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Sexual Risk-taking Behaviors among Youth in Secondary Schools in Bondo District, Kenya

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Research Article

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ABSTRACT

Sexual intercourse is the highest mode of HIV/AIDS transmission among youth who become sexually active as early as at 13 years. There is a concern that vulnerability to sexual risk-taking behavior varies across groups of youth. This study examined the sexual risk-taking behaviors of youth across age, gender and orphanhood. The study was carried out using cross sectional research design among 365 students. A total of 8 teachers were also interviewed on sexual risk-taking behaviors of the students.
Results indicated that premarital, multiple sexual intercourse were the most common, followed by unprotected sexual intercourse while the least engaged in was sexual intercourse for gifts. Males engaged in sexual intercourse at an earlier age and were more likely to be involved in sexual risk-taking behaviors compared to females. Orphans that had early sexual debut were more likely to be involved in sexual risk-taking behaviors compared to non-orphans. Students aged ≤16 years were more likely to indulge in sexual risk-taking behavior compared to their older peers.
Conclusion drawn from the study was that youth in secondary school engage in sexual risk-taking behaviors. The study calls for modification of the current intervention strategies aimed at reducing the high sexual risk-taking behaviors among youths by not only educating them about dangers of early sexual debut but also availing male and female condoms to sexually active youth.

Key words: Sexual risk-taking behaviors, Youth.

INTRODUCTION

Three decades into the epidemic, young people still remain vulnerable to the debilitating effects of HIV/AIDS (National Aids Sexually Transmitted Disease Control Program (NASCOP,2007). Globally, just like in Kenya, the principle mode of HIV/AIDS transmission is sexual intercourse which is initiated at an age earlier than 15 years with multiple sexual partners (UNAIDS, 2010). Youth vulnerability to sexual risk-taking behavior could be heightened by the fact that during the onset of the adolescent stage of development, youth are sexually very active and are out to experiment. They are more likely to underestimate any likelihood of being hurt by any potentially harmful activities (Steinberg, 2008). It is worth noting that the high infection rates among youth can likely lead to depletion of savings, reduced productivity, HIV/AIDS related deaths and consequently interfere with existing struggles to eradicate poverty (USAID, 2011).

Early sexual debut has been singled out to be the major risk-taking behavior among youths in Kenya (NASCOP, 2007). Anderson et al. (2007) reported that the high prevalence rate of HIV/AIDS infection in South Africa was attributed to the youth initiating sex at an early age; as a consequence most of them spent more years of their lives at the risk of the infection. Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro (2004) also reported that 18 % of women aged 25-49 had sex before attaining 15 years; more than half had first sex by their 18th year while 25 % of men aged 20-54 had sex before age 15. A similar study by Mathenge (2008) reported that 36% of girls aged 14-25 years in top schools in Nairobi, Kenya had their first sexual experience by age 15 years while 75 % did not use any protection.

According to UNICEF, UNAIDS and WHO (2002), youths who engage in sex before adolescence were more likely to have sex with high-risk partners or multiple partners, and are less likely to use condoms. Thus, delaying the age at which youth engage in sex for the first time could significantly protect them from infection. This suggests that the onset of sexual activity define potential exposure of adolescents to the risk of HIV/AIDS infection and again, engaging in first sex is the entry point to the subsequent risk-taking behavior.

Youths' sexual intercourse with older men and women in exchange for gifts is also sexual risk-taking behaviors that place them at a greater risk of contracting HIV/AIDS. In a study carried out in Homa Bay District, it was reported that men sought younger partners in order to avoid HIV/AIDS infection. They also believed that sex with virgins could cure AIDS (Onyango, 2008). Such situation is characterized by power difference between adults and immature youth; it is likely that youth were not expected to make sound decisions about sex. In addition, they could also not insist on the use of condoms, thus, become vulnerable to coerced sex and sexual abuse. The study also revealed that while many youth residing near the beaches had a high awareness of risk-taking behaviors, the obtained knowledge did not translate into attitudinal nor behavioral change. A significant number of them still believed that they were not at any risk of contracting sexually transmitted diseases (STD) including HIV/AIDS.

Unprotected sexual intercourse has been reported to increase the youths' vulnerability to STD infection (UNFPA, 2004). In many occasions youth were denied a chance to negotiate for the use of condoms or safe sex. This situation was catalyzed by negative attitudes and misconceptions which associated condom use with promiscuity, unfaithfulness and lack of trust. This displaced attitude and risk taking behaviors that could lead to HIV/AIDS infections were found to be common in both advanced and emerging economies. Groom and Nandwani (2006) in a survey carried out in United Kingdom observed that 43 % of adult respondents reported that they had paid for sex with 10 or more younger partners in a period of 5 years. However, only 15 % were reported to have used condoms consistently. This indicated that young people rarely negotiated for safer sex (Population Reference Bureau, 2001).

Another sexual risk taking behavior is sexual intercourse with many partners. According to Jepchirchir (2009), although many youths were aware of the consequences, they still engaged in risky sexual relationships with multiple partners. This indicated that either the knowledge in the youth's domain did not significantly lead to behavior change or there were factors beyond their immediate control that likely increased their vulnerability. Steinberg (2008) also noted a dramatic rise in teenage multiple sexual intercourse over the recent decades. The study reported that during the youthful stage of development, unlike adults who rationalize health risks of activities they engaged in, the youths look at rewarding social consequences of their actions. Hence, young people maximize the benefits while minimizing costs of what they engage in. For instance, they are more likely to engage in sexual intercourse or drug use without looking at the consequent risks.

It is worth noting that researchers of the above studies had adopted either Behavioral Decision Theory or Health Belief Model to investigate factors which influenced risk-taking behaviors. The Behavioral Decision Theory postulates that all decisions even the risky ones can be seen as rational depending on how an individual estimates and evaluates their consequences. This theory, therefore, seems to rationalize risk-taking behavior among youth and does not attribute it to circumstances in the individual's social environment. Likewise, the Health Belief model postulates that the likelihood of an individual engaging in a particular action is a function of his perception of the relationship between behavior and subsequent illness and involves making a conscious effort to weigh the cost and benefits of its action. This model ignores other underlying social factors that could escalate HIV and AIDS infection amongst the youth. Instead, it presupposes that the likelihood of taking preventive measures is high when the threat of STD is also high (Odutolu, 2005). The current study therefore focused on the previously assumed social exclusionary factors in investigating the sexual risk-taking behavior among youth.

In the current study, it was preconceived that youth who are 16 years and below were more likely to be misinformed or pressurized by their peers to engage in sexual risk-taking behavior such as unprotected, commercial and multiple sexual activities. On the other hand, it was presumed that youth who are aged 16 years and above are likely to be viewed as people approaching adulthood and consequently, may be involved in some social activities.

Apart from age, female youth were predicted to be more marginalized in participating in the social and sexual matters in the community compared to male youth and this in turn increased their propensity to sexual risk-taking behavior. Female youth were viewed as people who are culturally deprived of the opportunity to negotiate for safe sex, are less informed and have low self-esteem. They were presumed to be at a greater risk of engaging in sexual risk-taking behaviors compared to their male counterparts (Aggleton et al., 2004; and Akunga et al., 2004).

Orphans are more often than not segregated from their peers who suspect that their parents could have died of HIV/AIDS and that they might be infected. They were therefore, more likely to lack parental love and care (Nyambedha, 2004). When faced with this situation, orphans would seek for a sense of belonging, gratification and basic needs from any available sources. The orphans are hence more likely to engage in commercial sexual activities with many partners at an early age and not likely to afford or negotiate for condoms.

METHODOLOGY

The study was conducted in Bondo District which records high HIV/AIDS infection rates which could be attributed to sexual risk-taking behaviors. A cross-sectional survey design was employed by the researcher among 365 students and 8 teachers. The sample was randomly and proportionally drawn from each of selected school and class. While the main focus of the study was students, Guidance and Counseling teachers were also identified as key people in schools who discuss personal issues with students and would provide vital data to this study. The data collecting tools were questionnaire, Focus group discussion guide and Interview schedules. The questionnaire was adapted from Marin School student Health Questionnaire designed by The University of California at San Francisco Centre for Aids Prevention Studies and ETR Associates (Cleland et al., 2001) that assesed sexual reproductive behavior among students in secondary schools. It also assessed involvement of students in health prevention programs. For the questionnaire to suit this study, the researcher included items that would enable gathering of information on demographic data such as age, gender and orphanhood which were not in the initial questionnaire. Items in the initial questionnaire which were used to gather information on methods of family planning were excluded. The researcher also reversed a total of 8 items from the general direction of other items so as to reduce chances of guessing, over reporting or under reporting by the respondents.

Reliability of responses on the interview schedule and focus group discussion guides was assessed using test-retest method where consistency of responses on the items was assessed. Cronbach's alpha of Likert sub scale questionnaire yielded an alpha level of $\alpha = 0.8$. Permission to conduct the study was sought from the National Council for Science and Technology. Permission was also sought from the District Education Officer (Bondo) and the Head Teachers of the relevant schools. Consent of the respondents to participate in the study was sought and instructions about how to respond to the items by ticking in the right column were given to them. They were then assured confidentiality of the information they would provide.

The students were grouped based on gender orphanhood and age. A 16-year age mark was deemed suitable for this research as the students were generally considered sexually active. According to Ferede and Erulkar (2009), youth younger than 16 years are presumably not ready for most sexual, marital and reproductive transition because of their physiological immaturity, cognitive status and concept of what is old enough.

The obtained responses on likert scale were scored as: Strongly Disagree -SD (1) to SA (7). Items which had been reversed from the overall direction of the scale were reversed before summing up the total to get a composite score. Data obtained on demographic information and on Yes/No items were analyzed using frequencies, percentages and means. Independent sample *t* test was used to compare means scores on sexual risk-taking behavior based on gender, age and orphanhood status.

RESULTS AND DISCUSSIONS

Results of the responses on items that investigated previous sexual experiences of the youth indicated that engaging in premarital sexual intercourse was the most common sexual risk-taking behavior (57%), followed by unprotected sexual intercourse (39%) and the least engaged in sexual risk-taking behavior was sexual intercourse with strangers (4%).

The obtained data also indicated that more than half of the sampled youth engaged in premarital sexual intercourse at mean age of 13 years old with an average of 2 sexual partners. These findings concur with a study by UNICEF, UNAIDS &WHO (2002). The authors had observed that adolescents who start having sex early are more likely to have sex with high-risk partners or multiple partners, and are less likely to use condoms.
Similar findings emerged from focus group discussion sessions where participants were asked whether they had friends who engaged in sexual intercourse. In 4 out of the 5 focus group discussions, majority (80%) of the participants reported that they knew of friends who were involved in premarital sexual intercourse. Almost 40% of members of the groups noted that they have friends who were previously infected with sexually transmitted diseases. This suggested that the students engaged in premarital sexual intercourse at an early stage without taking precautionary measures.

Both boys and girls reported that they did not have courage to buy a condom at a shop counter because most of the shopkeepers were older than them and they also feared that people around might look at them suspiciously. In 2 out of the 5 groups (40%) members confirmed that they had developed a language that was only known by them to refer to condoms. Unfortunately, almost 99% owners of shops in Bondo District were said to be elderly men and women and hence they still found it difficult to request the condoms over the shop counters.Having multiple sexual partners was also pointed out to be rampant among the sampled students in Bondo District where 20% of the respondents reported that their friends engaged in sexual activities with more than

one sexual partner. The respondents were asked about what they felt about sexual experiences of boys and girls. Almost all the boys (80%) reported that boys and men were supposed to be more experienced in sexual affairs and that it was embarrassing for them to say no to a sexual intercourse advance from a lady who was willing to have sex with them. They noted that girls were not supposed to be sexually experienced because they were likely to get pregnant before marriage, break their virginity and make their genitals big or get used to many sexual partners; something that is socially unacceptble.

This perception was similarly reported in study findings in Iran by Mohammad et al., (2006). These authors noted that 56% of male aged 15-18 years felt that women should not have sex before marriage and that those who did so unlike men regretted it later. The author linked this to social perception where sexual behavior is a proof of masculinity but an embarrassment of femininity.

Sexual Risk-Taking Behaviors of youth Based on Gender

Both male and female engaged in sexual intercourse at an average of 2 sexual partners, a condition that was more likely to predispose them to HIV/AIDS infection. The study found out that male initiate sexual intercourse a year earlier than women at mean age of 13 and 14 years respectively. The obtained results suggested that both male and female youth initiate sexual intercourse even before 16 years although male were sexually active a year earlier than the females. This finding corroborated results of an initial study by Alda and Vernar (2004) which indicated that majority of youth aged 10-24 years had their first sexual relationship before age 16 with male sexual debut occurring earlier than females which was attributed to masculinity and sexual behavior that was reinforced by culture.

Independent sample *t*-test was used to compare mean sexual-risk taking behavior of male and female students. There was a significant mean difference between male and female_(M= 3.55, D=0.70, *n* =172) for male and (M=3.43, SD=0.67, *n* =164), *t* =1.68, *df,* 334, *p* =.05 for female. This indicated that male students were more likely to be involved in sexual risk-taking behaviors than female students. This was likely attributable to fact that some traditional African norms, male sexual promiscuity is revered. Similar observation was also made by Aggleton et al. (2004) and Odek (2006) that masculinity and sexual behavior is reinforced by culture. For example, these authors noted that amongst the ethnic Luo culture extra marital affairs is sometimes condoned especially where males are concerned and abhorred if it involves female infidelity.

During focus group discussion sessions, high involvement in sexual activity by both male and female students was perceived as being the norm. Whereas female students engaged in sexual intercourse in search for social groups and a sense of belonging, and for the added possibility for compensating for their being excluded, the male students strived to maintain their superiority status. Some participants reported that the availability of pornographic materials that could easily be accessed through phones made youth anxious to practice and experiment with what they watched by having sexual intercourse. Again almost 80% of boys alleged that it was only through sexual intercourse that a boy and a girl could derive satisfaction and real love.

Two participants from the sample group also narrated that sometimes they did not intend to have sexual intercourse but were forced into it when they met new friends in discos or funerals. These results concurred with findings obtained by Njue et al. (2009), the study suggested that most HIV/AIDS infections amongst youth occurred during Discos organized during funerals in Kisumu District, Kenya. Thus, in many funerals where youth reportedly had casual and unprotected sexual intercourse, they also engaged with multiple sexual partners. During these sexual experimentations, girls were either forced into sex; gang raped or exchanged sex for money. This was again observed by Odek (2006) who reported that during funerals in Mageta Island, Bondo while the night service was going on, small group of girls from the extended family of the deceased availed themselves for unprotected sexual encounters with relevant extended family male members. This sexual orgy or “Otusira” is aimed at ensuring that one of the girls will conceives to replace the deceased. This indicated that youth did not have sufficient knowledge of making informed choices regarding sexuality. This could be attributed to the isolation of adults in discussing such issues.

It also emerged from focus group discussions regarding unsafe sexual intercourse that even though most girls (60%) felt that women and girls have a right to request for safe sex, they noted that female condoms were not as readily available as was compared to the male condoms. This socially generated discriminatory practice made them to sometimes give in to the demands of men. The students said that sometimes they were forced to engage in sex with their sexual partners, for example, if it is in exchange of gifts, in which case, they had little room for negotiation since they needed and desired these gifts. They reported that, while male condoms could sometimes be obtained, female condoms were not a priority even to non-governmental organization campaigning for safe sexual intercourse. They observed that it would be easier for them to negotiate for safe sex if they could access

female condoms because they would guarantee them protection against sexually transmitted infections and HIV/AIDS.

Few boys (10%) noted that sometimes they engaged in unsafe sex with girl friends whom they suspected to be promiscuous with the intention of punishing them by making them pregnant and also because the girl that is already known to be having many sexual partners could not hold them responsible for the pregnancy. On the other hand, approximately 30% of the girls reported that having more than one sexual partner is not acceptable in the society and asking for safe sexual intercourse could make their sexual partners suspect that they were engaging in multiple sex with other men. Thus, to prove their fidelity, girls opted not to ask for safe sexual intercourse. This denotes that girls are likely to be devalued in the sexual world where their peer boys feel that they can exercise power over them and manipulate them the way they want, yet the same female students eventually bear the consequences of this brutal act in addition to probably getting infected with HIV/AIDS or getting pregnant.

Sexual Risk-Taking Behaviors of youth based on Orphanhood

Across orphanhood, data revealed that orphans and non orphans had sexual intercourse at a mean age of 13 years and 14 years respectively. Independent sample *t*-test indicated significant mean differences between orphans and non-orphans in sexual risk-taking behaviors suggesting that orphans were more likely to be involved in sexual risk-taking behavior than non-orphans (M =3.56, SD = 0.69, *n* = 220) and (M=3.55, SD=0.70, *n*=114), *t*=14, *df*=334, *p<5* respectively. This difference could be associated with search for sense of belonging and solace especially when they feel rejected by the families which are supposed to take care of them. It could also be attributed to lack of basic needs by orphans after the death of their parents and the hard economic times and the extra burden to the new families. For example, after the death of their parents, their guardians may not be able to fully cater for their needs alongside the guardians' children which make them vulnerable to engage in sex for gifts. The findings are in concordant with a report by Thurman et al., (2006) which observed that nearly half of orphan (49%) in their study sample had had sex compared to only 39% of non orphans. The study attributed the early sexual debut of orphans to economic difficulties of orphans after the loss of their parents.

Sexual Risk-Taking Behavior of youth based on Age

The findings indicated that the mean number of sexual partners for both groups; youth aged ≤16 years and those aged>16 years was 2 sexual partners and sexual debut was at mean age of 13 years. Results of the independent sample *t*-test revealed a significant mean difference in sexual risk-taking behaviors (M=3.60, SD = 0.69, *n* = 69) of youth aged ≤16 years and those aged > 16 years (M = 3.48, SD= 0.69, *n*=284) (*t*=1.01, *df*=329, *p*<.05). This suggested that youth ≤16 were significantly more likely to engage in sexual risk-taking compared to their older peers.

Interview schedules with teachers revealed that students initiate sexual intercourse as early as at 13 years and cases of pregnancy has been more among those aged below 16 years. They attributed this to early adolescent stage and lack of information on sexuality. This finding contrasted with studies by earlier researchers for example, Ferede and Erulkar (2009) who had observed that youth who are younger than 16 years were generally not ready for most sexual, marital and reproductive transition because of physiological immaturity and lower cognitive status**.** Similarly amongst our sample, it was projected that the higher likelihood of younger youths to be involved in sexual risk-taking behaviors could be attributed to their ignorance on issues of sexuality and HIV/AIDS.

CONCLUSION

Youth in secondary schools engage in early unprotected sexual intercourse with multiple partners. Males than females, orphans than non orphans and youth aged below than those aged above 16 years are more likely to be involved in sexual risk taking behaviors. This study calls for modification of the current intervention strategies by not only educating youth on the effect of early sexual debut, but also including them in sexual and social matters and more importantly, availing male and female condoms for sexually active youths.

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REFERENCES

Aggleton P, Elaine C, Kim R (2004). HIV/AIDS Prevention and Care among Especially Vulnerable Young People; A framework For Action. Retrieved from www.safepassages.soton.ac.uk/pdfs/evypframework.pdf on 16/6/ 2010

Akunga A, Kwamboka E, Muia D (2004). Finding Voices of Young Kenyans Gender, Sexuality and HIV/AIDS in Education. Nairobi: UNICEF.

Alda E and Vernar D (2004). Youth at Risk, Social Exclusion and Intergenerational Poverty Dynamic; A new Survey Instrument with application to Brazil (World Bank Policy Research Working Paper 3296). Retrieved from http//econ.worldbank.org on 6/3/2010

Anderson GK, Beutel MA, Maughan-Brown B (2007). HIV Risk Perception and First Sexual Intercourse among Youth in Cape Town South Africa. International Family Planning Perspective, 33(3): 98-105. Retrieved from http://www.commerce.uct.ac.ac.za/research_units/cssr/working%20papers/papers/w196_b .PDF on 20/9/2010

Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro (2004). Kenya Demographic and Health Survey 2003. Calverton, Maryland: CBS, MOH, and ORC Macro.

Ferede A and Erulkar A (2009). Social Exclusion and Early Unwanted Sexual initiation among poor urban Females in Ethiopia. International Perspectives on Reproductive Health 35(4)186-193.Doi:10.1363/3518609

Groom TM and Nandawani R (2006). Characteristics of Men who pay for sex: UK Sexual Health clinic Survey,UK. Retrieved from http.www.ADOLEC- Characteristics of men who pay for sex a UK sexual health clinic survey.htm on 20/9/2010

Jepchirchir H (2009). Sexual Behavior change and HIV/AIDS Infection among college students: A case study of Mosoriot Teachers Training College, Nandi (Unpublished Master's Thesis). Moi University, Kenya.

Mathenge O (2008). Students Surveys-Beware what your children are browsing. Sunday Nation, p. 5.

Mohammad RM, Mohamed K, Farahan KA, Alikhanas M, Teharan F, Ramezankhan A, Aladdini F (2006). Reproductive Knowledge, Attitudes and Behavior among Adolescent Males in Tehran, Iran. International Family Planning Perspective, 32(1). Retrieved from www.guttermaner.org/pubs/ journal/ 323506. pdf on 6/10/2010

NASCOP (2007). National HIV Prevalence in Kenya. Retrieved from, http://www.fpfk.or.ke/fpfk%20projects/aids/images/Resources/Resources/national_hiv_prevalence_in_kenya._released_jun_2007.pdf on 24-3-2012. Author.

Njue C, Voeten H, Remes P (2009). Disco Funerals: A risk situation for HIV Infection among Youth in Kisumu. AIDS, 23(4): 505-509. Retrieved from http// www.medscope.com/ view article/589286 on 6/10/2010

Nyambedha EO (2004).Change and Continuity in Kin Based support system for widows and orphans among the Luo in Western Kenya. African Sociological Review, 8 (1): 139-153.

Odek T (2006).Cultural challenges and sex Education in Mageta Island, Kenya. Post-sexuality leadership Development Fellowship Report (3).African Regional Sexuality Resource Centre.

Odutolu O (2005). Convergence of behavior change models for AIDS risk reduction in sub-Saharan Africa. International Journal of Health Planning and Management, (20): 239-252. Doi:10.1002/hpm.812

Onyango EO (2008). Some factors in HIV/AIDS Awareness and Sexual Behavior among Youth in Fish Landing Beaches around Homabay Town, Kenya, (Unpublished Master's Thesis), Moi University, Eldoret, Kenya.

Population Reference Bureau. (2001). Youth in Sub Saharan Africa: A Chart Book on Sexual Experience and Reproductive Health, Author; Washington DC. Retrieved from http://www.prb.org/pdf/YouthSubSaharanAfrica_Eng.pdf on 16/10/ 2010.

Steinberg L (2008). Adolescence. 8th Edition. London; Mac Graw Hill Publishers.

Thurman RT, Brown l, Maharaj P, Ritcher L, Magnani R (2006). Sexual risk Behavior among African Adolescents: Is Orphan status a Factor? AIDS and Behavior Journal, 10(6): 627-635. Doi 10.1007/s10461-006-9104-8

UNAIDS (2010). Global AIDS Epidemic. Author.

UNICEF, UNAIDS & WHO (2002). Young People and HIV/AIDS; Opportunity in Crisis. Geneva: Author

UNFPA (2004). Preventing HIV Infection Promoting Reproductive Health. New York: Author.

USAID (2011). HIV/AIDS Health Profile. Sub Saharan Africa. Retrived from rtRehttp:// www.usaid.gov/our_work/ global_health/aids/ Countries/africa/ hiv_summary_africa.pdf on 24-4-2012. Author