X GENDER DISPARITY AND ITS INFLUENCE ON THE SEXUAL BEHAVIOUR OF YOUTH IN KENYA

THE CASE OF UZIMA REPRODUCTIVE HEALTH PROJECT

Fredrick KererijLumiti
P. O. Box 4356-00200
Nairobi
Tel; 0733-939-705
Email: fredlumiti@hotmaii.com

University of NAIROBI Library
0443135 9

A project submitted in partial fuifiitment for the Post-graduate Diploma in Gender and Development at the Institute of African Studies, University of Nairobi, JULY 2004

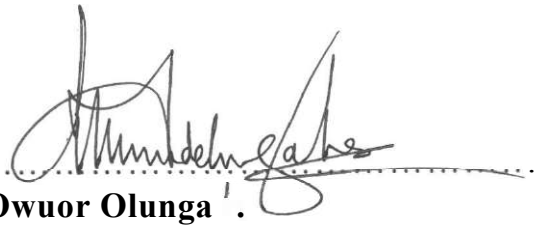
DECLARATION

This project is my original work and has not been presented for award of any Degree / diploma at any University

Signature. . . . . Date..Z²?:. . .

Fredrick Kereri Lumiti

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

Signature.  .....Date

Owuor Olunga '.

Institute of African Studies

University of Nairobi

P.O Box 30197

Nairobi

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency syndrome
FGD	Focus Group Discussions
HIV	Human Immune-Deficiency Virus
NASCOP	National Aids Control Programs
NACC	National Aids Control Council
KDHS	Kenya Demographic Health Survey
CYDPR	Center for Youth Development and Policy Research.
STD	Sexually Transmitted Diseases
BMI	Bodily Mass Index
T.V	Television
NGO's	Non Governmental Organization
YSRH	Youth Sexuality and Reproductive Health
III	Individual In-depth Interview
P.M.C.T	Prevention from Mother to Child Transmission.
YDF	Youth Discussion Forum
FGC	Female Genital Cut
ASL	Arid and Semi-arid Land

LIST OF TABLES. **Page No.**

Acknowledgement

I would like to extend my sincere thanks to the Ford Foundation, East Africa Office and Mary Ann Buris for recommending me for the study in Gender and Development.

More appreciation goes to my supervisor Owuor Olungah of the University of Nairobi, Institute of African Studies. I wish to thank him for the rich advice and help towards the research period.

I am indebted to my employer, UZ1MA Foundation for permitting me to carry out studies while on duty. I am grateful to Maina Kiranga of PATH for encouraging and guiding me from the initial stage of decision making process and recommendation to the Ford Foundation. I am also grateful to UZIMA Secretariat, Jacqueline Ogutu and Gladwell Oprong for their humble support in typing of the project work.

EXECUTIVE SUMMARY

Gender refers to the Social Construction of Men and Women. Gender disparity has been known to perpetuate inequalities that cause women and men to have less access to and control over economic resources. It is noteworthy that differences between young women and young men affect mostly women's sexual relationship.

Young people of age 30 constitutes over 30% and 40% when stretched to 40 years. Yet this is the most neglected groups in reproductive health services and education. Uzima's project on reproductive health endeavors to equip youth with knowledge and skills in understanding the maturation of the body and management of sexuality. There is a notable achievement in this project. However, there is also a notable disparity in leadership responsibilities in favor of young men. This disparity has a profound effect on the sexual behavior of the youth. This research project is set out to identify contributing factors and effects on the sexual behavior of the youth.

Study findings corroborates with other studies on sexual behavior of the youth. Studies show that youth are sexually active. Girls begin sexual activity at an earlier age than boys. A Kenya Demographic Health Survey (1998) shows that majority of the youth in Kenya are sexually active by the age of 16.

Several factors have been documented as being contributive to this scenario. The influence is in regard to psycho-social, environmental and physiological factors. Findings relate the behavior on the transitional nature of the youth that is characterized by both hormonal and social urge for identity. It is notable that girls mature very quickly and eventually attracting older men. However , behavioral scientists argue that the extent and level of social interaction influences the sexual behavior of the youth.

It is also reported that majority of young people in Kenya are infected with the dreaded HIV and AIDS pandemic. Similarly, young women are said to be more vulnerable than young men due to physiological, cultural and social differences between young women

and young men. Besides, the society in Kenya is patriarchal and therefore, favors young men to young women.

The study was carried out in 3 provinces of Kenya, namely Nyanza, Western and Nairobi. Information was gathered from 9 Field officers holding senior positions in the organization, 3 from each province. Data was then collected on the sexual behavior of the youth including sexual patterns, age at sexual debut, participation in community activities and effects of Uzima reproductive health project to the youth. The objectives were; to identify the effects of gender disparity on the sexual behavior of the youth and find out the influence of UZIMA Reproductive Health project on the sexual behavior of the youth. Semi-structured questions were used to collect information from key informants. Purposive sampling method was used to get information from program areas and control groups selected from communities and youth who are not in Uzima Programs.

Findings from the study were as follows;

- Youth are sexually active and majority begins sexual activity at an early age between 9-13. Girls begin sexual behavior at early age than boys.
- Majority of the youth have multiple sexual partners. However, the trend differs between girls and boys.
- Married youth have sexual partners besides their spouses.
- There is positive sexual behavior change among young people in UZIMA reproductive health activities as compared to control groups.
- Reproductive health programs and activities encourage youth to practice safe sex through use of contraceptives and abstinence.
- Participation in UZIMA group activities have improved the interpersonal communication skills among the youth
- Uzima youth are assertive and are able to negotiate effectively on matters related to sex.
- Parents contribute to gender disparity by discouraging the girls from participating in community projects for fear of girls getting pregnant.

Recommendations from community leaders and parents and the youth touched on various issues. These included;

Policy

- Gender Mainstreaming in Reproductive Health Policies and processes.
- Provision of comprehensive health services including voluntary testing, treatment and prevention of teenage pregnancy, STI/AIDS.
- Link prevention, care and support to individual and community behavior.
- Encourage a comprehensive behavior change approach involving the community and stakeholders on a gender disaggregated bases.
- Mainstream gender in all Policies.

Programs

- Comprehensive Reproductive health education programs
- Comprehensive Behavior change communication programmes and messages that is broad based including Faith-based, Civil society and governments.
- Involvement of youth in community programmes and activities
- Recognition of gender roles perspective in reproductive health education
- Equity in empowerment of the youth in socio-economic and political sphere, especially reducing the workload of women from their practical gender needs.
- Gender desegregated tools for monitoring and evaluation of reproductive health programs.
- Improving access to productive assets, legal status for women ownership of property, education and rights to use of common property.
- Allowing equal opportunities in decision-making and pay for comparative jobs even if there is a gender division of labour.

CHAPTER 1

1.0. INTRODUCTION

UZIMA Foundation is a charitable youth serving organization registered in 1995 in Kenya. Its main focus is to facilitate the development of capacities of individuals and groups in order to improve the quality of the individual, family and community. Through Youth For Life Program UZIMA endeavors to provide opportunities for young people to work with experienced people to identify the contribution they themselves can make to their own well being by engaging their innovative spirit, enthusiasm, and energy.

1.1. Objectives of Youth For Life Programmes are: -

- Explore ways of promoting compassion in young people, in the community and evolution of a social context in which a sense of partnership between young men and women is enhanced in the context of gender equity.
- Present scenarios that help the youth to see the careful review of new and modern options offered to them in order to identify strength that can be adopted and weakness discarded as to traditional practices.
- To explore the space available for action including income generating and employment opportunities that makes it possible for young people to contribute towards improving the quality of their lives for good future.
- To recognize the strength in African tradition of ordering Life that provide a foundation for quality lives.
- To promote the concept of freedom of the individual in the context of the social responsibility of the individual to self, family and to the community.

Through discussion forums facilitated by UZIMA secretariat, UZIMA has tailored projects to respond to youth challenges. The projects include: -

- Project for the Promotion of adolescent reproductive Health Education that includes understanding the maturation of the body and HIV/AIDS.

- Economic empowerment supported by a revolving loan fund.
- Promotion of compassionate acts that recognize strength in the African extended family and community concerns.
- Promotion of gender parity.
- Promotion of successful outcomes in education
- Promotion of peaceful co-existence and social justice in communities.
- Project on the Promotion of Clean and Safe Fun.

1.2 Geographical Coverage

UZIMA works with 13,000 youth in 137 youth groups in Kenya as indicated below:

Table 1. Distribution of Youth Group in District and Provinces of Kenya.

Province	District	Youth Groups
Western Province	Kakamega	11
	Bungoma	12
	Vihiga	6
	Busia	7
Nyanza	Nyamira	34
	Kisii	8
	Rachuanyo	7
	Gucha	5
Nairobi	Nairobi	11
	Total	**101**

Source: Primary Data

Note.
The table above provides data from all Uzima youth from western, Nyanza and Nairobi provinces of Kenya. Data was collected from all the groups using Focus group discussions and individual in-depth interviews. Self assessment workshops were conducted for all groups in the same regions.

1.3. Reproductive Health Education Project

Basing on information gathered from Discussion Forums, UZIMA tailored Reproductive Health messages activities and programs. Provision of reproductive Health services for young people in communities services included:

1.3.1. Capacity Building in Reproductive Health Education

Organized workshops for capacity building in reproductive health education for youth leaders is held at national level. Through the workshops, youth leaders are equipped with correct information on Reproductive Health issues and problems. Areas of education include:

- Reproductive health and problems affecting the youth,
- Prevention of unwanted pregnancies and promotion of abstinence.

Transmission, spread and prevention of STI/HIV and AIDS through

- Integration of HIV prevention and care in Education programs,
- Reducing HIV stigma and discrimination of people with AIDS,
- Infection control

Others areas are;

- Gender sensitive approach in reproductive health.
- Reproductive health intervention
- Skills for facilitating discussions
- Advocacy skills to use in outreach activities
- Peer counseling in reproductive health and HIV/AIDS issues.
- Human sexuality and Sensuality.

1.4. Outreach Activities In Reproductive Health

Trained youth leaders carry out outreach activities to the communities and institutions of learning uniquely. Education has been passed to communities through training workshops at community in groups and co-facilitated by UZIMA secretariat on acquired information in main training workshops. Information on reproductive health education is also communicated through folk media that includes puppetry shows and participatory theatre performances. Other methods include talks in institutions of leaning, talk shows, and speakers bureau.

In the Western province of Kenya, UZIMA collaborates with Amkeni project to create demand for reproductive Health services in voluntary counseling, testing and prevention from mother to child transmission (P.M.C.T). This includes HIV/AIDS counseling and testing centers. It also provides comprehensive services on the prevention of mother-to child transmission, mainly carried out by trained peer educators.

1.5. Counseling Services In Reproductive Health, HIV and AIDS.

Trained UZIMA youth and secretariat provide counseling services at drop in centers located at UZIMA offices, sub offices and organized youth groups in Kenya.

1.6 Discussion Forum

Through Youth discussion forums (YDF) organized at group level, young people share information on reproductive issues affecting them and jointly come up with practical solutions and interventions.

1.7. Problem Statement

For over five years, UZIMA has initiated activities in identified projects using youth groups in communities. Throughout these periods, UZIMA has achieved a lot in suggesting gender sensitive planning among young people. On the other hand, there are emerging disparities in leadership especially by young women. Subsequently, these disparities in participation levels have had profound impact on sexual behavior among the youth. This project set out to identify factors that contribute to this disparity and its effects on sexual behavior of the youth. It highlighted factors that promote gender equality. This has provided guidance for steering future approaches in the youth sector and agencies working with them. The youth are a vulnerable group that any project that places emphasis on their behavior change patterns has the net effect of protecting the future generation from the adverse effects of the HIV/AIDS scourge.

1.8. Justification

Program activities for control and management of sexual behaviors among the youth in Kenya have been going on at UZIMA Foundation through the reproductive health education program for eight years since 1996. Several achievements have been recorded since then. However, it is not clear why the sexual behavior is more pronounced among girls than boys. The explanation may be that UZIMA's reproductive health program including messages is effective to men than to young women.

This project will provide useful information on targeting women as a group that requires special attention in sexual behavior change programmes. It will generate related constraints, achievements and review activities for promoting positive sexual behavior that is Life enhancing to the youth.

1.9. Study Objectives

1.9.1. Broad Objective

1. To determine whether gender differentials in activities affect sexual behavior of the youth.

1.9.2. Specific Objectives

- Identify effects of gender disparity on the sexual behavior of the youth.
- To find out the influence of Uzima reproductive Health project on the sexual behaviour of the youth.
- Make recommendations for future programs aimed at promoting equal participation of young women and young men in the community programs.

Assumptions

- Sexual behavior among young male and young female is equally influenced by the environment.
- Sex education promotes health-seeking behavior among the young male and young women.
- Risky sexual behavior does not accurately reflect lack of education.

CHAPTER 2

2.0. Literature Review

Gender emphasizes the social shaping of feminity and masculinity. This social shaping challenges the idea that relation between women and men are ordained by nature. Gender studies indicate that differences between young women and young men affect mostly women's sexual relationship. It is notable that gender and sexuality intersect with other social divisions including race and social class (Hancourt 2003)

It is understood by gender analysts that gender disparity in developing countries perpetuate inequalities that cause women and men to have less access to and control over economic resources. This leads to dependence on either male or female partner and relatives for material survival. Resultant socio-economic position in turn affects the ability to enter into sexual relationships as partners. Even where there is measure of equality, powerful traditional cultural norms and practices about sexuality and sexual behavior construct and constrain women's behavior.(Khan et al 2002)

Gender inequalities are greatly reflected in sexual relationships between women and men. Male power has always exhibited itself through pressure and violence especially when the male demands for sex are not met. (George 1997). Studies undertaken in North America and Europe in the early 1990s found that abuse in childhood was strongly associated with adolescent high risk behavior.(Johnson 1999). In Kenya studies carried out among 2000 adolescents by population communication Africa and Pathfinder (2000) had some correlations between physical abuse in childhood and adolescent sexually transmitted infection than those not abused (Johnson 1999). Majority are victims of accidental Pre-marital pregnancy, sexuality transmitted infections and drug abuse.

2.1. Young and Vulnerable

It is estimated that 11.8 million young people aged 15-24 are living with HIV/AIDS. Statistics further indicates that almost half of all adult infections about 6,000 daily occur among young people (UNAIDS 2002).

It is reported that large numbers of young people begin sexual activity at a relatively early age and that they are sexually active before marriage. The same youth are not monogamous besides not using condoms regularly for protection. Statistics carried out from many countries give a significant proportion of young people that start sexual activity before the age of 15

Studies in Kenya indicate that majority of the youth are sexually active and that they begin sexual activity at a very early age. A Kenya Demographic and Health survey (KDHS 1998) shows that by age 16, majority of the Kenyan teenagers are sexually active. This study corroborates with that carried out by the population council (1999) which indicates that 90% of the Kenyan youth are sexually active by age 20.

2.2. Youth Empowerment

Empowerment in reproductive health context implies autonomy in sexual communication and decision making. This is based on an understanding of options for prevention in the context of relevant resources for protection. Empowered youth therefore, are assertive and negotiate effectively on the use of condoms and other protective measures. Sara Longwe's Empowerment framework shared features and approaches with Pan American Health on their work on gender.

Other scholars think of empowerment in terms of the ability to make alternatives. Kabeer (2000) associates poverty and disempowerment to insufficiency of the means for meeting basic needs by an individual. However, she gives distinction between choices. She notes that choices begin with strategic life choices that includes; choice of livelihood, where to live, whether to marry, who to marry, whether to have children, how many children to have, freedom of movement and choices of friends. These choices are also important.

It is also acknowledged that these type of strategic life choices help frame other, second-order and less consequential choices that may be important for the quality of one's life. Accordingly,

> "Empowerment therefore, refers to the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to the individual" (Kabeer et al 2000)

It is in this respect that the International Conference for Population and Development (ICPD 1994) proposed important strategies that are central in promoting women empowerment.

2.3. Health and Development

Studies on adolescent by Population Council (2000) shows a correlation between Education and economic empowerment with the sexual behavior of the youth. The 1998 Kenya Demographic and Health survey (KDHS) indicated that 21% of unmarried girls of age 15-19 in Nairobi reported having ever traded sex for goods or money, suggesting that in the absence of viable alternatives for real earning, survival sex with all of its incumbent dangers, including HIV infection becomes a reality. The point of entry by adolescents into labor force can also play an important role in transition to adulthood. However, the effects of labor force may be advance. Participation may force young people to drop out of school and interfere with their studies by lowering their academic achievement. On the other aspect, young girls in Kenya, out of desperate economic need and lack of alternatives, earn money through commercial sex work.

It is increasingly notable that opportunity to work and earn money encourage healthier social relationships by reducing dependency of young people on their parents, guardians, boyfriends, or otherwise. It may promote stronger and more rewarding relationships with peers and supportive friendship. It encourages mentoring relationship on the job with colleagues who can serve as role models. By exposing young people to the world beyond the household and the community this may promote their active interest and involvement in community life.

Youth from poor families without means of livelihood may increase their vulnerability to many risks that include; unplanned pregnancy and childbirth, early marriage, high rates of sexual violence and HIV/AIDS. ([Khaneta12002])

Table 2.: Labor force participation rates in Kenya for girls and boys of Ages 8-24 years.

	8-14 years	'5-19 years	20-24 years
Urban (1986)	N/A	31.8	53.7
females males	N/A	19.6	73.7
Rural 1988			
Females	82.6	91.5	94.8
Males	78.1	83.1	89.5

Source, Government of Kenya et al, 1988,1991

Note;

The urban labor force participation rate is calculated as the proportion of the total population in each age/gender group who were economically active i.e. working or looking for work. Sample survey data collected from a sample of 3,593 individuals in 1,644 urban households. The rural labor force participation rate is calculated as the number of economically active persons as a proportion of the total population in each age/ gender group. Economically active persons includes those working one hour or more last week in an economic activity (e.g. on a farm, as an employee, in a non-farm family business, gathering firewood, or fetching water. Data collected from a sample of 44,731 individuals in 8,102 rural household in first round and 41,689 individuals in 7870 rural households in the second

2.4. Gender disparity in Education in Kenya

The 1996 report indicates tremendous improvement in Primary enrolment over the years from 0.9 million in 1963 to 5,677,333 in 1977, in 17,060 schools. These represent a ratio of 2,280251 boys: 2,797,082 girls involvement. This indeed is near gender parity. In 1996, the ratio of boys to girls was 50.8% and 49.2% respectively. Regional disparities exist with some districts and provinces recording a ratio of 68 males: 32 Females. These are all districts in North Eastern Province, Arid and Semi arid Land (ASL) and Coastal area (Gichaga 1998).

However, involvement ratio has been declining since 1989 when it stood at 95% in 1995, it was at 79.2%, 1997, 76.5%. Completion Rate is 35% of girls compared to 55% boys. There is higher drop out rate for girls than boys. Secondary enrolment in 1997 showed Female at 323,625 in 3,028 schools and Male at 363,848 total 687,473 (Gichaga 1998).

Performance too has been poor for girls than for boys. In 1996 KCSE results only 5,948 girls compared to 11,339 boys attained quality grades between A and B-. Girls perform even poor in Mathematics, science and Technical subjects. (Gichaga 1998)

In University Education, there is wider gender disparity at this level of education. In the undergraduate programme, less than 30% comprise the number of women admitted 70% and above of those admitted are male students. A larger percentage of female who enroll in universities enroll in traditional Art based courses. Very few enroll in sciences and technical courses. Source: (Fawe 1998).

2.5. Theoretical framework

Various theories have been developed about gender that identifies approaches aimed at balancing the existing inequalities in relationship. Some social scientists explain factors that contribute to these imbalances. In this case, empowerment theory is used to show power at individual level to control or manage a situation to his/her benefit. The power will be expressed when an individual or a group tackles a problem together that converges into a greater force. This power within means that the individual has internal strength, self-esteem and confidence to taking responsibility of decision made.

The concept of empowerment connotes the raising of womens' status in relation to men. In this context, status is designated the roles of women and existent of their influence in decision-making and control of resources. Sarah Longwe, a Consultant on gender and Development from Zambia postulated the theory on empowerment in 1970s' in Zambia. She viewed women empowerment as enabling women to take an equal place with men. Women participate equally in the development process in order to achieve control over factors of production on equal basis with men. She viewed development as enabling people to take charge of their lives, it would include escape from poverty arising from oppression and exploitation.

Women empowerment therefore, will determine the way subordinate groups and individuals act in a way that resists the social cultural forces of a diversity exposing them to high risks.

Sarah Longwe uses levels of control, participation, conscientization, access and welfare to assess levels of women's empowerment in all social life. She emphasizes control as a more important development since it utilizes women in decision making processes. Control enhances conscientization and mobilization of resources in order to achieve equality of control over factors of production at the distribution of benefits. Most Development Agencies and government in Africa and especially United Nations Development Program adopted Sarah Longwe's empowerment theory. As a result, women issues were hurriedly incorporated into National Development goals. In Zambia and Kenya, departments were created to address women issues in early 1980s

The other element of empowerment is the extent to which it influences reproductive behavior. Manifestation of Women empowerment as reflected in biological and health factors that are most proximate to influencing health outcomes are as indicated below: -

- Nutrition status of women and girls measured by bodily mass index (BMI).
- Biology of women such as maternal factor of age at marriage, at first pregnancy, birth intervals, parity and non-maternal health conditions women-chronic reproductive health morbidities that include STDS/HIV and gynecological disorders. Environmental factors that have an influence on health such as hygiene, work and living conditions.
- Access and use of health care for 6th pregnancy and non-pregnancy related complications

2.6. Measures of empowerment

- Socio-economic
    - Ownership of property (land, houses, animals, jewelers, machines

- Employment /, Income
- Educational level
- Social cultural and gender relations
- Participation in decision-making process
- Participation in community activities
- Spouse age difference
- Husband wife communication
- Age at first marriage and choice of life partner
- Formal/informal association with support groups or Kin
- Age at first sexual activity

Nevertheless, Sara Longwe's framework does not track how situations change overtime. Examination of relationships between men and women from equality perspective isn't enough. Complex systems of rights, claims and existing responsibilities should be acknowledged. The assumption is that women are homogenous. Besides, the hierarchy of levels presupposes that empowerment is a linear process.

Empowerment theory is much suitable to this study since it presuppose multiplicity of factors influencing human behavior. It emphasizes the equity and equality devoid of sexual differences as a strategy towards realizing sustainable development. The framework is useful also in planning, monitoring and evaluation. It shares similarities with other scholars including Mosers frameworks concept of practical and strategic gender needs which are core areas of development.(UNDP 2001)

CHAPTER 3

3.0. Study Methodology

The study was mainly based on secondary data. Primary data was mainly collected in 3 provinces of Nyanza, Western and Nairobi.

3.1. Study Site

The study was carried out in three Provinces where Uzima operates. These sites include 4 districts; Rachuonyo,Nyamira, Kisii and Gucha from Nyanza. In Western province the study was carried out in 3 districts; Kakamega, Bungoma and Butere-Mumias. In Nairobi the study was carried out in Langata division in Kibera and Ngummo. Embakasi division in Kayole-Soweto slums, Umoja I. Dagoreti Division; Riruta Satelite and Waithaka,

3.2 Data Collection Methods

Semi- structured questions were used to collect information from key informants. Secondary data (through records review) was also used to supplement the data from key informants.

Field visits were carried out in the three provinces. Information was gathered from key informants that included field officers, assistants and documentalists. Data was collected on sexual behavior of the youth including sexual patterns, age at sexual debut and effects of Uzima activities on reproductive health project to the youth.

3.3 Sampling Method

Using a purposive sampling method, 9 secretariat, 3 from each province were selected for the interview. Out of the 3 secretariat 1 was the field officer and the assistant who were directly involved in program implementation and monitoring of Uzima reproductive health project. Documentalists by nature of their duty provided records and information on the sexual behavior of the youth.

A self reporting data on sexual behavior change was designed to gauge the extent to which youth have been influenced by Uzima reproductive health project.

3.4 Data Analysis Methods

Factor analysis of data was carried out based on the questionnaire. This included frequency of information on gender disparity and the sexual behavior of the youth. An effect of Uzima reproductive health project on the sexual behavior of the youth was systematically analyzed to identify negative and also positive effects.

Tables were used to indicate frequency of participation by young women and men in Uzima's reproductive health project. Majority of a given gender in participation, implied dominance by one gender to the other. Tables were also used to present distribution of executive positions in youth groups.

CHAPTER 4

4.0. Study Findings

Data Documented in the report indicates gender disparity in general. Reports on gender studies through Focus Group Discussion, Individual In-depth Interview (III) and Key informant interviews gathered data on the following issues: -

- Gender disparity and the sexual behavior of the youth
- Effect of UZIMA Reproductive Health Project on Sexual Behavior

4.1. Gender Disparity And Sexual Behavior Of The Youth.

4.1.1. Sexual Status Of The Youth

Information from other research finding agrees with the findings and follow-up interviews with key informants from UZIMA that many youth are sexually active. Besides, they begin sexual activity at a very early age. Four out of ten single young women between the ages of 15 and 19 years are sexually active due to early initiation of sexual intercourse in both boys and girls.

Indicators for sexual activities were given as

- Teenage pregnancies
- High rate of sexually transmitted infections including HIV and AIDS among the youth
- High consumption of condoms
- Abortions and attempted abortions.

4.1.2. Factors That Contribute To Sexual Activity Among Youth

Majority of the respondents identified poverty as a major factor that influences the sexual behavior of the youth. This is true of the low-income areas and disadvantaged groups.

Young girls whose parents are not able to provide them with basic needs, turn to commercial sex in order to provide those things for themselves.

- Majority of respondents noted that mass media has negative influence on the youth. Young women are more affected as majority are used in advertisement. The TV and more particularly channel 'O' and East Africa TV show a lot of sexual activity. One respondent said *"everything talks about sex, magazines, songs and mass media advertisement*". It is reported that majority of participants argued that young people learn about sex from Television programs such as "the bold and the beautiful, Camilla and La mujer de la vida".

- Others cited peer pressure as contributing to the high level of sexual activity and particularly among boys. They brag about the number of sexual intercourses and partners they have. Virgin girls are laughed at by other peers.

- It is documented that some communities abate promiscuity. Some parents have multiple sexual partners while some single mothers engage in commercial sex work and even bring partners home in full view of their children. These parents normalize sexual activity for unmarried youth. Majority of parents do not talk to their children about sex since some lack information while others are shy.

- Drug abuse and especially alcohol and cannabis sativa impair level of thinking of the youth.

- The presence of bars, discos and pornographic media shows in residential areas are blamed for sexual activity.

4.1.3. Age At Sexual Debut

Study findings shows early initiation of sexual intercourse and age at first marriage for females, than boys. For example in Nairobi, girls begin sexual intercourse at 9-11 while

boys are given as 12-14. In Nyanza, the report gives 9-10 for girls and 12-14 for boys while in Western province, the ages are 9-10 for girls and 13-15 for boys.

Reasons given for gender age differences at sexual initiation were;

The fast development of girls' bodies makes them look older than boys of the same age "a girl of nine years can have well developed breasts and body while boys have not yet undergone any physical change. This attracts the attention of older boys and men.

- Young boys do not have courage to approach girls for sex
- Older boys and men prefer younger girls. Boys aged 16-17 prefer girls aged 10-13
- Majority of informants agreed that boys are more engaged positively than girls in activities like sports and community activities.

4.1.4. Sexual Relations

It is reported from the study areas that majority of the youth have casual sexual relationship with multiple partners. Those relationships are short lived especially among the youth under 18 years. This is because, at this age the youth have little correct information about sex and are easily influenced by their peers. As the youth grows older, they tend to have regular relationship with one partner.

Multiple relationships were higher among boys in Nyanza than girls. In Kayole-Soweto slums in Nairobi, girls have more partners than boys. Various explanations have been given for this sexual behavior. These include

- Girls have many sexual partners for financial reasons.
- Many sexual partners is a proof of manhood.
- Sex drive is reported to be higher among the youth
- Girls try many partners to ensure they get a husband.

Other young people are influenced by their parents who have many sexual partners.

4.1.5. Sexual Relations Among Married Youth

It is reported that married youth have other sexual partners besides their spouses. This habit of multiple partners is mainly reported among married men. However, wives were said to be more faithful and seek other sexual partners due to various reasons. These were

Revenge after learning of their husbands infidelity
Wrong expectations of marriage
Lack of sexual satisfaction
Peer pressure
Living far from each other due to work or separation

4.1.6. Practice of Safe Sex

Youth have received information on safe sex from mass media, NGOs, social workers, youth groups. They do not practice safe sex especially those under 18.

Youth do not practice safe sex due to the following reasons: -

- Majority fear parents knowing they are sexually active
- Suspicious about free condoms and their safety
- Lack of money to buy condoms or pills
- Girls fear asking men to wear condoms
- Others believe death is inevitable
- Some do not practice safe sex due to ignorance
- The danger of AIDS is '"reduced" to witchcraft

Majority of the youth practice safe sex. This is mainly due to the following reasons: -

- After attending reproductive health education workshop
- Fear of HIV/AIDS and related stigma
- Protection from sexually transmitted infections

4.2. Influence of UZIMA Reproductive Health Project to sexual behavior of the youth

Majority of the youth reported having changed their sexual behavior since joining UZIMA groups. They are more informed having attended Reproductive health education workshops.

- Participation in group activities have improved their interpersonal communication skills
- For the year 2002-2003, data indicate that boys participated more than girls in reproductive health activities. UZIMA activities keep the youth positively engaged that they do not have time to think about sex.
- Discussion on Reproductive Health encourage them to discuss openly on issues of sexuality and other challenges facing each other. They therefore, help each other to deal with the sexuality and other social problems. Income generating activities have made majority of the youth self-reliant.
- There is low participation of girls in groups' activities
- Few girls occupy leadership positions.

Table 3: Participation of Young Men and Young Women in Western Province in 2002-2003

Activity	Male	Female	Total
Participatory theater education	900	750	1,650
Community outreach	700	620	1,320
Health Talks	500	300	800
Training Seminar	500	500	1,000
TOTAL	**2,600**	**2,170**	**4,770**

(Source: Primary Data)

Note.
The table presents data from Western Province. The data was collected from field reports on Reproductive project from the year 2002-2003. The number can change with increase participation in other projects and activities. Female participation is lower than male participation in reproductive health project.

4.3. Self Reports on Sexual Behavior Change

The results of the Self-reporting exercise agreed with the results from the interviews with key informants, focus group discussions and in-depth interviews. According to the self-reporting exercise, since joining an UZIMA Group, 40.6% of males and 20% of females reported they had reduced the number of sexual partners. A small number, 3% of males and 8% of females, reported that they had increased their sexual partners since joining the group, but 45.3% of males and 48% of females reported that they had only one partner. When asked if they were abstaining from sex, nearly 30% of males and 40% of females said they were. Nearly 30% of males had used a condom in past sexual encounters, compared to only 4% of females but 37.5% of males and 20% of females said they were using condoms with their regular partners.

It was also revealed that 100% of all the youth irrespective of sex had heard of HIV/AIDS and they all named the modes of transmission of HIV virus. They also named ways through with HIV/AIDS can be prevented besides ways in which HIV cannot be spread.

4.4. Discussions

4.4.1. Participation In Reproductive Health Education Programs And Activities

Although reproductive health is a sensitive area, its importance outweighs criticism. Gender equity crosscuts all UZIMA programs translating into tremendous impact to the youth. For example, there is increased communication between young boys and young women. This has opened room for negotiations and understanding among the youth.

Information on transmission modes of HIV and AIDS including preventive methods is high among youth in Kenya. It is also notable that this information has not translated into sexual behavior change among the youth. Nevertheless, self-report from youth indicates a tremendous change in sexual behavior among youth that have participated in UZIMA

activities. Majority of the youth have definitely had access to correct information on reproductive health issues and therefore, make appropriate decisions.

Traditional preventive approaches have been pre-occupied with pregnancies. Parents are worried of double tragedy in sexual infection that include HIV and AIDS that affect young men and women. The challenge is the ability for young women to negotiate for safe sex through condom use and rhythm method. This is exacerbated by the inadequate access to female condom due to cost implication. The cost of a male condom is Kshs 10.00 while female condoms costs Kshs. 300.00. This disparity in access to condoms make women more vulnerable to sexually transmitted infections and pregnancy. Sarah Longwe's theory of empowerment foresee that equality and equity in employment and pay could increase female affordability to female condoms and promote self reliance.

Improvement in communication through the mass media, radio, television and newspaper have opened the society to a lot of information. The society is worried by the pornographic information presented through the media in 'women magazines' G. Magazine. Often, young women are used as models in magazines glorifying sex among the youth. Dignity to young women will definitely increase choice in appropriate means of production besides beauty which in most cases exposes young women to exploitation.

The soap operas like **"The bold and the Beautiful, Camilla, home and away, young and the restless, la mujer de la vida, (the Jove of my heart)"** all expose young people to sexual information at an early stage. Reproductive health project of UZIMA Foundation assist disseminate correct information about the maturation of the bodies, management of sexuality and prevention of sexually transmitted infection including HIV and AIDS among the youth.

Reproductive Health Project engage majority of the youth in positive activities. Behavior change communication strategies are so involving that it enhances internalization of messages while reducing idleness. Theatre participatory methodologies in planned

outreaches require time and creativity. This engagement should be encouraged with clear support the to the objectives of the activity.

4.4.2. Culture And Its Effect On Sexual Behavior Patterns Of The Youth

A convention study on sexual behavior is contradicted by traditional social cultural structures. Most of the communities in Kenya are patriarchal and cultural practices and beliefs justify sexual promiscuity by men in the community. Young men among the Isukha community of the luhya tribe are prevailed upon by society to venture into multiple sex as a sign of transition from childhood to manhood. This pressure encourages adolescents' sexual activity. Yet the same societies do not caution the youth about the risks involved that include teenage pregnancies, sexually transmitted infections and abortion. It has been noted that majority of the youth do not see the need to have protected sex when having intercourse with their partners.

Female genital cut (FGC) among the Gusii community open them for marriage. In most cases, this is carried out with permission from the elders of the community. Besides, the practice is carried out without permission of the initiates.

Majority of the communities still ignore the presence of HIV/AIDS despite the awareness. They are superstitious and believe that AIDS is caused by inability of the community to fulfill certain traditional rituals.

Traditional societies being patriarchal, favor the boy child to the girls. Young boys are therefore, encouraged to join youth groups while young women are restricted due to fear of getting pregnant or being polluted. Young women are assigned domestic chores as a way of discouraging and limiting their movements. UZIMA project however discourage isolation of young people and encourage establishment of social support structures devoid of differentiation on the basis of sex. It is imperative that a structural framework for joining the youth group is defined with specific objectives and activities. Reasons for joining youth groups have to be explained in a broad way to gain support from the community.

4.4.3. Correlation between Reproductive Health Project and Sexual Behavior Change

Adolescent period is understood to be a healthy period of life. Yet most intervention programs ignore this. On the other hand, this is a period when majority of the youth are exposed to sexually transmitted infections, HIV/AIDS, teenage pregnancies and related abortions.

Studies on adolescent in Kenya provide a grim picture about the future of youth in Kenya. Studies indicate that young people begin sexual intercourse at an early age and that the girls begin sexual intercourse at an early age than the boys. The same study indicate that 15% and 32% of young men and women respectively had sexual intercourse by age 9-14. Young men have sex at a comparatively later age of 13-16 years. However, it is widely agreed that young men increase sexual activity in multiple relations with age while young women become steady in life. Majority of Women tend to be focused and begin to make rational, life long decision on whom to marry, when to marry, and how to marry from age 18 and thereafter.

Table 4: Distribution of position by Gender in Youth Group

Province	Total No. of groups	No. of female headed group	No. of male headed groups	Total No. of executive positions	No. of women in executive positions	% of female executive
Nairobi	9	3	6	35	11	31.43
Western	10	1	9	45	12	26.67
Nyanza	10	0	10	57	22	38.59

Source: (UZIMA 2000)

Note:

The data was collected in Nairobi, Nyanza and Western Province. The table indicates male dominance in leadership positions in UZIMA groups. Out of 29 groups interviewed, only four are from female headed groups. Out of the 4, 3 are from Nairobi and 1 from Western Province, Nyanza nil.

Participation in reproductive health projects has had profound benefits to the youth and the community. Young men and women are encouraged to adopt responsible health seeking behavior. Positive live enhancing behavior are examined in a gender roles perspective and responsibilities re-defined to set the requirements of the modern society.

The findings points at a systematic behavior change among youth in UZIMA. Health seeking behavior is realized as exhibited by their behavior. This is showcased by use of contraceptives like condoms and reduction in multiple sex partners.

CHAPTER 5: CONCLUSION AND RECOMMENDATION

5.1. CONCLUSION

From the findings of these study, the following Conclusions can be made: -

- Majority of the youth are sexually active and that young women begin sexual activity at an earlier age than young men. this is an area of concern because of biological factors, girls are more susceptible to infection, teenage pregnancies and abortion.

- Majority of youth practice safe sex after receiving sexual education through reproductive health education project.

- There is disparity in youth participation in UZIMA activities that is boys participate more than girls.

- UZIMA activities keep the youth positively engaged that they do not have to think about sex.

- Youth Empowerment should involve education and economic empowerment. This is crucial to ensure self reliance and independence.

5.2 Recommendations On Policy

Gender mainstreaming in reproductive health education is a prerequisite agenda for equitable provision of health information and services to the community. It is important that Reproductive health services embrace the following facets;

- Gender mainstreaming in reproductive health policies and processes
- Recognize gender roles perspective in reproductive health education
- Provision of comprehensive health services including testing, treatment and prevention of teenage pregnancy, sexually transmitted infections and HIV AIDS.

- Link prevention, care and support to individual and community behaviors
- Encourage a comprehensive behavior change approach involving the community and stakeholders on a gender disaggregated approach.
- Mainstream gender in all national policies

5.3 Recommendations On Programs

Gender disparity has profound effect on the effectiveness of any intervention programmes. Therefore, effective intervention in reproductive health should embrace a multifaceted approach that is multi-staged. It should embrace, the youth, parents, government department, faith based organizations in identifying relevant practices, strategies in reproductive health challenges among the youth in Kenya.

Areas for intervention

- Equity in empowerment of the youth in socio-economic and political sphere and especially reducing the workload of women from their practical gender needs.
- Comprehensive reproductive health education programs
- Comprehensive behavior change communication programs and messages that are broad based involving faith-based organization, civil society and governments.
- Provision of comprehensive reproductive health services.
- Youth involvement in community activities.
- Gender and age disaggregated messages.
- Gender disaggregated tools for monitoring and evaluation of Reproductive health programs.
- Improving education opportunities through free basic education.
- Improving access to productive assets, for example legal status for women, ownership of property, education and rights to use of common property.
- Allowing equal opportunities in decision making and pay for comparative jobs even if there is a gender division of labor.

Reference:

1. Davidson Neil et ai, 1998 Men's Sexual iicaith Matters. Health link world wide London, UK.
2. Family Planning Perspeetives, March/April 2001.
3. Gichaga S. N. presentation to UNFPA Regional Population 1LC. Training Programme for Anglophone Africa, 1998. Nairobi Kenya.
4. TIancourt Wendy (Ed)Journal June 2003, Development. Globalization. Reproductive Health and Rights; Vol 46 No. 2 Sage Publications London
5. Johnston Tony,(1999) Child Abuse in Kenya A National Survey. Population Communication Africa and Pathfinder
6. Johnston Tony, (1999) The Adolescent A[DS epidemic in Kenya, population council communication Africa and Pathfinder
7. Julie Pulverize at, 2003. The ABC and Beyond: Developing an operations research Agenda a comprehensive Behavior change Approaches for HIV prevention. New York, Population Council Inc.
8. Kabeer Naila, 2001, Discussing women's Empowerment- Theory and Practice, Novum Grafiska AB, Stockholm.
9. Kenya Demographic and health survey 1998, macro-international inc. Cleverton, Maryland, USA.
10. Khan A.B and Leonard Arm. (2002), Skills Training and Beyond: Expanding Livelihood opportunities For Adolescent Girls and young women in Kenya. The Regal Press Kenya Ltd, Nairobi Kenya.
11. National AIDS control Council, 2002. Mainstreaming Gender into the Kenya National HIV/AIDS strategic plan2000-2005.
12. Sen et al Cita. 1994, Population Policies Reconsidered; Health, empowerment and Rights, Harvard University Press, Boston, Massachusetts.
13. The youth exchange network newsletter July-September 2001.
14. IJNAIDS, (1999) Sex and youth: Contextual factors affecting risk for HIV/AIDS: a Comparative analysis of multi-site studies in developing countries.
15. UNAIDS (1999) Joint United Nations Programme on HIV/AIDS in Kenya.
16. UNAIDS July (2002). Report on the global HIV/AIDS epidemic. Nairobi
17. UZIMA Foundation 2002 "Documentation and Analysis of Factors that influence. The sexual behavior of youth in Kenya, creative arts Nairobi Kenya.

18. Were M.K 2002 "Youth Sexuality and Reproductive Health (YSRI i) programs in Eastern Africa "A state of field Review of Youth Sexuality and Reproductive Programs in Eastern and Southern Africa. Nairobi, Kenya.