ORIGINAL RESEARCH ARTICLE

Community Norms About Youth Condom Use in Western Kenya: Is Transition Occurring?

Paula Tavrow[*1], Eunice Muthengi Karei[2], Albert Obbuyi[3] and Vidalyne Omollo[3]*

[1]Department of Community Health Sciences, School of Public Health, University of California at Los Angeles, 650 Charles E. Young Drive South, Los Angeles,California 90095-1772, USA; [2]California Center for Population Research, University of California at Los Angeles, 337 Charles E. Young Drive East, Los Angeles, California 90095, USA; [3]Youth for Youth Program, P.O. Box 20, Bungoma, Kenya

***For correspondence:** *Email: ptavrow@ucla.edu, Tel: +1-310-794-4302*

Abstract

Most HIV prevention strategies for African youth have been ineffective in changing key behaviors like condom use, partly because community antagonism and structural barriers have rarely been addressed. Through qualitative research in rural Western Kenya, we sought to describe the attitudes of different segments of society towards youth condom use and to identify where transitions may be occurring. We found that about half of community members strongly opposed youth condom use, with many advocating punishment such as beatings and expulsion. Our research revealed significant differences in attitudes by gender, with females generally more opposed to youth condom use. Health providers, teachers and male students seemed to be transitioning to more permissive attitudes. They also had more accurate knowledge about the condom. Building on these transitional views, we would recommend that schools eliminate sanctions for students found with condoms and that clinics discourage providers from interrogating youths about their reasons for wanting condoms. Furthermore, we believe that health campaigns should portray condoms as "disaster preparedness" devices for responsible youths, and more efforts should be made to dispel myths about condoms' efficacy (*Afr J Reprod Health 2012 (Special Edition); 16[2]: 241-252).*

Résumé

La plupart des stratégies pour la prévention du VIH à l'égard de la jeunesse africaine n'ont pas été efficaces quant aux modifications des comportements clé comme l'utilisation des préservatifs, dû en partie au fait qu'on a à peine abordé l'antagonisme communautaire et les obstacles structuraux. A partir d'une étude qualitative au Kenya de l'Ouest rural, nous avons essayé de décrire les attitudes des secteurs différents de la société envers l'utilisation des préservatifs et d'identifier là où peut-être se produisent les transitions. Nous avons découvert qu'à peu près une moitié des membres de la communauté s'opposaient fermement à l'utilisation des préservatifs, beaucoup d'entre eux préconisant la punition telles la correction et l'expulsion. Notre étude a révélé de différences significatives dans les attitudes basées sur les sexes, les femmes étant en général les plus opposées à l'utilisation des préservatifs par la jeunesse. Les dispensateurs de soins, les enseignants et les étudiants mâles semblaient être en mesure de passer vers des attitudes plus permissives. Ils a avaient une connaissance plus précises des préservatifs. En nous basant sur les opinions traditionnelles, nous recommandons que les écoles éliminent les sanctions pour les étudiants qui ont des préservatifs en leur possession et que les cliniques découragent les dispensateurs d'interroger les jeunes gens pour savoir pourquoi ils ont besoin des préservatifs. De plus, nous sommes convaincus que les campagnes sanitaires doivent présenter les préservatifs comme des dispositions à « combattre le désastre » pour les jeunes gens responsables et il faut faire encore d'effort pour dissiper les mythes autour de l'efficacité des préservatifs (*Afr J Reprod Health 2012 (Special Edition); 16[2]: 241-252).*

Keywords: Sexuality, young people, HIV/AIDS, gender, condoms, norms

Introduction

Preventing HIV transmission to African adolescents continues to be a major challenge. Of the estimated 5.4 million young people infected with HIV worldwide, more than half reside in sub-Saharan Africa[1]. HIV prevention programs targeting African youths generally appear to have had little effect on behavior change, although some have improved knowledge and attitudes[2-5]. To reduce HIV incidence among African adolescents, it is important to identify community norms that may be impeding behavior change.

Over the past two decades, the dominant prevention strategy in Africa, including Kenya, has been to promote people's adherence to the "ABCs": abstain from sex (or delay debut), be faithful to one partner (or reduce number of partners), and use condoms correctly and consistently. For African youths, however, the abstinence message has been emphasized. Opposition to youth sexuality and condom use has obstructed young people's access to condoms in much of East Africa[6-9]. As the gate-keepers for condom information and supplies, adult attitudes can undermine youths' efforts to protect themselves[10]. For example, most nurse-midwives in Kenya and Zambia reported that if unmarried adolescents requested contraceptives, they would recommend instead that the youths abstain[11]. Less than half would encourage condom use for out-of-school youths. Similarly, a study in South Africa identified adult attitudes towards condoms and sex as the main barriers to youth condom use[12].

In Kenya, condom use at first sex among young people aged 15-24 has doubled in the past decade, from 12.5% in 2003 to 25% in 2009 [13]. However, a rural/urban divide has emerged: only 21% of rural young women used condoms as compared to 32% of urban. A study in Nakuru District in Kenya found that most youths believed condoms are ineffective, likely to spread HIV, physically harmful and immoral[7]. Even when youths viewed condoms positively, they often were reluctant to try to obtain condoms because of the shame associated with being found with them[9].

Social norms antagonistic to youth condom use are likely to have a greater impact in communal societies such as Kenya, where individual self-actualization is rare and confidentiality is often violated [14-15]. Yet to date little is known about how various segments of rural society—including trained peer educators—regard youths who use condoms and if gender differences exist. In this paper, we analyzed qualitative data to determine how different categories of adults and students in Western Kenya view adolescent condom use and whether they would penalize boys found with condoms. We also identified conditions or situations where youth condom use may be acceptable. Finally, we made recommendations for encouraging a transformation in condom attitudes to set the stage for more effective youth HIV prevention programs in rural Kenya.

Methods

Background

The study was based on focus group discussions (FGDs) conducted as part of an interim evaluation of the Youth for Youth program (Y4Y). The Y4Y program was launched in September 2003 in thirteen schools and three health centers in Bungoma District, Western Kenya. The purpose of the program was to test a peer education and service model to improve rural African youth's reproductive health knowledge and to reduce risky sexual behaviors [16]. In the participating schools, any secondary student in Forms 2 or 3 who wished to become a peer educator was asked to self-nominate. Elections were then held among the student body of each school to select the peer educators. In mixed schools, students voted separately for male and female peer educators to ensure adequate representation by gender. Afterwards, the Y4Y program staff directly trained the elected students to serve as peer reproductive health educators in high schools, and as mentor educators in primary schools. The training consisted of ten modules, including: setting personal goals, building self-esteem and resisting peer pressure, gender roles, puberty, relationships, contraception, sexually transmitted diseases, dating violence, communicating with parents and adolescent rights. The top peer educators received additional training to enable them to provide counseling in health clinics to youths seeking

information about specific contraceptive methods. A taskforce of representatives from the Ministries of Health and Education in Bungoma town provided oversight to the Y4Y program. The University of California at Los Angeles (UCLA) Institutional Review Board and the Kenya Medical Research Institute approved the study.

Procedures

FGD participants were recruited between June and August 2005, through convenience sampling from schools, churches, health centers and neighborhoods in three sub-locations of Webuye Division where Y4Y had been operational. The participants consisted of primary school students in Classes 7-8 (aged 13-15), secondary school students in Forms 2-4 (aged 16-19), peer educators, primary and secondary school teachers, parents, church leaders, health providers, and Y4Y taskforce officials. For each target group (except the Y4Y taskforce), one FGD was conducted in each of three sub-locations. This resulted in 31 FGDs, with 7 to 12 participants in each group. All focus groups were of mixed gender, except those involving students which were mixed. Altogether, 310 people participated (Table I). All FGDs were conducted in English by the same male Y4Y staff member (a middle-aged Kenyan). All participants were told that they could use Kiswahili if they preferred, but all seemed to be comfortable in English. His female assistant obtained informed consent from all participants prior to each FGD, tape- recorded the session, and transcribed it for subsequent analysis. The FGDs were conducted in empty classrooms, health center conference rooms, church halls, and a Ministry of Education office. The facilitator ensured that the sessions were private, and encouraged participants to speak freely. He used a semi-structured moderator's guide that covered a range of topics such as youth condom use, family planning use, and coerced sex. Because participants in Bungoma district were not familiar with the female condom, questions concerned the male condom only. Each focus group lasted 65 to 90 minutes. The questions used for this study were:

(1) If a school finds a youth with condoms, what should the school do? Why?

(2) If a boy who is about to become head boy is found with condoms, should the school still make him head boy? Why or why not?

(3) If a boy goes to a health center and asks for condoms, should the nurse try to discourage him from playing sex? Why or why not?

Table 1: Focus group participants, by role and gender

Role	No. of males	No. of females	No. of focus groups
Primary students (aged 12-16)[a]	34	34	6
Secondary students (aged 15-20) [a]	31	35	6
Peer educators (secondary students, aged 15-19)	18	19	3
Primary school teachers	19	10	3
Secondary school teachers	16	9	3
Parents	12	15	3
Church leaders	14	15	3
Health providers	8	14	3
Taskforce members	4	3	1
TOTAL (n=310)	156	154	31

[a]*The focus group discussions with students were single gender.*

The FGDs were entered into MAXQDA qualitative software. Content analysis was used to code the data and identify clusters. Codes were developed independently by two investigators and refined through an iterative process of discussing themes and reviewing codes. Investigators used the MAXQDA Code Matrix feature to compare themes by role and gender.

Results

For about half of the focus group participants, a youth found with condoms was considered to be engaging in unacceptable or deviant behavior. Nearly one quarter believed that youths discovered with condoms at school should be actively punished—e.g., expelled from school, beaten or not allowed to become a head boy (a position of honor). Those most inclined to punish youths

found with condoms were female primary pupils, female peer educators, parents and church leaders. Surprisingly, peer educators, themselves secondary students, were more antagonistic to youth condom use than were other secondary students. Peer educators views' approximated those of primary school teachers. A clear gender gap was found in adolescent responses, with female youths being considerably more antagonistic to adolescent condom use. Among adults, a similar gender difference was observed for teachers only. The greatest gender disparities were found among high school students and teachers. Only a small minority, mostly health providers, believed that condoms should be promoted unconditionally to youths. In this section we first present the main reasons for opposing condom use by youths. Opposition was found within all FGD categories. Then we examine the main conditions by which some participants would permit youths to have access to condoms, which we label "transitional" views, since in rural Kenyan society it has been normative to oppose sexual activity and condom use by young people.

Condom use as deviant

Our research revealed that many participants considered youth condom use as deviant and deserving of punishment or censure. Deviance has been defined as "departures from norms that draw social disapproval and may elicit negative sanctions" [17]. When a behavior is considered deviant by society, most people avoid doing it. Sociologists have determined that behaviors are classified as deviant if society assesses negatively the *actors* involved (their characteristics, behaviors, and motivations), has concerns about the *object* itself (in this case the condom), or has misgivings about *contextual* issues (i.e., where the behavior takes place). In this section, we used this deviance framework—actors, object, context—to categorize and describe community norms regarding condoms.

a. Actor characteristics

The predominant reason participants opposed youth condom use related to their perceptions of the youths themselves. Many participants considered youths "immature" and "too young" to act responsibly about sex and condom use. Youths were thought to be easily distracted by sex. Having access to condoms would cause them to pursue multiple "love affairs" and "forget about their education." Some participants expressed concern that male youths would not use the condoms properly because of their age. As one female primary student noted, "The nurse should not give him condoms, because he can read the instructions badly and get HIV or any other disease." Several teachers worried that young boys would re-use condoms or turn them into balloons.

Those who believed youths should be *punished* for having condoms focused on the youths' motivations and their influence on others. Participants seemed more inclined to consider youths immoral who "planned ahead" for sex. Abstaining from pre-marital sex was viewed as the moral ideal for both sexes. A youth who carried a condom, even if he had not yet had sexual intercourse, was "plotting" for sex and therefore a "bad" person. As one female primary student explained, "The youth [with condoms] should be beaten and the teachers should send him home to call the parent, because youths are supposed to abstain from sex until they are married." This was not merely a theoretical assertion. One man told his fellow participants:

> *When my son was in… Boys High School, he was found with condoms and I was called. We agreed with the teachers and we beat the boy. We have never seen him with them again. Even the teachers are saying he has now changed. (Male health provider)*

These participants believed that a boy's chief motivation for wanting condoms was to enable him to become promiscuous. Permitting boys to have condoms was tantamount to encouraging them to engage in sex, which could have serious consequences for girls:

> *They [boys with condoms] may start raping girls because they know that they have protected themselves. (Male primary student)*

> *The nurse should not give [condoms], because if he is given he will continue having sex even more and will spoil so many people. (Female secondary student)*

Because many participants believed that a male youth found with condoms was immoral, they would oppose making him the head boy at his secondary school. Head boys are expected to set an example for others and to assist the teachers and school administration. Participants generally felt that a head boy with condoms would be a poor role model, would influence other students to engage in sex, and would lower school standards.

> *A school head boy should be a good leader and a role model to the others. If he is the one found with condoms, then we as teachers will look at him as an immoral person and even the students will not respect him. So he should not be made the head boy if he is found with condoms. (Female secondary teacher)*

> *A boy [found with condoms] should not be made the head boy, because the school will think that this is encouraging sex. Other students will also follow his footsteps and the whole school will be in a mess. (Male secondary student)*

b. Object attributes

The condom itself seemed to represent deviance to many focus group participants. Some participants perceived the condom as *causing* youths to feel reckless and disinhibited from abstaining. They felt that access to condoms conveys the message that boys can have sex without suffering negative consequences, which is sufficient to motivate youths to have sex.

Participants who opposed youth condom use often harbored misconceptions about condoms' efficacy. The vast majority of adults (including a few health providers) and about half the youths (including some peer educators) had serious misgivings about condoms, even though the latter had been participating in the Y4Y program which provided accurate condom information. The most prevalent myth was that condoms have holes which permit the HIV virus to pass through. Numerous participants mentioned hearing that condom have tiny holes that can only be seen under a microscope. Apparently, some participants had attended AIDS education sessions where misinformation was given.

> *I attended a seminar on HIV and the doctor was saying that there is very little chance that they can prevent [transmission], even if you put on sixteen condoms. They have micro holes and the virus can still pass, so it is not safe. (Male secondary teacher)*

Another common belief was that condoms can cause infections because they are "very light and weak," which makes them burst easily during sex. As one male primary teacher described, "Condoms are recommended to stay within a given temperature. If a man is having sex the body temperature goes very high, beyond the required temperature for the condoms." A female primary teacher argued that since condoms existed prior to AIDS and were meant for family planning, they would need to be modified to prevent the AIDS virus from passing through. Others noted that people who use condoms still get HIV. Many have misinterpreted the AIDS prevention message that condoms are "not 100% safe" to mean that condoms are dangerous and should be avoided.

c. Contextual issues

To virtually all participants, school premises and condoms were considered antithetical. Many maintained that allowing students to bring condoms to school would harm the academic enterprise and undermine a school's ability to maintain dignity and order. Some female secondary students averred that having condoms in their pockets would interfere with youths' studies, leading them not to be able to concentrate in class. This would in turn reduce the school's performance and affect its academic standing.

It was often noted that allowing condoms on campus directly conflicted with existing school regulations. For co-educational schools, "love affairs" among students generally are prohibited.

To reinforce the rules against relationships, some participants advocated that students found with condoms be punished or even expelled. Several male participants thought that a solution could be to educate youth about the right time and place for condoms. Others, mostly females, felt strongly that students should concentrate exclusively on their academic work.

> *Youths should be discouraged completely not to use the condoms and be encouraged to serve one master at a go. When they are still in school they should focus on their studies. [If] one has condoms then he will not be focused [on school]. (Female parent)*

Transitional views on condoms

While about half of the participants opposed youth condom use, the remainder believed that condoms should be made available to youths, although usually with conditions. Male students, male secondary teachers and health providers of both sexes were the most likely to favor youths' access to condoms. We consider these views "transitional" because they represent a more liberal attitude than historically, and may be attributable to AIDS educational efforts in Kenya and the Y4Y program, which several participants mentioned. Male peer educators were more conflicted about condoms, even though they taught youths about proper condom use. They usually recommended that students found with condoms be "guided" (counseled) as a gentle way to discourage condom use, which implies that youths could continue using condoms if they had a good reason. Teachers and female secondary students generally shared this view. However, female peer educators were mostly antagonistic to youth condom use, despite having the highest condom knowledge.

a. Actor characteristics

Just as those who opposed youths' access to condoms often justified their position based on characteristics of the youths themselves, so did those who favored youth's access to condoms. They argued that it was misguided to deny a youth condoms if he were "already mature." This designation did not necessarily relate to a youth's chronological age, although one participant stated specifically that only youths 18 and above should be permitted condoms. Participants seemed to assess a youth's maturity based on how he presented himself to a nurse and if he were already having sex. Being forthright and persistent with nurses in his demands for condoms suggested that a boy was sexually active. Since being denied condoms would not deter him from having sex, some participants felt it would be pointless and even wrongheaded for a nurse to turn him away or interrogate him.

> *[If the boy comes for condoms and]the nurse doesn't give, the boy may go ahead and have unprotected sex, because this boy already has food on the plate and can eat it if he is not allowed to wash his hand. That is the same with having sex without a condom. The nurse should counsel him and also give him the condoms. (Male primary teacher)*

> *The nurse should give unconditionally because he/she [needs to adhere to] professional ethics. If the boy comes and is denied the condoms, he will still go and have sex, and later come back to the nurse with an STI and the nurse will have to treat him. Yet it is the nurse to blame, because the boy came for the condoms and he/she refused to give. So the nurse has to give without any question. (Male secondary teacher)*

These participants—mostly male—felt that it was futile to try to prevent boys from being sexual. Abstinence, while morally desirable, was not considered realistic for all youths. As one female peer educator noted, "The nurse should give [condoms to those who ask for them,] because not all boys can control their feelings." Others readily acknowledged that boys in and out of school were having sex. Trying to insist that all boys act the same seemed unreasonable. A male peer educator explained that "all of us have different sexual feelings and we behave differently from each other." The more male youths were likened to adults, the less inclined participants were to deny

them condoms or to penalize them if found with condoms.

While youths' maturity was the most commonly cited reason to permit them access to condoms, the other major reason was nearly the opposite: boys could be potential victims needing protection. These participants considered boys as fairly passive players in a dangerous world due to AIDS. They argued that boys at times were subject to peer pressure about sex, which may be difficult to resist. Alternatively, a boy might "find himself" in a situation where he needed "protection." As one female primary teacher explained, "The nurse should just give [condoms] because the boy [needs to be] prepared for disaster." Male participants were much more likely than female participants to believe that boys might land in a predicament not of their own choosing, where the condom could serve as an emergency protective measure:

> *[A youth found with condoms] should not be punished, because there are those people who are HIV positive and they can force one into sex. If the boy is caught in such a situation, then he can just put on that condom and use it. Then he is not infected. (Male primary student)*

> *No action should be taken [against a head boy found with condoms], because even if you are saved, you may have bad company, which may influence you to have sex. Therefore you should use a condom for protection. (Male primary student)*

b. Object attributes

In contrast to those participants (mainly female) who believed that the condom itself induced youths to engage in sexually promiscuous and aggressive behavior, some male participants were inclined to consider the condom a benign object that should no longer stigmatized. One male secondary teacher argued that it was "high time [the condom] be taken just like anything else, like a textbook." Participants acknowledged that the condom is still difficult for many to accept because of its association with sexuality, but felt that youths should have a right to something that could protect their health.

> *The manufacturers and some other cultures do not see anything wrong with the use and giving out of condoms, but for us here even mentioning this word is just a taboo. But since the condoms have been introduced, let the youths have them in order to save their lives. (Male primary teacher)*

Participants with transitional views often referred approvingly to training seminars or media advertisements that extolled the condom as a protective device. They seemed to trust that the government would not promote a product that was harmful or defective, so long as it were used properly and not expired. As one male peer educator noted, "The reason why these condoms were made is to protect people from contracting STIs, instead of dying." Probably due to their repeated exposure to AIDS refresher training, not a single health provider averred that condoms had holes in them. These participants often expressed confidence that condoms would confer protection, and were skeptical about claims to the contrary.

> *[Condoms do not have holes] unless the person using it is not careful and does not follow instructions, because these condoms are fully tested and found effective for people to use. If they could be having holes, they could not be recommended for people to use. (Male secondary student)*

> *I don't think they have holes because I have attended so many seminars. I think these are just myths that condoms do have holes and I also think it is a polite way of promoting abstinence. (Male secondary teacher)*

c. Contextual issues

A consistent theme across all participants was their opposition to sexual activity on school grounds. However, for those who felt it was unrealistic to expect all boys to remain abstinent, the anticipated context of condom use made a difference. Mixed and urban schools were considered more

acceptable venues than single-sex or rural schools for youths to be found with condoms. Whereas participants who opposed condoms often presumed that a boy found with condoms would engage in sex on the school premises, those with transitional views generally believed that boys were planning to engage in sex elsewhere, so it was acceptable for the boy to be found with condoms at school.

> *If the boy is in a day school then maybe he always meets his girlfriends on his way home. Then he just has to carry them [condoms] to school, so that he can use them after school on his way home. (Male health official)*
>
> *The youth [found with condoms at school] should be helped. He [should be] told that the condoms are not supposed to be used in school, but at home in their free time. (Male secondary student)*

A few participants praised the youth found with condoms and definitely felt that he should be made head boy. One female health provider would not only make the youth a head boy, but "would even use him to campaign for safer sex and to educate others." These participants believed that a head boy who used condoms could even be a positive influence on teachers who did not see the value of condoms for AIDS prevention. While these opinions were rare, considerably more participants felt that youths have a "right" to condoms and the nurse should "just give." Yet for a student discovered with condoms to be made head boy, most believed that he should be able to articulate morally acceptable reasons for needing condoms.

> *[If a youth is found with condoms] the school should find out where he got them from and why he is having them. After you have known the purpose of having the condom, maybe he is using them for protection and to maintain his good health. Then he can still be made the head boy. (Male primary teacher)*

Although the question was not posed directly, even participants with transitional views seemed averse to condom distribution on school campuses. As one male peer educator declared, "To me the nurse giving out condoms [to youths] is not an offence. It depends on the situation: as long as it is not in the school but…in the health center." A number of participants were disinclined to allow current students to have access to condoms but felt they should be available to boys not in school. Many parents felt that nurses should provide condoms and "not ask questions" of ordinary boys, but should actively discourage boys wearing school uniforms.

Discussion

This study found that about half of participants in a rural community in Western Kenya felt that youth condom use was deviant, even though an after-school youth reproductive health program with condom demonstrations had been in operation for two years. Parents, primary school teachers, church leaders, female peer educators and female primary students were the most antagonistic to youth condom use, and many maintained that punitive measures should be taken if male students were found with condoms. Only among health providers and male secondary students who were not peer educators did a majority believe that youths should be given condoms unconditionally.

A clear gender divide in viewpoints emerged, with females considerably more oppositional to male youth condom use than males, perhaps because males were more likely to identify with young men wishing to use condoms or to have used condoms themselves. Male participants were more inclined to believe that youths could use condoms responsibly to protect themselves from HIV, that condom use prevented HIV, and that boys would have sex regardless of whether they obtained condoms. The gender division was most pronounced among young people. A study in Tanzania similarly found that boys were significantly more likely than girls to approve of adolescent condom use[18]. This may reflect female youths' greater distrust of a male youth's motivations and actions, possibly because of previous firsthand experience of being sexually harassed or seduced by male youths[12]. Girls also might be less inclined to support youth condom use because the male condom is not within their

locus of control, so girls may see it as another way for boys to dominate sexual decision-making. On their part, boys may consider condom use by male peers or by themselves to represent responsible sexual behavior.

An important finding was that both male and female peer educators' opinions more closely paralleled teachers' views than those of other secondary students of the same gender. More than half of peer educators felt that youths should not be allowed access to condoms, despite being trained in the Y4Y curriculum which spelled out youths' rights to condoms and the effectiveness of proper condom use. It is possible that the peer educators' special training and status led them to identify more with teachers, and to distance themselves from their peers to show moral superiority. Alternatively, peer educators might have gravitated towards their teachers' views in order to avoid appearing too provocative and risking censure. In South Africa, Campbell and MacPhail noted that HIV peer educators who "disrespected" teachers might have their programs shut down[19]. A study in the United States found that HIV peer educators in schools assume altruistic role identities and hold themselves to a higher standard concerning risk behaviors [20]. Further research is needed to determine if student educators in Africa generally become more ambivalent about youths' access to condoms, because this could have important programmatic implications.

The results from this study suggest that community perceptions about male youths' intrinsic characteristics and motivations, the nature and viability of condoms, and the sanctity of the school campus can explain their antipathy for youth condom use. Regarding their perceptions of male youths, opinions seemed polarized. Among those who believed youth condom use to be deviant, youths were likely to be characterized as young and immature. They often were constructed as rogues who needed to be strictly policed to prevent them from inflicting sexual harm. These views correspond to traditional parenting norms in much of Africa, where authoritarian and punitive approaches to child-raising still hold sway[21]. In contrast, participants with transitional views were inclined to perceive boys desiring condoms as mature and responsible, who had a right to protection. Rather than being the sexual aggressor, these participants constructed boys as potential victims who could become infected if they did not take precautions.

However, even participants with transitional views were reluctant to permit a student found with condoms to become a head boy unless he was counseled to avoid sex and be a moral role model. The head boy is a potent symbol: an upstanding young person who is the teachers' alter-ego. Very few participants could envision a male youth using condoms (and therefore having sex) as an acceptable role model, since the official line in Kenya is that students should be abstaining [22]. Only if he were using condoms for "educational purposes" would some consider him eligible for head boy. Important exceptions to this general norm were health providers, in contrast to the findings of an earlier study of provider attitudes in Kenya[11]. Perhaps youth-friendly training and exposure to forthright boys permitted health providers in this study to consider a head boy with condoms as a potential ally.

For many participants, their stance on youth condom use appeared to color their perceptions of the condom (or possibly vice versa). Except for female peer educators, those who considered condom use deviant were considerably more suspicious about condoms' properties and efficacy. These participants framed the condom as a device that could "destroy" the school because it would motivate boys to become promiscuous, since they would no longer fear HIV. Yet these same participants also usually contended that condoms were weak and contained holes large enough for the HIV virus to pass, a common misconception in rural East Africa [23-24]. A few female adults acknowledged that they had never seen a condom, yet they still voiced concerns about condoms' durability. No participant seemed aware of this apparent contradiction between characterizing the condom as a catalyst for adolescent sex because it shields youths from disease, yet considering it too flimsy to prevent HIV transmission. Perceptions about condoms' efficacy are important because they seem directly linked to youths' actual use of condoms [18, 25]. However, greater familiarity with condoms may

increase reports that condoms break, possibly because of incorrect use [26].

The school campus was almost always considered off-limits for condoms. As noted elsewhere, romantic relationships among African youths are considered to be intensely distracting and hence discouraged, rather than accepted as a natural part of adolescence [5]. Since many believe that the condom spurs youths to be more sexual, it is considered an impediment to youths' ability to concentrate on academics. Second, many people consider students as too young and immature to use condoms. The school is heralded as a pristine environment where children's innocence can be maintained if it is not sullied with sexuality education and condoms [8, 22, 27]. Lastly, schools in Western Kenya often have a religious sponsor, however nominal. Church leaders in this study were among those most oppositional, believing that condoms violated the sanctity of the school grounds and tempted youths to be immoral. Some teachers and school administrators invoked a school's religious sponsorship for why a student found with condoms should be expelled.

Participants were most divided about whether male youths should be entitled to obtain condoms at a health center. If a boy were in a school uniform, many participants seemed uneasy about allowing him access to condoms without at least some effort of the nurse to discourage him. However, for youths out of school or not in school uniform, most participants would not deny them condoms. The teachers felt that the boundaries of their authority did not extend beyond the school grounds; the youths believed that what they did in their personal lives away from school was their own concern. Only parents and church leaders seemed to oppose youths' access to condoms in these circumstances. In fact, a significant number of participants invoked the language of "rights" and "professional ethics" in declaring that nurses at health centers should not withhold condoms from students, particularly in view of the AIDS epidemic. The notion that young people have rights to condoms may derive from repeated exposure to "rights of the child" discourse of international organizations operating in Kenya, such as UNICEF, as well as to constant media coverage about AIDS. Bhana suggested that the intrinsic appeal of children's rights could be exploited to expand and enhance sexuality education in schools in sub-Saharan Africa[28].

Limitations

Because this study was limited to a single rural locality, its generalizability is not known. An added complication was that many focus group participants had received training through the Youth for Youth program, which gave detailed information about sexuality and condoms. Furthermore, the facilitator of the focus groups was the local Y4Y manager, which may have biased some participants to speak more favorably about youth condom use. Hence, it is possible that rural residents elsewhere would be more conservative. To reduce courtesy bias or the repetition of Y4Y messages, the focus group questions were intentionally framed to evoke normative responses.

The use of English as the language of discussion may have hindered some participants in articulating their views, particularly parents and church leaders who do not use English regularly. However, no one objected to using English, and the facilitator was conversant in both Luhya (the predominant language of the district) and Swahili. The advantage to conducting the focus groups in English was that participants' words could be reproduced verbatim, without losing nuance from translation.

Conclusions

Overall, the results of our study indicate that opposition to youth condom use in rural Kenya is still entrenched. Even after participating in or being within the vicinity of an adolescent reproductive health program that attempted to demystify the condom, about half of community members (including youths themselves, especially girls) considered male youths with condoms to be engaging in deviant behaviors, and a sizeable minority would actively punish them. Peer educators also tended to oppose youth condom use, more so than members of their same-sex age sets. This means that a male student in rural Kenya who followed ABC prevention messages

and chose to use condoms could risk stigmatization, loss of status, beatings, and expulsion from school.

On the other hand, a transition did seem to be occurring. Health providers were nearly all supportive of youth condom use and a few even portrayed male youths with condoms as role models. Nearly half of participants, particularly male students and teachers, would permit youths' access to condoms in certain circumstances. Some felt that youths have rights to condoms and were critical of nurses who interrogated boys or denied them condoms.

Since community labeling of adolescent condom use as deviant is likely to be hindering youths from using condoms effectively, the Kenyan government and media may need to be more pro-active in dispelling myths about condoms' efficacy and properties. Although Kenya introduced Life Skills education into the primary and secondary curricula in 2008, a recent situational analysis conducted by the Network of Adolescents and Youth of Africa (NAYA-Kenya) found that comprehensive sexuality education still is not being taught[29]. Given that our study revealed that both teachers and students have considerable misunderstandings about the condom, the Ministry of Education may wish to consider augmenting its Life Skills curricula with factual information about condoms and other contraceptives, as well as sensitizing teachers to the efficacy of condoms for HIV and pregnancy prevention.

Regarding health care providers, the government needs to reinforce its policy that all Kenyans be given full access to condoms with no questions asked. Demanding to know a youth's purpose for requesting condoms is counter-productive. Demonstrations of condoms' durability in the mass media and through outreach by health providers—such as pouring water into them and showing they do not leak—could also help to confront directly the notion that condoms have small holes and break easily.

Lastly, the results of our study indicate that communities may be receptive to portraying condoms as "disaster preparedness" devices for responsible people, instead of as instruments to help people have safer sex with whomever they please. Delinking condoms in the popular imagination from casual sex and promiscuity seems to have been done with some success elsewhere in Africa[30-31]. Rather than showing the condom user as a hip young man who keeps a condom in his back jeans pockets (as occurred in a recent social marketing campaign in Kenya), depicting the condom user as a mature, responsible, clean-cut and intelligent young man might be more effective. The condom might be best shown as banal and sanitary (like soap), not as a flashy accessory for a disco-hopping youth. Until all condom users are re-framed as responsible, non-deviant people, sexually-active youths will have difficulty accessing condoms and using them consistently.

References

1. UNAIDS. 2010. *Report on the global AIDS epidemic* [Online]. Geneva: Joint United Nations Program on HIV/AIDS (UNAIDS). Available: http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2010/2010_Global_report.asp [Accessed December 18, 2011].
2. Gallant, M. & Maticka-Tyndale, E. 2004. School-based HIV prevention programmes for African youth. *Social Science & Medicine,* 58(7)**,** pp.1337-1351.
3. Wathaika, M. & Bessinger, R. 2001. Sexual Behavior and Condom Use in the Context of HIV Prevention in Kenya. Washington, DC and Nairobi: Population Services International.
4. Paul-Ebhohimhen, V. A., Poobalan, A. & Van Teijlingen, E. R. 2008. A systematic review of school-based sexual health interventions to prevent STI/HIV in sub-Saharan Africa. *BMC Public Health,* 8**,** pp.4.
5. Katsidzira L, Hakim JG. HIV prevention in southern Africa: why we must reassess our strategies? *Trop Med Int Health*. 2011 Sep;16(9):1120-30.
6. Wight, D., Plummer, M. L., Mshana, G., Wamoyi, J., Shigongo, Z. S. & Ross, D. A. 2006. Contradictory sexual norms and expectations for young people in rural Northern Tanzania. *Social Science & Medicine,* 62(4)**,** pp.987-997
7. Pulerwitz, J., Lillie, T., Apicella, L., Mccauley, A., Nelson, T., Ochieng, S., Mwarogo, P., Kiragu, K. & Kunyanga, E. 2006. ABC Messages for HIV Prevention in Kenya: Clarity and Confusion, Barriers and Facilitators. Population Council.
8. Mathews, C., Everett, K., Binedell, J. & Steinberg, M. 1995. Learning to listen: Formative research in the development of AIDS education for secondary school students. *Social Science & Medicine,* 41(12)**,** pp.1715-1724.

9. Nzioka, C. 2001. Perspectives of adolescent boys on the risks of unwanted pregnancy and sexually transmitted infections: Kenya. *Reprod Health Matters,* 9(17)**,** pp.108-17.
10. Mmari, K. N. & Magnani, R. J. 2003. Does making clinic-based reproductive health services more youth-friendly increase service use by adolescents? evidence from Lusaka, Zambia. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine,* 33(4)**,** pp.259-270.
11. Warenius, L. U., Faxelid, E. A., Chishimba, P. N., Musandu, J. O., Ong'any, A. A. & Nissen, E. B. 2006. Nurse-midwives' attitudes towards adolescent sexual and reproductive health needs in Kenya and Zambia. *Reprod Health Matters,* 14(27)**,** pp.119-28.
12. Macphail, C. & Campbell, C. 2001. "I think condoms are good but, aai, I hate those things": Condom use among adolescents and young people in a southern African township. *Social Science & Medicine,* 52(11)**,** pp.1613-1627.
13. Demographic & Health Surveys (2010). "Kenya (2008-9): Final Report." Available at: http://www.measuredhs.com/publications/publication-FR229-DHS-Final-Reports.cfm [Accessed January 25, 2012].
14. Giles, M., Liddell, C. & Bydawell, M. 2005. Condom use in African adolescents: The role of individual and group factors. *AIDS Care,* 17(6)**,** pp.729-739.
15. Fekadu, Z. & Kraft, P. 2001. Predicting intended contraception in a sample of Ethiopian female adolescents: The validity of the theory of planned behavior. *Psychology & Health,* 16(2)**,** pp.207-222.
16. Tavrow, P. 2005. *Report on Youth for Youth (Y4Y) Program in Bungoma District, Kenya* [Online]. Center for the Study of Adolescence, Nairobi, Kenya. Available: http://www.csakenya.org/pdfs/y4y_brief.pdf [Accessed December 18, 2011].
17. Clinard, M. B. & Meier, R. F. 2004. *The Sociology of Deviant Behavior,* New York, Thompson-Wadsworth.
18. Babalola, S. 2006. Gender differences in the factors influencing consistent condom use among young people in Tanzania. *Int J Adolesc Med Health,* 18(2)**,** pp.287-98.
19. Campbell, C. & Macphail, C. 2002. Peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth. *Social Science & Medicine,* 55(2)**,** pp.331-345.
20. Ott, M. A., Evans, N. L., Halpern-Felsher, B. L. & Eyre, S. L. 2003. Differences in altruistic roles and HIV risk perception among staff, peer educators, and students in an adolescent peer education program. *Aids Education and Prevention,* 15(2)**,** pp.159-171.
21. Wilbraham, L. 2009. Manufacturing willingness: parents and young people talking about sex in an HIV&AIDS epidemic. *South African Journal of Psychology,* 39(1)**,** pp.59-74.
22. Njue, C., Nzioka, C., Ahlberg, B. M., Pertet, A. M. & Voeten, H. A. 2009. "If you don't abstain, you will die of AIDS": AIDS education in Kenyan public schools. *AIDS Educ Prev,* 21(2)**,** pp.169-79.
23. Plummer, M. L., Wight, D., Wamoyi, J., Mshana, G., Hayes, R. J. & Ross, D. A. 2006. Farming with Your Hoe in a Sack: Condom Attitudes, Access, and Use in Rural Tanzania. *Studies in Family Planning,* 37(1)**,** pp.29-40.
24. Kaler, A. 2004. The moral lens of population control: condoms and controversies in Southern Malawi. *Studies in Family Planning,* 35(2)**,** pp.105-115.
25. Meekers, D., Ahmed, G. & Molatlhegi, M. T. 2001. Understanding constraints to adolescent condom procurement: the case of urban Botswana. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV,* 13(3)**,** pp.297 - 302.
26. Yotebieng, M., Halpern, C. T., Mitchell, E. M. H. & Adimora, A. A. 2009. Correlates of condom use among sexually experienced secondary school male students in Nairobi, Kenya. *Sahara J-Journal of Social Aspects of Hiv-Aids,* 6(1)**,** pp.9-16.
27. Bhana, D. 2008. Discourses of childhood innocence in primary school HIV/AIDS education in South Africa. *AJAR-African Journal of Aids Research,* 7(1)**,** pp.149-158.
28. Bhana, D. 2007. Childhood sexuality and rights in the context of HIV/AIDS. *Culture Health & Sexuality,* 9(3)**,** pp.309-324.
29. Seehttp://kelinkenya.org/tag/effective-sexuality-education/ [Accessed February 6, 2012].
30. Plautz A, Meekers D. Evaluation of the reach and impact of the 100% Jeune youth social marketing program in Cameroon: findings from three cross-sectional surveys. Reproductive Health. 2007;4(1):1.
31. Keating J, Meekers D, Adewuyi A. Assessing effects of a media campaign on HIV/AIDS awareness and prevention in Nigeria: results from the VISION Project. BMC Public Health. 2006;6(1):123.