

# Contraceptive Use Among High School Students in Kenya

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*Data from a 1989 survey of 2,059 secondary students in Nakuru District of Kenya show that 69% of the males and 27% of the females were sexually experienced. Among the sexually experienced students, 49% of the males and 42% of the females had ever used a contraceptive. Only 25% of the males and 28% of the females had used a method the first time they had sex, and similar percentages had done so the last time they had sex (31% and 29%, respectively). The condom was the method most frequently used at last intercourse (55% males, 43% females), followed by the "safe period" (29% males, 43% females) and the pill (6% males, 10% females). To obtain contraceptives, 33% of males and 46% of females visited clinics, and 36% of males and 25% of females relied on friends. Logistic regression analysis shows that for females, high socioeconomic status, high academic achievement and a favorable attitude toward contraception were the most important factors predicting use of a contraceptive method at first sex and use at last sex. None of these factors predicted male contraceptive use. Males who said their partner approved of contraception were twice as likely to have used a method at last sex. (International Family Planning Perspectives, 21:108–113, 1995)*

Adolescent reproductive behavior is now recognized as an important health, social and demographic concern in Kenya. Studies estimate that as many as 70% of unmarried male adolescents and nearly 25% of their female counterparts have premarital sexual experience.<sup>1</sup> Data from the 1993 Kenya Demographic and Health Survey (KDHS) indicate that the median age at first marriage for women aged 20–49 is 19.2 years, while the median age at first intercourse is 16.8 years. The KDHS does not provide comparable data for men; however, it shows that only 4% of men aged 20–54 have married by age 18, although 64% say they have had sexual intercourse before that age.<sup>2</sup>

Although many individuals are exposed to the risks associated with precocious sexual activity, use of contraceptives by adolescents is a sensitive issue in a country with strong religious leanings, and young people face many difficulties when they attempt to obtain birth control. Government policy is to "ensure availability of contraceptive services for those men and women who are ready for and need them,"<sup>3</sup> but in practice, adolescents have

limited access to such services.<sup>4</sup> Studies have found that fewer than 12% of sexually active unmarried teenage women report using a contraceptive method.<sup>5</sup> As a result, rates of unwanted pregnancy,<sup>6</sup> abortion<sup>7</sup> and sexually transmitted disease<sup>8</sup> are high. Family life education, particularly contraceptive education, is also a sensitive issue, and the extent to which it is addressed varies from school to school. A recent announcement that it would be introduced brought a wave of protest and opened the debate anew.<sup>9</sup>

## Sex and Contraception in Kenya

The sociocultural context in which adolescents in Kenya find themselves has changed considerably within the past few generations. In Kenya, as in much of Africa, adolescents are experiencing social turmoil resulting from conflicting values as the country becomes more urban and industrial. The smaller and slower paced communities of the past provided clear guidelines for young people in such aspects of their socialization as recreation, religion, relationships with elders, and cultural rituals.<sup>10</sup>

In most ethnic groups, adolescence generally commenced with circumcision, a rite of passage that marked emergence from childhood on the way to adulthood. Over a period of several weeks, initiates were secluded from the community while a selected tutor explained their role in society to them and taught them about sexual behavior and pregnancy. Such customs con-

ferred peer-group identity and promoted a social and personal sense of belonging.<sup>11</sup>

Many African cultures had an open attitude toward sexual relations and did not place sexual behavior at the center of their moral and social systems, nor did they necessarily value chastity. For example, in Kenya, the Akamba allowed premarital sex for both boys and girls after circumcision. In fact, a virgin bride brought shame to the family because she had not been adequately prepared.<sup>12</sup> The Kikuyu allowed unmarried youth to engage in a nonpenetrative form of sexual intercourse called *ngwiko*.<sup>13</sup>

Periodic abstinence, withdrawal and nonpenetrative sex were taught and widely practiced as means of preventing pregnancy. Among the Egoji clan of the Meru, young people were taught about the "wrong time of the moon," when a girl might get pregnant.<sup>14</sup>

Such traditions were by no means universal, however, and some ethnic groups were highly restrictive, particularly of females. The Luo, for example, expected proof of female virginity at marriage, demonstrated by a certain amount of blood on the consummation bed; otherwise, the bride price was lowered. On the other hand, premarital sexual activity for boys was accepted.<sup>15</sup> The Maragoli rewarded a girl's virginity at marriage with much ululation but tolerated prepubertal sexual activity among boys.<sup>16</sup> The Masai did not permit girls to have premarital sex in any form.<sup>17</sup> This differential treatment of boys and girls has contributed to the sexual double standard that exists in modern-day Kenya, where girls who become pregnant often face school expulsion and social disgrace, but boys who father a child are allowed to continue their education.

Most ethnic groups had explicit customs governing sexual conduct among youth, allowing various sexual outlets, particularly when lengthy periods separated sexual maturity from marriage. Clear messages regarding sexual behavior were conveyed to young people. Each tribe was unique, however, and no single code of sexual behavior applied to all groups.

With the arrival of missionaries and colonialists in the 1800s, and new politi-

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**Table 1. Variables and how they are measured for multiple logistic regression analysis**

Variable	Measure
Sexual experience	Ever had sex vs. never had sex
Contraceptive use	Three measures: ever used birth control; used at first sexual intercourse; and used at last intercourse
Age	In years
Frequency of sexual activity	No. of times in the 4 mos. preceding survey
Years of sexual activity	Calculated from date of first intercourse
Residence	Attends school in Nakuru, Naivasha, Molo or Njoro (urban) vs. any other area (rural)
Religiosity	Sum of 2 measures: how important religion is to respondent (very to not at all), and frequency of church attendance in preceding 4 wks.
Partner's view of contraception	Based on 3 questions asking whether the respondent thinks the current sexual partner is supportive of contraceptive use by either partner
Risk-taking behavior	Two measures: Substance use (frequency of use of cigarettes, beer, local brews and marijuana; Kronbach's alpha=0.71) and how often respondent attends discos
Socioeconomic status	Based on measures of education, literacy and occupation of both parents, presence of electricity, and structural materials of the house
Contraceptive knowledge	Ability to identify birth control methods and nonmethods from a list (number correct)
Attitude toward premarital sex	Measured by five questions asking when it would be acceptable to engage in premarital sex, ranging from always disapprove to sometimes or always approve
Attitude toward birth control	Measured by questions asking whether teenagers should use contraceptives and whether they should have access to them (Kronbach's alpha=0.46)
Academic achievement	Assessed by whether the respondent had ever repeated a grade, and by rank in class during the preceding term

cal, social and economic orders, most sexual socialization rituals were discarded. Industrialization and urbanization have continued to alter the sociocultural structure of the traditional community. Educational functions, which formerly rested within the family and community, are increasingly being taken over by local and national governments, churches and community groups. These institutions must now unite diverse ethnic groups and develop a national message dealing with personal areas such as sexual activity. Often, conflict results. Therefore, leaders remain apprehensive and uncomfortable about policies and legislation related to youth, such as those affecting sex education, access to contraceptives, expulsion of pregnant girls from school and enforcement of regulations governing age of consent and marriage.

The lengthening process of formal

schooling and the concomitant postponement of marriage can be expected to lead to an increase in problems associated with premarital sexual activity among men and women. The need for policy and programmatic interventions addressing these problems is clear. However, designing such programs requires an understanding of the many factors affecting adolescent use of contraceptives, and very little analytic investigation of this subject has been done in Kenya. In this paper, we describe the sexual and contraceptive dynamics in a sample of high school students and examine some of the factors that influence their use of birth control.

## Methodology

The data for this study were collected in 1989 from 2,059 males and females enrolled in 29 urban and rural co-educational secondary schools in the Nakuru district of Kenya. We used a table of random numbers to select schools from a sam-

pling frame of 91 high schools. The sample excluded special schools, such as private schools designed exclusively for members of specific religious denominations and institutions catering to the elite or to students with special needs.

We recruited and trained 16 interviewers to assist with the research, which used a self-administered, anonymous questionnaire written in English, the language of instruction in Kenyan schools. To minimize any discomfort the students might feel, we requested teachers to leave the classroom while the respondents completed the questionnaire. Only one student refused to participate in the study, and he did so because of religious beliefs. The first author field-edited and coded the questionnaires. After the data were entered, we checked the key-punched records against the questionnaires and corrected errors.

The research variables and how they are

measured are shown in Table 1. We selected these variables to test the following hypotheses: Urban adolescents are more likely to use birth control; adolescents who have strong religious beliefs are less likely to use birth control; adolescents whose partners approve of birth control are more likely to practice contraception; adolescents who engage in risky behavior are less likely to use birth control; adolescents with higher socioeconomic status are more likely to use a contraceptive; students who know of many birth control methods are more likely to use one; adolescents who would permit premarital sex are more likely to use birth control; adolescents who believe sexually active teens should use birth control are more likely to practice contraception; and adolescents who are high academic achievers are more likely to use birth control.

In this research, we were interested in each respondent's contraceptive use at two points—first intercourse and most recent intercourse. First, we used chi-square tests to examine the association between contraceptive use and each of the independent variables. Then, we used logistic regression to examine the effect of each variable after controlling for the effects of all others. We analyzed data for males and females separately to avoid obscuring differences between the sexes.

## Results

### Respondent Characteristics

The sample for this analysis included 1,244 males and 815 females (Table 2). The mean age was 17.8 years for males and 17.2 years for females. Nearly 60% attended schools in an urban area. More than 90% were Christian, and the majority of these respondents were Protestants.

Overall, 69% of males and 27% of fe-

**Table 2. Selected background characteristics of a sample of secondary school students, Nakuru District, Kenya, 1989**

Characteristic	Males	Females
<b>All</b>	<b>1,244</b>	<b>815</b>
Mean age	17.8	17.2
% in urban schools	60.5	58.7
% Christian	93.1	97.1
% Catholic	31.2	31.7
% Protestant	61.9	65.4
% sexually experienced	69.3	27.0
<b>Sexually experienced respondents</b>	<b>862</b>	<b>220</b>
Mean age at first sex	13.1	15.5
Age of first partner	13.1	18.0
Age of last partner	17.3	21.7
Contraceptive use		
% ever	48.7	41.8
% at first sex	24.7	27.5
% at last sex	30.5	28.6

**Table 3. Percentage distribution of respondents who used a method at last intercourse, by method used and source, according to sex**

Method and source	Male (N=263)	Female (N=63)
<b>Method†</b>		
Condom	55.0	42.9
Safe period	28.8	42.9
Pill	5.9	9.5
Sponge	2.7	0.0
Foam or jelly	1.9	0.0
Diaphragm	1.9	1.6
Injectable	1.5	1.6
Withdrawal	1.5	1.5
IUD	0.8	0.0
<b>Source‡</b>		
Clinic	32.9	46.4
Friend	35.7	25.0
Pharmacy	22.0	21.4
Other shop	9.4	7.2
Total	100.0	100.0

†Used by the respondent or the partner. ‡Distribution excludes respondents who used nonsupply methods.

males reported coital experience. This large difference may reflect the double standard that operates in Kenyan society. Males are likely to exaggerate their sexual exploits, which are tacitly encouraged. However, female students who become pregnant are almost invariably expelled from school, so the minority of girls who have advanced to secondary school may be unwilling to put their education at risk. On the other hand, they may simply be less willing than males to admit they are sexually active.

The mean age at first sex was 13 years among sexually experienced males, compared with almost 16 years among their female counterparts. Most males reported that their first sexual encounter was with a female of the same age, but females reported that their first partner was slightly older. The average age of the last sexual partner for males was 17.3 years, about six months younger than the average male re-

spondent. However, the average age of the females' last sexual partner was 21.7 years, 4.5 years older than the average female respondent.

Fewer than half the sexually experienced respondents had ever used a contraceptive method, and males were more likely than females to have done so (49% vs. 42%). Only 25% of males and 28% of females had used a method the first time they had sex, and 31% of males and 29% of females had used a method the last time they had sex. Overall, only 7–11% considered themselves to be frequent users of birth control.

**Methods and Sources**

Table 3 presents the methods used by respondents or their partner the last time they had sex. The condom and periodic abstinence ("safe period") were the methods used by most of these respondents: More than half of males (55%) and 43% of females reported using a condom, and 29% of males and 43% of females reported relying on periodic abstinence. Although many adolescents reported using periodic abstinence, few had accurate knowledge about it: Only 17% of males and 46% of females who claimed that they had last had sex during the female's "safe period" could correctly identify that segment of the menstrual cycle (not shown), and they were most likely to say that it is during menstruation. Therefore, even more students are at risk of pregnancy than the estimates of contraceptive prevalence would indicate.

When asked where they would go for birth control, more than 90% of those who had practiced contraception the last time they had sex said they would go to a clinic. However, the data in Table 3 suggest that fewer than half had actually done so. In fact, a quarter to a third had obtained the method they used from a friend, a possibly un-

reliable source of information and supplies.

We asked sexually experienced students whether they felt they knew enough about how to avoid unwanted pregnancy (data not shown). About half the males and 61% of the females said they did not. Males who had not used a method at last intercourse were more likely than those who had to say they did not know enough (53% vs. 40%). There was no difference among females, with 68% of nonusers and 71% of users saying that they did not know enough about pregnancy prevention. Thus, many of those who are using a method could use more information.

From a list of 12 possible choices, sexually active respondents were asked to indicate the most important reason that had ever prevented them from using birth control (data not shown). Among males, the most frequent reason given was that it was the safe time of the month for their partner (20%), followed by the belief that the male was too young to make a girl pregnant (16%). About 12% of the males said that they had not planned to have sex, 10% thought birth control was too dangerous and 8% said it was too expensive.

The deterrent most often mentioned by females was the fear that contraceptives are dangerous (36%). Nearly 20% did not procure birth control because they thought it was the "safe time of the month," 13% said that they were too young to become pregnant and 9% said that they had been forced to have sex.

**Reproductive Health Knowledge**

To assess the students' level of knowledge, we asked them a series of questions (to be answered true, false or don't know) on common beliefs young people hold about pregnancy and STD prevention and about general reproductive health issues. The data suggest that their overall level of knowledge

**Table 4. Percentage distribution of responses to true-false questions on reproductive health and contraception, by accuracy, according to sex**

Question	Males			Females			Total
	Correct	Incor-rect	Don't know	Correct	Incor-rect	Don't know	
A girl can get pregnant even if she has sex only once.	70.0	18.7	11.3	74.3	11.2	14.5	100.0
Once a girl starts having monthly periods, she can get pregnant if she has sex.	81.2	12.4	6.4	78.2	14.2	7.6	100.0
When in the month is a girl most likely to become pregnant if she has sex?†	15.5	66.7	17.8	31.3	39.8	28.9	100.0
If a girl washes her genitals after sex, she will not get pregnant.	80.9	2.7	16.3	72.3	1.4	26.3	100.0
A girl cannot get pregnant if she has sex standing up.	65.1	8.8	26.1	55.8	5.0	39.2	100.0
If a girl jumps up and down after sex, she will not get pregnant.	66.3	5.6	28.1	61.0	2.6	36.4	100.0
If a girl takes 2 birth control pills just before sex, she will not get pregnant.	21.3	30.8	47.9	15.2	24.9	59.9	100.0
If a male takes 2 birth control pills, he cannot make a female pregnant.	32.6	27.5	39.9	25.5	26.8	47.7	100.0
A girl can have an STD and not know it.	70.1	13.4	16.6	61.2	14.8	24.0	100.0
If you get an STD once, you cannot get it again.	64.7	13.0	22.3	56.0	9.4	34.6	100.0
If a person has an STD, he or she can give it to others if he or she has sex with them.	86.6	6.8	6.6	82.6	7.4	10.0	100.0
Using condoms can help prevent STDs.	72.0	11.2	16.8	43.3	21.1	35.6	100.0

†A multiple choice question with seven possible answers: one week after her monthly period begins, two weeks after her monthly period begins, three weeks after her monthly period begins, during her period, any time she has sex, other times (please specify), and don't know/not sure.

was quite low (Table 4). For example, only about three-quarters knew that a female could become pregnant even if she had sex only once. One in five did not know or gave the wrong answer when asked whether menstruation signaled the potential for a female to become pregnant. When asked when in a month a female is most likely to become pregnant if she has sex, only 16% of the males and 31% of the females gave the correct answer (two weeks after her period begins or any time she has sex).

In Kenya, many adolescents believe that they can avoid pregnancy by such measures as washing their genitals after intercourse, having sex standing up, and jumping up and down after sex. In our sample, substantial proportions of the females said they did not know if they could prevent pregnancy by washing after sex (26%), by having sex standing up (39%) or by jumping up and down after intercourse (36%).

The questions about birth control pills were generally answered incorrectly: Only 33% of the males and 26% of the females in our sample were aware that if a man takes the birth control pill, his partner can still become pregnant, and just 21% of the males and 15% of the females knew that two birth control pills taken by a female just before sexual activity did not prevent pregnancy.

The respondents were better informed about sexually transmitted diseases (STDs) than about pregnancy. Seventy percent of males and 61% of females were aware that STDs are not always symptomatic in a female. More than 80% knew that STDs are transmitted through sexual contact, but fewer than 65% knew that a person can get an STD more than once.

### Factors in Contraceptive Use

Many of the independent variables had statistically significant effects on contraceptive use in our bivariate analyses, but these effects were often not significant in the multivariate models. Table 5 summarizes the logistic regression results for use at first intercourse and last intercourse.

Frequency of intercourse, the only factor affecting the odds of contraceptive use at first intercourse among males, did not have a significant effect among females. The primary factors increasing the odds of method use at first intercourse among females were high socioeconomic status (odds ratio, 4.1), a positive attitude toward birth control (3.4), and ranking in the top 25% of their class during the preceding term (2.9). The results for females support our hypotheses about the effects of these three variables.

The same general pattern appeared in our analysis of effects on contraceptive use

at last intercourse. Frequency of sexual intercourse had highly significant effects among both males and females. Among females, high socioeconomic status (odds ratio 3.3), a positive attitude toward birth control (3.8) and ranking in the top 25% of the class (3.8) were the most important predictors of use.

Knowledge of family planning methods was negatively associated with contraceptive use among females: Those who identified the most birth control methods were significantly less likely than those who identified the fewest to have used any contraceptive at last intercourse (odds ratio, 0.35). More knowledgeable males were slightly (but not significantly) more likely to have used a method.

The data failed to support several of our hypotheses: We did not find significant differences in use between urban and rural young people, perhaps because Kenyan adolescents have little or no access to contraceptive services, regardless of where they live. We also found no significant effects for religiosity, attitude toward premarital sex, substance use or disco attendance.

### Conclusion and Discussion

In this sample of high school students in Kenya, 69% of the males and 27% of the females reported coital activity. Although these figures probably reflect some degree of male exaggeration and female concealment, they are consistent with those found by other researchers in Kenya.<sup>18</sup> Only about 10% of young people who were sexually active reported regular use of birth control, a figure close to that found by Ajayi and colleagues.<sup>19</sup>

These low levels of contraceptive use probably reflect the spontaneity of adolescent sexual activity and lack of knowledge, as well as the many barriers young people face when they attempt to obtain

**Table 5. Estimated adjusted odds ratios (and 95% confidence intervals) of the likelihood of contraceptive use at first and last intercourse, by background characteristics, according to sex**

Characteristic	Males	Females
<b>FIRST INTERCOURSE</b>		
<b>Frequency of sexual activity</b>	1.12** (1.04, 1.20)	1.35 (0.94, 1.94)
<b>Socioeconomic status</b>		
Low	1.00	1.00
Medium	0.62 (0.36, 1.06)	1.49 (0.51, 4.36)
High	1.21 (0.68, 2.14)	4.12** (1.31, 13.0)
<b>Attitude toward contraceptive use</b>		
Negative	1.00	1.00
Positive	1.04 (0.65, 1.67)	3.36** (1.28, 8.81)
<b>Rank in class</b>		
Bottom 75%	1.00	1.00
Top 25%	0.78 (0.49, 1.26)	2.87** (1.04, 7.83)
<b>LAST INTERCOURSE</b>		
<b>Frequency of sexual activity</b>	1.12** (1.04, 1.19)	1.78** (1.19, 2.68)
<b>Partner's opinion about contraceptives</b>		
Both should use	1.00	1.00
One should use	0.57 (0.25, 1.28)	1.09 (0.21, 5.67)
Neither should use	0.53* (0.30, 0.96)	1.74 (0.66, 4.57)
<b>Socioeconomic status</b>		
Low	1.00	1.00
Medium	1.04 (0.64, 1.68)	1.81 (0.57, 5.78)
High	1.37 (0.80, 2.37)	3.33* (0.99, 11.22)
<b>Contraceptive knowledge</b>		
Low	1.00	1.00
Medium	1.47 (0.81, 2.68)	0.68 (0.21, 2.19)
High	1.38 (0.78, 2.440)	0.35* (0.13, 0.99)
<b>Attitude toward contraceptive use</b>		
Negative	1.00	1.00
Positive	1.11 (0.71, 1.73)	3.76* (1.31, 10.78)
<b>Repeated a grade</b>		
No	1.00	1.00
Yes	1.07 (0.68, 1.68)	0.35** (0.14, 0.89)
<b>Rank in class</b>		
Bottom 75%	1.00	1.00
Top 25%	0.94 (0.61, 1.47)	3.82* (1.35, 10.80)

\*p<.05; \*\*p<.01, based on Wald's chi-square test for the significance of the regression coefficient. Note: Odds ratios are adjusted for age, years since sexual debut, religiosity, urban-rural school location, substance use, disco attendance and attitude toward premarital sex, as well as for all variables in the table.

contraceptive protection. To use birth control in Kenya, an adolescent must raise the issue with a possibly suspicious or resistant partner, regularly obtain funds for supplies, overcome fears about rumored side effects and bargain with a health system that is not accommodating to adolescent clients.<sup>20</sup> Use of natural family planning avoids some of these difficulties but requires meticulous charting and a comprehension of the female menstrual cycle that few young people possess. It is not surprising, then, that few adolescents use contraceptives and that many rely on friends for information and supplies.

The practice of discouraging young people from obtaining professional birth control education and services places them at an increased risk of pregnancy and STDs, including AIDS. Research in the United States has shown that the greatest risk of

adolescent pregnancy is in the first months following sexual debut: Half of all premarital conceptions among teenagers occur in the first six months after coital initiation.<sup>21</sup> If this holds true in Kenya, young women are at highest risk of premarital pregnancy at a time when institutional barriers to contraceptive services are strongest.

The data show that females with high academic achievement, those with high socioeconomic status and those with a positive attitude toward contraception are two to four times as likely to practice contraception during both their first and their most recent sexual encounter, while males with these characteristics are not significantly more likely to do so.

Although some sexually active adolescents practice contraception, appreciable proportions lack knowledge about contraception and reproductive health. Many females are worried by rumors about the side effects of contraceptives. In our sample, only 17% of the males and 46% of the females who said they had relied on the "safe period" the last time they had sex could correctly identify that time in the menstrual cycle. Large proportions of the sample, particularly females, have mistaken notions about how to prevent pregnancy and STDs.

The negative association among young women between contraceptive use and number of birth control methods known may result from fears about side effects rumored to be associated with contraceptives. A young woman may know of many methods but may have heard only negative rumors about them. The data indicate that the main deterrent to contraceptive use among the young women in our sample was the belief that birth control methods are dangerous. The ability to name many methods does not necessarily imply correct knowledge about them. In addition, a person may know of only one method but use it consistently. Conversely, an individual may have heard of many methods but may never have used one. Therefore, it is possible that contraceptive knowledge as we measured it is not a determinant of contraceptive use.

Young people are not taught about contraceptives in Kenya, for fear that this will encourage permissiveness and promiscuity. This policy leaves young people in an information vacuum. Studies elsewhere have shown that sex education does not increase sexual activity and can in fact lead to postponement of sexual initiation and to protective behavior once sexual activity begins.<sup>22</sup> Carefully constructed education programs that address the needs of young peo-

ple, gain their trust and correct their many misconceptions and fears would be more successful than the present silence.

Other than frequency of sexual activity, the only factor in our model that significantly explains male use of contraceptives is being in a relationship with a partner who supports its use. This suggests that some young men can be influenced to practice contraception, a hopeful finding for those involved in male motivation programs. It also points to the importance of promoting discussions about family planning between partners. The woman is usually younger and less experienced, and she often experiences greater pressure to please her partner. Teaching young women how to resist pressure to have sex and how to negotiate contraceptive use will help them protect themselves. Young men also need to learn how to resist pressure from their peers and how to raise the issue of contraceptives if they are sexually active.

Young people and their parents are facing a culture radically different from that in which previous generations grew up. When most of today's older generation were adolescents, social roles and expectations were better defined. Individuals appointed by the community taught adolescents clear and unambiguous rules governing sexual conduct. It is impossible to return to those days or to protect youth from modern sexual influences. Therefore, it is vital that policymakers and program planners and managers become responsive to these changing circumstances, which have been created in large part by the progress achieved by Kenyan society.

The role played by community-appointed teachers must now be assumed by government agencies, nongovernmental organizations, church groups, parent groups and youth groups. Although dissension is inevitable, these agencies and groups must work together to develop programs to deal with the issues facing today's youth.

Teachers and parents must be provided with the skills to socialize their children in sexual matters. For teachers, this training can begin in colleges; for parents, it can be incorporated into various forums such as parent-teacher meetings, community meetings and church activities. Programs that build communication skills on sexual matters may be an important starting point. In communities where others can assume this role—for example elders, health care providers and adults who work with adolescents in extracurricular activities—they should be encouraged to do so.

The increasing duration of schooling, later marriage, AIDS and other STDs present youth with unique problems, but these problems can be minimized by the provision of appropriate adolescent reproductive health services. Such services would particularly benefit young women from poorer socioeconomic backgrounds by giving them a chance to continue their education and thus gain a fairer footing in society.

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## Resumen

Datos de una encuesta realizada en 1989 entre 2.059 estudiantes secundarios de Nakuru, distrito de Kenya, indica que el 69% de los varones y el 27% de las mujeres habían tenido experiencia sexual. Entre los estudiantes sexualmente activos, el 49% de los varones y el 42% de las mujeres, alguna vez habían usado anticonceptivos. Solamente el 25% de los varones y el 28% de las mujeres habían usado un anticonceptivo en su primera relación sexual y un porcentaje similar lo había hecho la última vez que mantuvieron relaciones sexuales (31% y 29%, respectivamente). El condón era el método más comúnmente utilizado la última vez que mantuvieron relaciones (varones 55%, mujeres, 43%), seguido del "período seguro" (varones 29%, mujeres 43%) y la píldora (varones 6%, mujeres 10%). Para obtener anticonceptivos, el 33% de los varones y el 47% de las mujeres recurrieron a clínicas, y el 36% de los varones y el 25% de las mujeres se lo pidieron a sus amigos. Un análisis de regresión logística indica que los factores más importantes que facilitan la predicción del uso de anticonceptivos durante la primera y última relación sexual entre las mujeres, son el nivel socioeconómico elevado, el alto nivel académico y una actitud favorable hacia la anticoncepción. Ninguno de estos factores incide entre los varones. Los varones que indicaron que su pareja estaba a favor de practicar la anticoncepción eran doblemente propensos a usar un método la última vez que habían mantenido relaciones sexuales.

## Résumé

Les données tirées d'une enquête effectuée en 1989 auprès de 2.059 étudiants du niveau secondaire dans le district de Nakuru, au Kenya, révèlent que 69% des garçons et 27% des filles avaient déjà eu des rapports sexuels. Parmi les étudiants sexuellement expérimentés, 49% des garçons et 42% des filles avaient jamais utilisé un contraceptif. Seulement 25% des garçons et 28% des filles avaient utilisé une méthode lors de leurs premiers rapports sexuels, et des pourcentages similaires l'avaient fait lors de leurs derniers rapports sexuels (31% et 29%, respectivement). Le préservatif

était la méthode utilisée le plus fréquemment lors des derniers rapports sexuels (55% chez les garçons, 43% chez les filles), suivi de la «période sûre» (29% chez les garçons, 43% chez les filles) et de la pilule (6% chez les garçons, 10% chez les filles). Pour obtenir des contraceptifs, 33% des garçons et 46% des filles visitaient les cliniques, et 36% des garçons et 25% des filles se fiaient à des amis. Une analyse de régression logistique révèle que, pour les filles, un rang socio-économique élevé, de bons résultats académiques et une attitude favorable à l'égard de la contraception étaient les facteurs les plus importants pour prédire l'utilisation d'une méthode contraceptive lors des premiers rapports sexuels et l'utilisation lors des derniers rapports sexuels. Aucun de ces facteurs ne prédisait l'utilisation de contraceptifs par les garçons. Les garçons qui déclaraient que leur partenaire approuvait la contraception étaient deux fois plus susceptibles d'avoir utilisé une méthode lors de leurs derniers rapports sexuels.

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