



## **Degree project**

Advanced level

### **Sex, a one man's show**

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**Perceptions and experience of sexuality, contraceptives, unwanted pregnancy and unsafe abortion among young people in Kisumu, Kenya – A qualitative study**

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## **Abstract**

This study aimed to explore perceptions and experiences concerning sexuality, contraceptives, unwanted pregnancy and unsafe abortion among young people in Kisumu, Kenya. The design of the study was inductive with a qualitative approach using personal in-depth interviews. Eight participants (four female and four male) were asked to describe their perceptions and experience concerning sexuality, contraceptives, unwanted pregnancies and unsafe abortion. The result showed that culture and norms, misconceptions and gender based power in sexuality are factors that impact Sexual Reproductive Health among young people in Kisumu today. Unwanted pregnancy was described as a shame, a burden and a destroyed life which lead to many unsafely induced abortions. The findings indicate that youth interventions are important, such as engaging young men in unwanted pregnancy and thus unsafe abortions and to empower young women.

*Keywords:* young people, perception contraceptive, gender based power, unsafe abortion, Kenya

## **Abstract**

Denna studie syftar till att utforska uppfattningar och erfarenheter om sexualitet, preventivmedel, oönskade graviditeter och osäkra aborter bland ungdomar i Kisumu, Kenya. Utformningen av studien var induktiv med en kvalitativ metod med personliga djupintervjuer. Åtta deltagare (fyra män och fyra kvinnor) ombads att beskriva sina uppfattningar och erfarenheter om sexualitet, preventivmedel, oönskade graviditeter och osäkra aborter. Resultatet visade att kultur och normer, missuppfattningar och könsrelaterad makt i sexualitet är faktorer som påverkar den sexuella och reproduktiva hälsan bland unga människor i Kisumu idag. Oönskade graviditeter beskrevs som en skam, en börda och ett förstört liv som leder till många osäkra aborter. Resultat visar att insatser för ungdomar är viktiga, såsom att engagera unga män i oönskade graviditeter och därmed osäkra aborter och att ge unga kvinnor egenmakt.

Nyckelord: ungdomar, preventivmedel, könsbaserat makt, osäkra aborter, Kenya



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## Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
FGD	Focus Group Discussion
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interviews
KAIS	Kenyan AIDS Indicator Survey
KDHS	Kenyan Demographic and Health Survey
KHRC	Kenya Human Rights Commission
KNBS	Kenyan National Bureau of Statistic
RHRA	Reproductive health and Rights Alliance
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	The United Nations Children’s Found
WHO	World Health Organisation

## Definition of central concepts

Polygamous	Multiple relations
Young people/youth	18-24 years
Sexual, reproductive health	“Reproductive health, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.” (World Health Organisation [WHO], 2011)
Unsafe abortion	“A procedure for terminating an unintended pregnancy either carried out by people lacking the necessary skills or in an environment that does not conform to minimal medical standards or both” (WHO, 2011)
Family planning	Contraceptive counselling

## Introduction

There are estimated 1.7 billion adolescents and young people - one in every five people - in the world today. Adolescents and young adults' sexual and reproductive health has been depicted as a human right and one of the key pillars of countries' social and development processes (Klepp, Flischer & Kaaya, 2008; Sundby, 2006). Adolescence is, however, a period of major physical and psychological changes, and of experimentations involving risky behaviour, such as unprotected sex, leading to unwanted pregnancy, abortion and Human Immunodeficiency Virus (HIV)/sexually transmitted infections (STI), (Blum & Nelson-Mmari, 2004; WHO 2004a). About 45percent of new HIV infections are among young people aged 15 – 24 years and in 2007, 5.4 million were estimated to be living with HIV (The Joint United Nations programme of HIV/AIDS [UNAIDS], 2008). Despite the fact that many young people have good knowledge and a positive attitude towards contraceptives, not many use contraceptives to protect themselves against unwanted pregnancies and HIV/STI (Kibuuka et al., 2009; Oindo, 2002; Van Eijk et al., 2008, Kenyan Demographic and Health Survey [KDHS], 2009).

Unwanted pregnancy and consequently unsafe abortion are responsible for significant morbidity and mortality among adolescents. About 1000 women die from pregnancy- or childbirth-related complications around the world every day, where one of the major complications is unsafe abortions. Almost all of these maternal deaths occurred in developing countries, and most could have been prevented (World Health Organisation [WHO], 2010). The risk of maternal mortality is highest for adolescent girls under 15 years old. Complications in pregnancy and childbirth are the leading cause of death among adolescent girls in most developing countries (Patton et al, 2009). Around 40percent of women of childbearing age (15–44 years) live in countries with highly restrictive laws which prohibit abortion or only allow the procedure to save a woman's life, or to protect her physical or mental health. In Africa, where abortion is restricted in most countries, almost all abortions are performed unsafely. Unsafe abortion does not affect everyone equally. Women with financial means can always find a way to travel or find a doctor who will be able to provide a safe legal/illegal abortion, whereas women who live in poverty have a greater risk of resorting to unsafe abortion (Rasch, 2011).

The dilemma related to unsafe sex is complex and the reasons for unwanted pregnancies, unsafe induced abortion and HIV/STI in many low income countries are numerous; insufficient knowledge of and misinformation about preventive measures, inaccessibility of such services or ineffective use of contraceptives (Rasch, Yambese & Kipingili, 2005; WHO 2004b; Rasch & Silberschmidt, 2008). Other reasons for not using contraceptives are religion and culture which is deeply rooted in many African countries and a guideline in life for many people (Njue, Voeten & Remes, 2009; Oindo, 2002 ;Ambasa-Shisanya,2007). Transactional sex and poverty tend to put women in a position where they may submit to men's sexual demands, this also put the woman in a poor position to negotiate about condom use (Chatterji, Murray, London & Anglewicz, 2004; Njue, Voeten & Remes, 2009).

Several studies, have called for increased focus on adolescent/young people's sexual and reproductive health (SRH) in Eastern and Southern Africa. To avoid myths and misconceptions, young people need clear information, guidance and support related to contraception, pregnancy, abortion and HIV/STI, but also in relation to love and relationships (Warenius et al., 2007). Improving access to and quality of contraceptive services (Singh, 2006), including emergency contraception, (Byamugisha, Mirembe, Faxelid & Gemzell-Danielsson, 2006) improvement in health workers performance and attitudes (Warenius et al., 2006; Faxelid, Musandu, Mushinge, Nissen & Zvinavashe, 2008); parents involvement (Guttmacher Institute, 2009a); and men's involvement (Were, 2007; Mmari & Magnani, 2003) are suggested improvements needed to safe guard young people's SRH.

Many contributing factors might lead young people to engage in risky sexual behaviours at even younger ages. In a country like Kenya where almost 50 percent of young people reporting not using contraceptives in sexually activities (KDHS, 2009), and where young women are four times more likely to be infected with HIV/STI, (Kenyan AIDS Indicator Survey, [KAIS], 2007) the raised subject is eminently current.

## **The Kenyan Context**

Kenya is situated across the equator in east-central Africa and with its population of nearly 39 million the country are wide-ranging: more than 40 different ethnic groups are present. Kenya is a republic and the capital city is Nairobi. Tourism, agriculture, industry and manufacturing are the three largest contributors to Kenya's gross domestic product (GDP) (Kenyan National Bureau of Statistic [KNBS], 2009).

English is used as the official language, and Kiswahili is the national language. Kenya is a former British colony and gained independence in 1963. Kenyans are deeply religious, about 80percent of Kenyans are Christian, 10percent Muslim, and 10percent follow traditional African religions or other faiths. Kenya is one of the countries with highest fertility rates in the world: 4.6 children per women and the child mortality (<5years) rate is 120/ 1000 live birth. Life expectancy is estimated at between 47 and 55 years. Young people represent more than 1/3 of the population in the country. Furthermore, more than half of women giving birth are usually less than 20 years old (KDHS, 2009). The year of 2008, there were only 6623 registered doctors and 14 073 nurses (KNBS, 2009). 43 percent Kenyan women give birth in a health facility, while 56 percent deliver at home and the maternal mortality rate is 488 per 100 000 live birth (KDHS, 2009).

In Kenya abortion is illegal, except from when the mother's life is at risk (Constitution of Kenya, 2010). Still the annually estimated abortion rate is about 300 000, and out of these 2000 women die from complications. The annual hospitalisation rate for treatment of complications from incomplete abortion is 21 000 women, (Guttmacher Institute, 2009b) consequently, unsafe abortion might be contributing to between 35 and 80percent of maternal deaths in a country like Kenya (Osiemo, 2005; Otsea, 1993).

The knowledge about contraceptive, HIV/ Acquired Immunodeficiency Syndrome (AIDS) and its transmission paths is high among both men and women, yet the use of contraception is poor. The Kenyan national HIV prevalence is estimated to be 7.1percent among adults aged 15-64 years. Young people aged 15-24 years, is the group who are in most risk of getting HIV, they stand for more than 60 percent of all

new cases (KAIS, 2007). The Nyanza province within which the study site Kisumu lies, has the highest prevalence of HIV in the country: 14 percent (KDHS, 2009).

The sexual debut among young people in the age 15-24 years, 11 percent of women and 21 percent of men had their sexual debut before the age of 15, and less than one-third used a condom the first time that they had sex (KAIS, 2007). Further only a little more than half of sexually active young people reported using contraceptives (Oindo, 2002; KDHS, 2009).

Unwanted pregnancy and unsafe abortion place a huge burden on scarce medical resources. Any improvement in preventing unwanted pregnancy would mean important improvements for the society, the concerned women and their families (Singh, 2006). Kenya is a country where more than 47 percent of all pregnancies among adolescents aged 15-19 years are unplanned (Gutmacher Institute, 2009b), the probability that a 15-year old woman will eventually die from a maternal cause – is 1 in 120 in a country like Kenya, versus 1 in 4300 in a developed country like Sweden (WHO, 2010).

In Kenya physical and sexual abuse towards women in all ages is common (Kenya Human Rights Commission [KHRC], Reproductive Health and Rights Alliance [RHRA], 2010) also the women consider themselves to have a lower status than a man (KDHS, 2009). Gender based power in sexuality refers to men who are expected to be dominant in a relationship. Pressure to be sexually adventurous and aggressive to prove manhood and masculinity is a common perception in Africa. These norms allow men to have more sexual partners than women, encourage older men to have sexual relations with younger women, and increase the acceptance and justification of violence against women. Such norms and societal power relations consistently tend to disadvantage young women, as evidenced by the high incidence of transactional and coerced sex in many sub-Saharan countries (The United Nations Children's Found [UNICEF], UNAIDS, WHO, 2002).

This clearly highlights the urgent need for a deeper understanding of the complexity surrounding unsafe sex among both young male and female. To be able to identify and reduce the underlying causes for ill sexual health and in order to improve young

people's sexual and reproductive health in Kenya we aim to explore the perspectives from both male and females.

## **The aim**

To explore perceptions and experiences concerning sexuality, contraceptives, unwanted pregnancy and unsafe abortion among young people in Kisumu, Kenya.

## **Design and method**

The design of the study is inductive with a qualitative approach. Data was collected by using personal In-depth interviews (IDI) where the participants were asked to describe their perceptions and experience concerning sexuality, contraceptives, unwanted pregnancy and unsafe abortion.

## **Setting**

The material for this study was gathered during a field work period of four weeks between May and June in 2010. The study was conducted in a slum area called Manyatta in Kisumu. The IDIs were held in a school for drop out students, Mactadi Domestic Training Centre. The school held education for young women and men in house holding, carpentry etc.

Kisumu located in the Nyanza province, is the third largest town in Kenya, which is an important port town close to Lake Victoria in the western part of Kenya. Kisumu have a population of 500 000 people and half lives in absolute poverty. The city has three crowded slum areas, located within the town. The largest slum area is Manyatta with a total population of 86,000. Over three hundred thousand people live closely packed together in miserable conditions, lacking the basic necessities of life.

Community toilets and showers are scarce and unhygienic. Household waste is hardly collected, soil and ground water is polluted. The unhygienic living conditions cause serious health problems. Women are usually heads of households and many are widowed, divorced or left by their husbands (Cordaid urban matters, 2010).

Luo are the third largest ethnic group in Kenya and one of the major tribes in the Nyanza province. Luo descend from early fishing, agricultural and herding communities from western Kenya. Majority of Luo are Christians and marriage is

very important. Luo are polygamous and traditionally sex plays an important role in many parts of Lou life such as during harvesting, planting and widow cleansing. Deeply rooted gender norms in Lou society contribute to a perception that controlling women is a sign of masculinity. If the husband dies, one of his brothers or close relatives inherits his widow and the women is expected to observe the cleaning ritual, which has a sexual component, before being re-incorporated into society. The Luo do not believe in circumcison and hence other Kenyan tribes consider them to be dirty or unhygienic and will refuse to allow their children to marry a Luo (Wikipedia 2011; Ambasa-Shisanya, 2007). In Kenya HIV prevalence is highest among the Luo people where 23 percent of women and 17 percent of men aged 15-49 is infected (KDHS, 2009).

## Participants

The participants were sampled through a convenience sample. In order to find participants the recruitment was done with help from a local female student, who herself lived in the slum area. Including criteria was married and unmarried males and females (18-24 years) who was selected purposively. The sample resulted in four male and four females, all informants were Christians and two females had children. The participants that were asked to participate in the study were also offered compensation in terms of payment.

Table 1. **Socio demographic profile of the participants**

Sex	Age	Married	Children	Age when pregnant	Occupation
Female	19	Not married	0		Waiting to go to college
Female	20	Not married	0		Catering
Female	22	Married	2	16	Tailor
Female	23	Married	1	20	Tailor, catering and computer
Male	21	Not married	0		Carpentry
Male 1	19	Not married	0		Tailor
Male 2	19	Not married	0		Carpentry
Male	24	Not married	0		Waiting to go to college

## **Research process**

Our research process started with four Focus Group Discussions (FGD) (one male group and three female groups) that was done with the intentions to be a part of the study, but along the way the result of the FGD was not as satisfying as we expected. The subject was too sensitive to be discussed in a group. The assumed reasons by the researcher was that the deeply religious youth, who according to the society are too young to even be involved in sexually activities, was to shy and embarrassed to talk about the current topics in a big group. The FGD come to serve as pilot study and resulted in a few changes in the guide lines and settings.

## **Individually In-depth interviews**

The main data collection method applied in the study was IDI. Characteristic of qualitative interviews is that they entail a high level of participation on behalf of the participants. An IDI also allows the participants to speak with their own words (Dahlgren, Emmelin & Winqvist, 2004).

The team developed an interview guideline (appendix 1) that was pre tested in the pilot study and revised in collaboration with our local supervisor to make sure that the questions were appropriate concerning culture, customs and traditions.

The guideline contained unstructured, open ended questions that allowed flexibility and made it possible for the researchers' to follow the interests and thoughts of the participants (Holloway & Wheeler, 2010).

## **Data Collection**

The IDIs was held in Kiswahili, English and Luo. With the permission of the participants all was taped recorded and transcribed. All the interviews were held in the same empty classroom at the school, Mactadi Domestic Training Center. The IDIs begun with questions to collect socio demographic information such as age, civil status and religion. The participant's reproductive history was also explored. After that followed topic focus that aimed at increasing the knowledge about the participant's perceptions and experience related to sexuality, contraceptives, unwanted pregnancies and unsafe abortions. For each topic additional prompts and expansion material were used to support and develop the answers from the participants. Eight interviews (four female and four male) were conducted and were all analysed and presented in the result section. All the interviews was recorded and

lasted for about one hour, they were transcribed and analysed in total confidentiality. We used the same moderator for all the IDI, she was a midwife who lived herself in the slum area. English was at first the choice of language, but to make it easy for the participants to express themselves, they used the language that they felt most comfortable with and consequently we used a moderator who spoke all the local languages. The interviews were conducted in Kiswahili, Luo and English, and were later transcribed into English by a local assistant who was conversant in English, Kiswahili and Luo.

## **Data Analyses**

Inductive content analysis was the chosen method of analysis, where the unit of analysis was the transcribed interview material. This is an analytical tool relevant for research problems regarding interactions of culture and social structures (Berg, 2009).

All the interviews that were recorded was translated from Kiswahili and Lou into English and transcribed verbatim by the local assistant. The transcribed interviews were read through several times by both authors in order to understand the overall picture. Grammar and sentence structure was adjusted in order to facilitate the understanding and the further work and analysis. Throughout the procedure, the text has been re-read to make sure that significant element has not been overlooked. At first, meaning units and expressive words were singled out from the manifest content and then condensed to codes, which lead to six sub-categories. The authors also explored similarities and differences in responses based on gender. The sub-categories were then grouped into two different created categories. The data were examined to find patterns, similarities, significant statements and verbal quotes and where the gathered under each category.

Throughout the analysis the authors has been searching for links and relationships between sections of data, categories or themes. Quotes were lifted from the raw data to illustrate the extracted themes and categories.

## Research Cooperation

This study was conducted within an on-going research project at the Division of Global Health (IHCAR), Department of Public Health Sciences and Department of Women and Child Health, Karolinska Institutet. Division of Global Health has a long-term partnership with the University of Nairobi, Kenya and KMET, Kisumu, Kenya. The first contact in Kenya was established with Theresa M A Odero, Ag. Director School of Nursing Science, University of Nairobi, and she served as our primary supervisor in Kenya. Mrs Odero helped us with the contacts in Kisumu and introduced us to the persons who assisted us at the study site during the study.

## Ethical Issues

The issues of interest in this project are sensitive, especially since sexual activity among unmarried women and men is stigmatized in Kenya and also as abortion is not permitted unless the life or health of the mother is in danger. Several ethical principles have been carefully considered in the planning of this project: *Respect for autonomy*: All participants was given information about the aim of the project and what their participation would mean (appendix 2). They were assured that participation in the study was not to have any negative consequences for their future and all data collected was to be handled with confidentiality. Furthermore they were also free to interrupt their answering or withdrawn from the study at any time without being questioned. After the information they were asked to give a written consent (appendix 3). *Beneficence*: As unwanted pregnancies and consequently possible complications from unsafe abortion and transmitting of HIV have a large impact on society, we believe that the potential benefit of this study is high on a public level as well as the individual level. The participants in this study may also benefit to some extent as participation in the studies might raise their awareness in relation to unsafe sex and its consequences. *Non-maleficence*: The confidentiality of the participants is protected as only researchers involved in the studies have access to the collected data. All data was handled according to national law and guidelines. Thus, the potential harm induced on the participants is minimal. Taking all of the above ethical considerations into account, we believe that the benefit of this research project by far outweighs the potential harm induced on the participants. In view of the circumstances data was

collected by using personal IDI where the participants could narrate their experiences in confidentially. The IDIs was held one to one with a local female moderator that spoke the language of the participants.

Ethical clearance has been approved by the ethics committee at Dalarna University in Sweden.

## Findings

Both male and female interviews were analysed separately however emerged in the same categories. Both the male and female result is presented under the same overall theme: (Table 2): *Submissive vs. domineering sexual behaviours*, and the same three main categories *Experimenting or refraining from sex*, *Unequal power in sexuality* and *The social context for unwanted pregnancies and unsafe abortions* and six sub categories

Table 2.

Sub-Categories	Categories	Overall theme
Perception of sexuality among youth	Experimenting or refraining from sex	Submissive vs. domineering sexual behaviours
Inter-generational sex Gender based power	Unequal power in sexuality	
Perception of contraceptive Responsibility in contraceptive use Unwanted pregnancy and unsafe abortion	The social context for unwanted pregnancies and unsafe abortions	

## **Submissive vs. domineering sexual behaviors**

*Experimenting or refraining from sex*

### **Perception of sexuality among youth**

According to both males and females young people in general start having sex as early as 12-13 years in Kisumu. They further described how they thought that sex before marriage is something that people should not get engage in, however everyone agreed that it happens, it is common and they were quite liberal about the subject. Some of the females believed that sex before marriage could be good, if the involved persons were faithful to one another but if not, then people would have to refrain, and wait until they are married.

*It is not good but nowadays we do it because if there is one you love and so you will go ahead and do sex before marriage. Yes, it happens because maybe you have a lover, and he did not plan to marry you, so you can just have sex with him. (Female 20yrs, unmarried)*

The risks in relation to premarital sex mentioned were described to be mainly sexual transmitted diseases and unwanted pregnancy. One 19 year old unmarried male<sup>2</sup> described:

*Sex is not good. It destroys your body because you slept or had sex without a condom therefore you get AIDS because you were not ready.*

The females interviewed considered adolescent period a time of experimenting, when young people do not acknowledge parents perspectives or follow their advices. The youth interviewed believed it were common that young people hang around in groups and this was thought to promote risky behavior such as pre-marital sex, unprotected sex and unwanted pregnancy.

*Yes, maybe she will hear them say this is my boyfriend and he gives me” this and this”(sex) and if she has not experienced sex she will end up looking for a*

*boyfriend to provide for her too and she will end up having sex. (Female 20 yrs, unmarried)*

The young male's perception of sexuality was discussed and it appeared among the males that sex was "not as important as daily food". On the other hand the males described that when young people reach a certain age their body sense "danger" and they start to look for a sex partner.

One 19 year old unmarried male<sup>2</sup> about why young people have sex:

*They sense "danger in their bodies and if it is a boy he will go out looking for a girl and a girl will go looking for a boy. They then make a date and since they both sense danger in their bodies they do it. Their bodies want and this is what leads them to indulge in a lot of sex*

Temptation and curiosity were words that both males and females interviewed used when they talked about reasons why young people get involved in sex at the first time. They believed that when young people hear about sex they want to try what others are talking about. The males further described feelings of desire and peer- pressure; they also believed sex was a reason to maintain the relationship. The females described that when a woman have her first menstruation she will feel a different reaction in her body, and depending on how a girl handle herself she will have sex or not. The females stated that some women will wait until they are married and some will not. It was said that "If you are weak you will start having sex early, but if you are strong you refrain".

*There's a certain stage and if you reach this and a boy is beside you, you will be filled with butterflies and you have sex. (End with laughter) (Female 22yrs, married)*

It was further described by both male and female participants that young males do not want to miss an opportunity, they said if they were offered an opportunity to have sex they would never say no and that could lead them to have sex without a condom. One of the male interviewed were not involved in sexual relationships and reasons for that was described and illustrated below:

*Because I'm not financially stable and haven't finished school yet I can't indulge in sex. I will refrain until I reach the age for marriage (Male1. 19 yrs, unmarried)*

### *Unequal power in sexuality*

#### **Inter-generational sex**

The phenomena inter-generational sex / sugar daddies/mummies were elaborated in the interviews and described as follows:

*They are big old men who look for young girls to fulfill their wants and needs, I can even be his granddaughter, but you can like him because he is wealthy and he can give you money. Yes, he is older and he wants a young girl like me. Just like am a young girl in school, I have no money, he will give me money, maybe he has a car, he will drive me around in his car and buy me whatever I want. But it's not good because he destroy your future. At times they cheat the young girls and maybe there is something wrong with him, now he wants to destroy the life of a young girl and yet he is taking care of his own young children well, and here he wants to destroy a young girls' life after that he will just drop you. (Female 20yrs, unmarried)*

*A sugar daddy is an old man who wants a young girl, yes it happens a lot and I has seen so many. The old man even wants the age mate of his granddaughter, or an old woman who wants a young man to live in her house. It happens a lot even in town even in the village. Money, all these happen because of money. The old man has sold a piece of his land he goes to town and sees a young girl and now he want to go hang out with her. He wants to go and buy her a bottle of soda that is why all this happens and that is why the name sugar daddy comes in. Maybe a lady has been given some money from her husband. She comes to town meets a young man and she feels she wants to go and relax with him somewhere. Maybe she wants sex and she can't get it from age mates (Male2. 19yrs, unmarried)*

The youth described about sugar mummies; older women, who take advantage of younger boys and sex in exchanges for money and favors, .All of the interviewed females told the same story about sugar daddies; young women that come from poor families are often lured by these elderly men, who give them money, and promises and then want sex in exchange. The females did not talk about the sugar daddies as their boyfriends, because they said no one will ever marry a sugar daddy. Sugar mummies were also described by the females:

*..if a boy doesn't like hard work, he just want to lazy around, this is where he'll meet a widow who was left with wealth by the late husband, and since he doesn't want to work, he will start sleeping around with this lady. They approve because of the promises. (Female 22yrs, married)*

The young women in our study believed that young women get involved with sugar daddies because parents who do not care about their adolescent, the parents do not provide their children with basic needs. Also the mothers do not inform their daughters to stay away from older men. The young women interviewed conclude that sugar daddies replace parents by providing money and support and make the young women dependent on them. One male described that young women get involved with sugar daddies because of the way they dress. By wearing short skirts and tight clothes the men will feel a strong desire for the young women and they will end up having sexual relationships. The males felt that young women prefer older men because they have more money. The youth meant that this could lead to unwanted pregnancy and this force the young women to drop out of school. They also believed sugar daddies/mummies contribute to the spreading of HIV/STI.

*It's because of poverty, the girl has no money it is not because she want to have sex, she has been driven to do it because she doesn't have money and she wants to be like other people. (Male 24 yrs, unmarried)*

### **Gender based power in sexuality**

It was described by the males that it is good for a man to marry when he has completed basic education and has an employment. He is then mature to start his own

family and take care of a wife and ready to leave his old life behind. One male said that marriage should be between an older man and a younger woman, so that she will have respect for him.

*... you know that it is good to have a age difference in a marriage, so that if you marry a girl and it is a big gap in age there will be respect in that marriage but you see if this difference is small there will be no respect in this house.*

*Somebody has even married their age mate, things can't work here it is better if a man is older by at least 4 years that gap is good and the lady will respect you. There may be love but they will lack respect. (Male 24yrs, unmarried)*

The males explained that, according to Luo tradition, if an unmarried woman gets pregnant she will be provided an old man to stay with her. Further the woman might never get married because no man wants to marry a woman with a child out of marriage. Marriage and the first child occurred at the young age of 16-20 among the interviewed women, however when asked, the women actually thought that the appropriate age to get married was between 20 and 30years, when one is mature. They believed getting married at young age was not good for a woman. A woman should have an education and a job before getting married, so that she could support herself and will not have to depend on her husband for everything.

*Even me when I got married, I found it rough, you know I was still young and my husband could really mistreat me, at times he could even bring other girls to the house. If you complain, he beats you so it is good to marry when one is mature enough. (Female 22yrs, married)*

The young women thought marriage was something good and written in the Bible, it proves that a woman is mature and can handle responsibility. They believed every young woman has to get married and leave their parents at some point, and if she does not, people in the village will start talking and calling her names. If the man is serious he will come to the parent's house and make an agreement so that the woman officially will be released by the parents. None of the interviewed females believed that sex is a must, but in a relationship with a man, he will not accept to be a woman's friend if they do not have sex.

*Sex is not a must it depends on your relationship, at times you can like a man and you think you are just friends, not knowing that this man has a hidden agenda. In a relationship, sex is a must because the man will say that if you love him how come you don't want to give him that thing, so you will be forced to give him. Yes, so that your relationship does not end. Boys know how to convince girls... his sweet words will make you do it... So you just decide to do it for him. (Female 22yrs, married)*

This is confirmed by all the interviewed males: they believed that sex is a must in a relationship. They also described that they often put a lot of pressure on the woman and due to the love she has for him she can be forced to give in to sex without not really wanting to:

*Ok it happens, but mostly it happens to girls, because of pressure from the man! You see he can say -it seems you don't love me it seems like you are seeing someone else. And in order to make him happy it will force the girl to give in to sex, though in her mind she did not want have sex. (Male 24yrs, unmarried)*

It is reflected in the female's belief that in a relationship, male's needs in sexuality was central and woman needs to agree. The females further talk about how they often where lead in to sex without really wanting to, they believed that men are weak and as long as they interact with a young woman they want to have sex, women on the other hand can control themselves. It is the man who will decide if sex is going too happen, and the woman is depending on him whether she wants or not.

*At the time you did not have a plan of having sex but you will find yourself doing it. (Female 20 yrs, unmarried)*

The males talked about how young men buy young women present and get sex in return.

*Yes it happens sometimes you want a girl and she doesn't want you, so you look for other ways of getting her, because maybe you have talked to her and she is*

*just running away and now you look for a way to get her. If you can give her something (a present) she will have no alternative. (Male 21 yrs, unmarried)*

The males further described how men sometimes even use violence to get sex, hence the woman is raped. The females described rape or sexual cohering as a woman's own fault because a woman cannot really say that she did not want to have sex with a man if she chooses to go with him to his place, because she is well aware what could happen. The males were also describing situations where they felt they had to have sex with a woman, so she would not spread rumors about him as a man being useless, or not being able to satisfy a woman.

*If you have a girl, and let her go without having sex. The other youth will be talking; they would say that the girl will spread rumors; she will say that you are useless. So that is why a boy will force himself to have sex, so he can praise himself. Yes, that is why he will do it even without a condom, maybe he does not have a condom around and if he does not have this sex it will be a missed opportunity. (Male1. 19 yrs, unmarried)*

The females spoke about their fear about being cheated by a man; men, who just sleep with young women, make them pregnant and then leave them for someone else. They described men do not want to help and can even get aggressive if a woman argue. They also added that some men are good and will help a woman if he really loves her. If a man care about a young woman, he will help her to prevent pregnancy so she can continue her school. Also the fear of being infected by a man who does not use a condom was pointed out:

*Mostly this happens with the sick people, they always feel like why should I die alone? I have to die with somebody. Such people are the ones who do such things, but if you are just a normal person you can't accept sleeping around whit somebody whose status you don't know. They do this because they know they are sick and want to infect others. (Female 22yrs, married)*

## *The social context for unwanted pregnancies*

### **Perception of contraceptive**

According to both male and females, talking about contraceptives and family planning were in general considered to be uncomfortable and stigmatized. Some of the interviewed males felt they could talk with their parents about contraceptives while others felt embarrassed and feared discussing this. They also said that parents fear talking about contraceptives with their children.

*My parents will say – our son is spoiled, there are funny things you are doing out there, so it's kind of embarrassing - we thought you are a good child but it seems you are spoiled. So you can't discuss with them, you become afraid of telling them. (Male 24yrs, unmarried)*

The females described that, as young women they did not talk to their fathers about contraceptives because of the fear of being questioned, and that the father would think that his daughter had become promiscuous. Talking with the mother was on the other hand something that they did, in the beginning they said they felt shy and uncomfortably, but it was something important and most of the girl said they felt free and opened up and talked their mothers. It was believed that if it would have been talked about more in the society, young people would have known more about it.

*I think it is something that is so hard to feel comfortable about for us who still have people to call our fathers or mothers but then I don't think it is an easy thing. One cannot feel comfortable to talk about them.”(Female 19yrs, unmarried)*

The females talked about parents who told their children that if they start using contraceptives they will become infertile, and parents that do not want to talk about it at all so the children will have to hide and do it on their own, but they were also talking about the lucky adolescents who had very understanding and helping parents.

*When I delivered my first baby I didn't stay long before conceiving again, so I went and talked to my mother, she said I should not worry because immediately after delivery she would take me for family planning. My mother saw the way this man treated me, she told me this was not the kind of man you deliver many children with. So immediately after I delivered my second born she took me there, to family planning. (Female 22yrs, married)*

All the youth were aware of several methods of contraceptives and they all knew that it prevents pregnancy and HIV/STI. The contraceptives they knew of were injections (Depo-Provera), Norplant's, the pill and condoms. Injections and condoms as a methods seemed to be the most common way of protection, they believed the pill was easy to forget. Emergency-pill was something that all of the females had heard of, and it was advertised through the media but the females were not sure how it worked and what it actually did to them.

One male said he would give his girlfriend the emergency pill if they had unprotected sex. Traditional methods mentioned by the males were withdrawal method and getting traditional herbs from the elderly woman in the village. It was stated that traditional methods are more common in rural areas because the knowledge about modern contraceptives is low. Only one female had heard about traditional methods:

*There are traditional methods in the villages, they take the menstrual blood and put it..... (I have not done it but I heard about it) on the chimney where smoke passes, so as long as it is there you can't conceive but immediately you remove it you can conceive."(Female 23yrs, married)*

Condom use and its advantage and disadvantage were a discussed topic among the youth. They had different opinions about carrying condoms in their pockets for unpredictable situations. One female thought that walking around with condoms in your pocket was something that a young person should not do, even though she believed that the condoms were something good. It could show that one is promiscuous and it could make people engage in more sex.

*No, people should not walk around with condoms. A person who walks around with condoms shows that he can use them everywhere he goes, so if he is somebody who is responsible he should know the time and place where he can have sex, so it is not a must to walk around with condoms. Maybe you have put it in your pocket and as you remove your handkerchief it falls, people will think badly of you. (Female 20yrs, unmarried)*

The ones that were positive to carry condoms with them meant that it was for your own safety. As young people they believed the curiosity and temptation might lead one to have sex at places where you did not plan, for example at a party, but if you have a condom you will be safe. According to the females men should carry the condoms, because men are weak and women can control themselves.

*Yes young people should carry condoms, because like my girlfriend if I forget she assists me with the one she has in her pocket. (Male 24yrs, unmarried)*

*... but I think carrying it could be safer because you never know. I could be tempted at any time or my curiosity might push me into it and I will think of the condom as my safety.”(Female 19yrs, unmarried)*

*If you’ve tasted the waters you will be tempted to do it somewhere else or a man can go anywhere meet a lady and demand for sex. So it is good to be ready with weapons, Yes, you are ready for war `laughter`. (Female 22yrs, married)*

Females believed that contraceptives or family planning was considered something that protected them and was necessary for young people to use. Some of the women said they were told that contraceptives were not good for young single women because it could harm them, make them infertile, however almost all of the girls were using or had been using contraceptives of different kinds. One 19 years unmarried old male2 describe:

*Some love to use them while others don’t like them. The number of people with AIDS has increased a lot. The ones who have started having sex use condoms*

*but most people don't like using condoms and that is why cases of AIDS have gone up.*

Both male and females believed that men do not want to use condoms because of the way it reduces the sensitiveness they will not have the exact pleasure; they want to have sex “flesh to flesh”.

*There are those who don't want condoms, even if you tell them to use, they tell you they may leave a future president in the condom. He feels he's thrown away his treasures. (Female 22yrs, married)*

The males felt that people uses condoms mainly to prevent HIV and not prevent pregnancy.

*Normally they use condoms to protect themselves from AIDS. They don't want to contract HIV. They really don't use it to prevent pregnancy. That person who doesn't want to use condoms is somebody who is not seeing far. This is somebody who hasn't gotten proper health education. (Male2. 19 yrs, unmarried)*

Among both male and females reasons for young people not to use contraceptives were lack of knowledge, not knowing the benefits and believing that they had side effects. It was believed that the chemicals used in the manufacturing of contraceptives could affect the user. Other disadvantages about condoms were that they could burst, get stuck in the vagina and make the sperms dysfunctional in the future. Some male thought that contraceptives could destroy the uterus of the women.

*Its disadvantage is, if you don't know how to put it on, there are people who are not trained, they just put it on because everyone else is using, he can put it on in a bad way so that when you are having sex, and when you are through you will discover that the condom had burst and remained in your vagina and you see if this condom remains in the vagina it is another problem because you have to be taken to hospital for removal, so that's it is disadvantage. (Female 22yrs, married)*

The disadvantage with condoms was according to the young women, that people will become promiscuous because they know they are safe. Some females said condoms were not necessary when you knew your HIV status. A woman was normally not aware of how to put a condom on, their boyfriends never showed it to them. Some of the interviewed females did not use condoms because they trusted their boyfriends on the other hand the interviewed male thought that if a woman is smart she will refuse having sex without a condom, but they also said if the woman let her boyfriend have sex with her without a condom it's a sign that she trust him.

*Maybe the man will say: 'Madame, today I will not use a condom` and if she is a clever lady, she will refuse him but if she is a foolish one she will accept to sleep whit him without a condom. (Male2. 19yrs, unmarried)*

Reasons for not using condom could be according to one male that an infected person does not want to die alone so he/she will infect the other person intentionally. One male were not interested in contraceptives he felt that there were no reason for using contraceptives because you are supposed to use abstinence and that contraceptive are for married people. He also believed getting children is "God's will; you should not interfere with his wish".

The commercial and all information about contraceptives was according to the young woman mostly aimed for women, which was fair enough when they believed that they are the one who are affected the most. This was also confirmed by the males:

*I don't know what they say about men and women concerning contraceptives because mostly you just pay attention to what you have keen interest on, but I think mostly it is the women who should be told more about it because they are the ones who use it much though I've never been keen on the subject."(Male1. 19 yrs, unmarried)*

One woman was concerned about the fact that some people could have many different partners, and still not get infected or pregnant.

*... In fact there are some people who have sex without protection and they don't get pregnant or infections they are just fine. I wonder how such people are. Maybe she even doesn't have one partner, she has several, she even goes with married men and she is still fine (Female 20yrs, unmarried)*

### **Responsibility in contraceptive use**

The responsibility when it comes to use of contraceptive, in a relationship, was discussed differently among male and females.

Some males had the view that it is the man who decides about what kind of contraceptives to use and he is also the one who should prevent pregnancy.

*To prevent pregnancy it is only the boys who should use protection but the girls, I don't really know what they can use... between me and my girlfriend, it is me to see that we should have protected sex. I should tell her that `look her Madame let us use this or this thing so that we don't get any disease or infection` (Male2. 19yrs, unmarried)*

On the other hand all interviewed females told stories about how they believe that contraceptives and family planning are a woman's responsibility, even as a married woman, although their desire was that the man should take responsibility. They explained that in the end, she is the one who will suffer from the consequences of unprotected sex; it's her shame and burden when the pregnancy is a fact. They also talked about how a woman can never know when or how often her husband will be unfaithful to her, so she knows that it is up to her to take him to the clinic to get tested for HIV/STI, and even after that she could not be safe, she is the one who will suffer.

*As a woman you can't know what your husband does outside (Female 22yrs, married)*

It was described by the interviewed women that women have to use contraceptives in secret, because their husbands do not always agree with family planning, some men do not believe that contraceptives are appropriate in a marriage. Stories were told about how a team walks from door to door and give injections (Depo-Provera) to the woman when the man is at work and how important it is to hide the proof/card

afterward. The women are forced to do this in secret “as thieves” as one woman expressed herself, because in the end it is the woman who has to carry the burden, she has to take all the responsibility.

*If you have a good husband he will accept family planning but if he is not good he will want you to deliver forever. (Female 22yrs, married)*

*As a married person I will go to my husband if he accepts I will go to the doctor for family planning (Female 23yrs, married)*

However both male and females were talking about successful relations where both the man and the woman agreed on contraceptives and family planning.

*I will discuss with my girlfriend, I will tell her that we are still young and maybe I am not able to provide for her and at times sex is a must, maybe I really want sex or maybe she is the one who wants both of us want, therefore to prevent getting pregnant,. We can go for certain pills, we go choose a good method that now when we want to get married and want a baby we can go and it is removed. (Male 24 yrs, unmarried)*

The females believed that if an unmarried woman ends up pregnant, the man will normally not accept and take care of the baby; however the woman could be lucky to find a man who is responsible. But in general, if a woman is not ready to have a baby by herself, she will have to make sure to use contraceptives, it is her responsibility and not the man's. All the young women agreed that if a man does not want to use contraceptives a woman should refuse him sex:

*...so unless she is able to face the consequences, all of them, from getting infected to carrying that baby for nine months and taking care of everything, I think she should use contraceptives (Female 19yrs, unmarried)*

Although that rule had many exceptions, it seemed to be depending on the situation, one young woman said if a man promised her, that he would take care of her, she would agree to not use contraceptive.

*This will now depend on what the boy says, if you ask him, if we do this without condoms, wont I get pregnant? If he tells you there's no problem, I will take care of you even if you conceive, then you will have the courage of doing it without condom but if he is someone who can't take care of you after impregnating you then you look for ways of protecting yourselves and if you know he is not HIV positive then there is no problem.”(Female 20yrs, unmarried)*

### **Unwanted pregnancy and unsafe abortion**

Getting pregnant as a young unmarried school girl while still in her parents' house was according to the young women something perceived as stigmatized, a big burden and devastating for a young female. They said they would worry what the class mates would say when the belly would start growing, there was also a fear of what the neighbors and other people would say. Both male and females thought that a pregnant young unmarried woman will always be a burden to a parent. In worst case the young woman could be chased away to live with the father of the child. Some young women even commit suicide when the pressure and the burden become too heavy for her. The woman's education will be effected, her studies will end, but if the woman has good parents or/and a good boyfriend she could maybe continue her school after delivery.

*Her parents may chase her away. The parents will be annoyed because they have struggled paying her fees and now she becomes stupid and gets herself pregnant, but a good parent should let her deliver then go back to school.  
(Male2. 19 yrs, unmarried)*

The males interviewed in this study felt that they had no or very few responsibilities or problems if they made a woman pregnant. Problems they mentioned they could face were; they could be sued by the parents of the woman or be forced to marry her. The one thing they felt would be embarrassing was to be called a father at young age.

*Problems I can get into incase I impregnate a girl are very few, I will just have a lot of thoughts like I have impregnated my girlfriend and I will not be happy. (Male2. 19 yrs unmarried)*

The males' perception about induced abortion varied. Some of the male would help their partner organize the abortion and support her, while some would not accept an abortion at all. However, they felt that most women do not tell their boyfriends about the pregnancy and the planned induced abortion. They believed one of the most important reasons for doing an abortion was rape.

*Most of them don't tell their boyfriends. They keep it to themselves. But some discuss with their boyfriends and some boyfriends are the ones who organize the abortion because they fear the girls' parents may sue them. The boy sometimes helps the girl to look for somebody to do the abortion because abortions in hospitals are expensive (Male 21 yrs, unmarried)*

It was believed among both male and females that a young woman's delivery often brought complications because of her age, her bones or her cervix were not strong enough and the complications often led to operations. Most of the male did not think unsafe abortions were common because of the dangers in relation to procedure. The risks they mentioned with unsafe abortion were that she might not conceive or deliver again and she could even die.

*I cannot accept a girl to do an abortion, because we will be killing, secondly the abortion can harm her, and therefore I will refuse abortion. I will only counsel her to keep the pregnancy and deliver because she may abort and never deliver again (Male 21 yrs, unmarried)*

According to the women's description, unsafe abortion was something common. One woman had even done it herself, mixing strong tealeaves with "omo" which is a type of detergent. The young women were telling many stories about unsuccessful unsafe abortions. They describe that when it was raining they could see little fetal floating in a nearby river or in the trenches, this from unsafe abortions. One female is telling a story about her friend who had an unsafe abortion done that did not end successfully:

*Yes I have heard of such a person, she was my friend. She went and did abortion without the knowledge of her parents, it brought her problems because it was removed and the fetus didn't come out well, a time came when she had abdominal pains and was taken to hospital, it was then discovered that the doctor who assisted her didn't do it well, parts of the pregnancy had remained in her uterus and that was what was causing the pain... (Female 22yrs, married)*

*...she went to somebody who advised her to make a solution of soap detergent (Omo) and drink, she made a glass of this and immediately she drunk it, she started bleeding had abdominal pains, severe. She was breathless; she writhed on the floor screaming for help. When help came she was convulsing, she was immediately rushed to hospital. That I saw, because when I arrived at the scene the glass and omo (detergent) were there. (Female 23yrs, married)*

In general the youth did not believe in traditional doctors for abortion, they were not reliable as they “don't do it safely”, instead they said preferred to go to the hospital. However they never reflected over the fact that induced abortion is illegal in Kenya.

*Some do it at home but you can't trust the traditional ones, sometimes she (home midwife) does it wrongly and you may be injured but in hospital they know how to do it, it can be done and you leave hospital immediately but at home you can be injured. (Female 20yrs, unmarried)*

The females are telling stories about how sometimes it is the woman's own mother who helps her to do an unsafe abortion, to avoid shame and if it succeeds she can go back to school and continue with her education. And if the parents are very strict she can even ask her boyfriend to help her do the abortion.

All the males felt that unsafe abortion is very dangerous and the ones who do provide the abortions are old grannies in rural areas. The methods used for unsafely induced abortions at home are strong tea and herbs or attempts to remove the baby using devices which could lead to severe complications.

*If she is a clever girl, she should go to a competent doctor, tell the doctor she has conceived and she would like to end the pregnancy; the doctor will do the abortion for her. In case she decides to do it on her own she may have complications (Male 2. 19 yrs, unmarried)*

*Some pregnant girls go to old women to have an induced abortion. Because people at home don't have money to do abortion it is very expensive so they go to old women who do it for them, using traditional herbs (Male 21 yrs, unmarried)*

## Discussion

There are many factors that are involved in the highly complex situation for male and females in relation to their sexual and reproductive health in current Kisumu, Kenya. The main findings in our study highlights how young people in Kisumu face gender based power in their sexuality, how misconception and stigma about modern contraceptive use consequently leads to unwanted pregnancy and unsafely induced abortion. We will discuss our findings from three perspectives: *Gender based power in sexual relationship*, *Perception of contraceptives use* and *Unwanted pregnancy and unsafe abortion*.

### **Gender based power in sexual relationship**

The interviewed females meant that men have an uncontrollable desire for sex and will not accept if his girlfriend does not want to have sex with him. The female described how they often fell persuaded and get involved in sex without really wanting to. This was also confirmed by the males in how they sometimes give the woman presents to get sex in return and that violence was sometimes involved if a woman did not agree. These findings are confirmed in other international research and women's experiences of pressure into having sex against their will is explained to be based in gender power dynamics and poverty (Hayer, 2010; Nobelius et al, 2010b). A common perception in research is that men have biological uncontrollable sexual needs (Nobelius et al, 2010a; Nobelius et al, 2010b; Adaji, Warenius, Ongany & Faxelid, 2010; Molla, Berhane & Lindtjörn, 2008) and patriarchal structures force women to accept being powerless in sexual relationships.

Both males and females interviewed in our study described how older men and women take advantage of young people's social vulnerability by involving them in sexual relationship in exchange for money and/or favors. This phenomenon have been describe in the literature as "something-for-something love" or "transactional sex" and is defined as engaging in sex in exchange for money, favors and gifts (Samara, 2010). This has been described from different African contexts however with different labels. It is described that younger women are at higher risk than older women and undermines females position to negotiate about condom use as well as the timing and the frequency of sex (Chatterji, Murray, London & Anglewicz, 2004;

Nobelius et al, 2010a; Nobelius et al, 2010b; Darj, Mirembe & Råssjö, 2010; Robinson & Yeh, 2009). In the study of Samara (2010) the phenomenon is defended by the women, they claim it gives them a chance to earn money to be able to pay school fees; they say it can be something good as long as you practice safe sex. The male and females in our study described how they were exposed to the phenomenon and they labeled it “sugar daddies” and “sugar mummies”. One interviewed male believed that young women got involved with “sugar daddies” mainly due to the way they dressed and acted. While the females explained that parents absence and lack of involvement in their adolescents life acted as a contributing factor. This wide spread prevalence and acceptance of transactional sex, might lead to a tolerance for sexual coercion in specific situation, which put the exposed women in a low position and a very high risk (Samara, 2010).

Social factors such as early marriage and the importance of education and employment were discussed in the interviews. The females believed that a job and a education was important for a woman before getting married and marriage should occur at the age of 20 and 30 when one is mature, so that the woman do not have to depend on her husband for everything. However the females in the study actually got married at the age of 16 and this reflects the male’s expressed preferences for a young wife, this so that the woman will have respect for him as an older man. Most of our interviewees belonged to the Lou people, who is one of the largest ethnic groups in the study site Kisumu and are heavily influenced by traditional norms and values. The males among Lou people are the main decision maker and are the ones who are responsible to establish norms, to remain in control in order to keep his masculinity (Ambasa-Shisanya, 2007). It was also described by the women in our study that it is the responsibility of both married and unmarried woman to use contraceptives. Even a married woman never knows when or how often her husband will be unfaithful to her. This could also be referred to the Lou tradition of polygamous, which is condoned and common (Njue, Voeten & Remes, 2009). However Lou is not unique in relation to this, similar findings of multiple partners as a proof of masculinity was found in another study (Joshi, 2010).

### **Perception of contraceptives use**

The males in our study shared their preferences for having sex without a condom, claiming that sex was not to “be swept in a plastic wrapping”. This seems to be a common perception among young people globally (Nalwadda, Mirembe, Byamugisha & Faxelid, 2010; Ahlberg, Jylkäs & Krantz, 2001). The female interviews described that condoms were not necessary when you knew your HIV status, and some females did not use them because they trusted their boyfriends. The male’s perspectives indicate that sex without a condom was a proof of trust and love within a relationship. Misconceptions in relation to modern contraceptives including condom was described as barriers. However, the general knowledge about contraceptive methods among the participants seems to be high and they all believed it was something good. The awareness and relatively good knowledge about modern contraceptives methods among adolescents in Kenya, Kisumu was also confirmed in a study carried out in the year of 2002, however it also showed that the level of contraceptive use was low (Oindo, 2002).

The males interviewed in our study were well aware of the risks they faced when involving in unprotected sex and they knew that a condom protects them from HIV/STI. However, at the same time they were admitting, if not having a condom they would have unprotected sex because they did not want to miss an opportunity. Findings from a survey among male students in Nairobi, Kenya contrast with this. It was revealed that the young men did not see themselves as susceptible to HIV/AIDS and they questioned the condoms effectiveness in preventing HIV (Yotebieng, Halpern, Mitchell & Adimora, 2009). It appeared in our study that pressure and pleasure from sex override the fear for HIV and other STI. When the male in our study, mainly used the condom to prevent HIV/STI, it leaves the female at a high risk for pregnancy when the couple has overcome the fear of HIV/STI. Misconceptions and suspicion regarding contraceptives are numerous, and they are spread through the society on all levels and in all directions, it is short term thinking and it is definitely in a big problem and a risk for adolescents’ SRH (Kibuuka et al, 2009).

The youths in our study believed that an open communication around sexuality and contraceptive would be beneficial for all however it appeared in our study that communication about contraceptives in general was considered to be something

uncomfortable and embarrassing. The youths in our study further expressed a fear of communicating with their parents about contraceptives and also revealed a concern of being seen as promiscuous or unreliable daughter/son. The youths described that parents and others imply that contraceptive was not for young women as it could make them infertile, and even destroy the uterus. However most of the female in our study shared that they actually went to their mothers for advice and support. This is confirmed in a study from similar setting and describes how females preferred talking to their mothers and males to their fathers, unfortunately over 30 percent never or hardly talked to their parents about contraceptives at all (Namisi et al, 2009). The youths fear seemed to be a reflection of the parent's reluctance to talk about the subject. These perceptions extends back in the African history, where in most ethnic groups it has been a taboo against sex discussion between adults and their own adolescents (Mbugua, 2007). Mbugua (2007) emphasizes the responsibility of the Christian church for all the restrictions concerning sexuality. Other research describe how social and cultural inhibitions hindered most educated mothers in Kenya to give meaningful sex-education to their children as most of them neither received sexual educations from their own mothers (Mbugua, 2007). About 70-80 percent of the people in Kenya are Christians and the church holds an important place in the socio-economic and political life in the country. The religious institutions advocate chastity and sexual conservatism and these Christian morals clearly have an impact on young people's view of sexuality (Kangara, 2005; Warenius et al, 2007; Oindo, 2002). The interviewed youth in our study were all member of the Christian church and brought up religion as one of the reasons for not using contraceptives or not getting involved in premarital sex.

## **Unwanted pregnancy and unsafe abortion**

*“Abortion is not permitted unless, in the opinion of a trained health Professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.”*

The Constitution of Kenya 2010

Although abortion virtually is illegal in Kenya, none of the youth ever mentioned or reflected over this fact. When asked where to go for an abortion, the female without hesitation suggested to either go to a traditional doctor or the public hospital for the procedure. This lack of knowledge is reflected in recent national statistics from Kenya, where result show that almost all respondent were unfamiliar with the legal status of abortion and 92 percent of the respondents had obtained unsafely induced abortions (KHRC & RHRA, 2010). Most males in our study believed that induced abortion was not common in Kenya, and some of the male refused abortion as they believed it was murder. The females however had a more self-perceived belief that abortion actually was common. The male meant that they had very few responsibilities or problems when making a woman pregnant, while the women faced the risk of losing her family, not being able to continue her education and lose her chance to ever get married. This could even lead her to commit suicide as it is believed that it is the woman’s shame, her burden and her destroyed life. In a qualitative study from Kenya 2011 finds that unwanted pregnancy occurs at anytime during a woman's reproductive life and it often lead to abandonment and rejection by male partners, families and friends. The male in this study also felt that they had few responsibilities if he had made a girl pregnant (Izugbara, Ochako & Izugbara, 2011). This is also a great threat to young female’s future education it is reported that about 13,000 Kenyan girls drop out of school yearly and this due to unplanned pregnancies. This has however been highlighted by the government and the “Return to School” policy has been developed by the Ministry of Education, in order to support pregnant in-school girls to continue their education (KHRC, 2010).

The male perception about unplanned pregnancy and their lack of involvement and responsibility is supported in other studies carried out in Kenya and Sub-Sahara

Africa (Izugbara, Otsola, Ezeh, 2009; Nzioka, 2001). Researches further describe how young men believe that making a girl pregnant is a proof of manhood and it thus gives them a feeling of pride and social status. It was further revealed that the girls was to be blamed due to for the pregnancy; “the clever ones know how to protect themselves” (Nzioka, 2001).

The young women interviewed in our study shared many stories about unsuccessful tragically unsafe abortions sharing that it was sometimes even the mother or the boyfriends who helped them with the abortion procedure. Among both male and female it was well known that abortions carried out by an traditional doctors was highly risky, despite this they have no other choice but to use these unsafe alternatives. Interestingly when reading trough the latest Kenyan Demographic and Health Survey from 2008-09, abortion and its complications are not mentioned, which could be questioned as the annually estimated abortion rate in Kenya is about 300 000, and out of these 2000 women die from complications (KHRC, 2010). It is estimated that the factual maternal mortality rate is higher than this numbers and that abortion complications are the most important causes of maternal mortality in Kenya (Ziraba et al, 2009 and Gebreselassie et al, 2005). It was further found that the young women face significant barriers to obtain safe abortion and are also suffering from post abortion complications that could have been treated or prevented (Gebreselassie et al, 2005). The study of Ziraba et al. (2009) also reveals that almost 80 percent of all maternal deaths cases occurred among women who delivered without the help of a skilled birth attendant. All abortions related deaths followed an abortion carried by a non-professional and less than 50percent of the women experienced an unsafe abortion sought health care before death. Result from these studies( Ziraba et al.2009; Gebreselassie et al, 2005) identify a great need for a more skilled health care professionals involvement in abortion and post abortion care. However, in a study conducted by Warenius (2006) most of the 322 Kenyan nurses-midwives did not approve of induced abortion and about half where against modern contraceptives. This beliefs where more common among the nurses-midwives who had no continuing-education, they also said they would feel annoyed if an adolescent girl came for help with symptoms from induced abortion. Findings from similar setting in Africa, where abortion is illegal, almost 30 percent of the nurses/midwives believed that religions values and believes contradict with provision of contraceptives and /or

induced performing the abortion (Mngadi, Faxelid, Zwane, Höjer & Ransjö-Arvidson, 2008).

Health care providers working with sexual and reproductive health care face a critical intersection between values and norms. It is suggested that midwifery education and training should encourage value- reflective thinking around gender inequality and ethical dilemmas, in order to prepare nurses-midwives to address adolescent's reproductive health needs (Warenius et al 2006). In a study conducted in Tanzania almost all women that had an abortion done accepted post abortion contraception counseling. And almost 80 percent women stated they were using contraception at 12 months after the abortion. Condom use among the single women increased significantly during the 12 months follow up (Rasch, Yambesi & Massawe, 2008). It has been proved that if a country gives their midwives relevant training and education in safe abortion care and contraceptive counseling they can provide high quality abortion service independently, which result in post abortion contraceptives counseling and fewer complications for the patient (Dickson-Tetteh & Billing, 2002). This successful program could break new ground for midwives in Africa and around the world, it could be used as feasible model.

## **Methodological Discussion**

In any qualitative research study, four issues of trustworthiness can be discussed dependability, credibility, conformability and transferability.

Validity and reliability in qualitative studies is about being able to describe that one has collected and processed the data in a systematic and credibly way (Polit & Beck, 2004). The FGD's come to serve as pilot study and resulted in a few changes in the guide lines and settings and this together with well organized and prepared interviews is thought to strengthen the degree of dependability.

Content analysis was the method applied to structure and makes an understanding of the data. Quotes from the coded text has been included in the text which gives the reader an opportunity to criticize what characterize the different categories, and also

what distinguishes them and this is thought to increase the credibility. Granheim and Lundman (2008) argues that the credibility of the result of the study is based on that the persons who reads and examines the texts are well versed in the subject, this to make sense of credibility and choose the right codes and themes. A category system is proved to allow the reader to follow the analysis process (Table 1). With better understanding of the subject, the researcher can affect the study's results by bringing their own ideas and experiences, or by twist the information that the researcher received from the participants (Polit & Beck, 2004). The strength of this study is that the authors had the advantage of being in Kisumu, Kenya and gave them an understanding of the culture and context surrounding the topics studied. An advantage is also that we are women and have lived in Africa for long periods; and thus helps us to a better understanding of the situation of young people in Africa. At the same time, this understanding could have influenced our analysis and our interpretation of the texts. According to Polit and Beck, 2004, objectivity and neutrality can be strengthen when researchers are able to study a phenomenon without imposing their own values in the result. We have tried not to influence the study's results, by raising awareness in relation to our own understanding and we have made an effort being neutral when we read and analysed the interviews. We believe that the conformability is strong when the readers clearly can trace all the data back to their original sources. A detailed description of the research process provides the reader with the information necessary to follow our interpretations.

According to Holloway and Wheeler 2010, transferability is the extent to which results can be transferred to other groups or situations. We believe that the results of our study may be transferable to adolescent sexuality and reproductive health in Kenya that are in the same age group, because we have found similar results in other research. However because of the relatively small convenient sample consisting of eight interviews, it might be difficult to consider the result as a reflection of the larger population in Kenya.

Due to lack of time and financial funds we had to use an inexperienced moderator which led to misunderstanding concerning the guide line and the interview technique. The fact that we had a moderator resulted in us not being able to use the prompts and

expansion material that we considered appropriate, we had to depend on her. Furthermore, the translation of the material; it was collected in Swahili, Luo and English, then translated and transcribed into English by an inexperienced person. It was found out after the first draft of the transcription that a few rather important misunderstanding had occurred, the transcription was re done three times before it was correctly performed, this delayed the procedure considerably. The fact that the interviewer was a local midwife may have influenced the youth both positively and negatively. Positively since she speaks both English and the local languages and the participants could use the language that they felt most comfortable in, and a translator was not needed. What could have influenced them negatively was the fact that she was a midwife from the area, and the sensitive subject might have hindered them from answering unreservedly.

## **Conclusion**

The findings in our study show how young people in Kisumu face gender based power in their sexuality, how misconception and stigma about modern contraceptive use consequently leads to unwanted pregnancy and unsafely induced abortion. We have important suggestions for youth interventions. First, intervention strategies should engage young men in unwanted pregnancy and thus unsafe abortions; men in a country like Kenya generally control the terms and conditions of sexual relationships. Consequently, we need better strategies to engage men, and effective interventions to change their attitudes and behaviours related to power and control in relationships. Second, young women should be empowered in several ways; they should be taught how to negotiate safe sex. Their poverty should be addressed and equal economic conditions should be achieved.

When the practice of abortion in Africa often is hidden and stigmatized due to obsolete abortion laws, legal reforms ensuring women easy access to safe legal abortions is the primary option to prevent unsafe abortion. Kenyan women are denied access to a simple and safe medical procedure and face serious and multiple barriers to obtaining quality post-abortion care. There is also a need for nurse/midwifery participation to provide adolescents with contraceptive counselling and services. Unsafe abortion is a serious public health problem in Kenya that cannot be ignored.

We suggest that further research should focus on the question how we could strengthen the women's empowerment in a country like Kenya.

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We would like to thank the people who have helped us in conducting this study, and the participants - for willingly sharing your experiences and feelings.

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# Appendix 1

## Interview guideline for individual interviews

### Socio demographic information

Name:

Age:

Relationship status:

If married, age of marriage, type of marriage:

Education:

Occupation:

Religion:

Accommodation:

Siblings:

Number of members in family:

### Reproductive history

Age when menstruation started:

Age of first pregnancy:

Number of pregnancies:

Number of live birth:

Number of children alive:

Number of miscarriages:

Number of induced abortion:

### Interview guideline

#### 1) Contextualizing sexual activity among youth in Kenya

Can you please tell me when young people in Kenya usually start to have sex?

- Is sex necessary/expected in a relation between a man and a woman?

- Describe the circumstances, when and where?
- Difference between boys and girls?

What is your view about pre marital sex?

- Is it ok? Is it common?

At what age do you think it is appropriate to get married?

- What does marriage mean to you?

Young people sometimes have sex without really wanting to. What are your views about that?

- What are the reasons?
- Do you know anyone who has experienced having sex without wanting to?

What is your view about “Sugar daddies”?

- How would you describe it?
- In what situations does it happen?

## 2 ) Contraceptive usage and access to information

If you need to talk to someone about contraceptives or other related issues, who do you talk to?

- How do you feel like talking about these issues?
- Is it ok to talk about it openly in the society?
- Whom or what are the most important sources of information to young people?
- Do the sources of information about contraceptives vary for young men and women?
- Where do young people get their contraceptives from?
- How you think that they should be handed out? From who or where?

## 3) Risk prevention

What risks are involved when you are sexual active?

- What contraceptives do young people use?
- Modern and or traditional?

- What is according to your view the purpose of using contraception?
- Who (the men or the woman) is responsible for contraception and protection?
- How do young people feel talking about contraception with Parents?
- What do young people think about condoms?
- What are the advantages and disadvantages with condoms?
- Should young men/women carry condoms?
- What do you think would make people of your age to use condoms?
- What reasons do you think there are why young people who are sexually active don't use contraceptives?
- Is it necessary for young people to use contraceptives?

#### 4) Unwanted pregnancy and induced abortion

##### What is your view about teenage pregnancy?

- What are the consequences of pregnancy if a girl is unmarried?
- If she is married?
- What does it mean if a girl gets pregnant while she is still in school?
- **What are the consequences/ responsible for you as a man, if you make a girl pregnant? (for males)**

##### Do you know anyone who have experienced unwanted pregnancy and what did she do?

- What do young women in your community do to avoid getting pregnant?
- Where/who does a young woman turn to when she wants to do an abortion?
- Apart from medical methods how else is abortion done among young people in this community?
- How common is it that young women make abortion in this community?
- **What responsible do you as a man have if you and your girlfriend want to do an abortion? (for males)**

## Appendix 2

### Missive letter

**You are hereby asked to take part of a study titled:**

**“Attitudes and views towards sexuality, contraceptives and unwanted pregnancy among young people in Kisumu, Kenya –community based studies”**

There are estimated 1.7 billion adolescents and young people - one in every five people - in the world today. Adolescents and young adults' sexual and reproductive health has been depicted as a human right and one of the key pillars of countries' social and development processes. In Kenya young people represent more than 1/3 of the population. In Kenya only about half of sexually active young people reported using contraceptives; this can lead to sexual transmitted diseases and unwanted pregnancy. Unwanted pregnancy and consequently unsafe abortion are responsible for significant morbidity and mortality among adolescents in the world. There for an increased focus on the sexual and reproductive health among adolescent/young people is needed.

*The aim* of this study is to describe, knowledge and attitudes towards contraceptives and abortion among adolescents in Kenya.

*The methods* which will be used are focus-groups and in-depth interviews.

The interview will take approximate 1- 1 ½ hours, it will be a one to one dialogue and the interview will be recorded.

The focus-groups will also take approximate 1-1½ hours, you and 4-6 other participants will sit down and discuss the current topics, the discussion will be recorded.

*Confidentiality:* No information that identifies you will be included in the report from the interviews/focus groups. All data will be unidentified which means that your responses can not be traced back to you. At your request, you will be provided with a copy of our results at the end of the study. All data will be stored safely.

*Benefits:* The results of the study will be a base for developing guidelines for sexual education and sexual reproductive healthcare for young people. This to provide young people with adequate information and healthcare adjusted to their needs.

*Your participation* in the study is completely voluntary. You may at any time end your participation without stating your reasons.

Two midwifery students from the University of Dalarna, School of Health and Social Science, Sweden, will conduct a pilot study about preventing unwanted pregnancy, and sexually transmitted diseases among youth in Kenya. The study is a part of our education. The investigation will be presented in the form of an essay at University Dalarna. The study is ethically approved by our school's ethical board at the University of Dalarna with record number: If you have any queries contact persons below:

Sincerely

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## Appendix 3

### Consent Form

Titel: “Attitudes and views towards sexuality, contraceptives and unwanted pregnancy among young people in Kisumu, Kenya –community based studies”

I agree to participate in a study being conducted by Jennie and Jessica for the University of Dalarna.

I have made this decision based on the information I have read in the Information letter. In addition I have had the opportunity to receive any further details I wanted about the study. I understand that I may withdraw from the study at any time, without penalty, by telling the researcher.

I also understand that this project has been reviewed by, and received ethical clearance from the Ethical committee at University of Dalarna and that I may contact these offices if I have any concerns or comments resulting from my involvement in the study.

Participants Name: \_\_\_\_\_

Participants signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### Consent form for audio taping interview

I understand that the interview will be audio taped to facilitate the collection of information with the understanding that all information, which I provide, will be held in confidence and I will not be identified in the thesis, summary report, or publication. I understand that I may withdraw this consent at any time, without penalty, by advising the researcher.

Participants Name: \_\_\_\_\_

Participants signature: \_\_\_\_\_

Date: \_\_\_\_\_