Nyanza province, Kenya, sexual encounters were described as both mundane and inevitable and followed a predetermined scripted sequence of events and interactions in which girls and boys played complementary roles. Maticka-Tyndale and colleagues found further that young people in this study tended to organize their knowledge of sexual behaviour according to a temporally ordered script grounded in the social, cultural and interpersonal norms and contexts of their present lives and the traditional scripting of male-female sexual relations. For example, girls reported little or no control over how, when and where playing sex occurred, while boys viewed girls as readily available to satisfy their sexual needs. Boys felt that playing sex was their duty, an expectation of their friends, kin and society; girls described sex as just an ordinary part of life, an obligation to boys and men. Additionally, the script described by young people in this study closely paralleled the script reported by young people elsewhere in sub-Saharan Africa (2005, p. 37).

The discussion of sexual scripting above within the context of symbolic interactionist theory would indicate that social factors have a strong influence on young peoples' perceptions of sexuality, which may be important to understanding also their perceptions regarding HIV/AIDS. Implicit in this discussion is that understanding a culture's scripted sexual meanings

will tell us the who, what, when, how and where individuals' in the culture will engage in sexual behaviour. It follows from this theory that we need to understand the Kenyan cultural norms on sexuality and gender as they apply to young people if we are to come to a better understanding of the factors that might inhibit condom use. In the corridors of HIV prevention, such understanding will lead to design and implementation of culture specific programs that are more likely to be effective in combating the spread of HIV/AIDS. As such, the focus of this paper is to outline the sexual scripts in Kenya that seem to prohibit condom use.

## **LITERATURE REVIEW**

With 11% of the world's population but 67% of its HIV/AIDS cases, Sub-Saharan Africa is the region that has been the most affected by the AIDS pandemic (UNAIDS, 2008, p. 7). Numerous studies reveal that HIV in sub-Saharan Africa is spread primarily through unprotected heterosexual sex (Mbugua, 2000; Moore & Oppong, 2007; UNAIDS/WHO, 2008). Given that HIV in Africa is spread through unprotected sex, those interested in controlling the spread of HIV in Africa have held on to the belief that changes in sexual behaviour (such as abstinence, condom use, being faithful to a single partner—the ABC approach) can reduce the spread of HIV significantly. Indeed, in his study of the development of anthropological research in response to AIDS, Parker (2001, p. 164) charged that much of the social science research activity that emerged in response to AIDS, not only during the mid- to late 1980s, but up to the present time, focuses on surveys of risk-related sexual behavior and on the knowledge, attitudes, and beliefs about sexuality that might be associated with the risk of HIV infection. These researchers subscribe to the idea that knowledge is the ultimate weapon against HIV/AIDS. Thus, most of these studies have recommended educating at-risk groups about the dangers of HIV/AIDS and

about how to protect themselves against infection. The belief is that such education could induce behavioral change with regard to HIV/AIDS.

Conversely, many studies disclose that HIV knowledge does not translate into abstinence or condom use (Moore & Oppong, 2007; Nzioka 2001; Thumbi 2002). For instance, while studying the perspectives of adolescent boys aged 15-19 attending schools in rural, eastern Kenya on the dual risks of unwanted pregnancy, STDs and HIV, Nzioka (2001, p. 108) found that sexual knowledge does not necessarily translate into behaviour changes. What's more, according to Thumbi (2002, p. 10), the proportion of Kenyans who know of somebody with AIDS or who has died of AIDS has increased from 42 percent women and 40 percent men in 1993 to 72 percent and 70 percent, respectively, in 1998, reflecting the spread of the AIDS tragedy in Kenya. In addition, the country has put in place advocacy, information and education strategies to address change of behaviour including promoting the use of condoms. These programmes have, however, had limited success. As Thumbi (2002, p. 11) has found, only 6 percent of women and 21 percent of men reported using a condom during their last sexual encounter. One possible explanation for this is that sexuality in Africa has deep, entrenched social meanings that are often contrary to aspects of implemented HIV educational programs. As a result, it is believed that while the people may have the necessary HIV/AIDS knowledge, cultural beliefs and practices mitigates against successful implementation of HIV/AIDS prevention programmes in Sub-Saharan Africa (Thumbi, 2002, p. 11). As such, young people in sub-Saharan Africa organize their knowledge of sexual behaviour according to temporally ordered scripts that are grounded in the social, cultural and interpersonal norms and contexts of their present lives and the traditional scripting of male-female sexual relations. Because sexual

behaviour involves complex dynamics and people tend to produce and reproduce their cultural norms, safe sex practices such as condom use, for example, may not be an easy option for many people living in Africa (Moore & Oppong, 2007). It is therefore not surprising that while adolescents in sub-Saharan Africa may know of the risks of HIV infection, they may nevertheless choose to practice risky sexual behaviours.

Owing to the fact that sexuality is deeply entrenched in social and cultural meanings, the purpose of this research is to investigate how cultural norms regarding sexuality and gender contribute to risky sexual practices among Kenyan youth (upper primary school pupils aged 11 to 16 years). But first, a little background information about the country is warranted. Kenya lies along the central part of East Coast of Africa and had an estimated population in 2006 of 34 million (IPPF/UNFPA, 2008, p. 1). Kenya's population has large numbers of people in the younger age groups and tapers off with increasing age (p. 1). Indeed, about 60 per cent of the population is less than 20 years old; including over 5.5 million adolescents aged 10-19 (p. 1). The youthful nature of Kenya's population and the knowledge that the fastest growing demography in HIV/AIDS infection in Africa is among the youths, makes this study very essential.

According to a joint report published by UNAIDS and World Health Organization (WHO), Kenya's AIDS epidemic is of the same scale as Uganda's. An estimated 5.1% of adults (15-49 years) lived with HIV in 2006 representing nearly 1 million people—a large epidemic, despite evidence of a slow but steady decline in HIV prevalence (2008, p. 13). Adult HIV prevalence is almost twice as high among women (8.7%) than men (4.6%) (UNAIDS/WHO,

2008, p. 14). Additionally, AIDS kills 700 Kenyans daily and up to the present time the disease has killed a total of 1.5 million people in Kenya. It is estimated that 2.2 million or one in fourteen people are HIV positive in Kenya (Thumbi, 2002, p. 9) even though knowledge of the dangerous nature of HIV/AIDS and how to guard against infection is almost universal in Kenya (Thumbi, 2002, p. 10).

Attempting to figure out why this is, many researchers have explored socio-historical development of sexual scripts to see how the scripts influence conceptualizations of sexuality (Maticka-Tyndale, et al, 2005; Maticka-Tyndale, 1991, Prazak, 2000). It follows therefore that to understand Kenyan youth sexuality, which is what this paper is interested in, and why they engage in risky sex, we need to study the Kenyan culture discourse especially around sexuality and gender. Looking at the literature on HIV/AIDS in sub-Saharan Africa in general, and Kenya specifically, cultural beliefs and practices such as transactional sex, forced sex, early sexual debut, mistrust and non-use of condom, myths and misconceptions of how the disease is transmitted, are widespread in the society. To understand how these sexual scripts have been written for Africans and young Kenyans particularly, it is important to explore the socio-cultural meanings that have been used to define their sexual behaviors and experiences (Prazak, 2000, p 82).

One consistent characteristic of sub-Saharan African sexuality is the exchange of money, food and products for sex. In fact, transactional sex is so established in sub-Saharan Africa that almost any gift from a young man to a young woman, such as a snack, soap or 'loan' of money, is seen by both parties as a contract to have sex (Wight et al., 2006, p. 992). Thus, virtually all

sexual encounters outside of marriage (unless physically forced) involve material exchange. Nzioka (2001, p. 109) reported that, in Kenya, as many as 17% of unmarried boys aged 15-19 had paid for sex, defined as giving money, gifts or favours in exchange for sex, in the 12 months preceding the survey, compared to 21% of unmarried girls of these ages who reported receiving money, gifts or favours for sex. How did transactional sex come to be so entrenched in African sexuality? Chidwick (1970, p. 143) observed that there is one common characteristic in African Marriage: the fact that money, goods, manual labour, or symbolic articles are provided by the bridegroom (or his family) and passed into the hands of the father of the bride. Chidwick sought to discover the factors which have motivated the transaction to take place in this particular way. Not finding a great deal of useful information in books regarding the origin of bride wealth, he conducted a study through personal interviews, and through a questionnaire which he sent to a selected number of church leaders, who in turn gathered the opinions of local people. The area covered ranged widely over Kenya and Tanzania. The most fruitful results were a collection of sayings and proverbs about bride wealth, marriage, and parent-child relationships. Chidwick (1970, p. 145) found that bride wealth encourages a sense of respect for a woman because a “man will value more highly what he has had to pay for”. If it is discovered that a certain husband paid nothing for his wife, it is quite possible that the other members of the village would be suspicious that something was wrong with her. She would not, in fact, be honoured and respected (p. 145). For example, former South African President Nelson Mandela reportedly followed an African tradition and paid Graca Machel’s family 60 cows for her hand in marriage (South Africa Star, 1998). Asked if he thought the price was justified, King Zwelibanzi of the Tembu clan, of which President Mandela is a royal member, told the Star newspaper, "Even if Rolihlahla (Mandela) had paid a million cows for Graca, she is worth every bristle of hair and

hoof" (South Africa Star, 1998). Implicit in this utterance is the knowledge that the amount of money, service and herds of livestock that a woman received in exchange for her hand in marriage, determined her wealth to the man.

Linking the past to the present, examination of African scripts of sexuality and marriage reveals the belief that puberty awakens sexual desire within young people particularly boys (Maticka-Tyndale, et al, 2005, p. 37). This is because, historically, adolescence was not recognized in Africa. Puberty marked entry into adulthood and readiness for sex, reproduction and marriage (p. 37). Rites of passage ceremonies which include formal instruction in sexual and gender matters ushered a child into adulthood. Marriage and parenthood followed soon after. Maticka-Tyndale et al (2005, p. 37) in their Kenya study, found that for girls, the time between sexual maturity and marriage was relatively short. Boys were more likely to postpone marriage until they were more economically secure, but often had culturally sanctioned access to sexual partners prior to marriage. However, today, prolonged education and economic changes has led to postponing marriage and the creation of adolescence, and has “created a situation where non-marital, sexual liaisons are likely” (p. 37). According to Maticka-Tyndale, et al (2005, p. 28-29), many of the traditional norms associated with marital and sexual relations have become part of the sexual scripting of boy–girl relationships. For instance, traditional expectations of a bridewealth have become gift-giving to gain sexual access. Girls speak of being ‘worth something’ and expecting to receive something. They speak of how much they could get, of strategies for increasing the value of gifts, and of selecting partners based on potential material gains. As such, adult men are prized over adolescent boys because of the size of gifts they are able to offer. Girls described older boys and men as better partners because they were a

dependable source of financial support and more accommodating of a girl's needs than same-age peers. However, after analyzing a cross-sectional behavioral data linked to HIV-status from 4,138 men and 4,948 women interviewed in rural Zimbabwe to investigate the distribution and consequences of early first sex, Hallet et al. (2007) concluded that young girls who have sex with older men are unlikely to be able to insist on the use of condoms, thus increasing their risk of exposure to HIV infection. The reason is simple. Due to the economic reality that forces girls to depend on the gifts from men for survival, the high demand for "rich old men", and the abundant supply of young girls who are looking for rich men, the bargaining power of girls to insist on condom use is extremely limited.

Although transactional sex as it is practiced today in Africa may have its roots in traditional dowry/bridewealth systems, its continuation today may be more a survival mechanism for women. For example, the Zimbabwean Demographic and Health Survey suggested that the most educated and the wealthiest men and women experienced sexual debut later than their less educated and poorer counterparts. This finding suggests that a primary motive for young women to begin sexual activity may be to obtain money and gifts from their partner, usually older men (Hallett et al, 2007). Maticka-Tyndale and colleagues (2005) have suggested that the reason for this "sex work" may be that gender roles dictate differences in mobility, economic access, sexual power and agency, family responsibilities, and personal resources. Mobility, for example, is tolerated, and at times required, for boys, yet forbidden for girls. Girls are kept close to home and work in the family compound. Boys' activities are away from home (e.g., tending grazing animals) and often with groups of peers (e.g., team sports). The containment of girls means they have no way to earn money. Boys are not contained, and consequently, have money from jobs.

Girls' only access to money is therefore from boys and men. Dinkelman, Lam and Leibbrandt (2008) designed research to study the possible link between household income and income stress, and risky sexual behaviour of young people. They analyzed data obtained from the Cape Area Panel Study (CAPS) that surveys individual youths aged 14 to 22 in Cape Town, South Africa in 2002 and again in 2005. CAPS covers a range of aspects of adolescence, including schooling, entry into the labour market, sexual and reproductive health, and experiences within families and households. Most data are collected from the young people themselves, but data are also collected from parents and other older household members. Dinkelman, Lam and Leibbrandt (2008, p. 55) observed that for women, and most especially young unmarried women, sexuality is conceptualised as a resource that can be drawn upon for material or economic advantage. For example, small focus group surveys of young people (13-25 years) in Khutsong, South Africa revealed that a common reason for young women to have sex is economic: "Participants spoke of young women and females in Khutsong who engage in sexual relationships in exchange for lifts home from school, gifts and subsistence cash" (Dinkelman, Lam, and Leibbrandt, 2008, p. 54-55). Consequently, multiple partnerships for women, especially young unmarried ones, are very common in Africa. For example, Oshi and colleagues (2007) investigated whether self-perception of risk of HIV infection causes Nigerian youth to reduce risky sexual behaviour and to seek HIV testing. In-depth interviews were conducted among 90 undergraduates in three Nigerian universities. In each university, three focus group discussions were facilitated for males only, females only, and for both males and females (mixed). Oshi and colleagues (2007, p. 197) reported that 25.6% of the females in their study had more than five sexual partners compared to 8.9% of the males. Likewise, Bishai et al. (2006, p. 372) conducted a survey on rates of sexual contact in the last 12 months among 1709 respondents age 18-60 living in Uganda in early 2001.

Households were selected at random from Demographic and Health Survey (DHS) 2000 household sampling frame listings in 12 districts and 120 clusters. They established that sexually active unmarried women reported a median of 3 partners in 12 months with a maximum of 5 partners. Oshi et al., (2007, p. 197) further revealed that 13 of the 43 females who had initiated sex four weeks preceding their study had had sex more than ten times within the period compared to 7 of the males. Further analysis of the data showed that 11 of the 13 female respondents who had sexual intercourse more than ten times in four weeks belonged to poor socio-economic backgrounds (parents were rural farmers, petty traders, artisans). Nonetheless, having multiple partners did not appear to be a critical factor in the decision to use condoms for the female respondents. Respondents who reported having more than five partners in the four weeks preceding the study did not use condoms more frequently than those who indicated they had one or two partners. Indeed, female respondents who had more than five sexual partners and reported having sexual intercourse more than ten times, paradoxically, indicated less condom use.

Luke (2006) suspected that exchange of money for sex without a condom may not be a phenomenon only within commercial sexual partnerships, but among non-commercial relationships as well. She conducted a study in Kenya that consisted of a random sample of 2,700 Luo males ages 21–45 in 2001. Kenyan Census Bureau enumeration areas were used as primary sampling units. Of the 2,700, 121 were randomly chosen for the survey. All eligible males in households in the selected enumeration area were visited and interviewed. A specific aim of the survey instrument was to gather information on male non-marital sexual behavior. In addition to background demographic and socioeconomic questions, respondents were asked the number of

non-marital sexual partners they had in the last year, and information on the five most recent partners was gathered. Partner information included female partner age, marital status, and if the female was a commercial sex worker. Partnership information included duration of relationship, time of last sexual intercourse, condom use at last sexual intercourse, and material transfers respondents gave to each non-marital partner in the last month (Luke, 2006, p. 327-328). She found a strong negative relationship between transfers and condom use in informal relationships. She also observed that non-monetary transfers, such as gifts and meals, have the same effect on condom use as monetary transfers. Furthermore, the results reveal that the trade-off between transfers and condom use does not differ between partnerships involving adolescent girls and adult females; in other words, the same value of transfer induces the same response in non-marital female partners of different ages.

Still on the issue of exchange of money and goods for sex, Bene and Merten (2008) discussed the link between fish-for-sex (FFS), which is found predominantly in Sub-Saharan African inland fisheries and HIV/AIDS. They reviewed the literature to identify the various documents and media that report the occurrence of fish for sex (FFS) transactions in fisheries across the world. They also used data from research conducted in the Kafue flats (Zambia) fishery as a case study. This fieldwork took place during 2002–2004 and extended over two periods of 6 months. It included ethnographic observations in a local settlement in the woodlands and in the fishing villages and was aimed at gaining an insight into local livelihoods, power structures, and local politics. Six focus group interviews were conducted on the subject of fishing activities and related problems. Another six focus group interviews were carried out on the topic of HIV/AIDS. In addition, semi-structured interviews on fishing, trade, and related problems

were conducted with 84 fishermen in two fishing camps. Fifty-seven fish traders (26 females, 31 males) were surveyed using a common interview frame. Sixteen fishermen and the 26 female traders were further interviewed about fish-for-sex deals by local fieldworkers, who, to ensure confidentiality, came from a different area. In addition, seven local female fish traders from the woodlands, who were willing to reveal their fish-for-sex activities, were interviewed in depth (Bene and Merten, 2008, p. 877). The results indicated that FFS is generally the consequence of individual economic impoverishment: if these female fish traders—often widowed, divorced, or single—engage in such activities it is because they lack the cash necessary to purchase the fish from the fishers and are therefore ‘forced’ to offer sex to secure their access to the product (Bene and Merten, 2008, p. 876). However, most of these fish-for-sex transactions involve unprotected sex, putting both parties—the fisher and the fish trader—at risk (Bene and Merten, 2008, p. 876). Dinkelman, Lam and Leibbrandt (2008, p. 54-55) argue that transactional sex rarely involves safe sex because safe sex is expensive. According to them, safe sex implies welfare loss because unprotected sex generates economic resources to provide compensation for the risk. However, in an economy where percentage of the population who lives below income poverty line of \$1 per day stands at 46% (IPPF/UNFPA, 2008, p. 1), it is anticipated that most women who engage in transactional sex will be coerced by their economic realities to choose unprotected sex. What’s more, exchanging sex for money is officially illegal in Kenya and highly stigmatized (IPPF/UNFPA, 2008, p. 2). As such, though exchange of sex for material gain is common practice in Kenya, few women who engage in such transactions identify as sex workers (Dunkle et al, 2004, 1582). However, condom use is linked to recreational sex which is provided by promiscuous women (IPPF/UNFPA, 2006, p. 6). Consequently, while financial constraints do provide an incentive for young women to play sex, the cultural link between

condom use and prostitution influences them to eschew condom use (Kaufman and Stavrou, 2002).

Expounding on the cultural norms that inhibit condom use in Kenya, Maticka-Tyndale et al. (2005) revealed that in Kenya, like other sub-Saharan cultures, sexuality tends to follow a predetermined script in which males and females play complementary roles. Oshi et al. (2007) determined that the differences in sexually risky behaviour stems from differences in negotiating power based on money, and also on the social construction of masculinity and femininity by which females are supposed to be submissive recipients in the act of sexual intercourse while males are supposed to be the aggressive decision-makers. For example, Maticka-Tyndale et al. (2005, p. 36) reported that Kenyan girls described little or no control over how, when and where having intercourse (playing sex) occurred. Boys viewed girls as readily available to satisfy their sexual needs. They felt playing sex was their duty, Girls on the other hand described sex as just an ordinary part of life, an obligation to boys and men. Nzioka (2001) found that young men exhibited high risk sexual behaviour because they felt the need to conform to social prescriptions of male prowess which involved early sexual experience, non-condom use and having more than one partner. Beliefs about negative consequences of remaining abstinent were thus numerous. As Maticka-Tyndale et al. (2005) reported, boys, for example, expressed concern that if they were not involved in playing sex at a young age they would not be able to impregnate a wife when married. Indeed, the prestige of sexual experience is particularly related to sexual conquest and the ability to seduce many partners (Wight et al., 2006). As such, those youths who have never had sex are laughed or jeered at by those who already have started having sex. This fear of being excluded, stigmatized and rejected by their peers for refusing to play sex was also interpreted as

forcing boys to play sex (Maticka-Tyndale et al, 2005). Boys described being taunted by both their male and female peers. Eleven to fifteen years of age was cited repeatedly as the ‘natural’ and expected age for initiation of both dating and playing sex and boys were at least two, and more often four or more, years older than their girlfriends (Maticka-Tyndale et al, 2005, p. 36). However, in Melhado’s (2008) analysis of nationally representative data from Burkina Faso, Ghana, Malawi and Uganda in which 19,500 adolescents aged 12–19 had been asked about their sexual experiences, socio-economic status, education, childbearing, contraceptive use and HIV knowledge, he found that young people who delayed sexual debut were more likely than those aged 12–14 to report having used a condom at last sex. This perhaps may be because sexual encounters among adolescents often took place out-of-doors going to or from school, while engaged in routine chores such as fetching wood or water, or at beaches or marketplaces (Maticka-Tyndale et al, 2005, p. 33).

Moreover, according to Nzioka, (2001), because of the prestige surrounding sexuality for boys, proving one’s virility becomes very important. Contracting other curable sexually transmitted diseases such as gonorrhoea and syphilis may be acceptable to some boys. If anything, such an infection can occasionally be a source of glory rather than condemnation; contracting an STI at least once may be seen as a way of gaining sexual experience. Within popular discourse, this perception is often tied to the dominant views of masculinity (Nzioka, 2001). Clearly, the links between the risk of contracting an STI and those of contracting HIV are not necessarily well understood by young men. The tendency to associate the experience of STIs with masculinity may be a serious obstacle to the adoption of strategies for the prevention of STIs/HIV.

However, despite the importance of a young man's ability to seduce and play sex with many girls to masculine self definition, condom use is rarely mentioned in sexual discourses. Indeed, in Bosmans et al.'s (2006) study, in which they conducted focus group discussions with adolescents and interviews with peer education programme officers on how a rights-based approach could contribute to an effective and appropriate response to the sexual and reproductive health needs of Congolese adolescents, condom use was not mentioned as a method of protection against HIV. Interestingly, the respondents who mentioned condoms as a means of protection also warned that condoms did not fully protect. Chimbiri (2007) assessed the condom situation within marriage in Malawi with particular attention to people's perceptions about the compatibility of condoms and marriage by analyzing the Malawi Demographic and Health Surveys 1992 and 2000, and via semi-structured interviews with married men and women from three districts in rural Malawi. Her results revealed a fear of condoms among Malawians. Condoms were believed to be ineffective (they have holes), to transmit rather than prevent disease, and that condom use was a sin. The misconception is that the fluid in the condom contains either the AIDS virus or the bacteria that causes tuberculosis. Thus, using the condom is viewed as putting one at risk of contracting either AIDS or TB. So, it would seem that condoms carry a host of negative symbolic meanings for men and boys: condoms are acceptable for use only by adults, 'bad' boys, 'boys who love sex' or 'promiscuous' boys. Condoms also symbolise physical and moral contamination and reveal a hidden sexual history or the sexual intentions of those who use them - and are not considered usable in heterosexual relationships even when they are readily available (Nzioka, 2001, p. 114). Consequently, consistent condom use among young people tends to be infrequent and erratic. It has been observed that while some 60-70% of

adolescents in Kenya are at risk of contracting HIV, about 80% have at one time or another engaged in unprotected sexual intercourse (Nzioka, 2001, p. 109). Bishai et al. (2006, p. 372) found that the proportion reporting that they always used a condom while having sex with someone other than a spouse never exceeded 20% whether respondents were male or female, married or unmarried. In fact, the percentage of condom usage by the respondents in Oshi et al's, study (2007, p. 199) stood at 12% for the males and 5% for the females.

Additionally, as in much of sub-Saharan Africa, sexual debut in Kenya occurs in adolescence, with evidence of increased rates of unwanted pregnancy and sexually transmitted infections including HIV/ AIDS (Nzioka, 2001, p. 108). Bosmans and colleagues studied how a rights-based approach could contribute to an effective and appropriate response to the sexual and reproductive health needs of Congolese adolescents. They conducted focus group discussions with adolescents and interviews with peer education programme officers in Kinshasa and Bukavu in April–May 2004.

When they asked their subjects whether they knew boys and girls of their own age who had already had sexual relations without being married, Bosmans and colleagues (2006) found that the common answer was that there were many adolescents, including friends, who did not wait until marriage to have their first sexual experience and did not necessarily protect themselves. Moreover, in surveys conducted in Nyanza province in Kenya, with young people aged 11–16 years, Maticka-Tyndale et al. (2005, p. 29), found that a significant proportion of these young people reported being sexually active (56% of a sample of over 4000 boys and 50% of a sample of over 4000 girls) and having experienced sexual force, with the median age of first intercourse being 12 years. Sexual debut occurs early among boys. The national Kenya Demographic and

Health Survey (KDHS) 2003 found that about 32% of unmarried adolescent boys aged 15- 19 had had sexual intercourse by age 15, as compared to 15% of girls. According to Hallett and colleagues (2007), women who begin to have sex earlier than others of their age are more likely to be infected with HIV. This may be because such girls would have a greater lifetime number of sexual partners than those whose first sexual experience occurred later and because the period of potential exposure to infection is longer.

Additionally, for young women, physiological and immunological immaturity of the female genital tract may increase susceptibility. For example, earlier onset of puberty and subsequent adolescent sex increase girls' risk for STIs, HIV/AIDS, and other reproductive tract infections because ectopy (thinner, more vascular columnar epithelium) normally present in the immature cervix makes them more susceptible to these diseases (Ohalete, 2007, p. 740). However, widespread in Kenyan sexual norms is the belief that boys could not control their sexual urges when they reached adolescence (Maticka-Tyndale et al., 2005). Boys and girls alike reported that these urges forced boys to play sex. The sexual norms, however, were not only centered on boys' sexuality. Beliefs that a girl must be sexually active or her 'vagina will be blocked' reinforced the sense that puberty marked readiness for sex. In predominantly patriarchal sub-Saharan Africa, it is typically males who are the key decision-makers on the timing of sexual activity and contraception use (Nzioka, 2001). For instance, girls reported little or no control over how, when and where playing sex occurred. Boys viewed girls as readily available to satisfy their sexual needs. In this setting, rarely was sexual encounter mutually planned by the two individuals involved. At times encounters took place in a boy's or girl's home, but most often out-of-doors going to or from school, while engaged in routine chores such as fetching wood or

water, or at beaches or marketplaces and was emotionally uncharged and a hurried act (Maticka-Tyndale et al, 2005, p. 33).

What is more, Nzioka (2001) found that preventing pregnancy was not the responsibility of the boy but of the girl. This belief allowed the men to absolve themselves from the need to take preventive measures against pregnancy. As a result, men did not walk around with condoms in their back pockets. Indeed, in analyzing data drawn from six focus group discussions with male and female students aged 18–24 in three public tertiary education institutions, and supplemented by a survey of 3,000 students aged 17–24 in Durban, KwaZulu-Natal, South Africa, the evidence suggested that men experienced more difficulty than women (40% versus 27%) in carrying condoms because it implied that sex had been planned (Maharaj and Cleland, 2006, p. 108). Men said they only carried condoms when they expected to have sex. Furthermore, men admitted that there was a double standard about women carrying condoms, and that it was still more acceptable for men to introduce condom use in a relationship. In fact, if a girl carried a condom or introduced a condom during sex, she was generally seen as a slut. However, as has been previously stated, girls are responsible for preventing pregnancy while at the same time socio-culturally proscribed them from carrying condom. Also, because of the socio-cultural construction of subservient females (Oshi et al., 2007; Maticka-Tyndale et al., 2005), girls are put in awkward position where they are not able to say no to boys' sexual advances and at the same time unable to protect themselves.

Cultural beliefs and practices, ignorance, myths and misconceptions of how the disease is transmitted, and poverty induced transactional sex however, are not the only barriers to

consistent condom use in sub-Saharan Africa. It is common knowledge that comprehensive sexuality education, accurate information about condoms and a free condom supply are essential to enable adolescents to make informed choices regarding their sexuality and thus reduce their susceptibility to HIV infection. Accordingly, deliberately denying them this information is a violation of their right to protection and their right to health and life. Nevertheless, Bosmans and colleagues (2006) have found that religious beliefs have been used as the justification for trimming the ABC (abstinence, being faithful to one partner, and condom) approach to just AB. For example, in Bukavu, Kenya, the programme officers explained that they emphasised the risks of condom use when they promoted abstinence and fidelity, which were the only methods to prevent HIV allowed by the Catholic Church (Bosmans et al, 2006, p. 84). Indeed, the President of the United States' Emergency Plan for AIDS Relief (PEPFAR) funds, under President George W. Bush, could not be used for active condom promotion to youth and the married population (Cleland, Ali, and Shah, 2006). Although this restriction has been lifted under President Obama's administration, the strict obedience to religious doctrine that informed the previous HIV prevention strategies not only prevented adolescents from receiving accurate and comprehensive sexuality education, it also blocked condom supplies by peer education programme officers (Bosmans et al, 2006, p. 80). In Bukavu, the decision not to supply condoms was said to be in line with the policy of the diocese. The general director of the Health Department of the diocese, a Catholic sister who had senior responsibility for the peer education programme, was quoted as saying she fiercely rejected the idea of supplying condoms, even to girls living on the street and surviving as sex workers. She did not consider condoms as a means of protecting them from unwanted pregnancies, HIV or other sexually transmitted infections, but rather as an encouragement to continue their way of life. In another case, some young men who

wanted to use condoms had no idea where condoms could be obtained for free. Despite the existence of a centre that received a free condom supply from international organisations for distribution, neither the boys nor the girls knew about the existence of free condoms at the centre. Why was this the case? According to Bosmans et al. (2006), the centre had decided not to distribute the condoms because ‘‘they did not want to encourage the young people to have sex’’ (p. 84). Here, condom use is associated with promiscuity rather than seen as an act of responsible behaviour based on respect for the adolescent’s own well-being and that of his or her girlfriend or boyfriend. In Bosmans et al.’s interview of an AIDS educator about these religious barriers, the educator summed up the church’s position this way (Bosmans et al, 2006, p. 85):

*As we take abstinence as a basic value, we do not give unmarried girls clear information in order to avoid that they start behaving like married women. . . the information we give the children on this subject is correct but not complete, in order not to liberalise sexual relations.*

Moreover, in most parts of sub-Saharan Africa, there are strong social and cultural norms that restrict the open discussion of sex since it is believed that teaching children about sex will ‘‘encourage the young people to have sex’’ (Bosmans et al., 2006, p. 84). As such, children are not supposed to ask their parents questions about sex and sexuality, and parents do not discuss sex and sexuality with their children (Oshi, Nakalema, and Oshi, 2005). Therefore, young people are unable to communicate their sexual health needs or to discuss issues of sexuality with parents or teachers. Society’s notion, which they have understood all too well, is that young people’s involvement in sexual activities is ‘‘premature if not immature, immoral or at least unfortunate’’; this is in conflict with the biological reality that young people have sexual needs regardless of

whether their sexuality is seen as socially acceptable or not (Nzioka, 2001, p. 115). As a proof of the existence of adolescents' sexuality, the pubescent fertility rate in Kenya is also among the highest in the world, with 220 births per 1,000 women aged 15–19 years (Bosmans et al, 2006, p. 80). Nevertheless, because religious, cultural and social norms forbid the open discussion of sex, especially with young children, teachers are not willing to teach sex education. Oshi, Nakalema, and Oshi (2005) analysed how teachers perceive passing their knowledge of HIV/AIDS prevention measures to their students in the context of their cultural and social norms, which restrict open discussion of sex. They conducted in-depth interviews with 60 teachers drawn from secondary school teachers in Eastern Nigeria, supplemented with five focus group discussions, and content analysis of teachers' lesson preparatory notes. They reported that teachers stated fear of persecution by the parents and guardians of their students, expulsion from their churches, losing their jobs and social ostracization as constraints to offering sex education, though they admitted that their students could possibly get infected with HIV through sexual intercourse. Fifty-four (90%) of the teachers in this study said that they could not just embark on teaching their young students about sex because it is culturally and socially wrong to teach sex education to young people; a further 73.3% felt that it was a taboo to teach sex education to young boys and girls because it would make them unabashed about sex, and this may lead to their becoming promiscuous. Importantly, all the teachers (100%) cited religious beliefs as prohibiting open discussions about sex, especially with young children, because it will corrupt them. Eleven (33.3%) said their church does not allow the use of condoms for any purpose (even family planning) and so they cannot encourage their use. Fifteen of the teachers (25.0%) said they would like to overcome their personal beliefs and teach sex education but they feared persecution by the parents and guardians of their students, which could lead to dismissal from their jobs. As a

result, there was a lack of willingness to teach students about how to prevent the sexual transmission of the HIV virus. This sheltering of young people from sexual knowledge and how to protect themselves from exposure to HIV has, unfortunately, a dire consequence for them. Not only is this lack of communication linked to early sexual debut, it also leaves many youths ignorant about the risks of HIV infection and thus prone to engaging in risky sexual behaviours.

In spite of the numerous HIV/AIDS education programs, condom distribution, and efforts of religious and non-governmental organizations to reduce the spread of HIV/AIDS in Africa, the number of HIV infections annually in sub-Saharan Africa remains high. This literature review suggests that socio-cultural norms and beliefs, religious doctrines, illiteracy, poverty and many more reasons have and continue to hamper the HIV/AIDS education and condom distribution programs. The existing literature also suggests that unless these socio-cultural norms are studied and understood as they pertain to specific societies, the spread of HIV can not be curbed. It is with this knowledge that this study proposes to study how cultural norms regarding sexuality inhibit condom use among Kenyan youth. I believe that understanding cultural inhibitions to condom use would help in designing and implementing cultural specific condom and HIV education which would invariably lead to sexual behavior change and condoms use.

## **METHODOLOGY**

The purpose of this study is to examine the discourse on sexuality, HIV/AIDS and condom use in Kenya and to find out if cultural norms regarding sexuality contribute to risky sexual practices among Kenyan youth. More specifically, the research question to be explored

will focus on how these norms might inhibit condom use and thus increase risk of exposure to HIV infection.

To answer this question, secondary analysis of focus group transcripts data taken from a larger study that evaluated the Primary School Action for Better Health (PSABH) programme was undertaken. First, because secondary analysis generally entails evaluating pre-existing data in order to investigate or examine a concept or question that was not central to the original research (Schutt, 2006), permission was obtained from the project director, Dr. Eleanor Maticka-Tyndale to analyze data collected as part of the evaluation of the Primary School Action for Better Health (PSABH) programme. The PSABH was an HIV/AIDS educational prevention programme delivered in all primary schools in Kenya. It provided in-service training for teachers, community representatives, and peer supporters to deliver HIV education as a way of reducing the risk of exposure to HIV among upper primary school pupils. Questionnaires were completed by upper primary school pupils and teachers from 220 communities and focus group and in-depth interviews with pupils, teachers and community representatives in 22 of these communities.

Evaluation of the programme implemented in Nyanza and Rift Valley was carried out in waves (pre- and post-programme) from October 2001 to October 2004 at pre-programme, 9-months, 18-months, and 30-months after program initiation. Evaluation was based on questionnaires completed by upper primary school pupils and teachers from 220 communities and focus group and in-depth interviews with pupils, teachers and community representatives in 22 of these communities. Pre-programme focus group interviews in 28 schools in Nyanza and Rift Valley provinces were also conducted to figure out the knowledge, attitudes and behaviors

related to HIV/AIDS, sexual behavior and condom use that existed prior to the establishment of the program. Respondents were aged between 11-16 years, attending standard 7 (upper primary school). Teachers assisted in the selection of the FGD participation, approaching those who were generally more outspoken in class to ascertain their willingness to talk about issues related to HIV and sexuality.

FGDs were chosen for data collection because they replicated the same-sex, near-age-mate groupings that are the common settings for discussions of boy-girl relationships and sexuality in these regions. Focus group discussion guides were created to explore perceptions of HIV/AIDS, personal risk, dating, and sexual activity and expectations. Data were collected by trained, multilingual facilitators, from Steadman Research Services, a private Kenyan research company. The facilitators' gender matched that of focus group participants they dealt with. Each focus group and interview was conducted in a mixture of English, Kiswahili and the local dialect. Permission was obtained to tape all focus group discussions. Tapes were transcribed and translated to English with translation checked by supervisory staff.

For this study, secondary analysis of the focus group discussions through the application of thematic coding was undertaken. Specifically, the transcripts of the pre-programme, single-sex focus group interviews conducted in March and July of 2002 in 28 schools in Nyanza and Rift Valley provinces were subjected to thematic analysis. The respondents of these pre-programme FGDs were upper primary school pupils aged 11 to 16 in Nyanza and Rift Valley provinces. 2 focus group discussions were conducted in each school; one for each sex. A total of 157 upper

primary school pupils aged 11 to 16 years were involved in the pre-programme FGDs with males (N= 82) and females (N=75).

According to Braun and Clarke (2006), thematic analysis is a method for identifying, analyzing and reporting themes or patterns within qualitative data. It can be done inductively or theoretically. In an inductive thematic analysis, the themes identified are strongly linked to the data themselves (Patton, 1990). In this approach, analysis is data-driven. That is, analysis is a process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions. In contrast, a 'theoretical' thematic analysis would tend to be driven by the researcher's theoretical or analytic interest in the area, and is thus more explicitly analyst driven. This form of thematic analysis tends to provide less a rich description of the data overall, and more a detailed analysis of some aspect of the data. Additionally, the choice between inductive and theoretical maps onto how and why you are coding the data. In the former, the themes will depend on the data, but in the latter, you might approach the data with specific questions in mind that you wish to code around (Braun and Clarke, 2006).

Since this study is interested in identifying Kenyan socio-cultural sexual scripts and how these might affect condom use among Kenyan youths, theory (scripted theory) driven thematic analysis was adopted. This theory proposes that much like scripts that stage actors use to guide their behavior, social scripts instruct members of a society as to appropriate behavior and the meanings to attach to certain behaviors. Therefore they dictate what one should be doing at a particular time and in a particular place if one is to be a member of a particular group. Since this study was driven by scripted theory, an attempt was made to code particular features of the data

set that spoke of learned sexual behavior. Coding was therefore focused on subjects dealing with socio-cultural and religious sexual norms, condom knowledge, use and non-use of condom, HIV knowledge and youth sexual activities in the transcripts. So, the transcripts were examined to identify primary coding categories around the afore mentioned themes. Identified coding categories were organized into a code book, and illustrative quotes relevant to these codes were extracted (Seal et al, 2008, p. 629). 93 initial codes were identified in the examination of the 28 pre-programme focus group discussions. Using thematic mapping, I analyzed the codes and considered how different codes may combine to form an overarching theme. Themes that were found to overlap were consequently merged to create bigger, groups encompassing new themes and sub-themes. 10 overarching themes emerged.

An attempt was made to connect the themes and patterns in order to reveal their broader meaning and implications as well as to theorize their significance. This was done in relation to the previous relevant literature (Aronson, 1994; Braun and Clarke, 2006) as a way of developing broader theme statements that help make sense of the data and appropriately answer the research question.

However, before I get into discussion of the results, there are method (secondary analysis of qualitative data) specific limitations encountered in the course of this study that needs to be attended to in order to ensure the validity and reliability of the research as well as to maintain its methodological integrity. Of first concern is generally, the suitability of the data for purposes of secondary analysis (Medjedovic and Witzel, 2005). Since secondary analysis involves analyzing pre-existing data in order to investigate or examine a concept or question that was not central to

the original research. Not only must data from the primary study be readily accessible, but the researcher must ensure that the research questions of the secondary analysis can be addressed by the primary study data. However, while this may be a problem for other secondary analysis studies, it was not the case for this study because the research question under review in this study was part of the original research. A second concern regarding secondary analysis of qualitative data is the risk of decontextualization (Kelder, 2005 and van den Berg, 2005). Since data in the primary study are usually collected for different purposes than that of the secondary analysis, there is the problem that data will be interpreted out of context and thus render the analysis potentially invalid. However, the research question for this study was part of the original research. As a result, the problem of decontextualization is very unlikely in this case.

A third concern revolves around ethical issues. Since secondary analysis is unobtrusive in that it does not involve direct research with human subjects, the usual ethical considerations regarding research involving human subjects do not appear to apply. However, there are ethical issues to consider in conducting secondary analyses of data collected involving the participation of human subjects. First, permission to use primary data for secondary analysis purposes should be obtained (Kelder, 2005). For this research, permission was obtained from the project director, Dr. Eleanor Maticka-Tyndale, to use the data collected in the evaluation of the PSABH programme. Secondly, Ethical clearance was sought and obtained from University of Windsor Research Ethics board for this project. I also relied heavily on the ethical standards and practices adhered to in the primary study in which the data were collected. As the original study was a funded research project carried out under the direction of an academic professional in a recognized educational institution, ethical approval for the study was obtained and the usual

ethical standards adhered to in carrying out data collection involving a population of Kenyan youth. To maintain this ethical integrity and to further re-contextualize the data, the ethical issues regarding the primary study and the practices guiding the data collection were reviewed. As further safeguards, extreme care was taken to ensure the confidentiality and to maintain the security of the primary data that was secondarily analyzed for this research.

These however, were not the only limitations encountered in the course of this study. There were others, but since those were limitations stemming mostly from the study, I will discuss them a little bit later.

## **Results/Discussion**

Looking further at the ten themes and sub-themes that emerged from the data, it was found that they either encouraged/discouraged young people from playing sex or inhibited/promoted condom use. Topics like sex equals maturity, imitating sexuality of adults, expectation to play sex, forced sex, peer pressure, gifts for girls and lack of sexual control in adolescence came up in several studied communities and were noted to lead young people to play sex. However, these were not the only themes observed. Topics that discouraged young people from playing sex were also observed. The breakdown of these two variables (encouraging/discouraging playing sex) as well as the number of communities out of the 28 in which the topics were mentioned is presented in table 1. Table 2 shows the topics that inhibited/promoted condom use among the young people as well as the number of communities in which these were mentioned. In depth discussion of broader, cross-cutting themes as well as

how they affect youth sexuality and condom use will be presented in the remainder of the results/discussion.

**Table 1**

**Encourages/discourages youth to play sex**

<b>Encourages youth to play sex</b>	<b>Number of communities (total - 28)</b>		<b>Discourages youth from playing sex</b>	<b>Number of communities (total - 28)</b>
Sex equals maturity	12		Fear of STIs	15
Lack of sexual privacy/Imitating adult sexuality	13		Church against playing sex	18
Expected to have sex	15		Parents' advice against sex	21
Forced sex/rape	26		Sex (pregnancy) destroys education	24
Social and cultural pressures	26			
Lack of control in adolescence	27			
Gifts (for girls)	28			

**Table 2**

**Encourages/discourages condom use**

<b>Facilitates Condom use</b>	<b>Number of communities (total – 28)</b>	<b>Barriers to condom use</b>	<b>Number of communities (total – 28)</b>
Avoiding STDS/HIV	17	Contradictory message on condom	11
Girlfriend demands condom use	21	Modesty and femininity	12

Fear of conception	26	Abstinence based sex education	13
		Suggesting condom denotes HIV status	14
		Don't know how to use condom	16
		Misconceptions about how HIV spreads	17
		Desire to spread the disease	19
		No adult/parental sex education	20
		Myths about condom	24
		Inaccessibility of condom (social and religious barriers)	24
		Forced sex/rape	26
		Young girls vs. men	27
		Transactional sex	28

### **Summary of tables**

Explaining the tables further, table 1 depicts factors that encourages as well as discourages young people to play sex. It was found that the belief that sex equals maturity, that young people are expected to play sex, that young people, particularly young boys cannot control their sexuality, that young girls will be raped if they refuse to have sex, as well as transactional sex, peer pressure, and imitation of adult sexualities encouraged young people in Nyanza and Rift Valley provinces to debut sex early. That is, because these were the sexual script by which people in the community interpreted their personal and collective sexualities, for young people, doing anything but these made them seem different from everybody else. For example, a boy who controls his sexuality and thus abstains from sex and has no girlfriend is perhaps as different as a person who drives on the wrong side of the road here in the West. Such difference as we will discuss later is sanctioned through insults, alienation, and gossiping. As a result, people rarely

deviate from their cultural sexual proscriptions. Such people may know about the fatal nature of HIV for instance and know how to protect themselves, they are likely to continue practices risky sex if the prevention method is contrary to their sexual scripts.

As is evident in Table 1, although other factors such as fear of STIs including HIV, fear of conception, parents' advice against sex, and religious doctrines against sex were present in the discourses of the young people in the data and were observed to discourage young people from playing sex, there were more factors encouraging sex than discouraging it and more youths spoke about the encouraging factors.

In table 2, factors such as cultural construction of femininity, contradictory message on condoms, lack of complete sex education, misconceptions about HIV, lack of adult/parental sex education, inaccessibility to condoms, forced sex/rape, young girls and old men sexual liaisons, transactional sex, as well as myths about condoms, the belief that suggesting condom denotes HIV status, the desire of those already infected not to die alone, and the fact that some young people do not know how to use condoms, were found discourage young people from using condoms. Again, other factors such as fear of conception, girlfriends demanding condom and fear of STIs including HIV were present and encouraged condom use. However, these encouraging factors were again very short compared to the discouraging factors.

In depth analysis of the factors in table 1 and 2 will be presented later on. However, due to space constraint, not all the factors presented in the tables will be addressed. Commonly held factors that were perceived to influence youth sexuality in terms of encouraging/discouraging sex, or discourage/encourage condom use will be discussed.

## **Factors contributing to sexual activity and discouraging condom use**

### Poverty/transactional sex/rape

Let us look at the factors in Nyanza and Rift Valley, Kenya that encourage young people to play sex in more detail. According to Njue, Rombo and Ngige (2007, p. 50), poverty is defined as the inability of families and households to afford basic necessities, such as food, clothing, housing, health, and education. Kenya is ranked among the 30 poorest countries in the world, holding the 146th position out of 177 countries studied by the United Nations Development Program (UNDP) (2003). According to the Welfare Monitoring Survey of 1997, 52 percent of Kenyans were living below the poverty line (determined by the Government of Kenya to be 1,240 Kenyan shilling per person per month) (Place, Adato and Hebinck, 2007, p. 313). The population whose expenditure on food is insufficient to meet the recommended daily allowances of 2,250 calories per adult is 48.7% (Njue, Rombo and Ngige, 2007, p. 50). The figures in rural Kenya are said to be even worse. According to the 2003 figures compiled by Kenya Central Bureau of Statistics, Western Kenya is one of the poorest, with the percentage of the population living below poverty ranging from 58% to 68% in the districts in which this research takes place (Place, Adato and Hebinck, 2007, p. 313). Sadly, there exists a link between poverty and HIV vulnerability. Poverty is thought of as a major element of the risk environment that fuels vulnerability to HIV in Africa (Pronyk et al, 2008, p. 2000). With the overwhelming poverty gripping western Kenya, it is not surprising that Nyanza district has the highest prime-age HIV/AIDS infection and mortality rates in Kenya (UNAIDS/WHO, 2001). For example, while Kenya's HIV/AIDS prevalence rate is estimated at 13.9%, Nyanza and Western Province report rates of 17.4% (Adari, Rahnama and Starnes, 2007, p. 357). It is believed that economic necessity pushes girls to debut sex early and to have multiple partners, thus, making them prone

to HIV/AIDS infection. In this study, the influence of poverty on early sexual debut and other risky sexual behaviors was widespread. Transactional sex, multiple partnerships, early sexuality due to sharing of rooms with sexually active older siblings or parents and non-condom use as a result of inaccessibility of condoms, all of which are a direct result of poverty, were all mentioned as influential on the young people's decision to engage in risky sex.

Poverty is also linked to young people's decision to exchange sex for money and gifts. According to Wight et al. (2006, p. 992), transactional sex is so established in sub-Saharan Africa that almost any gift from a young man to a young woman, is seen by both parties as a contract to have sex. In this project, as illustrated on Table 1, young people in all 28 communities studied, alluded to the existence of some form of transactional sex present among them. For instance, in one female focus group discussion, when the interviewer asked why they think girls of their age find it difficult to wait until they are married before playing sex, one answer was:

*Due to their desire the boys deceive the girls they promise to give the girl many things. Maybe the parents of this girl are not financially stable, this girl does not get what she wants from home that is why she goes to that boy so as she can be given money, in the process they have sex (community 22, females).*

This answer reveals the lack of agency of young girls when it comes to sexuality due to economic dependence on boys and men. In their analysis of the focus group data, Maticka-Tyndale and colleagues (2005) pointed out that girls are kept close to home and work in the family compound whereas boys' activities are away from home. The containment of girls means they have no way to earn money. For instance,

*\* Q: Money, when you offer them money, they give in?*

*Here the work of girls is mainly cultivation and they don't get money easily because they don't have jobs. When you offer her money, she is ready to do anything for you (Community 8, male).*

Boys on the other hand are not contained, and consequently, have money from jobs.

*\* Q: And where exactly do you get money to give to girls so that you can have sex with them?*

*From pyrethrum picking.*

*\* Q: What else?*

*Cultivating.*

*\* Q: Farming?*

*Casual labour.*

*Selling eggs (community 8, male).*

Girls' only access to money is therefore from boys and men. These boys and men, on the other hand, expect girls to play sex in exchange for this money. Moreover, the rampant economic deprivation that exists in most households in the western provinces of Kenya means that some families are sometimes unable to provide even some basic items to their youngsters. For such families, all they may be able to provide for their youth are food, clothing and shelter. However, the young people in the data mentioned food, money, shoes, bags, clothes, soda, braziers, lotions, comb and many more as items that induce them to play sex.

While we in the Western World may look at these items and consider them necessary for a girl's upkeep and lack of them as deprivation, in a society where almost no one has them, these items are able to induce young girls to play sex because of desire to have them. But, according to

Luke (2006), transfers of money and other gifts for sex are significantly associated with lower probabilities of safer sex. She presents convincing evidence that there is a market for risky sex even in informal relationships (Luke, 2006). By comparing the use of condoms (her measure of safe sex) by men aged 21-45 years in Kisumu, Kenya, she finds that partnerships involving larger transfers are strongly and significantly associated with lower probabilities of safer sex. She did not find a difference in this trade-off for younger compared to older women (Luke, 2006). A cursory look at Table 2 shows 27 out of the 28 communities speaking about relationships between older men and young girls. However, Dinkelman, Lam and Leibbrandt (2008, p. 56) argue that a market for risky sex exists for all women who are willing to trade off higher incomes for greater disease and pregnancy risk. In addition, widespread in this study was the expression that a boy will leave a girl after a while if she refuses to have sex with him. When the facilitator asked the girls' focus group in one community, *why do you think girls of your age are finding it hard to wait?* The following answer was given:

*When she loves her boyfriend, and the love is very strong she will agree into having sex with him because she gets money from him and she gets everything she wants, she wonders what would happen if she loses him (Community 1, females).*

In another girls' group, when the interviewer asked for clarification regarding *what a girl will do if someone is pushing her to play sex when she doesn't want?*

One young girl answered:

*It is easy but you find most cases the girl has been already brought gifts. Now you see she is going to lose the chances of getting gifts. Now she must stick to that boy to get gifts (Community 28, females).*

Thus, fear of losing a source of money and gifts may force girls to stay in relationships and to engage in sex even when they don't want to.

Furthermore, because reception of any money or gift from a young man by a young woman in sub-Saharan Africa is seen as a tacit agreement to have sex with him (Maticka-Tyndale et al, 2005; Wight et al, 2006), refusing him sex is tantamount to reneging on a contract. Widespread in this study was the notion that the aggrieved party is socially sanctioned to take measures to redress the situation. The step mostly spoken of by focus group participants was rape. As is evident in Table 1, 26 communities mentioned forced sex or rape as a consequence for refusing sex with a boy or man. They mentioned that a boy will demand to be given back everything he has ever given to the girl if she refuses to have sex with him. In that situation, the girl has to either “*agree to play sex so that she can clear her way*” (Community 21, females) or risk being raped. For example, when asked *what would happen if a girl doesn't want to play sex but the boy does*, one male participant expressed that forced sex or rape may result.

*If they are like fetching firewood at the riverbank the boy must force her.*

*He can ask her, if she refuses he will throw her down, tear her clothes and force her to play sex (Community 20, male)*

Being gang raped was also mentioned as a way boys redress being “cheated” by girls. The aggrieved boy, it is mentioned, could assemble a group of friends who will assist him in getting retribution. For example, in one male focus group discussion, one boy stated:

*I have heard in the village that there is somebody who forces girls so they can play sex with him. He has a group of friends who get hold of the girl and others hold the hands*

*and legs and put some stuff soil in her mouth of the girl so that she does not scream  
(Community 10, male).*

When asked if such incidences were common in that community, another boy simply said: *Yes, it does (Community 10, male)*

Unfortunately, there was not a single situation in the data where mention of rape was accompanied by reporting to police or even to parents. Instead, the youth spoke of girls “accepting to play sex” when they were forced. The following are some of the reasons given in 3 different communities for not reporting rape:

*On refusing to have sex with him, the boy will lure the girl into going to his place. At his place he tells the girl that if she does not, he threatens her on hearing this the girl thinks if people hear me scream they will wonder and ask me what I was doing in his house. So she will accept to have sex with him (Community 22, female)*

*If you tell your parents, it will be obvious they will end up beating you because they will say that you had done it before so why should you come back and tell us later  
(Community 18, Female).*

*It is not easy for the girls to tell their parents because they will think it is just the mistake of the girl (Community 15, female).*

In a society where having a boyfriend is a necessity for living and where refusing sex is punishable by gang rape, it is conceivable that most girls will agree to play sex rather than be forced to have sex, and research repeatedly shows that condom use is rare in situations of rape.

### Cultural construction of femininity

The difference in sexually risky behaviour between men and women, does not only stem from differences in negotiating power based on money, but also on the social construction of masculinity and femininity. According to Simon and Gagnon (1987) men and women learn different scripts because they inhabit different social locations meaning, gender identities are partly forged through the language we use to describe ourselves and others. The gendered identities of the boys and girls in this study were often expressed and affirmed in relation to sexual desire (Pattman, 2005, p. 498). The typical sexual script for young boys included the active pursuit of sexual partners, peer validation of sexual activity, inability to control sexuality once aroused, and sex undertaken solely for the sake of pleasure. As Table 2 depicts, the typical sexual script for women on the other hand included, waiting to be chosen instead of pursuing a partner and a wish to please men. For instance, young people in 12 communities equated femininity with modesty. According to this script, females are supposed to be submissive recipients in the act of sexual intercourse, while the males are supposed to be the aggressive decision-makers (Oshi et al, 2007, 200). Markle (2008, p. 47) argues that people rarely stray too far from the sexual scripts that consistently result in sexual success.

This is very true in Kenya. Pattman (2005, p. 497) explored the significance of sexuality in relation to the ways boys and girls in southern and eastern Africa construct their identities. He

drew on a UNICEF-funded study conducted in the region with 6–18-year-olds from 2001 to 2002. In the UNICEF study hundreds of young people were interviewed in the participating countries – Botswana, Kenya, Rwanda, South Africa, Tanzania, Zambia and Zimbabwe – about their relations with and attitudes towards people of the same and the opposite sex, boyfriends and girlfriends, parents and teachers, interests and leisure pursuits, pleasures and fears, future projections, role models, views on HIV/AIDS (p. 499). Much like Markle, Pattman found that the young boys and girls did not deviate from the socio-cultural gender scripts when they talked about gender and sexuality. For example, when asked whether they would like to change sex for a day, young teenage boys in Kenya expressed horror at the prospect, constructing boys as active, free and strong and girls as passive, tied to the home and emotionally and physically weak. Meanwhile, some girls in Kenya envied boys for their freedoms to stay out late and mix with friends, and wanted, for this reason, to change sex (p. 500). What’s more, in all the countries studied, boys were constructed as initiators of heterosexual relations through ‘proposing love’. ‘Proposing love’ was always something that boys did to girls, and encompassed a range of ways of initiating displays of sexual interest, from asking a girl out to calling her ‘sweetie’ and ‘baby’ (p. 502). However, girls’ failure to ‘propose’ to boys did not reflect lack of sexual interest in them (p. 503). Significantly, there was much laughter when the girls were speaking about the boys’ sexual feelings. No doubt this reflects embarrassment and implies that the girls share these feelings – but are not supposed to articulate them (p. 501). When probed further by the interviewer, the girls admitted that they also had sexual feelings (p. 501). Although culturally inhibited from “proposing love” to boys, girls spoke of giving out signals to boys to indicate their willingness to be with or even play sex with them. The following excerpt from Pattman’s study drives this point home.

*Interviewer: Why?*

*Pupil: It's embarrassing to ask a man out.*

*Interviewer: So what do you do when there is a boy you like? How can you let him know that you want him?*

*Pupil: You simply do a lot, make some moves, actions, or even dress attractively and let him notice you, and greet him so often, especially when wearing a miniskirt to attract him ( p. 503).*

Consistent with the studies cited above, it was found in this study that girls in the focus groups are socialized to be passive and sexually coy. Young people in 12 focus group discussions brought up topics on sexual passivity of women as shown on Table 1. They suggested that girls are told to be sexually non-responsive and to never say yes right away when propositioned to have sex. Boys on the other hand are raised to be sexually aggressive “hunters” and to never take “no” for an answer. They are told that girls will say “no” even when they are willing and will therefore relent and play sex with them if they persist. So, boys consistently spoke of looking for telltale signs and clues as to whether a girl likes them or is willing to play sex with them. Giggling, following you everywhere, visiting your home, exposing herself to you etc, were all said to be signs of a girl’s willingness to play sex. For example:

*\* Q: How do they show they want to play sex?*

*They follow boys at all times.*

*She pretends she has come to see your sister.*

*\* Q: If you have a sister?*

*Yes*

\* Q: *And then when she gets in?*

*She calls you*

\* Q: *And then she calls you?*

*She tells you to escort her to her home.*

\* Q: *And then you take her to...*

*Your house*

\* Q: *You take her to your house?*

*Yes*

\* Q: *And you finish with her there and then?*

*Faster.*

*(Laughter)*

\* Q: *And how will you know she wants apart from her coming to look for your sister?*

*How else can you tell that they want to have sex?*

*When you meet her and she follows you.*

\* Q: *Yes?*

*She touches you.*

*(Laughter)*

\* Q: *Where exactly does she touch?*

*She holds your shoulder.*

\* Q: *She puts her hands like this?*

*Yes.*

\* Q: *And how do you feel when she touches you?*

*You take hold of her hand and you go (Community 9, male)*

While it is true that the culturally constructed sexually coy, and nay saying female may cause some sexually willing girls to want to play “hard to get” or resort to signalling rather than stating their intentions, the blanket assumption that all girls say “no” when they mean “yes” and thus relent when forced is problematic. The assumption that a polite, giggly, girl who may have accidentally exposed herself is expressing her willingness to play sex with a boy may be masking rape in the communities. Rarely however, according to the literature, is forced sex executed with condom use, thus, exposing youths and their subsequent partners to HIV infection (Zambuko and Mturi, 2005, p. 582).

#### Lack of sexual privacy/Imitations

Prevalent across Kenya is the belief that boys cannot control their sexual urges when they reach adolescence (Maticka-Tyndale et al, 2005) and that hearing about or seeing people play sex compels them to do likewise. As one can see in Table 1, this notion is so widespread that young people spoke about it in 27 of the 28 focus group discussions conducted. As a result, in order to control children’s sexuality, the cultural context within which sex has traditionally occurred in Kenyan communities and in the African sub-region has emphasized discreteness in sexual activity, reinforced through a myriad of taboos and sexual norms (Amuyunzu-Nyamongo and Magadi, 2006, p. 153). For instance, many cultures in Africa expect sexual acts to be between adults and take place in privacy (p. 153). However, to do so requires space. Given that most households in Western Kenya are poor, it is foreseeable that they will have very limited rooms/space in the households to enable sexual privacy. As a result, these “out of control” adolescents, share rooms, most of the time, with their older, sexually active, siblings or even with

their parents. Amuyunzu-Nyamongo and Magadi (2006) examined sexual privacy as a factor that influences the relatively earlier sexual debut among the urban poor in Nairobi. They conducted 40 focus group discussions with people aged 13–17, 18–24, 25–49 and 50+ years, community leaders and service providers in four informal settlements of Nairobi. They observed that on average, three people occupy the single-roomed structures in the slum communities (p. 144). Although adults reported using various means to acquire some measure of privacy, such as waiting for children to fall asleep, switching off the lights and separating the sleeping areas using curtains, these measures were found to be inadequate to prevent children from witnessing coitus (Amuyunzu-Nyamongo and Magadi, 2006). Living in single rooms and the consequent lack of sexual privacy on the other hand, was reported to be giving the children the ‘urge to have sex’ (p. 151). For example, when asked “*what are the reasons for these people playing sex*”, a boy I will call Alex answered:

*Like children have not seen it anywhere, they may watch dogs playing sex so from that they may also want to try. And also parents, some parents like to sleep with their children in the same room. And sometimes in their minds they have not imagined what the child can do. But maybe the child has already imagined and even seen. So the next day the child will decide after my parents have gone let me also try this thing and see what people feel (Community 23, male).*

When asked if he agreed with Alex or had a different opinion on the subject, another pupil from the same school said:

*I agree with them because when parents decide to sleep with their child on the same bed. When the mother crosses over to the other side of the bed, the child will see what is happening, it might wake up and see what is happening (Community 23, male).*

As is evident in the quotes above, the lack of sexual privacy breaks the social mores upon which many communities rely to raise their children and to regulate sexual activity. Comparing the cultural belief that witnessing sex compels one to have sex, as well as the traditional expectations that an adolescent boy cannot control his sexual urges, to the lack of sexual privacy and the seemingly open manner in which sex takes place (Amuyunzu-Nyamongo and Magadi, 2006, p. 154), it is not surprising that this belief was expressed during focus groups conducted in 13 communities as is shown in Table 1. They identified that lack of sexual privacy socializes children into early sexual activity. Indeed, young people mentioned that seeing their siblings and even their parents in sexual situations peaked their curiosity and caused them to think about sex and eventually play sex. Indeed, one intoned *“you know words follow the wind (It means if the parent is playing sex and the kids know, they will also do the same)”* so if a parent tells a kid *don't play sex and he/she is doing even the kid sees and does the same (Community 6, female)*.

### Social and cultural pressures

In Kenya, sexuality is linked to health. Virility, especially for men, is associated with being healthy. Within popular discourse, sexual prowess is tied to masculinity and health (Nzioka, 2001). Widespread within Kenya is the belief that sexual release is natural and necessary once sexual maturity is reached (Maticka-Tyndale, et al, 2005, p. 37). As such, numerous myths linking abstaining from sex with medical, reproductive and even mental problems exist in the society. For women, abstaining is said to cause vaginal blockage which in turn causes reproductive problems and even barrenness. What's more, sperms were said to become stronger with the more sex a man plays. Therefore, abstaining from sex was believed to

cause men to have weak sperms incapable of impregnating a woman. Abstaining men were also said to be impotent, unable to convince girls to play sex, or were simply stupid. In line with scripting theory which claims that what is considered sexually appropriate behaviour is socially constructed and passed on, these sexual norms have found their way into the sexual scripts of young people in Kenya. Consequently, young people have accepted that they must play sex in order to prove their virility, their masculinity, and in order to be mothers and fathers in future.

Indeed, among teenagers, adolescence was referred to as a bad age. It is believed that young people, particularly boys in that age bracket, cannot control their sexual urges and are forced to play sex. "*Sex is a must for boys when they reach puberty*" (Community 7, male). Both men and women within the society agree that adolescence awakened sexuality within young people. Men at this age were therefore expected to play sex and with as many girls as possible (Nzioka, 2001). Consequently, adolescent boys who are not interested in playing sex are seen as different. They are seen as weak, immature, stupid and were believed to be potentially childless in future. However, according to (Nzioka, 2000), in African sexual script, society has two ways of preserving itself: either through the biological reproductive process or through what might be described as a process of 'social grafting'. It constitutes the immortalization of the dead through the naming of the living after the departed. Through this process, the individual is not only reborn, but society is also able to preserve its cultural identity, traditions and character. For many Kenyan Africans, the loss of one's name(s) amounts to the loss of one's personality and human existence. This notion according to him is still central to Kenya African sexual codes such that anybody of mature age who dies without children is counted as 'lost' (Nzioka, 2000). For this, among other reasons, it is extremely important in African societies to get married and bear

children since it is their descendants who will keep the departed in memory (Nzioka, 2000). As a result, impotence, infertility or barrenness is scorned in Kenya (Nzioka, 2000, 7). Impotence is considered very humiliating and the subject of much gossip (Wight et al, 2006, 994). Therefore, the fear that abstaining from sex would cause barrenness or impotency in future compels some young people to engage in sex.

### Pressure related to belief

Moreover, perhaps because rites of passage, marriage, and sexuality signal transformation from childhood to adulthood in traditional African societies and because sexuality in Africa today is seen as an adult business, sex among the young people has come to represent maturity. When asked if *sex was a sign of maturity*, the answer was: *Yes because they think that if you have sex you become mature (Community 15, female)*. Thus, having a boy/girlfriend is seen as a sign of being mature. Indeed, as illustrated in Table 1, in 12 focus group discussions, the young people linked being in a relationship and playing sex with maturity. For them, having had sex is an indication that one is mature. Conversely, remaining abstinent is an indication that one is still a child. As such, single teenage boys and girls were said to feel bad when they saw younger boys and girls with partners or playing sex.

\* Q: *Those younger than them?*

*If younger people are doing it, then she can think that the younger ones are defeating her in life and that they know more than her and she should be knowing better than them.*

\* Q: *They do it because of that, they do not want to be defeated?*

*Yes (Community 2, female)*

In order not to remain immature or feel left out, these older single boys and girls were said to play sex. So, for young people, playing sex allows them *“to boast”* (Community 24, male). Indeed, when asked what *“makes people feel they have to play sex”*? One young person answered, *“some do it to make people think they are heroes”* (Community 24, male). It is therefore not surprising to hear young people referring to not having partners and abstaining from sex as loosing out. They feel that *“their day of marriage is far”* (Community 4, male). Indeed, one asked *“when will I ever finish school to marry and play sex”*? (Community 20, male). Some even believed that *maybe God will come back before they do it* (Laughter) or *if they wait they will become old and they will not get (to play sex)* (Community 22, female). Therefore, *“they now feel that, now I am a girl my hips have grown, I have breasts so what else is remaining let me have it”* (Community 5, female).

The problem however is, among these same young people, it was very common to hear them equate playing sex with love. In fact, sex was seen as the proof of love for a partner. A girl proved her love for her boyfriend by playing sex with him. Refusing to play sex with a boyfriend indicated lack of love and was a reason for dissolution of the relationship. Not wanting to be labelled immature for not having a boyfriend, or backward for being a virgin, or not wanting to lose their source of income, most girls gave in and played sex. However, because most children do not have their own rooms and share rooms with their parents or siblings, sex usually took place in bushes, abandoned houses, and deserted marketplaces. For such young people, sex was an unplanned occurrence. It happened on their way from school, when fetching water, fire wood or when they ran into each other when running errands. Unlike adult sexual encounters which is condoned and expected *“so they don’t have to worry of being caught, for children, they do it fast*

*so that they are not caught” (Community 17, male).* Implicitly, because sex was unplanned and a hurried event, condoms were rarely introduced into such liaisons. For example, the facilitator wanted to know why they don’t use condom in such situations. He asked:

*\* Q : Or is it that they don’t know condoms?*

*They are usually in a hurry not to be caught.*

*It (condom) delays them, putting it on is so delaying.*

*They just put it in “like that”*

*They simply do it skin to skin (Community 17, male).*

As we can see from the excerpt above, one of the many reasons why condoms were not used in such encounters even in instances when condoms were available was because the immediate concern for young people engaged in sex, because youthful sexuality is frowned upon, was not being discovered rather than on disease prevention. Consequently, condoms were not used in such situations, thus exposing the parties to the threat of HIV/AIDS.

### Peer pressure

Furthermore, because the male sexual script posits that real men should play sex and this belief has filtered down to the youth sexuality, 12 to 15 years was referred to as the common age to start playing sex. Young people of and above this age of who have never played sex are seen as different, weak and stupid. As such, youths who have never had sex are laughed or jeered at by those who already have started having sex. For instance participants commented on expectations surrounding male youth sexuality:

*If one of them does not have a girlfriend, they will despise him and they will not accept to walk with him, so they end up saying “so and so is not informed”.*

*If they realise that one does not have a girlfriend they look down upon him (Community 14, female)*

What's more, perhaps because the male scripts about sexuality indicate that a young male should be always wanting sex, be always ready to have sex, and be ready and able to perform penetrative sex (Measor, 2006), sexual performance is policed within youth culture. For instance, widespread across the data were friends “hooking up” their single friends. In this instance, the friends did not stop at jeering, mocking and ostracizing the single friend. They went a step further by getting him a girlfriend. According to the male sexual script in the communities studied, the single boy was supposed to accept the “gift” and play sex with her. If he refused to play sex in this situation, it meant he was not a real man and is therefore called names and kicked out of the group.

*\* Q: How?*

*They get him a girl.*

*\* Q: What happens if he doesn't have sexual intercourse?*

*His friends abandon him (Community 3, female)*

*\* Q: Okay, how do his friends respond to this?*

*They will say that the boy is young and he is not mature.*

*\* Q: What will the other boys tell him, if he doesn't want to play sex?*

*They will laugh at him*

*Some of the boys will tell him that he is behaving badly that how can he refuse to play sex with a girl who is available (Community 15, female).*

\* *Q* : What if a boy decides he doesn't want to play sex?

*They will nickname him Impotent (Community 7, male)*

What's more, within the Kenyan culture, refusing sex with a willing girlfriend is said to be an insult to the girl. Being sexually rejected by a boy was said to be an indication of a girl's positive HIV status. That is; if a boy refused to have sex with a girl, it meant the boy did not trust the girl and was unsure of her HIV status. The young people believed that the rejected girlfriend would not take such an insult lying down. The girls were said to react to being discarded by insulting the boy. It was widely believed that the girl would not only call the boy names and end the relationship, but that she would also spread rumours about him. As one participant conceded, if a boy refused a willing girl, *the girl will go out saying that is a useless boy and she will spoil his name (Community 16, male)*. Both boys and girls who participated in the focus group agreed that the aggrieved girl would tell other people that the boy was impotent, or suffering from HIV/AIDS. However, because of the status attached to virility as well as the HIV stigma in Kenya, such a rumour was enough to coerce a boy to play sex.

Also, because sexual performance is policed within youth culture, young men anticipate female ridicule and rejection in response to any 'failure'. In 26 out of the 28 focus group discussions as presented in Table 1, peer pressure was mentioned as a reason for young people, particularly young men playing sex. Inability to respond in ways the script prescribes (play sex) therefore, did not only threaten the *young men's sense of sexuality and incipient adult status, but also threatened their sense of themselves as masculine (Measor, 2006)*.

Because abstaining from sex has a potential of making you barren or impotent in future, playing sex guarantees status among peers, because abstaining is punished through jeering, mockery and ostracization, most boys started playing sex when they were still quite young. Indeed, 12 to 15 years was referred to as the common age to start having boy and girl friends and dates and in effect play sex. Not having a girlfriend at this age, thus, is a cause for concern.

*\* Q: Anyone (silence) Lucy why do you think it is common to have a boyfriend?*

*If you do not have a girlfriend or boyfriend at this age, you will feel like life cannot continue. This is why many people have boyfriends and girlfriends at this age and they even make love before their time comes (Community 1, female).*

While all these pressures which leads to for youthful sexuality espoused above are male centered, that is not to say that girls were immune to peer pressure. Though theirs was more subtle than the boys', it was pressure nonetheless and most girls were not able to withstand it. Nowhere in the data did girls speak of jeering, mockery or ostracization from their friends as reasons for playing sex. Rather, they talked of economic and social pressures. For instance, seeing their friends with beautiful things bought for them by their boyfriends or with their boyfriends' money was said to be the driving force behind girls' early sexuality. As shown in Table 1, young people in all the focus group discussions suggested that gifts for girls led them to play sex. As has been discussed previously, poverty in most Kenyan households prevents parents from providing beyond food, shelter and clothing. "Leisure items" such as lotions, stylish clothes, new shoes, etc are beyond the budgets of most parents. What is more, there are limited employment opportunities for girls, unlike boys, to allow them to acquire these items for

themselves. Therefore, girls' only way to get the means to acquire such items seems to be by playing sex with boys and men (Maticka-Tyndale et al (2005).

However, all the socio-cultural views, reasons and examples on reasons young people engage in sex given above were not universal in the studied areas. As table 1 above indicates, there were other factors in the data that worked to discourage the youth from playing sex. Religious teachings and parents' advice against sexuality, fear of diseases and pregnancy and motivation to finish their education were all given as reasons for not playing sex. For instance, throughout the focus groups, young people spoke of fear of pregnancy as a reason for not wanting to play sex. The young people in this study reasoned that pregnancy would disappoint their parents because of the struggles their parents had gone through to put them through school. So they spoke of not wanting to disappoint them. For example:

*\* Q: Let's say you have a boyfriend, and you have sexual intercourse, do you think it's okay and why do you think it's bad. Tell me the reasons?*

*And him being a boy and you are in school with this boy, you might get pregnant and that's the end of your education and maybe your parents struggled to pay your fees then you disappoint them (Community 27, female).*

The expecting mothers were said to:

*\* Q: Betty what do you think. What can a boy do if he is being pushed to play sex when he doesn't want to?*

*He advises the girl that if they do it the girl might be pregnant, and sometimes when a parent sees that she may be chased and go to the street, she might become a street girl (Community 28, female)*

Even if they are lucky and don't get kicked out from under their parents' roof and support, they lose their education, and possible good employment in future. However, pregnancy did not only spell trouble for the girl. It was said that impregnating a girl also brings trouble to the boy's family. For example, when asked what they think about parents and older people saying that young people should wait until they get married to play sex, the following answer was given:

*It is bad for young people because sometimes you can play sex with that girl and you don't know that you have impregnated her in that community so you are going to bring up a problem for your father and mother (community 24, male).*

The family in this case would have to take care of the girl and her baby. Also, she will usually be forced to terminate her education and marry the girl. For this reason, it is found that young people in schools across Africa tend to use condoms in their sexual activities more than non-students. In fact, in their analysis of Demographic and Health Survey data from 18 African countries from 1993 to 2001, Cleland, Ali and Shah (2006, p. 18) found a large increase in condom use by single young women for pregnancy prevention. This trend was statistically significant in 13 of the 18 countries and the average annual rate of increase was 1.4 percentage points per year or 14 percentage points over the decade (Cleland, Ali and Shah, 2006, p. 18). As such, perhaps it may prove more effective to promote condoms for contraceptive purposes among sexually active young people than for HIV control (Maharaj and Cleland, 2006).

Religious teachings against playing sex were also observed to discourage youth sexuality.

The following excerpts from 2 communities speak to that fact.

*\* Q: What do you think about this, young people should not play sex until they are married what do you think?*

*If you have sex before marriage, I think it is a sin.*

*\* Q: That is (name of pupil), (name of pupil) tell me what you think about this story?*

*It is good to wait until you are married to have sex, because even in the bible God has said 'do not play sex when you are young until you get married' (community 22, female)*

*\* Q: Parents or older people say that young people should wait until they get married to play sex? What do you think about this?*

*It is bad for young people because sometimes you can play sex with that girl and you don't know that you have impregnated her in that community so you are going to bring up a problem for your father and mother (community 24, male).*

As a result, we can argue that the HIV/AIDS education programs, condom distributions and the efforts of religious organizations in Nyanza and Rift Valley provinces have impacted young people as far as HIV prevention is concerned, even if it is being hampered by socio-cultural and religious norms (Bosmans et al, 2006; Luke, 2006; Maticka-Tyndale et al., 2005).

## **Factors inhibiting condom use**

### **Religion**

In most parts of sub-Saharan Africa, the large majority of the general population belongs to religious institutions. As such, religion informs some of the daily lives of most sub-Saharan Africans. Consequently, there are strong religious norms that restrict the open discussion of sex as well as condom distribution. Looking at Kenya's population, we find that of the 32 million Kenyans, Christians comprise approximately 66 per cent. Muslims vary between 15 to 33 per cent of the population. The remainder follow various traditional indigenous religions or offshoots

of Christianity (Waris, 2007, p. 39). However, Warenius et al, found that regardless of religious affiliation, premarital sex is prohibited (2006, p. 120). For instance, both Christianity and Islam; the two dominant religions in the sub-region hold similar teachings and beliefs regarding sexuality: (1) sex is only acceptable to God/Allah within marriage, (2) people are easily tempted to sin, (3) teaching about sex can tempt youth to sin and is unnecessary since they don't need to know. As such, most Christian and Islamic denominations preach against teaching young people about sexuality, about contraceptives, and about condoms. When they educate young people at all about the dangers of HIV infection, they insist on abstinence until marriage. Any other method such as condom use is considered sinful because it encourages youth or gives them an excuse to play sex. However, some Christian denominations do teach about sex, HIV and condoms.

Nevertheless, because almost all Kenyans belong to a religion and religious norms usually prohibit premarital sex and extensive sex education, it is imaginable that the desire to prevent young people from getting condoms will be far reaching. For example, as shown in Table 1, young people in 18 communities said that churches teach against playing sex and by extension, using condoms. Consequently, when asked where they think they should learn about sex and who should teach them, young people in this study rarely mentioned the church. In fact, when facilitators mentioned the church and priest, some of the youths suggested sexual issues should be learnt in school and *“at home because if you say in church that is bad now you are going to Satan things”* (Community 6, female).

Moreover, since nurse-midwives are the core health care providers of adolescent sexual and reproductive health services in eastern and southern Africa (Waris, 2007, p. 121), Warenius et al, (2006) conducted a study to investigate attitudes among Kenyan and Zambian nurse-midwives (n=820) toward adolescent sexual and reproductive health problems, in order to improve services for adolescents (Waris, 2007, p. 119). Their findings revealed that nurse-midwives disapproved of any form of adolescent sexual activity, including masturbation, contraceptive use and abortion (p. 119). The majority of nurse-midwives in both countries (Kenya 77%, Zambia 81%) agreed that “their first option would be to recommend unmarried adolescent boys and girls to abstain from sex when they ask for contraceptives” (p. 123). Indeed 59% of Kenyan and 47% of Zambian respondents disagreed that “schoolboys asking for condoms show responsibility” (p. 123). Instead, asking about condoms was seen as a sign of bad manners or promiscuity. Consequently, these health care professionals tried to prevent young people from accessing condoms. As can be seen in Table 2, young people in 24 focus groups discussions spoke of inaccessibility to condom. The young people mentioned other reasons for this lack of access to condoms, such as embarrassed to buy condoms, and lack of purchasing power, however, one reason that came up persistently, was adults preventing young people from accessing condoms. For instance, young people in the focus groups spoke of other young people who had gotten into trouble for trying to buy condoms. They spoke of pharmacists telling their parents about their desire to buy condoms and thus getting them into trouble with their parents. They also spoke of situations where nurses and midwives had told others in the village about a youth’s desire to get condoms and thus destroyed their reputation in the community. As a way to avoid getting into trouble with parents or risking their reputation, most youths avoided trying to buy or get free condoms. Some spoke of trekking long distances to villages/towns far away

where they were not known to buy condoms. Yet other young people spoke of some children picking up used condoms, washing them, and re-using them. All these avoidance techniques inhibit consistent condom use and expose youth who are sexually active to danger.

#### Discouraging and contradictory message on condom use

Rankin et al (2008) have speculated that condom messages from religious organizations may be contradictory to those of the state and thus may cause people to hesitate about using condom. They utilized in-depth interviews with a purposive sample of 40 central leaders from 5 faith-based organizations to glean data on government positions from the religious leaders and the media to examine the impact of two mitigating social institutions, religious organizations, and the state, on Malawi women's vulnerability to HIV (Rankin et al 2008, p. 597). Rankin, et al observed that conflicting messages exist and resulted from the confusion around HIV prevention messages and a "demonization" of the government because religious leaders did not support condoms and they were suspicious of the government, believing that they had no right to mandate behavior (p. 601). This situation however, is not specific to Malawi. In fact, the situation is not any different in Kenya as demonstrated in Table 2. Because religious institutions emphasize abstinence, marital fidelity, and faithfulness as virtues, condom promotion and distribution by the government is seen as condoning sin, and is therefore vigorously opposed. This opposition is realized in the contradictory condom messages that are passed on to the youths. While governmental programs on one hand promote condoms as protective and even distribute them to youth, religious institutions and faith-based organizations on the other hand actively promote condoms as dangerous and sinful. However, due to the high percentage of people who are affiliated with a religious organization in Kenya (IPPF/UNFPA, 2008), the anti-

condom message from the pulpit has permeated the studied communities. Parents, grandparents, teachers, coaches, village elders, friends and religious leaders, were all mentioned as preaching against the use of condom. This was reflected in the focus group discussions. Table 1 shows that in 27 communities, parents for instance advised against condom use. When asked *tell me who talks to young people about condoms?* A young male in community 19 answered:

*Somebody like a pastor, a parent or a teacher.*

However, when asked *what they say*, the same young man said that “*they say we abstain from sex ‘til marriage. And that is what the pastors and teachers say (community 19)*”. In another community, another young man answered: “*they are in a group of many boys and they are also taught about Bible scripture to discourage sex*” (community 10, male). Again, when asked in another community if they thought young people should be taught how to use condoms, one young man answered: *No. Because in church we are told strictly not to use (community 20, male)*

The media was also mentioned as contributing to the conflicting messages on condom use. One youth noted that: *it is advertised that condom has some holes so it is not good if used very much because for some people it can help spread AIDS (Community 23, male)*.

Contradictory messages from people who are supposed to have all the right answers leave the youth with more questions than answers and with no clear direction. It may cause them to hesitate about using condoms. Lamentations by some youths indicate this point:

*Some of them say it helps prevent others say they have holes so you do not know which is which (Community 23, male)*

*In most cases some (Sunday school teachers) encourage us others discourages about condoms now we don't know who to follow we are still looking for the right answer (Community 28, female)*

While the contradictory condom message may encourage some young people to hesitate or even abandon condom use, it does not diminish youth sexuality.

### Socio-cultural barriers

Religious barriers are not the only roadblock to condom use in Kenya. There are strong socio-cultural norms in the society that restrict comprehensive sex education to young people. It is believed that talking about sex arouses people and encourages them to have sex (Bosmans et al, 2006, p. 84). Hence, forbidding sex talks from parents, teachers, peers and most family members, is to a great extent, to keep them from crossing the boundary to sexual activity. As such, sex is a taboo topic and is supposed to be discussed and practiced behind closed doors, between adults and for procreation purposes. Talking about sex openly is bad manners and a sign of promiscuity. However, Miroslava (2000, p. 84) points out that there are expected channels for the transmission of information on sexuality. Drawing on gossip, interviews, and fertility histories of men and women, young and old, opinion polls of adolescents, and popular press and the media in western Kenya, he found that grandparents are designated as the appropriate people to teach the youth about sexuality (p.89). Furthermore, the young people in the study routinely mentioned medical people, and chiefs as people who should talk to them about sex. Miroslava argued that the types of information learned from grandparents on one hand and from peers and other sources on the other, are significantly different (p.89). Because grandparents, and to a great degree chiefs and traditional elders, are the arbiters of norms and values, they communicate the

importance of marriage as the context for sexual activity, with reproduction as the primary goal (p. 89). No sexual instruction is given to girls prior to marriage (p. 89). According to Miroslava, the discussion of sexual activity happens after a girl is married and sexually active, rather than before, in preparation (p. 89).

In view of the restriction on sex talk, children do not ask their parents questions about sex and sexuality, and parents do not discuss sex and sexuality with their children (Oshi, Nakalema and Oshi, 2005). For example, as is evident in Table 2, young people in 20 focus groups expressed that they had never been taught about sex by parents. Consequently, young people are unable to communicate their sexual health needs or discuss issues of sexuality with parents. Some reasons given by parents for not teaching about sex include embarrassment, discomfort, and the fear that knowledge will make the children promiscuous. This desire not to “corrupt” the young by teaching them about sex however extends beyond the home and beyond parents. Not only do parents and guardians fail to educate the youth about sex, HIV/AIDS, and condoms, teachers refrain when it comes to teaching about sex. For example, despite the high prevalence of HIV in the country, Kenya’s curricular content which is set by the Kenyan Educational Institute has traditionally placed reproductive health topics within the religious education (RE) or social education and ethics (SEE) curricula. The primary focus of curricula has been on the moral aspects of human sexual behavior (Halpern et al, 2008, p. 629). As a result, as young girls said in the focus groups, information on how to protect one’s self from HIV/AIDS infection is avoided because it is believed that *“If you are taught and you know, you will be like now I wont get anything let me do” (community 25, female).*

Because sexuality is not talked about, young people across the focus groups spoke of not knowing how to use condoms as indicated in Table 2. In fact, this was mentioned in focus groups conducted in sixteen of the twenty eight communities. Some of the reasons given by young people for not knowing how to use condoms include inaccessibility of condoms, no condom education from adults, inability to read, and village dwelling. The young people mentioned that those in rural areas do not know how to use condoms. For example:

*\* Q: Why don't some know?*

*They come from remote places.*

*They did not go to school (Community 9, male)*

According to IPPF/UNFPA (2008), those in rural areas, do not have access to media that transmits HIV related messages, and are unable to access information and subsequently services. While bill board advertisements have become one of the main means of disseminating HIV related messages, there are more bill boards disseminating information about HIV/AIDS prevention in urban centres than in rural areas. They exist mainly in urban and peri-urban areas. Furthermore, voluntary counselling and testing (VCT) sites are situated in urban centers, while services are lacking in rural districts. Consequently, the young people revealed that *“there are those in Towns who attend clubs where they learn what others are doing when they visit rural areas they teach the rural people how to use condoms” (community 19, male).*

However, judging from the fact that 63% of Kenya's population in 1999 lived in rural areas (Thumbi, 2002, p. 3), and that not many communities have people travelling to urban areas, suffice it to say that the number of men/boys who do not know how to use condoms is probably significant. Even though the boy who does not know how to use condoms may know about HIV,

be aware of his vulnerability, and know condoms could protect him, the fear of fumbling with a condom and looking inexperienced in front of a girl, some young people suggested, was enough to compel him to play sex without a condom.

Additionally, most children cited friends, siblings, media and reading disposed condom packages as their source of information when asked where they learned about what condoms are and how to use them, ironically, in a society where the illiteracy rate is so high, learning about condoms by reading discarded packages has the potential of leaving more people ill/uninformed about the protective nature of condoms. Moreover, learning about condoms from peers and siblings, unfortunately, allows myths and mistakes to be passed on as truth about condoms. Myths such as condom containing tuberculosis viruses, being itchy, being porous, being too big for young boys, and being potentially dangerous for girls, then becomes barriers to the adoption of consistent condom use.

### Condom myths

Condom myths abound in the data. As indicated in Table 2, in the focus group discussions in 24 of the 28 communities, young people revealed some condom myths. These myths prevent young people from practicing safe sex. I argue that even if informal distribution of condoms outside of health facilities and through existing social networks (Myer, Mathews and Little, 2002, p. 773) were adopted all throughout Kenya, the existing socio-cultural myths about condoms would still serve as a barrier to consistent condom use. Therefore, for condoms to be adopted and used consistently in Kenya, we need to acknowledge and understand these myths and actively work to change them.

Owing to the fact that sex in sub-Saharan Africa is mainly for purposes of procreation, condom use has come to be associated with recreational sex which is something only loose women or prostitutes offer. As such, condoms tend not to be suggested or used in a marriage or lasting or serious relationships. Suggesting or using condoms might indicate lack of trust and infidelity (Levine and Ross, 2002, p. 89). Introducing condom into such relationships means you either believe yourself or your partner to be infected. The young people suggested that the boy “*might think the girl has a disease or the girl thinks he has a disease that is why she wants him to use it*” (community 24, male), *he may think the girl doesn't trust him* (community 7, male), or “*that may be the girl doesn't love him*” (community 12, female). As a result, the young people in the focus group discussions constantly suggested that condom use in such relationships is not possible. It was believed that the girls will feel embarrassed and afraid to ask their boyfriends to use condoms. Afraid because “*when the girl asks him to use a condom and he doesn't want he will go and look for another girl*” (community 21, female) and embarrassed because exerting sexual autonomy by demanding condom use goes against the socio-cultural sexual script which posit females to be sexually passive and submissive.

Also, widely mentioned in the focus groups were condoms being itchy, being porous and thus a conduit for HIV transfer, too big for young boys, and containing AIDS and tuberculosis viruses. For example, a young girl in one community said: “*The disease might be inside because they are made with medicine and AIDS might be inside*” (Community 25, female). Fear of being infected through condoms notwithstanding, when asked why young people don't like to use condoms, some of the subjects compared using a condom to eating “*a sweet with a wrapper*”

(Community 15, female), *bananas with it's peel* (Community 9, male), or *chicken with it's feathers* (Community 16, male). These youth argued that condoms diminished pleasure and prevented a man from proving “*his power when he uses condoms*” (Community 7, male). As a result, for some men, the diminished pleasure and the desire to “*be a real man*” (Community 7, male) are grounds for them to engage in risky sex.

A more serious and commonly held condom myth, in Nyanza and Rift Valley, Kenya was the notion that condoms could unknowingly come off the penis during intercourse, and get pushed into the woman's stomach. This was a very strongly held myth, and was reported across the focus group discussions irrespective of tribal affiliations. Indeed, as shown in Table 2, it was mentioned across 24 of the 28 studied communities. The ‘consequences’ of this were reportedly surgery to remove the condom from the woman's body, or even death. Obviously, this fear is directly related to the belief that sexual relations are the prerogative of adults only. Consistently the young people interviewed, said “*condoms are meant for older people only*” (Community 7, male). As such, they have come to believe that because condoms are meant for adults, they “*might be too big for you*” as a young person (Community 24, male). Consequently, they fear that using condoms during sex endangers rather than saves the girl. For example, when asked if *it is easy or difficult for a boyfriend and girlfriend to use condoms when they are playing sex*, some females in Community 6 answered:

*Because the way we have said when you use it you say you are protecting yourselves from this disease AIDS. Now if that condom goes into the girls stomach won't she die? Now it will be difficult.*

Another answered: *no the girl will not agree they use a condom* (Community 6, female).

When probed why the girl would not agree, another responded:

*We told you that that girl the condom might go into the girl's stomach and there the girl might be operated or die so she can't agree (Community 6, female)*

In a culture where youthful sexuality is frowned upon, fear of being hospitalized, or worse, dying from a condom imbedded in one's stomach is a potent inhibition against condom use.

Paradoxically, while this fear prevents young people from using condoms, it does not seem to prevent them from engaging in sex. Indeed, the majority of young girls in sub-Saharan Africa are sexually active, sometimes with multiple partners. Studies indicate that youth are initiated into sexual activity as early as age 12 for girls and 13 for boys. It is also estimated that 62 per cent of all mothers in sub-Saharan Africa are within the 15-19 age cohort (Cherutich et al. 2008, p. 923). Unfortunately, avoiding condom use, while actively engaging in sexual activities is the ideal condition for the continued spread of HIV.

#### Older men vs. young girls

Lastly, it has been well established that sexual mixing of younger women and older men, which is generally characterized by economic asymmetry, poses a high HIV risk for women and girls in sub-Saharan Africa (Gregson *et al.*, 2002; Kelly *et al.*, 2003; Longfield *et al.*, 2004; Luke, 2003; Meekers and Calves, 1997). However, as Table 2 shows, sexual relationships between young girls and older men are common practices among Kenyans. Such sexual liaison is primarily economically motivated (Sa and Larsen, 2008, p. 509). Maticka-Tyndale et al. (2005) have contended that adult men are prized over adolescent boys because of the size of gifts they are able to offer. Girls described older boys and men as better partners because they were a

dependable source of financial support than same-age peers. The older boys were also believed to be in a position to marry or take care of the girls and their babies should conception result from the liaison. However, while girls look for older males as partners for economic and “marriageability” reasons, older boys/men on the other hand look for younger girls in order to guarantee themselves sexually compliant as well as inexperienced partners. Young girls are said to be easy to sway with small gifts and easy to convince to play sex. They are also presumed to be sexually innocent and thus free from STDs including HIV/AIDS. So, boys “*just believe that the young ones are the ones who don’t have (HIV), so they go for them*” (Community 24, male). In another community, when the facilitator asked *what are the reasons for having sex with a boyfriend who is older than you?* One male participant answered:

*For me I think that the bigger boys for example there is a boy who has finished school now he wants a girl who has not finished school, now he thinks that the girl doesn’t have AIDS (Community 28, female).*

When the facilitator probed “*so young girls usually do not have diseases?*” A resounding unanimous

*Yes.*

*Yes*

*Yes (Community 7, male)* echoed in the room.

Thus, for older men, having sex with younger girls in a sense has become a way of protecting themselves from HIV. However, because these young women are perceived as innocent and disease free, it suffices to say that such liaisons are unlikely to involve condom use. It is therefore expected that women who partnered with a man of older age would be more likely to be infected with HIV (Sa and Larsen, 2008, p. 509).

What's more, according to Bontempi, Eng and Quinn, (2008, p. 65) young girls, found it very difficult to insist on condom use when involved in this type of a relationship. The reasons, it seems, are twofold. Firstly, studies show that the greater a woman's perceived relationship power, the higher her reported rates of condom use, birth control, and the more control she has over sexual decision making (p. 65). However, a study conducted in Kenya found that among men older than 30 who reported having non-marital partners, 25% had a partner at least 10 years younger than themselves (Longfield, et al, 2004, p. 126). Moreover, because suggesting condom denotes one's HIV status as shown on Table 2, these young women's power to negotiate condom use is compromised by age disparities, economic dependence within such relationships and socio-cultural beliefs about condoms (p.126). Trying to find out the motivations for women and men to enter into such relationships, including the various personal, financial, and social rewards associated with such relationships, Longfield, et al (2004, p. 126), conducted eight focus group discussions with women and 28 interviews with men in four Kenyan towns; Nairobi, Mombasa, Kisumu, and Meru. They observed that cross-generational relationships are relatively common and that young women actively seek partners who are willing to spend money on them (p.127). Female participants explained that most young women pursue older partners who can provide them with money and gifts that are unavailable from partners of their own age (p.128).

However, men who engaged in relationships with younger girls were believed to be more likely to be infected with STIs or HIV compared with the women's age-mate cohort, because these men were likely to have experienced longer periods of sexual activity (p. 126). Nevertheless, several participants of both sexes explained that even if young women recognized

the risk of infection while participating in cross-generational relationships, they are often unable to negotiate condom use with their older partners because men are reluctant to wear condoms, dislike them, and believe that they reduce sexual pleasure. These men often employ their dominant position in relationships by refusing to use condoms, sometimes accusing younger partners of not trusting them. A man may threaten to break off the relationship if his partner insists on using a condom. In that case, “*if you don't want him to send you away, you go without a condom*” (p. 132). Rather than lose the financial and social rewards they depend on in such relationships, most women acquiesce and forgo condom use (p. 132). Implicit in this is that, where there are fewer financially stable men as is the case in Kenya; women tolerate infidelity, abuse and risky behaviours in order to keep their relationships. On the other hand, the shortage of “wealthy” men emboldens the men to philander and to refuse condom. For instance, (Pronyk et al, p. 2008) revealed that economic wellbeing and multiple partnerships are positively related for sub Saharan African men. Needless to say, the economic dependency that women find themselves in, and the jostling among themselves for economically well off men, limits their ability to leave such risky relationship or even to negotiate protection (Luke, 2003).

Secondly, most African societies are gerontocratic. Age in these African societies is revered and respected. The old are regarded as senior members of society who impart wisdom and should at least be held in respect (Okoduwa, 2006). They are the custodians of knowledge and holders of cultural artefacts. As such, theirs is a voice that is sought in difficult situations and rarely are their views challenged. This respect and deference are not only reserved for senior citizens. Children are brought up to respect anybody older than themselves. They are not supposed to challenge the views of adults even when the adults are clearly wrong. In fact, the

Ashanti tribe of Ghana have a proverb which says “when an old man takes a bath, all the water in the house should be finished.” This adage simply means that once an old man (person) speaks, all other voices should be silent. It is therefore, not surprising to see children in most African countries docilely accepting the views of adults. For example, when asked if a girl can get her boyfriend to *respect her wishes if he is older than her*, two girls in community 28 stated:

*I don't think because the boy who is older will say that the one who is older than you is the one to say what you will do.*

Another responded:

*If the boy is the one who is older the boy might just say that I am the one who is older so you must agree what I say. So the girl might just say that the people who are older are the ones who advise the young ones. So she will just agree because the boy is older (Community 28, female).*

From these excerpts, it appears that such deference to adults extends to all aspects of adult/child relationships. For the fear of sounding disrespectful and being replaced, young girls in such relationships readily accept the men's proposition to play sex without a condom. Unfortunately, in an era of HIV/AIDS, this deference to the views of adults in sexual relationship between young girls and old men comes at a devastating price.

#### Facilitating condom use

Although factors that inhibited condom use as outlined above were widespread in the data, these do not suggest that only those factors existed in the communities. As summarized in Table 2, reasons that facilitate condom use also were observed. In 21 of the 28 communities, when asked how a girl can get her boyfriend to use a condom, respondents answered that she will

“tell the boy to use a condom” (Community 4, male). Some pointed out that *most of them (boys) will use condom if asked by their girlfriends (Community 27, female)*. They suggested that the girl will *leave (stop) having sex with him (Community 7, male)* if he refused to use condom. However, when the facilitators probed whether girls actually do this, majority of the respondents (in 19 out of 28 communities) stated that they don’t. For example;

\* Q : *What should a girl do if she wants her boyfriend to use a condom?*

*She may tell him that she doesn’t want to become pregnant.*

*She leaves having sex with him.*

\* Q : *Do girls usually do this?*

*No.*

*They just accept without (Community 7, male)*

\*Q: *Is this what girls usually do? Do they do this?*

*Some will not refuse, they just agree.*

\*Q: *Some just agree?*

*Yes (Community 5, female)*

According to the young people, some of the many reasons why girls fail to suggest or insist on condom use during sex are because insisting on condom use suggests you either mistrust yours or your partner’s HIV status. It is suggested that the boy “*may think the girl doesn’t trust him, that she thinks he has a disease*” or “*he may suspect that the girl has a disease*” (Community 17, male). As such, many girls in the studied communities may know in theory what to do regarding condoms, in practice, the sexual scripts that obligate females to

please and to be emotionally available to males also make it tough for females to refuse sex or insist on condom use. Females may find saying “no” difficult because it breaches an anticipated sexual script (Markle, 2008, p. 47). All is not lost however, girls were said to be able to trick boys into using condoms. The young people revealed that girls tell their boyfriends that they have STIs or “*tell him, I have my monthly periods so that the boy can decide to use it so that he doesn’t become dirty*” (community 6, female). So it appears that where socio-cultural ideologies assign sexually dominant role to males and subservient positions to females, teaching females many more such tricks may be one way to go. It may scare the males straight to using condom while still believing that they are in charge. Admittedly, while this is far from empowering women, relying solely on empowering women to insist on condom use and persuading men to adopt condom may be costly in the long run in terms of human life.

### **Limitations**

The original research was done among upper primary school pupils. Therefore, it was not possible to test whether the fear of conception given as the reason for using condom was true of the general population.

Also, teachers helped in choosing volunteers for the original study. As already established, the selected those who were naturally outspoken in class. They also asked these pupils if they wanted to take part in a research where they would be required to speak about sexual issues. It is possible that this selection criterion may have eliminated those who were not outspoken and those who were shy to discuss sex. However, as established already, literature shows that majority of people, particularly young people in Kenya do not like to discuss sexual

issues openly. Therefore, the respondents for the original research may have been the exceptions. It is therefore possible that the results generated from the focus group discussions were that specific to this group of young people and not applicable to the general population.

## **Conclusion**

In conclusion, sexual scripts, according to scripting theory, are used as a guideline for appropriate sexual behavior and sexual encounters. However, the socio-cultural context in which adolescents in Kenya find themselves has changed considerably within the past few generations (Warenius et al, 2006, p. 120). Here, as in much of Africa, adolescents are experiencing social turmoil resulting from conflicting values as the countries become more industrialised and urbanised. For instance, historically, there was no adolescent stage. Children transitioned from childhood to adulthood, and marriage followed soon after. However, modernisation has prolonged the process of formal education and postponed the age at marriage. Because young people of both genders interact together in their schools, falling in love and wishing to experiment sexually have become common (p.120)

However, the traditional sexual scripts remain. As has been previously established, Kenyans, and to a large extent sub-Saharan Africans, see children as easily corruptible and asexual, therefore, teaching young people about sex and how to use condoms are frowned upon. Teachers, parents, aunts, uncles, pastors, coaches and many influential other people in the young peoples' lives, it was said by the young people in the focus group discussions, did not teach them about sex. It was believed that teaching about sex lead to sexual arousal and may cause these people to cross the line with the young people. The only appropriate people to teach about sex

included grandparents and other “elders” in the communities such as chiefs and assistant chiefs. However, because grandparents and to a great degree chiefs and traditional elders are the arbiters of norms and values, they communicate the importance of marriage as the context for sexual activity, with reproduction as the primary goal (Miroslava, 2000, p. 89).

Ironically, this culture which frowns upon young people's sexuality also have beliefs that seems to encourage youth sexuality. Beliefs that not playing sex leads to vaginal blockage and shrivelled sperm, the belief that young people cannot control their sexuality, and the cultural link between virility and health are all part and parcel of Kenyan sexual scripts and young boys and girls feel they must live by them in order to be members of the societies.

Furthermore, in sub-Saharan sexual scripts, procreation is highly valued. Parents live through their children. As such, not being able to have children is one of the worst things that can happen to a sub-Saharan African. In fact, in her journal article “better a dead child than a dry womb” reproduction and HIV/AIDS in Sub-Saharan Africa, Nyanzi (2006) pointed out that so important is procreation for sub-Saharan Africans that HIV positive women still engage in unprotected sex in order to conceive. As a result of the culturally important nature of procreation, the condom is not used in marriage and in committed relationships. Indeed, condom use is associated with recreational sex; something that promiscuous women engage in. Furthermore, male sexual identity is related to sexual performance. As a result, for men, condom use may become a threat to sexual identity. However, because youngsters learn what is culturally appropriate, including sexual behavior from adults, young people in Nyanza and Rift Valley have come to hold the same values and misconceptions about condoms and therefore do not use them.

Thus, in accordance with scripting theory, in order to effectively tackle the high rates of HIV/AIDS infection in Kenya, it is necessary to take a critical look at the local culture on sexuality and how that culture impacts the behaviour of Kenyan youth. This framework suggests that understanding risk context and its relationship to culture and ultimately to outcomes as far as HIV/AIDS is concerned, may provide a means for effectively focusing prevention efforts. Specifically, identifying the elements of the risk context for sexual activity, examining the relationship of cultural buffers to risk context, and delineating the way risk context might then operate to increase (or decrease) the probability of having sex or unprotected sex may suggest points of prevention or intervention for encouraging healthy sexual decision-making (Kaufman et al, 2007). This study therefore examined the way in which cultural norms regarding sexuality and gender contributes to risky sexual practices among Kenyan youth. The results of this research highlights the complexity of sexual interaction and support the contention, as Maticka-Tyndale et al. (2005) have suggested, that HIV prevention programs need to pay attention to cultural forces, social norms and patterns, situational factors, and gender roles. It is only when we take these into consideration that we will begin to develop and implement policies and programs that will be effective in reducing the HIV/AIDS acquisition rate in Sub-Saharan Africa. For these and many reasons, some cultural specific recommendations based on the findings of this study have been made below. I believe that implementation of these programs would not only redefine what proper sex is, but would also redefine masculinity and femininity to include condom use in sexual encounters and thus protect individuals from HIV acquisition.

## **Recommendations**

As has been established in the paper, health and masculinity in Kenya is tied to virility. Playing sex and with as many women as possible determines one's health and masculinity. This belief however is conducive to HIV/AIDS epidemic. In line with scripting theory, identifying the elements of the risk context, and delineating the way risk context might then operate to increase (or decrease) the probability of having sex or unprotected sex may suggest points of prevention or intervention for encouraging healthy sexual decision making.

According to this theory, people do not want to be different, as such, individuals rarely deviate from socio-cultural sexual scripts established in their societies. Thus, while people in those societies may have all the information about HIV/AIDS and how to protect themselves for instance, they are likely to engage in risky sex than to adopt safer sex if safer sex methods are contrary to their established sexual scripts. In order to get the people to adopt safer sex therefore requires working within the sexual scripts rather than overthrowing them.

In this case, one way of working within the Kenyan sexual script includes redefining masculinity within Kenya. Among sub-Saharan Africans and specifically Kenyans, it is a man's job to protect the home, the wife and the children. For example, in a study of condom use among married couples in Kampala, Uganda, men's reasons for accepting condoms were to please their partner, protect her from HIV and protect their children (Williamson et al, 2006, p.89). Therefore, one way of redefining masculinity with regard to HIV/AIDS perhaps may include extending protection of women and girls to include protection from HIV. Promoting the idea that real men, that good boyfriends and husbands not only protect their wives and girlfriends from physical harm, but also from sexually transmitted infections, may encourage men to be faithful to

their wives and girlfriends or use condoms in their extra-marital sexual liaisons and thus protect themselves and their wives.

Moreover, as the Ashantis in Ghana say, as you admonish the cat, you also make sure to advise the meat. This adage simply means, in any situation between two parties, you do not only advise one party. As a result, as we work to redefine masculinity in Kenya, we also ought to redefine the cultural perception of femininity. As has been established, femininity in Kenya means passivity, subservience, sexually available, and lack of sexual agency. As such, more women than men in Kenya are infected with HIV/AIDS. In order to change this, we will have to work within the conception of femininity in order to change it. Perhaps this could be achieved through the African idea around good motherhood. Good mothers in sub-Saharan Africa are available to their children and provide for them. Any mother who does otherwise is seen as a bad mother. Perhaps, the desire to be there for their children always and to provide for them could be expanded to include protecting themselves and from HIV/AIDS in order not to orphan their children.

What's more, good mothers are not only available and provide for their children, it is also their job to protect their children from harm. Therefore, we need to teach women that being sexually passive, subservient and welcoming would not only give them AIDS and thus orphan their children, but may in fact infect their children as well. We need to educate them that demanding condom use during sexual encounters will not only protect them, but will make them good wives by protecting their husbands, and good mothers by protecting their children. This could encourage more women to demand condom use in their sexual activities.

Since according to scripting theory, sexual behavior is socially constructed and passed on, encouraging condoms use by adults in marriage and in serious relationships may lead to condoms becoming part of Kenyan Sexual script and thus encourage young people to adopt consistent condom use as well.

If more men are encouraged to use condoms in playing sex through redefinition of masculinity and if more women are encouraged to demand condom use through the redefinition of femininity, then perhaps the Kenyan idea of good sex may change. At the moment in Kenya, because good sex is culturally approved between adults and for procreation purposes (Martinez and Waldron, 2006), sex is seen as a mechanism for perpetuating the cultures. According to Kaufman et al (2007, 2160), where fertility is linked to clan or ethnic or family name continuation, semen symbolises responsibility of procreation. Indeed it becomes the responsibility of men to deposit semen in women during coitus in such situation. As such, any sexual activity that does not involve ejaculation into the body of a woman is not considered true sex and men involved in such sex are not true men. In fact, such sexual interaction is seen as wasteful. If masculinity and femininity are redefined, then men and boys would want to protect women and girls by wearing condom during sex and women and girls would demand condom use. Good sex therefore will come to mean sex that involves protection of the partner, not the unprotected sex that we have today.

What's more, if good sex comes to mean sex that involves protection of their partner, then the myths that surround condoms such as condom being itchy, reducing pleasure, being too big for young people, being porous, and containing HIV and TB viruses would be debunked. As

more men and boys begin to use condom in their sexual activities, they will realize that it is not too big, itchy and does not reduce pleasure. As unwanted pregnancies are reduced, they will realize that it is not porous either. Eventually, condom use will become part of the sexual script of Kenyan men and women and would thus become part and parcel of Kenyan sexuality.

Finally, one fear expressed by the pupils in all the studied communities was fear of conception. As is evident in Table 2, young people in 26 communities mentioned condoms' protective nature or ever using condoms and gave pregnancy avoidance rather than disease prevention as the reason for doing so. Most gave reasons such as complications during delivery due to younger age, parental reaction to the pregnancy, bringing shame to parents, and fear that life would be destroyed if they conceived, as reasons for using condoms rather than disease prevention. Alter (2008) attributes this desire to avoid pregnancy, to education. He argued that when girls go to school, they postpone sexual debut, and marry later. He continued that for these girls pregnancy spells disaster for progress through college and hopes of a well-paid job (Alter, 2008). Indeed, in 24 communities as shown in Table 1, young people said they don't play sex because sex may to pregnancy which will consequently destroy their education.

Furthermore, in a study of female adolescents receiving reproductive health care and between the aged 15–19 in Kenya, it was found that participants with at least a high school education were close to three times more likely to be condom users. For each additional year of education, the odds of condom use among these adolescents increased by 1.2. Thus, among adolescents completing a secondary school education the odds of condom use increased nearly 5-fold compared with adolescents completing only a primary school education (Cherutich et al.

2008, p. 926). Although Kenya has instituted free primary education (UNESCO, 2006), causing Primary school enrolment ratio from 2000-2006 to shoot up to 78% for males and 79% for females, Secondary school enrolment ratio from 2000-2006 remained low at 42% for both males and females (UNICEF). The biggest barrier to secondary education for these young people remains the fees that too many countries continue to charge parents for each child in school. Families are also required to cover the cost of school uniforms, transportation, school maintenance, school levies, books, and pen/pencils (Silvers, 2003). The practical effect is that poor families (disproportionately in rural areas) are unable to send their secondary school aged children to school. However, since condom use is higher among youth in school than those out of school, it is important to promote education, especially secondary school education in Kenya. Education will not only help the youth to learn about HIV and how to protect themselves, it may also help to delay sexual debut, encourage uptake of condom and thus reduce AIDS infection.

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## **Vita Auctoris**

Collins Kyeremeh was born in 1983 in Kumasi, Ghana. In 1996, he graduated from Atwimaman Secondary School in Kumasi, Ghana. In December 2000, he moved to Canada and enrolled at Kipling Collegiate Institute. From there he went to University of Windsor where he obtained a Bachelor of Arts in Sociology and Criminology in 2007. Currently, he is finishing a thesis in Fulfillment of the Requirements for the Degree of Master of Arts at the University of Windsor and hopes to graduate in the spring of 2009.