Sexual Networking and Response to HIV/AIDS among the Luo of Kisumu District, Kenya

Vincent Mutua Muange

A thesis submitted for the degree of Doctor of Philosophy
The Australian National University
March 1998
Except where otherwise indicated, the work in this thesis is my own, and is based on original research performed at the Australian National University.
ACKNOWLEDGMENT

This thesis has benefited greatly from the contributions of several institutions and individuals. Unfortunately it is not possible to mention all of them in this section. First, I would like to extend my gratitude to the following institutions: to the Australian Agency for International Development (AusAID) for awarding me a scholarship for my PhD; to Moi University for granting me study leave; to the Australian National University for admitting me for the degree course; and to the National Centre For Epidemiology and Population Health for providing me with facilities and a grant from the African AIDS research in care of Professor John C. Caldwell for fieldwork. I also wish to thank the Office of the President of the Republic of Kenya for giving me a permit to conduct fieldwork in Kisumu. I would also like to thank the District Commissioner for Kisumu District and his staff, and the Chief of Nyahera Location and his Assistant in Kabando Sub-Location for their assistance which facilitated my fieldwork.

My deepest gratitude goes to Professor John C. Caldwell, the chairman of my supervisory panel, for his guidance, advice and support throughout the course of my study. His insights towards the study of sexuality have greatly influenced my approach to this subject. I am also profoundly grateful to my advisers, Dr. Shail Jain and Dr. Philip Setel, for their invaluable advice, comments and suggestions. Despite their tight teaching and research schedules, my supervisory panel provided me with their time, support and great insights which were of great assistance to me in writing this thesis. I also wish to thank Ms. Wendy Cosford and Ms Catherine J. Roberston for their comments, suggestions and for patiently editing my writing to bring it up to the required standard. Catherine read and edited every chapter of my thesis and made various improvements to my writing.

I am most grateful to my parents, sisters and brother for their patience and continuos encouragement throughout my higher education. My parents, Mr. and Mrs Joachim Mutua Mulelya deserve my deepest thanks for their love, support and guidance.
I own great debt of gratitude to the many people who were involved in this study. I wish to impart my most sincere thanks to all the interviewers who carried out the interviews; to Mr. and Mrs. Absolom Onyango who kindly allowed me to live in their home for three months; to Jackson Osewe, Ochieng Omondi, and Carlos Otieno who were moderators in male group discussions; and to Dorcas Menya and Petronila Auma Abuk who were moderators in female group discussions. I also wish to thank all the people who volunteered to participate in interviews and focus group discussions. I would to thank the staff and members of the Association of People with AIDS in Kenya (TAPWK) in Kisumu town for enabling me to have first-hand experience with people with HIV/AIDS. Finally, special mention must be made of informants and in-depth interview participants who have died of AIDS in the last two and a half years since the completion of this study.
ABSTRACT

Heterosexual transmission plays a dominant role in the spread of the AIDS epidemic in Kenya. The epidemic which is particularly severe in Western Kenya and in the major urban centres such as Mombasa, Nairobi, Nakuru and Kisumu. Since the first cases were diagnosed in the early 1980s among patients at sexually transmitted disease clinics and groups at high risk such as prostitutes, and truck drivers, there has been a dramatic increase in the prevalence of HIV in the general population. In order to understand and combat the spread of the epidemic it is vital to study sexual behaviour and patterns, and identify factors which foster multiple sexual relationships. It is also important to understand the factors that explain why many people continue to engage in risky behaviour despite the wide prevalence of AIDS.

This study explores sexual behaviour and networking among the Luo of Kisumu District in Western Kenya. It also examines socio-economic factors which affect the sexual behaviour of men and women in Kisumu. Between August 1994 and May 1995 sixty men and women were selected for in-depth interviews and focus group discussions in order to gain an insight into patterns of sexual behaviour and relationships. A total of 14 focus group discussions were conducted. Subsequently, 312 men and women were selected from both urban and rural areas of Kisumu District for face-to-face interviews.

This study found that in the pre-colonial period premarital sexual relations, especially for women were less common. Women were expected to remain chaste until marriage and to remain monogamous thereafter. Female adultery was, and is still, strongly condemned. On the contrary, men enjoyed a considerable amount of freedom in their sexual relations. However, since the early 1900s there have been considerable socio-economic changes which resulted from advent of colonialism and the introduction of the capitalist economy. These changes profoundly altered sexual behaviour and the way sexual relations are conducted. It is now common for young men and women to engage in sexual relations prior to marriage. There is no longer any expectation for women to remain chaste until marriage. Over ninety per cent of currently married
respondents had had sex prior to marriage. Women tended to experience their first sexual intercourse and marry earlier than men.

A high of sexual networking was found in the study population, especially among males. Men reported significantly higher numbers of sexual partners in their lifetime and for the different periods of time which were investigated in the study. Serial and concurrent multiple partner relations were common among both men and women. About two-fifths of currently married men reported ever having sexual relations other than with their wives. Monogamously married men and women in polygynous unions were more likely to report ever having extramarital sexual relationships.

The study found that prostitution is widely prevalent in Kisumu District, especially in the main towns and small rural market centres. About one-third of men had engaged in sex with prostitutes and one-tenth had contact with prostitutes in the year prior to the survey. However, many other non-prostitute sexual relationships also involve the exchange of cash, gifts and other material support hence making it difficult to distinguish some of them from prostitution.

One striking finding in this study is that men believe that they should have more than one partner while women tend to confine their sexual activity to monogamous unions. Beliefs about male sexuality tend to support the notion that men need more than one sexual partner. For instance, it is believed that men have insatiable sexual drive, that they need a variety of partners, and that they are polygynous by nature. These beliefs tend to encourage men to engage in multiple sexual relations.

The study found that there are high levels of awareness about STDs and AIDS but a some people still hold erroneous beliefs about the causes and modes of transmission of these diseases. Luo cultural beliefs about the cause of illness and misfortune also influence the way people perceive and cope with the disease. Because AIDS is a mysterious disease with no cure, people offer commonly a supernatural explanation for it, and hence frequently attribute HIV/AIDS to witchcraft. Some people also believe that AIDS is 'chira', a fatal wasting disease which is believed to result from violation of sexual norms and rules of seniority.
High awareness about AIDS has not led to subsequent changes in sexual behaviour especially among men. Less than 10 per cent of men and less than five per cent of females reported regular use of condoms. There are differences between men and women with regard to perceptions about risk of infection with HIV/AIDS. For instance, more than half of the men did not consider themselves to be at risk of infection with HIV/AIDS while nearly two-thirds of women perceived themselves to be at risk of infection. The men’s attitudes hinder behaviour change and encourage the continued practice of having multiple partners. However, in general, the increase in awareness about AIDS, and its wide prevalence in Kisumu and Nyanza has slowly led to changes in attitudes towards multiple sexual relations among some sections of the population. As people gain experience with the disease through the loss of loved family members, relatives and friends, attitudes towards sexual activities are beginning to change. These slowly emerging changes in attitude may lead to sufficient changes in sexual behaviour in the future to affect the course of the epidemic.
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To obtain both comprehensive and realistic information on sexual behavior and sexually transmitted diseases, we have employed qualitative and quantitative methods. The qualitative method included personal and group interviews and unstructured interviews, and from group discussions. Quantitative data were collected through a randomly selected sample of households. Data were collected on sexual behaviors, attitudes, beliefs and motivations as well as on knowledge, attitudes, beliefs and behavior-making behaviors regarding STIs, including HIV/AIDS, condom use and various other responses to the epidemic.

### 2.2 Background of the study

The following sections provide brief background information on Kenya in general and insight into the HIV/AIDS situation in Kenya.

#### 2.2.1 Kenya's geography, socio-demography, and economic factors

Kenya has an area of 581,000 square kilometers and a population of 34 million people at the 1989 census, with a growth rate of 2.6 per cent (Nyandega, 1984; CBS
CHAPTER ONE

1.1 Introduction

Among the major health problems facing Africa are diseases that are transmitted by sexual contact. Sexually transmitted diseases (STDs), including ulcerative STDs (chancroid, syphilis, HSV) and discharge STDs (gonorrhoea, chlamydia and trichomoniasis), as well as AIDS, have made it imperative for social scientists to understand sexual behaviour. This study examines sexual behaviour and networking, response to HIV/AIDS and other STDs, and response to people with AIDS in Kisumu, Nyanza province of Kenya. This chapter provides background information about Kenya, Kisumu District and the Luo people, and the emergence of the AIDS epidemic. The rationale and objectives of the study are also described in this chapter.

To obtain both comprehensive and adequate information on sexual behaviour and sexually transmitted diseases, this study employed qualitative and quantitative methods. The qualitative methods comprised formal and informal, structured and unstructured interviews, and focus group discussions. Quantitative data were collected through a cross-sectional survey of a randomly selected sample of households. Data were collected on sexual behaviour, attitudes, beliefs and relationships as well as on knowledge, attitude, beliefs and treatment-seeking behaviour regarding STDs, including HIV/AIDS, condom use and various other responses to the epidemic.

1.2 Background of the study

The following section provides brief background information on Kenya in general and insight into the HIV/AIDS situation in Kenya.

1.2.1 Kenya: geography, socio-demographic and economic features:

Kenya has an area of 582,000 square kilometers and a population of 24 million people at the 1989 census, with a growth rate of 3.6 per cent (Ocholla-Ayayo 1994; CBS
Kenya borders Ethiopia to the north, Sudan to the northwest, Uganda to the west, Tanzania to the south, and Somalia to the east, and has a 400-kilometre Indian Ocean shore line to the southeast. The country is divided into eight provinces, subdivided into 48 districts.

Figure 1.1. Map of Kenya and location of Kisumu district

Nyanza Province, where Kisumu District is located, is the second most populous province after Central Province and is largely inhabited by the Nilotic Luo, Luyia, Gusii, and Basuba. There are 43 ethno-linguistic groups in Kenya; the Kikuyu, Luo,
Luhyia, Kamba, Kalenjin, Mijikenda, Meru, Embu and Kisii are the major ethnic groups.

In the decade since 1980, Kenya has experienced a remarkable decline in fertility. Census, demographic and health survey results show that the total fertility rate (TFR) declined from 6.7 children per woman in 1989 to 5.4 children per woman in 1993 (KDHS 1989, 1993). The population growth rate declined from 3.8 per cent in 1979 to 3.4 in 1993 (KDHS 1993). The level of contraceptive use has almost doubled from 19 per cent in 1984 to 33 per cent in 1993 (KDHS 1993). However, Kenya's annual population increase, estimated at between 3.6 and 3.8 per year, remains one of the highest in the world (Ocholla-Ayayo 1994).

Along with the rapid fertility decline, the general health situation of the Kenyan population has improved. In the health sector, emphasis has been placed on providing preventive as well as curative health services. These past policies have yielded a considerable decline in the Crude Death Rate from 20 per 1000 at independence in 1962 to 12 per 1000 in 1993 (GOK 1994:48). Similarly, the Crude Birth Rate (CBR) dropped from 50 to 46 per 1000 and the Infant Mortality Rate (IMR) from 120 to 67 per 1000 over the same period. Life expectancy also increased from 40 at Independence to 60 in 1993. In 1993, 71 per cent of children received all recommended vaccinations during their first year of life (KDHS 1993).

Kenya's economy is essentially agriculture-based. Agriculture accounts for about 25 per cent of the Gross Domestic Product (GDP), while manufacturing accounts for about 13 per cent. The major industries, factories and other commercial enterprises are based in the capital Nairobi and in other major towns such as Mombasa, Kisumu, Nakuru and Eldoret.

Coffee, tea and tourism are the main foreign exchange earners. Since Independence in 1962, Kenya has undergone five major economic phases. The first phase (1962-1973) was characterised by low inflation, high employment creation and an average GDP of 6.5 per cent per annum. The second phase (1973-1980) was characterised by sharp rises in oil prices, which created internal as well as external economic imbalances.
Economic growth declined to an average of 5.2 per cent per year. The third economic phase (1980-1985) was characterised by slow growth in GDP of 2.5 per cent, high oil costs, famine and drought. The fourth phase started at the end of 1986 and was characterised by the introduction and implementation of the World Bank/IMF recommended Structural Adjustment Programmes. These adjustment programs included drastic reductions in government expenditure on education and health, and cutbacks in public sector employment. In the area of health, one of the effects of the adjustment programme was the introduction of a user-fee system to replace free public health care. Many people were retrenched from their jobs in both public and private sectors, and employment opportunities were scarce. Many young people leaving school and other training institutions found it difficult to secure employment. The introduction of Structural Adjustment Programmes accelerated the growth in GDP to an average of 5.8 per cent per annum.

The fifth phase of the Kenyan economy began in 1990 when the GDP fell to 4.3 per cent. It further fell to 2.2 per cent in 1991 and 0.4 per cent in 1992. This decline was partly attributed to a decline in external resources (bilateral and multilateral donor funding), drought, famine, political problems, and poor performance of Kenyan exports. In 1994, the GDP grew to 3.0 per cent, a remarkable improvement from practically zero growth in 1993. This current phase is also characterised by economic liberalisation in trade and industry with the government withdrawing controls over public investments.

1.3 Kisumu District

Kisumu district is one of the seven districts of Nyanza province and is situated on the area surrounding the Nyanza gulf of Lake Victoria. It is composed of six administrative divisions. Kisumu town is located on the shore of Lake Victoria and is the third largest town in Kenya; it is served by the major highway and railway line to Uganda and beyond. According to the 1989 Census, Kisumu district had a population of over 600,000 people (1989 Census Report). About 40 per cent of the district’s population are urban based (mainly in Kisumu town) while 60 per cent reside in rural
areas and are engaged in agriculture; fishing is a major source of income (Kisumu District Development Plan 1994-1996). Agriculture in Kisumu is small-scale and subsistence-based even though cash crops such as sugarcane, rice and cotton are also grown. The urban population is involved in various commercial and industrial activities while others are employed in the public service. In rural parts of the district, females out number males with a sex ratio of females to males of 1.04 except in cash crop growing areas such as Muhoroni and Miwani (Kisumu District Development Plan 1994-1996). This may be attributed to migration of males for wage employment to other parts of the country.

1.4 The Luo: socio-cultural background

The Luo are a Nilotic speaking people and among the three largest ethnic groups (Kikuyu, Luhyia and Luo) in Kenya. They occupy the areas of South and Central Nyanza around the Kavirondo Gulf of Lake Victoria in Western Kenya (Ogot 1967; Cohen and Odthiambo 1989). They are part of the migration of Nilotic groups over the past four or five centuries from the Bahr-el-Ghazal region of Sudan to the present settlements in Western Kenya (Ogot 1967: 28-41; Ocholla-Ayayo 1976). They are closely related to the Dinka and Nuer who are also Nilotic-speaking people (the two are also Dholuo speakers). The Kenyan Luo live in densely populated settlements around the eastern shores of Lake Victoria.

The Luo occupy a large territory stretching from close to the Uganda border in the northwest to Tanzania in the south. They neighbour the following communities in Kenya: Luyia, Nandi (Jalango), Gusii, Maasai, and Kuria. They have contact with these neighbouring communities as well as others in other parts of the country. Traditionally, the Luo were both agriculturalists and pastoralists. Grain, fish, and milk made up their diet (Ocholla-Ayayo 1976). Today they have a mixed economy growing maize, sorghum, millet and vegetables for food and subsistence, and various cash crops such as coffee, sugarcane, tobacco, cotton, and ground nuts, depending on altitude and rainfall, soils and access to markets (Shipton 1989). Some also fish around the lake shores and streams. The Luo also keep cattle which they use for bridewealth payments.
The Luo have a patrilineal descent system and a segmentary lineage system (Evans-Pritchard 1950). The largest lineage segment is called *piny*, which comprises land occupied by the whole Luo community. The next lineage segment is called *gweng* and is composed of several households which are either closely or distantly related to one another (Ocholla-Ayayo 1976). This is similar to a clan. The smallest lineage segment is known as *jakokwaro*, comprising people with the same grandfather, but it also extends to include several generations. Homesteads in the Luo community are distributed into lineage neighbourhoods. People belonging to one lineage live in one particular locality (Potash 1978; Parkin 1978). Although Luo lineages are traditionally territorial, the degree to which this applies today is debatable, because various changes have occurred as a result of migration and privatisation of land. In Kisumu, former settler plantation areas such as Miwani and Muhoroni are composed of Luo migrant populations from other parts of Nyanza Province who bought farms or were settled there by the government (Cohen and Odhiambo 1989).

Luo kinship groups are based on real or putative descent through male ancestors and are divided into clans which are subdivided into subgroups of lineages on the same line. In the past and to some extent today, the kinship principle governs the control of land in that inheritance is through the male line. Luo are patrilineal society, virilocal in post-marital residence and in a third of the family households, polygynous. Reproduction is a key underlying factor of the Luo lineage system. Women live as strangers among their husbands’ kinsmen and their social status depends on their fertility. They are expected to produce offspring for the lineage.

Women live their married lives as only partial members of their husbands’ kingroup. As immigrants from all over Luoland (and occasionally from outside) living among interrelated men, the married women of a locality lack the convenient framework of social and political organisation the men make of lineages ... Wives keep separate houses within the circular homesteads of the larger polygynous families, and they farm separate fields and have separate granaries, but men are generally considered the *weg dala*, homestead heads, and they reserve both symbolic and practical rights over homestead property. Husbands and wives tend to do separate farm tasks, the women doing most time-consuming work on basic staples (Shipton 1989: 19).

In precolonial times the Luo did not have a unified or centralised political system. They had a decentralised political system of local leaders with rather weak and semi-
formal positions at the head of exogamous clans or maximal lineages (Ocholla-Ayayo 1976; Shipton 1989). There were no elaborate hierarchichal structures of bureaucracy as in the interlacustrine kingdoms of Uganda. The Luo have no formal age-grade system like those of neighbouring ethnic groups such as Maasai, Nandi or Kuria (Shipton 1989). Traditionally the Luo society is gerontocratic, with older men controlling the allocation of bridewealth cattle, and land; it is considered natural for elders to control wealth and command respect and family obedience; they are repositories of wisdom (Ocholla-Ayayo 1976).

They have no elaborate ceremonies marking adulthood such as male circumcision or female clitoridectomy. However, Ocholla-Ayayo (1976) noted that in the past there were two important stages for boys and girls, namely nak and chodrouk, which took place at age 14 or 15. Boys and girls were not considered grown up until nak which involved the removal of lower teeth (mainly incisors). This was culturally compulsory in the past but the intensity with which it is practised has waned over time. Chondrouk involved cutting of the ligament frenulum of the penis; no ceremony was involved in this act (Ocholla Ayayo 1976).

For about 50 years, about a third of Luo middle-aged men have lived outside Luo homeland because of wage labour either in Kenya's plantations, towns, and cities, or in other countries in East Africa (Parkin 1978). Within Nyanza province, there are several large sugar plantations which provide casual seasonal manual jobs. Rural families depend on households migrant labourers’ remittances in cash and kind. Migrants also depend on rural farms as sources of food, and social security for old age.

1.5 AIDS in Kenya

HIV/AIDS infection is rapidly increasing not only in Kenya but also in other countries in the sub-Saharan region. Recent studies show that HIV/AIDS is endemic in East Africa, especially in Masaka and Rakai Districts of Uganda, and Mwanza and Kagera regions of Tanzania (Mhalu, 1987; Barnett and Blaikie, 1992). The Western and Nyanza provinces of Kenya also have a serious AIDS problem. These regions are
geographically located in what is referred to as the main AIDS belt in sub-Saharan Africa (Caldwell and Caldwell 1994a).

The first HIV/AIDS cases were reported in Kenya in 1983 (Temmerman et al. 1992). In Kenya, as in other sub-Saharan African countries, the main mode of transmission is heterosexual, with transmission from mother to baby accounting for 20 per cent and blood transfusion for less than five per cent (NACP). Initial reports of an AIDS epidemic in Kenya were denied by the government because of the potential threat of such an epidemic for the tourist industry. However it has since been recognised that AIDS is a serious problem in Kenya and this has attracted the attention of both government and non-governmental organisations.

According to reports from sentinel surveillance sites and small-scale surveys there were 41,175 AIDS cases in 1993. Overall adult HIV prevalence had increased from 3.5 per cent in 1990 to 5.6 per cent in 1993. In urban areas the prevalence was estimated to be twice as high, about 11-12 per cent, while the rural prevalence was about 4-5 per cent. Nationally, the HIV infection rates had more than doubled over three years, from 6 per cent in 1990 to 13 per cent in 1993 (NACP 1994) It was also estimated that there was a total of 730,000 HIV positive adults and 30,000 children (NCPD, 1993).

In the 1994 National AIDS Control Programme (NACP) report, the total number of HIV cases reported since the early 1980s was about 1,000,000. The estimated number of AIDS cases during this period was about 150,000, but only a small proportion had been reported in official health statistics (Kenya National AIDS Control Programme, December 1994; Daily Nation 17 April 1996:3). It was estimated at the time that every year 10,000 people die of AIDS or AIDS-related complications in Kenya. In 1995, the estimates from NACP indicate that over 1,100,000 people were HIV-infected. The estimates for 1996 showed that over 1,270,000 people are infected with HIV, of whom 755,000 were adults aged 15-34; and 65,647 reported AIDS cases (Daily Nation 4 July 1996).
However, it is important to note that not all cases of AIDS are reported for several reasons. First, some people never seek hospital care for AIDS because they go to traditional healers and therefore they remain uncounted. Secondly, some doctors do not record a diagnosis of AIDS because of the stigma attached to the disease. Thirdly, some people with HIV die of other diseases before they are diagnosed as having AIDS, and finally, some rural health care facilities lack the equipment to test for HIV infection.

AIDS has spread throughout the country and cases have been reported from every district. Kenya has an NACP Sentinel Surveillance system which provides a basis for estimating the extent of HIV infection; this system operates in 13 sites around the country. The Sentinel Surveillance sites are all antenatal clinics, where pregnant women go for care during pregnancy. Each year, 200-300 pregnant women are tested for HIV at each site (see Table 1.1). Sentinel Surveillance results for 1993 from Busia, Kisumu and Nakuru showed that the proportion of pregnant women infected with HIV was between 20 and 30 per cent. In Mombasa and Nairobi 10-20 per cent of pregnant women were infected. In Kitale, Kakamega and Nyeri infection rates ranged between 5 and 10 per cent. Much lower rates of 2-10 per cent were recorded for Kisii, Kitui, Meru and Garissa. These sites may have lower infection rates because the sexual behaviour patterns of people in these areas were different or because the epidemic started later in these areas. On average, the HIV infection rate among women of reproductive age was estimated to be 7 per cent (NACP 1994).
Table 1.1 Percentage of pregnant women testing positive for HIV in sentinel sites in Kenya reported in 1990 and 1993

<table>
<thead>
<tr>
<th>Sentinel site</th>
<th>1990</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>Busia</td>
<td>17.0</td>
<td>22.0</td>
</tr>
<tr>
<td>Garissa</td>
<td>4.9</td>
<td>3.8</td>
</tr>
<tr>
<td>Kakamega</td>
<td>5.3</td>
<td>8.6</td>
</tr>
<tr>
<td>Kisii</td>
<td>1.6</td>
<td>2.5</td>
</tr>
<tr>
<td>Kisumu</td>
<td>19.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Kitale</td>
<td>3.5</td>
<td>7.5</td>
</tr>
<tr>
<td>Kitui</td>
<td>1.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Meru</td>
<td>2.7</td>
<td>23.3</td>
</tr>
<tr>
<td>Mombasa</td>
<td>10.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Nairobi</td>
<td>5.8</td>
<td>17.1</td>
</tr>
<tr>
<td>Nakuru</td>
<td>9.9</td>
<td>22.0</td>
</tr>
<tr>
<td>Nyeri</td>
<td>2.9</td>
<td>6.4</td>
</tr>
<tr>
<td>Thika</td>
<td>2.5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: NCAP 1994

NACP (1994) reported that three-quarters of HIV and AIDS cases in Kenya occurred in adults aged between 20 and 45 years. The peak age for AIDS cases was 25-29 years for females and 30-34 years for males. Most HIV infections in Kenya were heterosexually transmitted. There was a slightly higher number of reported cases for males than females and this might have been due to both poor reporting of female cases, and the higher concentration of males in large urban towns and cities with high infection rates. There was also a significant number of AIDS cases reported among young children. Most received the infection from their mothers when they were born. NACP estimated that there were 30,000 children under the age of five years who were HIV infected (NACP 1994).

By December 1993, Nyanza province had reported the highest number of AIDS cases by district of birth and accounted for 30.7 per cent of the total number of AIDS cases reported in Kenya. Table 1.2 shows the cumulative number of AIDS cases in Kenya by province of birth by December 1993.
Table 1.2 Cumulative number of AIDS cases reported in Kenya by province of birth by December 1993

<table>
<thead>
<tr>
<th>Province</th>
<th>AIDS cases</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nairobi</td>
<td>2202</td>
<td>4.4</td>
</tr>
<tr>
<td>Central</td>
<td>4029</td>
<td>8.0</td>
</tr>
<tr>
<td>Coast</td>
<td>5697</td>
<td>11.4</td>
</tr>
<tr>
<td>Eastern</td>
<td>6992</td>
<td>14.0</td>
</tr>
<tr>
<td>North-Eastern</td>
<td>174</td>
<td>0.3</td>
</tr>
<tr>
<td>Nyanza</td>
<td>15,065</td>
<td>31.7</td>
</tr>
<tr>
<td>Rift Valley</td>
<td>3452</td>
<td>6.9</td>
</tr>
<tr>
<td>Western</td>
<td>4613</td>
<td>9.2</td>
</tr>
<tr>
<td>Other</td>
<td>6991</td>
<td>14.0</td>
</tr>
<tr>
<td>Total</td>
<td>49,745</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: NACP 1994

Other provinces which reported many cases includes Eastern, Coast, Western and Rift Valley. Kisumu District is representative of an area that has had high infection levels for some time. Table 1.3 shows the cumulative number of cases reported by district of birth in Nyanza province.

1.3 Cumulative number of AIDS cases reported in Nyanza Province by district of birth by December 1993

<table>
<thead>
<tr>
<th>District</th>
<th>AIDS cases</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kisii</td>
<td>1635</td>
<td>10.5</td>
</tr>
<tr>
<td>Kisumu</td>
<td>4154</td>
<td>26.6</td>
</tr>
<tr>
<td>Siaya</td>
<td>4042</td>
<td>25.9</td>
</tr>
<tr>
<td>South Nyanza</td>
<td>5774</td>
<td>37.0</td>
</tr>
<tr>
<td>Total</td>
<td>15605</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: NACP 1994
By December 1993, the district had reported a total of 4232 AIDS cases, about 8.2 per cent of the total national number of reported cases. Sentinel Surveillance results showed that HIV infection among pregnant women increased from 19 per cent in 1990 to 20 per cent in 1993. Sentinel Surveillance of all blood donated at the provincial hospital (New Nyanza Hospital) in Kisumu showed that HIV prevalence had increased from 3.6 per cent in 1987 to 9.2 per cent in 1993 (NACP 1993).

Although the probability of transmitting HIV in a single act of intercourse can be quite low, a number of factors increase the risk of infection dramatically. The presence of ulcerative STDs and discharge STDs, such as gonorrhoea and syphilis, place individuals at two to six times the usual risk for sexually transmitted HIV. Nationally, the number of gonorrhoea cases was estimated in 1994 at between 230,000 and 460,000 cases, or approximately 1-2 per cent of the total population (NACP 1994). Multiple STD infections were common among STD clinic patients.

1.6 Projected HIV infection and AIDS cases

As HIV prevalence was increasing rapidly in most areas of Kenya in 1994, it was likely that the increase would continue for at least the following six to seven years (NACP 1994). NACP estimated that HIV prevalence would increase from about 5.7 of the adult population in 1993 to 9 per cent by the year 2000 and would then stabilise at that level (NACP 1994). From this assumption, NACP and the Ministry of Health made projections that by the year 2000 there would be 1.6 million people infected with HIV and this would increase to 1.9 million by the year 2005. The number of new AIDS cases each year resulting from this infection would also increase to over 230,000 by 2000. The cumulative number of AIDS deaths would increase from about 150,000 in 1993 to 1 million by 2000 and to over 2 million by 2005.

In recognition of the potentially devastating effects of AIDS, and despite earlier denial of the extent of the AIDS problem in Kenya, the government constituted the National AIDS Control Programme and AIDS program secretariat within the Ministry of Health in 1987. The first Medium Term Plan (MTP) was initiated for the period 1987
to 1991; it focused on awareness campaigns, strengthening laboratory services, surveillance of HIV/AIDS and training of health personnel.

By the end of the plan period in 1991, over 83 per cent of people surveyed knew about AIDS (NACP 1991). The results of the 1993 Kenya Demographic and Health Survey (KDHS) showed that 99 per cent of men and 98 per cent of women surveyed knew about AIDS. This high level of knowledge about AIDS did not differ on the basis of age, urban-rural residence or education. The survey also found a high level of knowledge of HIV transmission routes (KDHS 1993).

Despite this high level of awareness it was recognised that not much behaviour change had occurred and there was evidence of new infections of HIV. Thus, in 1992, the second Medium Term Plan (MTP II) for 1992-1996 was formulated, based on the experience gained over the previous five years of the first plan. The second plan adopted a multisectoral approach in which emphasis was placed on collaboration with other non-governmental organisations to initiate a collective response toward AIDS.

The major strategies for the prevention of HIV infection in the second MTP included serologic screening of blood products from donors, promotion of condom use through information and distribution, and treatment of STDs (Ngugi 1989; Mulindi 1992; NACP 1993). An Information, Education and Communication (IEC) subcommittee was established under NACP. A number of non-governmental organisations such as the African Medical Research Foundation, Care International, Red Cross Society and Church organisations are also involved in the campaign to prevent the spread of AIDS.

Despite massive IEC campaigns, there is still some misinformation and denial about the seriousness of HIV/AIDS in sections of the population. For instance, there are some people in Kenya who attribute the disease to witchcraft, while in parts of Luoland people say it is Chira a wasting disease that afflicts people as a result of violation of certain taboos regarding sex and behavioural conduct (Ocholla-Ayayo et al. 1993a).
1.7 Justification for the research

This study is timely because HIV is spreading and devastating quality of life, economies, health care and the future of many people (Ainsworth and Over 1994). Since HIV was identified in Kenya in the early 1980s, there has been a continuous increase in HIV seroprevalence and AIDS-related mortality. Many people have lost relatives and friends to AIDS, and this has raised the need to prevent further infection.

The presence of other sexually transmitted diseases (ulcerative and non-ulcerative) has been recognised as enhancing the risk of HIV infection. The control of other STDs through early treatment has become a priority in the effort to reduce or halt the spread of HIV/AIDS. This study will contribute toward the understanding of STDs by examining the beliefs, attitudes, practices and treatment-seeking behaviour regarding various diseases contracted through sexual contact.

The study incorporates a many other factors, social, cultural, political, legal, biological, physical and psychological in an effort to understand sexual behaviour and response to risk of and infection with AIDS. The study examines at how these factors influence sexual behaviour and the risk of infection with HIV/AIDS. Previous studies or models of AIDS research have not incorporated many factors in their analysis of AIDS studies. For instance, biomedical factors only focus on physical or biological factors and do not adequately address other factors that determine an individual’s risk of HIV/STD infection.

This study is relevant to continuing HIV/AIDS prevention program activities especially in exploring the links between sexual behaviour and HIV/STDs. Indeed, the Kenya National Development Plan 1994-1996 and the Kisumu District Development Plan have called for more baseline studies on awareness and prevalence of HIV/STDs and how people are coping with the epidemic. Thus this study meets both national and district needs.
1.8 Research questions

In approaching the above objectives, I assert that Luo beliefs and practices relating to sexual relations, health and illness are part of a traditional system which is inextricably linked to the wider spiritual and social order. These beliefs and practices are evident in the social meaning attached to HIV/AIDS and other STDs and the response to the disease in Luoland. This study addresses the following questions.

The main research question of this study is why are people in Kenya not significantly undertaking preventive behaviour to reduce their risk of HIV/STD infection?

1. Are there any differences in knowledge or attitudes toward HIV/AIDS on the basis of age, sex, education, marital status, residence or religious belief in the study population?

2. Are there any differences in the study population in sexual behaviour and number of sexual partners on the basis of age, sex, education, occupation, marital status, residence, religion?

3. Are there any differences in knowledge, attitudes and practices related to contraceptives, condom use and other safe-sex practices on the basis of age, sex, marital status, education, occupation, residence in the study population?

4. What social networks do people use to cope with HIV/AIDS?

5. Do traditional Luo beliefs about sexuality, witchcraft and cursing influence perception and response to STDs, including AIDS, and other treatment seeking behaviour?
1.9 Study objectives

This study seeks to contribute to the greater understanding of sexual behaviour, sexual networking, sexually transmitted diseases, including HIV/AIDS, condom use and response to HIV/AIDS in Kisumu district. Its specific objectives are as follows.

1. To explore sexual networking, beliefs and attitudes towards sex. The study looks at factors that influence sexual behaviour.

2. To examine knowledge, attitudes and practices pertaining to contraceptive and condom use. The study seeks to determine factors that influence use and non-use of condoms and contraceptives.

3. To examine the prevalence, beliefs and practices regarding sexually transmitted diseases, including HIV/AIDS. The study seeks to determine whether people recognise these STDs, the local terminologies used to describe these diseases, and treatment-seeking behaviour.

4. To determine the various strategies employed by individuals, the household and community to cope with the HIV/AIDS crisis.

5. Based on the above, the study seeks to make suggestions on how the AIDS prevention program could be improved within the national policy of reducing the rising incidence of HIV and other STDs through behavioural change.

1.10 Significance of the study

HIV/AIDS in Kenya is an important and distinct problem because of the ethnically heterogeneous nature of the population. Indeed it is difficult to deal with a very large number of ethnic groups within a common or single socio-economic framework. This raises the need for culture-specific or ethnic-specific studies in order to grasp the dynamics within which the AIDS epidemic is spreading.
There is evidence from studies in Kenya that recurring changes of heterosexual partners are important in determining prevalence of HIV and other STDs. Ocholla-Ayayo et al. (1993a) report that in Kenya, multiple heterosexual relationships are the result of many types of marriages, polygamy, separation, widow inheritance and un-institutionalised prostitution. However, little is known about the frequency of partner exchange, especially among the Luo people who have some cultural practices that encourage partner exchange such as widow inheritance, polygamy, and funeral rites that involve ritual cleansing. The instability of many sexual relationships provides grounds for sexual mobility, increasing the risk of spreading STDs such as HIV/AIDS.

This study contributes towards greater understanding of behavioural factors that determine people’s risk of HIV infection. It provides information regarding sexual practices and relationships and partner exchange, and explores the cultural logic behind these practices.

Evidence from other parts of Africa shows that AIDS has had devastating effects on the health care system and household resources, especially where HIV seroprevalence is high (Barnett and Blaikie 1992). The need to conduct studies on household and institutional care was recognised by the World Health Organization at the end of the 1980s. P. Caldwell (1990:3A-4A) emphasises the need for such studies for three reasons: first, for formulating policies on institutional care for persons afflicted with AIDS and people infected with HIV; secondly, to develop and monitor interventions to improve alternative forms of care, especially at household level. Finally, such studies can provide data on morbidity and mortality trends in a population. This study explores household and institutional responses to care for people with HIV or AIDS. It looks at the various strategies of individuals, households and communities to cope with the short and long-term effects of the epidemic. Thus the study contributes information that is relevant for policy formulation, planning and implementation of HIV/AIDS prevention interventions.
1.11 Organisation of the thesis

This thesis is comprised of nine chapters. Chapters 1 to 3 describe background information and the methods used to collect the data. Chapter 4 to 8 provides the results of the study, followed by the concluding chapter.

Chapter 1 gives background information about Kenya, Kisumu district, the Luo people and the HIV/AIDS epidemic. It also presents research rationale and the objectives of the study. Chapter 2 gives a review of studies on sexual behaviour, sexually transmitted diseases (including HIV/AIDS), and condom use. Chapter 3 outlines methods used to collect and analyse the data, sample site and the socio-demographic characteristics of the survey and informal interview respondents. Chapter 4 highlights courtship behaviour, marriage customs and rituals pertaining to widowhood and widow inheritance. Chapter 5 is devoted to the sexual behaviour of men and women in the study area. It examines premarital sexual relations, attitudes towards virginity, sexual debut and networking of survey respondents. It also explores commercial and transactional sexual relations and reasons why people engage in such relations. Chapter 6 focuses on sexually transmitted diseases, including AIDS: it examines knowledge, attitudes, and beliefs about standard STDs and AIDS, history of infection with such diseases and treatment-seeking behaviour. It also explores how Luo beliefs about disease and illness influence people's interpretation of these diseases. Chapter 7 focuses on condoms, mainly knowledge, use and attitudes. It examines various macro and micro factors that facilitate and hinder condom use. Chapter 8 describes the responses of people with HIV/AIDS to diagnosis with the disease, the responses of their relatives and of the community at large to their illness. Chapter nine provides a summary of research findings and ends with suggestions for future research and policy.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Recent studies show that sub-Saharan Africa has been struck by the AIDS epidemic with varying degrees of ferocity (Mann, Tarantola and Netter 1992: 30; Erwin 1993; Caldwell and Caldwell 1993:1). During the initial stages of the epidemic very little was known about the dynamics of the disease. However, in the past decade several studies have examined various aspects of HIV/AIDS epidemiology, sexual behaviour, knowledge and attitudes about HIV/AIDS and other STDs, and the context within which the epidemic is spreading (Ndinya-Achola, 1991; Plummer et al. 1991; Temmerman et al. 1992; Garland et al. 1993; Ocholla-Ayayo et al. 1993a).

2.2.1 STD/AIDS research in Kenya

Before the outbreak of the HIV/AIDS epidemic, little effort was made to control or even understand STDs in most of Africa by either government Ministries of Health or non-governmental organisations. More attention was given to nutrition, family planning and other health problems, such as diseases of childhood and endemic infectious diseases such as malaria and schistosomiasis.

During the first decade of the AIDS epidemic, most research was dominated by epidemiological studies of 'risk groups' such as prostitutes and people attending STD clinics. Women attending antenatal and family planning clinics were also being studied (D’Costa et al. 1985; Kriess et al. 1986; Piot et al. 1987; Ngugi et al. 1988; Ndinya-Achola et al. 1991). These first biomedical studies were carried out in medical research and teaching institutions in East and Central Africa such as Nairobi, Kampala, Kinshasa and Kigali, and their findings led to the popular belief that AIDS was an urban disease (D’Costa et al. 1985; Kriess et al. 1986; Piot et al. 1987; Setel 1995).
Sexually transmitted diseases have been a major public health concern in Sub-Saharan Africa for many years and have been the major cause of infertility in Central Africa (Caldwell and Caldwell 1993). Their importance has recently been recognised with the emergence of the AIDS epidemic and studies show that they are a co-factor in the transmission of HIV.

Sexually transmitted disease have a long historical background in Kenya. They began in urban and coastal areas, and eventually spread to rural areas; before the twentieth century they were almost unknown in the interior of the country (Carothers 1948). Studies conducted in the early 1930s and 1940s show that gonorrhoea, syphilis and chancroid were common, especially among certain urban populations. These diseases were recognised and had local names. Carothers (1948) reported that the incidence of syphilis had doubled in Kenya between 1933 and 1943.

Recent studies in Kenya, particularly in Nairobi, among selected populations such as prostitutes, STD clinic clients and pregnant women showed that STDs are common. A study of 151 men attending an STD clinic in Nairobi found 54 per cent had chancroid, 19 per cent had syphilis and 5 per cent had chlamydia (Fast et al. 1983). Greenblatt et al. (1988) reported that 70 per cent of lower socio-economic status male STD clinic clients had chancroid. The study found a close association between genital ulcers disease (GUD) and HIV infection; 63 per cent of HIV-positive men had a history of previous genital ulcers compared with 30 per cent of HIV-negative men.

Several studies also showed that STDs are a common occupational hazard among prostitutes in Kenya (D'Costa et al. 1985; Kreiss et al. 1986; Piot et al. 1987; Greenblatt et al. 1988; Simonsen et al. 1990; Plummer et al. 1991). These studies showed that men infected with STDs were more likely to have acquired them from prostitutes. This suggests that prostitutes are at substantial risk for acquiring and passing on STDs, including HIV.

There have been few STD prevalence studies in the general population in Kenya. Recent studies showed that STDs are common outside what medical researchers consider as core transmitter groups, for example prostitutes and their clients.
Simonsen (1992) observed an increase in syphilis among women attending antenatal clinics in Nairobi from 3 per cent in 1988 to over 5 per cent in 1991, and an overall HIV prevalence of 8.8 per cent. Even though these women did not report risky behaviour, such as having multiple partners, and while the proportion with more than one partner declined during two years, their risk was not reduced. Hunter et al. (1994:94) found that 4.9 per cent of 4,404 women attending two periurban family planning clinics in Nairobi were HIV-positive. Of these HIV-infected women, 76 per cent were either married or cohabiting and 93 per cent had only a single partner. This suggests that the risk of infection was influenced by their partners’ sexual behaviour.

Biomedical and epidemiological research also shows that the presence of other STDs (syphilis, gonorrhoea, chancroid, and other ulcerating STDs) and non-circumcision facilitate HIV transmission (Nsanze et al. 1981; Plummer et al. 1991; Gilks et al. 1992; Hunter et al. 1994; Moses et al. 1995). These studies conducted in Nairobi showed that non-circumcised men, especially the Luo, are more likely to be infected with STDs including HIV than circumcised men from other ethnic groups. Studies in Uganda and Tanzania showed a close association between non circumcision and the risk of STD and HIV infection (Nunn et al. 1994) and thus suggest that circumcision has some protective effect against STDs including HIV. It is possible that non-circumcision is a risk factor in the transmission of HIV and other STDs among the Nyanza Luo of Kenya among whom this study was conducted.

A series of events and factors in the colonial and post-colonial periods set the stage for the rapid spread of STDs in Kenya and Africa in general. These included the development of migrant labour and the subsequent separation of spouses, urban influx accompanied by great disparities in the ratio of men to women, and the growth of commercial sex (Larson 1989). Migration has been dominated by men and there are few economic opportunities for women in urban settlements. The separation of spouses and families, and the poverty of most rural areas, place both men and women in situations which can lead them into transactional sex. Hunt (1989) and Obbo (1993) have observed that migrant labour and population movement in East Africa have a significant influence on the growth of commercial sex and the spread of STDs including HIV into rural areas.
Rapid movement into large urban centres has concentrated impoverished, poorly paid wage earners and unemployed people into poor living conditions. In such circumstances, access to health care and treatment of STDs has been poor. A problem which impedes effective control of STDs is that of diagnosis and treatment, especially in rural areas where there are relatively few trained staff and no laboratory facilities. Thus in many rural settings, all urethral and vaginal discharges are diagnosed or described as gonorrhoea and genital ulcers as syphilis (Adwok 1986). Some STD cases are handled by traditional healers or self-medication because of fear of stigmatisation, so many cases are not treated correctly. As a result it is difficult to estimate and compile prevalence statistics in the general population.

This study examines the social aspects of prevalent STDs in Kisumu. It focuses on knowledge and attitudes about STDs, beliefs about cause and symptoms, and treatment-seeking behaviour. The context (social, cultural and economic) within which these diseases spread is also examined.

2.2.2 Studies on sexual behaviour

Before the AIDS epidemic social scientists had been reluctant to study sexual behaviour, not sex roles or the sexual division of labour, but sexual ideologies and the realities of sexual desire and practice (Pellow 1990; Ahlberg 1994). However, before the AIDS epidemic was recognised in the mid-1980s, studies on human sexuality in Africa focused on two perspectives. First, customs in traditional societies were studied by ethnographers and anthropologists and secondly, in the 1960s and 1970s, surveys were conducted on Knowledge, Attitude and Practice (KAP) about family planning. In the 1980s, as part of fertility and family planning studies, demographic and health surveys were also carried out. These studies focused on childbearing, marriage, contraception, mortality and child health and thus provided limited information on sexual behaviour.

Since the AIDS epidemic was recognised in the mid-1980s, social science research has focused on behavioural factors that increase the risk of HIV infection and the socio-cultural and economic factors fuelling the spread of AIDS in Sub-Saharan
Africa (Larson 1989; Caldwell, Caldwell and Quiggin 1989; Caldwell, Caldwell and Orubuloye 1992; Ntozi and Lubega 1992; Bauni 1992). These studies show that in Africa, HIV infection is sustained by heterosexual contact with a large pool of sexually mobile partners, and high rates of infection with STDs, especially those that cause genital ulcers (Larson 1989; Caldwell and Caldwell 1993; Anarfi and Awusabo-Asare 1993a). The major focus of these studies has been on numbers of sexual partners and frequency of partner exchange, and not on the different discrete types of relationships.

Anthropological studies provide useful information on cultural and behavioural aspects of HIV infection. When the epidemic was first identified, ethnographic and anthropological studies carried out before the epidemic by social scientists were widely reviewed for information about sexual behaviour (Lindenbaum 1991:856). These studies give us some account of precolonial social organisation in Africa through oral interviews conducted by early ethnographers and anthropologists. The early ethnographers were preoccupied with exotic behaviour or practices that they viewed as strange to their own culture and these accounts have been criticised for being heavily loaded with the ethnographers’ own cultural biases (Ahlberg 1994). Ahlberg (1994:225), commenting on the quality and reliability of early ethnographic studies on sexuality in Africa, notes that

Objectivity may be hampered by racially, culturally and class predetermined and prejudiced attitude. The very ideas of studying the sexual lives of savages, which characterised early anthropological studies, underlies the prevailing prejudiced attitude.

The accounts were largely descriptive and have limited generalisation because they were not replicated to verify the extent to which the practices described were widespread. These studies are of less use because of the changes in the social, economic and political conditions that have occurred in Africa from the early twentieth century to present day. However, such studies have provided valuable qualitative data that are important as a starting point for quantitative studies. Recent ethnographic studies have begun to focus on behaviour and gender issues that are important in the analysis of sexual behaviour. In recent years, there has also been
increased emphasis on combining anthropological methods of participant-observation and in depth interviews, and quantitative methods.

Caldwell, Caldwell and Quiggin (1989) and Larson (1989) using documented anthropological studies, provided a comprehensive analysis of different sexual practices and marriage patterns that are potential avenues for the spread of HIV in Sub-Saharan Africa. They argued that Africa has unique marriage and sexual systems which are different from ‘Eurasian’ systems (representing Europe, Asia and the Middle East). Caldwell, Caldwell and Quiggin’s (1989) central thesis was that the African sexual system is characterised by permissiveness and lack of a religious morality on sexual behaviour. Using data from various parts of Africa, Caldwell, Caldwell and Quiggin (1989) showed the wide spectrum of non-marital sexual activity ranging from commercial sex to informal polygyny (outside wives, mistresses) among men and women. Caldwell, Caldwell and Quiggin (1989) theory of the existence of an African sexual system has been subjected to a number of criticisms. Ahlberg (1994) argues that the theory fails to look at the importance of historical factors, such as colonial rule and Christianity, that destabilised the African sexual system in the colonial and post-colonial periods. Ahlberg (1994) also notes that Caldwell, Caldwell and Quiggin (1989) were selective in providing ethnographic evidence that showed African sexual behaviour was not related to moral and religious sanctions.

In general Sub-Saharan Africa is characterised by diversity in sexual behaviour and marital patterns (Caldwell, Caldwell and Quiggin. 1989; Caldwell, Caldwell and Orubuloye 1992; Ahmed and Kheir 1992). In Kenya, there are communities which traditionally proscribed premarital sex while others did not. For instance, Kikuyu and Luo girls are expected to be chaste until marriage (Kenyatta 1962; Parkin 1973:324; Ocholla-Ayayo 1976; Ahlberg 1994). Jacobs (1973:402) also noted similar sanctions among the Maasai of Kenya and Tanzania. However, it is important to observe that among the Luo and Kikuyu, young unmarried males and females were allowed to have controlled sexual activity for the purpose of sexual satisfaction (Ocholla-Ayayo 1976; Ahlberg 1994). In contrast, there are communities which gave young unmarried men and women a considerable amount of freedom in sexual activity as long as it did not result in pregnancy. For instance, unmarried Akamba men and women were expected
to have had practical sexual experience before marriage (Ndeti 1978; Kabwegyere and Mbula 1979).

In many African societies female sexual activity was strictly controlled as compared to that of men, whose premarital and extramarital sexual relationships were condoned (Caldwell, Caldwell and Quiggin 1989). For instance, among the Baganda of Uganda, and the Tutsi and Hutu of Rwanda men premarital and extramarital sexual activity is expected and it is assumed that men will have more than one partner (Feldman 1987; McGrath et al. 1992). Men enjoy a considerable amount of freedom in their sexual relations compared with women.

Most studies of sexual behaviour in Africa have broad common assumptions about the historical and social experiences of study populations. They make the assumption that colonialism and urbanisation rapidly changed African societies and gender relations and that the factors which influenced this change were migration to cities, wage employment dominated by men, and the marginalisation of women in this process. An assumption has been that the introduction of a capitalist monetary economy brought with it wage labour, to which women had limited access.

Colonial and post-colonial Africa has undergone vast social and economic changes that have resulted in greater social and sexual freedom (Ocholla-Ayayo, Wekesa and Ottieno 1993b). Some writers have singled out migrant labour, urbanisation and the breakdown of traditional structures of authority as being responsible for high levels of sexual networking in Sub-Saharan Africa (Caldwell, Caldwell and Quiggin 1989; Larson 1989; Plummer et al. 1991; Anarfi 1993b; Ocholla-Ayayo, Wekesa and Ottieno 1993b). These factors have led to increased sexual freedom for both men and women to engage in premarital and extramarital relations at a greater rate than before.

Some of the recent studies on AIDS in Sub-Saharan Africa have used the Knowledge, Attitudes and Practice survey approach (Ankrah 1989; Feldman 1987; Ingstad 1990). These studies in different parts of Africa provided evidence of fairly high levels of sexual networking. Many surveys reported higher rates of partner change among married men and single men than among women. Orubuloye, Caldwell and Caldwell
(1992) reported that Yoruba men of Ondo state, Nigeria had an average number of seven different partners in their lifetime. In the same study, all male respondents currently had an average of 2.3 sexual partners while most single men did not confine themselves to a single partner.

Anarfi (1992) reported that in Ghana a quarter of ever-married male respondents had at least five sexual partners before marriage and many married men reported sexual encounters with a number of women other than their wives. Results from a six-country, WHO-sponsored study on sexual behaviour showed that more than twice as many men as women had extramarital sexual relations in the twelve months preceding the study (Carael et al. 1992:73). Young males in the age groups 15-24 and 20-29 had the highest number of casual sexual encounters. Overall, men reported significantly more lifetime sexual partners. However, the results of these studies may have been skewed through under-reporting by women and over-reporting by men (Heise and Elias 1995:933).

In Kenya, high levels of sexual activity have been reported among adolescents and young adults. Kiragu (1989:6) found that boys begin sexual activity at ages 11-13 while girls start at ages 12-15. Ngugi (1992b:10) makes similar observations and emphasises that multiple partners are common among teenagers. The involvement of adolescents and young adults in sexual activities has led to an increase in the number of girls dropping out of school due to unwanted pregnancies, abortion, single parenthood and incidence of STDs, including AIDS (Center for Population Options 1990; Ahlberg 1991; Temmerman et al. 1992). For instance, Juma (1992) found in Nyakach region of Kisumu District in Kenya, that almost every household had a girl who was a single parent.

This study examines sexual networking; it describes in detail sexual practices, history, frequency of partner exchange, the context and circumstances under which sexual encounters take place, sexual partners and sexual relationships. It also looks at the socio-cultural and economic factors underlying sexual behaviour.
Recent studies combining anthropological and quantitative data have begun to focus on gender relations and their influence on sexual behaviour (Preston-White 1994; McGrath et al. 1992). These studies have shown that in Sub-Saharan Africa there is diversity in the extent to which women have control over sexual relations (Ankrah 1991; Schoepf 1992; Orubuloye, Caldwell and Caldwell 1993). In East and Southern Africa, women generally lack decision-making power over matters of sex (Schoepf 1992; McGrath et al. 1992). This is based on the fact: that most societies in the region have a patrilineal system, where women do not have access to resources such as land, or have other economic opportunities. Cultural norms demand that women submit to their spouses' sexual demands and hence provide them with sexual services in all circumstances. Thus in such circumstances of inequality and dependency women cannot refuse to have sexual relations with their spouses or regular partners, or negotiate safer sexual practices.

By contrast, in West Africa women tend to enjoy greater autonomy in their sexual relations with their partners (Oppong 1983; Etienne 1983; Orubuloye, Caldwell and Caldwell 1993). Orubuloye, Caldwell and Caldwell (1993) argued that this was based on the women's ability to engage in off-farm activities such as trade, in either their villages or towns, and on the nature of the West African family. The West African family system provides wives with a separate resource base from their husbands and in case of divorce or separation they can return to their family of origin and still have access to resources such as land. However, the above studies have only dealt with the ability of married women to negotiate sexual matters and have not looked at single, divorced or separated women. Women are not a homogeneous group. There are differences among women in terms of their social status, marriages and ability to negotiate in matters of sex. This study examines the extent to which both married and unmarried women can negotiate sexual relations with their partners, in particular the power relations in sexual relationships.

2.2.3 Condom use, knowledge and attitudes about AIDS and other STDs

Analyses of the AIDS epidemic have also focused on the role of individual behaviour in reducing the risk of HIV. It is assumed that reduction in risk behaviour can be
attained by changing the knowledge, attitudes and practices of those likely to be infected or those who are already infected and may pass the virus to others. HIV/AIDS prevention programs focus on promotion of education about HIV/AIDS and distribution of condoms and information about how to prevent infection. The assumption is that persons who realise they are susceptible will reduce their high-risk behaviour or will undertake risk-aversion measures after they receive information about AIDS and are provided with a means to reduce their risk of being infected.

A number of KAP studies focused on condom use practices in Sub-Saharan Africa (Ngugi 1989; Taylor 1990; Moses et al. 1991; Hogsborg and Aaby 1992; Renne 1993; Asamoah-Adu et al. 1994; Deniaud 1994). These studies showed that condoms are unpopular, especially among men who associate them with promiscuity, infertility and loss of pleasure.

Hogsborg and Aaby (1992) reported that many women in Guinea Bissau consider the use of condoms by their partners an implicit demonstration of infidelity. In south-western Nigeria, some people avoid using condoms because they perceive them as a health risk; they believe that the condom may remain inside the woman and cause illness (Renne 1993). Deniaud (1994:140) reported unusual condom use practices such as removal during intercourse by many young men in Cote d’Ivoire. Taylor (1990) found that in Rwanda, where the exchange of body fluids is viewed as good, condoms are believed to interrupt the flow of body fluids (such as blood and semen) between men and women. In Zimbabwe, people believe that men and women should reproduce in order to be accepted in the spiritual world (Scott and Mercer 1991). Thus many women are reluctant to use condoms with their partners because it prevents reproduction. The use of condoms has also encountered a lot of resistance from the clergy, particularly the Roman Catholic Church which opposes artificial birth control and associates condom promotion with immorality. Condom use in the general population is infrequent and many people with multiple partners do not use them with their regular partners or spouses (Nyamwaya 1988; Ngugi 1992b).
However, there is evidence of increased condom-use among prostitutes. For instance, studies in the late 1980s in Kenya and in the 1990s in Ghana showed increased use of condoms among prostitutes (Ngugi et al. 1988; Asamoah-Adu et al. 1994).

There are also KAP studies which have focused on knowledge, attitude and the local (folk) representation of STDs, including AIDS. These studies carried out in the early and mid-1980s showed that, even though people knew about AIDS, they had many misconceptions regarding the disease. Wilson, Greenspan and Wilson (1989) found such misconceptions among secondary school students and teacher trainees. The study found that 40 per cent of the former and 30 per cent of the latter believed that AIDS was solely a homosexual disease. Ingstad (1990:29) found that in Botswana, people regarded AIDS as a radio disease because they had heard of it only through the radio. Green (1992:122-123) reported that STDs are linked to witchcraft and violation of social norms and sexual taboos. Similar beliefs have been reported in Uganda and Rwanda (Barnett and Blaikie 1992:43; Feldman 1989).

Recent surveys showed high levels of knowledge about AIDS in Sub-Saharan Africa (Kapiga, Nachtigal and Hunter 1991; Ocholla-Ayayo et al. 1993a; Kipp et al. 1994). Kapiga et al. (1991) found high levels of awareness about AIDS among secondary school pupils in Bagamoyo and Dar-es-Salaam, Tanzania but there was little knowledge of the non-sexual transmission of HIV. Kipp et al. (1994:329) reported that between 70 and 80 per cent of secondary school children in Kabarole District in Uganda knew about AIDS. Ocholla-Ayayo et al. (1993a), in a study of 29 ethnic groups in Kenya, reported that 90 per cent of all respondents had heard of AIDS but many did not know or were not sure what it was. Many people attributed it only to tourists, prostitutes and foreigners.

Even though these studies show high levels of HIV/AIDS awareness, there is little known about the extent to which this is translated into safer sexual practices and positive attitudes towards people with HIV/AIDS. This study examines local beliefs and practices about STDs including AIDS regarding cause, transmission and treatment. It also investigates whether knowledge about HIV/AIDS has influenced changes in behaviour.
2.2.4 Coping with HIV/AIDS

Research on AIDS has also looked at responses to AIDS, especially on how individuals and communities cope with the epidemic. Foreman and Belton (1992:48-49) outlined three stages of response to AIDS. The first stage is characterised by fear, despair and concealed panic on the part of the HIV-positive person. This stage involves stigmatisation and ostracism of people with HIV/AIDS. Caldwell and Caldwell et al. (1993a) observed this in Northern Ghana where AIDS patients were scorned and set apart and women were abandoned by their families. In the second stage, as cases increase and more people are themselves infected or affected by the death of relatives, there is greater concern to finding ways of coping with the crisis. In the third stage, death is common and the crisis affects most people, not just individuals or families. People come together and use existing social networks or develop new ones to confront the crisis (Foreman and Belton 1992). However, as more people suffered from AIDS, villagers came to regard it as a threat to the whole community and became determined to live with it. The community came together to support families with sick relatives. Barnett and Blaikie (1992) reported that extended family networks in Uganda play an important role in taking care of the sick and orphaned children despite the fact that the disease places severe economic burdens on many families.

Recent studies in East and Central Africa show the different strategies that people adopt to cope with AIDS. Barnett and Blaikie (1992) observed that these strategies involve an interaction of individual and social groups to mobilise resources and confront the disease. In Uganda people rely on tradition and custom to confront the situation. Afflicted household members are taken care of: this includes nursing, temporary visits and meeting hospital and funeral expenses. Similar behaviour has been reported in Zambia (Praul et al. 1991).

2.2.5 Strengths and deficiencies in HIV/AIDS research

Biomedical and social science research in Sub-Saharan Africa has provided data for broad assessment of the HIV/AIDS epidemic by identifying both biological, and
socio-cultural and economic risk factors in the transmission of HIV. Epidemiological studies provide data and methods that can be used to predict the epidemic and design interventions to halt the spread of HIV.

The social sciences have made a significant contribution by providing valuable quantitative and qualitative baseline data on sexual behaviour and patterns of sexual interaction (e.g. networks of sexual contact, partner change and changes in behaviour), and their determinants. The information that these studies contribute is vital for planning interventions, improving existing programs aimed at halting the spread of AIDS, and for coping with the crisis.

Biomedical and epidemiological studies on sexual behaviour have two major shortcomings. First, they tend to focus only on groups at risk, such as prostitutes, STD clinic clients, women attending antenatal and postnatal care, and truck drivers (D'Costa et al. 1985; Ngugi et al. 1988; Moses et al. 1991; Simonsen et al. 1992; Hunter et al. 1994). Second, they use data collection methods that are inadequate for the task of describing sexual behaviour in detail. Thus, most of these studies provide little detail about sexual activity that occurs, especially outside these high risk populations, and none provide information about behaviour patterns in rural populations. Given that most people live in rural areas, this seems to be a major oversight.

KAP studies on sexual behaviour and behaviour change patterns such as condom use and other safe sex practices, have some deficiencies. This limited survey method is not well suited to obtaining valid measures of intimate behaviour, especially that which is normatively sanctioned such as sexual behaviour. KAP surveys fail to provide detailed information on sexual behaviour and rarely provide insights into the context in which sexual encounters occur. They provide a limited amount of information about the relationship between partners, and informants' own descriptions of their sexual behaviour are non-existent. They focus on collecting data on sexual encounters and number of sexual partners. There are problems surrounding the collection of such information because there is a reliance placed on quantitative data
obtained through surveys. Likewise, KAP surveys occur at one point in time and lack the robustness of longitudinal surveys.

2.3 Macro and micro factors affecting sexual behaviour

At macro-level the sexual behaviour is influenced by the structure of the society such as poverty, and at a micro-level by individual characteristics: age, marital status, education and other socio-demographic factors.

2.3.1 Macro factors

2.3.1.1 Poverty

Poverty influences behaviour and patterns of partner change. Poverty is a major factor that pressures many poor and ill-educated women into risky behaviour, such as prostitution or casual sex, as a survival strategy. Although poverty is a common phenomenon in Sub-Saharan Africa, it has been exacerbated by the implementation of Structural Adjustment Programmes in many countries. The programs have increased impoverishment of both rural and urban populations leading to increased pressure on vulnerable groups to engage in multiple sexual relationships for survival.

2.3.1.2 Migration

Some studies in Africa have shown that migration has a profound effect on sexual behaviour (Konotey-Ahulu 1989; Anarfi 1993b). In Africa migration is selective by age and sex; for instance in Luo Nyanza, since the 1940s, about a third of middle-aged men have lived outside Luoland at any time due to wage employment in towns, cities, plantations or in neighbouring countries (Parkin 1978; Shipton 1989). Historically, colonial and post colonial policies have tended to weigh against female migration to towns. Migrants are usually young males, who if married, are unaccompanied by their wives or if unmarried are not attached to any woman. This situation creates ideal conditions for prostitute patronage and casual sexual relations. Migration also tends to remove migrants from traditional restrictions that are typical of rural areas in Sub-
Saharan Africa. It places people in a situation where they can freely enjoy sexual fulfillment without restrictions and also exposes individuals to people they can relate to sexually.

2.3.1.3 Cultural norms and practices

The Luo people have cultural traits and beliefs such as polygyny, widow inheritance, and pronounced mortuary rituals that involve multiple sexual contacts. Beliefs about sex and male and female relations are still traditional even though changes have occurred among the younger generation who are educated. The dominant patriarchal cultural ideology demands sexual monogamy for females but prescribes polygyny for men. Marriage practices such as polygyny and widow inheritance foster multiple partner relations. Luo marriage has a weak conjugal bond between spouses and emphasis is placed on links with the lineage, in addition to the practice of polygyny. These traits and practices encourage multiple sexual relationships.

2.3.2 Micro factors

At a micro level, socio-demographic characteristics such as age, education, marital status, residence, income, social lifestyles and attitudinal factors have an influence on the sexual behaviour and they determine the type of relationships individuals indulge in.

2.3.2.1 Age

Sexual behaviour and the risk of infection with STDs are related to age. The age at which an individual begins sexual activity may affect exposure to risk of HIV infection. In various studies in Africa younger men report more sexual partners (Nunn et al. 1994). Young women who begin sexual activity in their teens are at increased risk of being infected.

In Kenya, sexual activity begins early for many young people and thus they have higher chances of having many partners in their lifetime. The early age at which many
begin sexual relations means that they have a prolonged period of sexual activity, are exposed to more partners and thus are at an increased risk of HIV infection.

2.3.2.2 Education

Education increases chances of upward mobility and accumulation of wealth; these resources make it easier for an individual to have access to commercial sex and more casual sexual partners. Higher and better education may involve increased awareness about AIDS and other STDs but it does not reduce the chances of having multiple sexual partners. Research in Africa has shown that education is associated more with casual sex. The AIDS epidemic in many parts of Africa has plenty of casualties among the rich, well educated and economically productive people.

2.3.2.3 Marital Status

Marital status may also affect sexual behaviour and risk of HIV infection. Studies in Africa show that young single males and females do not confine themselves in monogamous relationships. Nunn et al. (1994) report that single women, both unmarried and formerly married, were more likely to be infected with HIV than married ones. Research has also shown that migrant married and single men living separately from their spouse or regular partner engage in multiple sexual relations especially in towns. These people also frequent prostitutes more often than men living with their spouses or regular partners. Migrants are also exposed to a much wider social network in which they can engage in casual sex.

2.3.2.4 Residence

There is more casual sex in urban areas, though this may be confounded by age, education and marital status. Married men living separately from their spouses in towns and cities are more likely to engage in extramarital relations. Some studies also
report that sexual activity begins early for many young men and women in urban areas (Anarfi 1993b).

2.3.2.5 Alcohol and social lifestyles

There are few studies in sub-Saharan Africa that examine alcohol consumption and sexual behaviour, although studies on income generation and expenditure patterns show that a large proportion of male income is spent on alcohol. There are studies that show that one of the survival strategies adopted by women in many urban areas in Africa is the brewing and sale of illicit liquor.

Alcohol trading in both local illicit and modern brews, is extensive in Africa. Most towns, small market centres, and even slums are well served with bars, eating places and sometimes nightclubs. These places offer opportunities for casual and commercial sex; hence in many parts of Sub-Saharan Africa sex is associated with drinking beer.

Alcohol consumption is positively associated with risky behaviour (Ocholla-Ayayo, Wekesa and Ottieno 1993b). Alcohol and sexual activity are closely associated with commercial sex and social spheres; the sale of alcohol is combined with commercial sex in that most women who sell alcohol are themselves prostitutes. Most women who work in bars and other alcohol brewing places combine this with commercial sex. Men also seek sexual pleasure in places where there is alcohol trade.

Alcohol plays an important role in social rituals and occasions such as birth, funeral and mourning rites, weddings and other social gatherings. These events are marked by heavy drinking lasting several days and sex with multiple partners who may be strangers. Alcohol consumption is also common among students and teenagers; discotheques and nightclubs are places where they can drink freely and meet a sexual partner.
2.3.2.6 Knowledge, attitudes about AIDS and other STDs

There is an association between risk perception and behaviour that predisposes to the risk of getting infected. Since the outbreak of the HIV/AIDS epidemic in the mid-1980s, massive campaigns to change behaviour have occurred. The prevention campaign has resulted in behavioural changes among prostitutes: some are practising safer sex and condom use has increased.

Awareness about HIV/AIDS and other STDs may have a profound effect on sexual behaviour. Individuals who are aware of the risk of infection may reduce their contact with prostitutes, and practise safer sex for example by using condoms; they confine their sexual activities in stable monogamous relationships or reduce the number of sexual partners. Condom use tends to be confined to commercial sex while in marital and regular partner relations it is considered inappropriate.

However, particularly for women, risk perception or awareness about HIV/AIDS does not always imply reduced risk of infection. A number of studies report that many women are vulnerable to infection because of their partners’ sexual behaviour. Awareness or knowledge of AIDS and its lethality does not necessarily imply safe sex practices or adoption of risk aversion measures.

2.4 Factors accounting for prevalence of STDs

Research has shown that people with a history of other STDs are at greater risk of HIV infection than those without (Erwin 1993). The following section discusses the political, economic and social as well as biological factors accounting for the prevalence of sexually transmitted diseases.

Until recently, reproductive health, especially sexual health care, had not received priority in Kenya. More attention was given to family planning, maternal and child health. The outbreak of the AIDS epidemic and its close association with other STDs directed more attention towards controlling the other diseases.
In Kenya sexual health care is provided by government hospitals, private and non-governmental clinics. The main users of these services have been prostitutes and their clients. Apart from orthodox medical care, there are traditional healers and herbalists who provide alternative care for people infected with STDs.

Recent research has shown that sexually transmitted diseases, such as gonorrhoea and syphilis, are endemic in the general population. Explanations for the prevalence of these ailments has focused on the role of prostitutes, who are reservoirs of STDs. Prostitutes have sexual relations with both married and single men who also have other subsequent sexual networks. These men get infected with STDs and in turn infect their spouses or regular partners, hence are responsible for spreading them to the general population. People in multiple-partner relationships, such as prostitutes and their clients, are at risk of getting infected and spreading STDs to a large number of people.

Apart from multiple sexual relations, there are other factors that may explain the prevalence of STDs in Africa and Kenya in particular. Under-reporting of genital symptoms and infection is common thus contributing to ineffective control of STDs. Thus, many people with these diseases do not report contracting the infection because it is asymptomatic, especially in women, among whom most STDs take longer than in men for symptoms to appear. As a result some people who are infected with STDs continue having sex and infecting others without knowledge of contracting the disease and transmitting it. Some do not even tell their partners about their infection status. Caldwell and Caldwell et al. (1993a) note that there is limited acceptability of genital examination by sexual partners because in much of Africa sexual intercourse occurs in the dark and people rarely get the opportunity to ascertain their partners’ infection status. Women in much of Africa rarely visit a gynaecologist and their sexual health is poor; in most cases the STD diagnosis takes place during pregnancy or after birth. Because of infection with STDs there is a high rate sterility among women who do not seek reproductive health care. The stigma attached to such diseases causes some young women to refrain from seeking health care for fear of jeopardising their chances of marriage.
Secondly, some people who suffer from STDs resort to self-medication, treating themselves with ineffective drugs while other seek alternative care from traditional healers. The social stigma and fear of victimization make many people shy away from orthodox medical care. The widespread misuse of antibiotics has led to the emergence of new strains of STDs that are resistant to penicillin and therefore difficult to treat. Other people seek care from traditional healers. Self treatment has dire consequences such as failure to cure the STD and re-infection.

Thirdly, the poor distribution, use and delivery of sexual health care services may be a contributing factor. More well-equipped health care facilities and trained personnel are based in major towns and cities. The rural areas are poorly served by these facilities and their services are very poor: they lack drugs and equipment, and are overcrowded. Most clinics in the rural areas are staffed by low-level health personnel and lack laboratory facilities and manpower to do tests for STDs. In some cases, there is no proper diagnosis, hence all discharge STDs are lumped together as gonorrhoea while those that cause ulcers are called syphilis. Thus, the spread of STDs in the general population owes much to the poor distribution and delivery of medical services.

Finally, lack of male circumcision and poor genital hygiene are shown to be linked to increased STD infection (Caldwell and Caldwell 1994a). Male circumcision is thought to provide protection against HIV transmission. Uncircumcised men are at increased risk of HIV because they are susceptible to other STDs. In Kenya, circumcision is a cultural practice in most communities. However, recent research in Nairobi shows that Luo men are at greater risk of contracting STDs than men from other communities. The effects of male circumcision have been widely debated by both social and biomedical scientists. Some studies have also documented the relationship between lack of male circumcision and HIV sero-prevalence (Simonsen 1988). Some researchers suggest that this association may be due to confounding factors such as sexual and hygiene behaviour (de Vincenzi 1992).
CHAPTER THREE

METHODOLOGY AND DESCRIPTION OF STUDY POPULATION

3.1 Study areas

This section provides a description of the research sites, including information on the methods used in data collection and analysis. The data was collected within Kisumu Central Location (Winam Division of Kisumu District, Nyanza Province) at Kabando village and in one urban site, Nyalenda in Kisumu town, between August 1994 and May 1995. Kisumu town is on the shores of Lake Victoria and is the largest and most important town in western Kenya. Kabando village is in the north-western part of Kisumu Central Location, about 35 kilometres from Kisumu town, and at Census 1989 it had a population of 2453 (CBS, 1989).

Figure 3.1 Location of research area and sites.

Source: Kisumu District Development Plan 1994-1996
The largest ethnic group within Winam Division is the Luo. Non-Luo immigrants from other parts of the country, consisting of civil servants, businessmen and women, itinerant traders, fishermen, traders as well as people working or seeking employment in government and private institutions are also live in the town. The people living in villages around the lake subsists through small-scale farming and fishing. Major crops produced include maize, cassava, millet and other subsistence crops. Commercial agriculture, mainly sugar plantation, is carried out in Muhoroni and Miwani Divisions of Kisumu District.

Winam Division is relatively well served by health infrastructure compared to other divisions within the district. Six out of nine hospitals in Kisumu District (three public and three private) are located in Winam Division (GOK 1994). Apart from these, there are public health clinics and centres run by non-governmental organisations. The largest hospital in Nyanza province is located in Kisumu town.

3.2 Choice of research sites

Kisumu District has certain features which underscore the need for this study. One is its proximity to Uganda, which has certain regions that have been identified as experiencing the worst AIDS epidemic in the East and Central African region. The second feature of Kisumu District is related to population movement within and from outside the district, and beyond the national boundary. In many parts of Kisumu District, with the exception of cash crop producing areas such as Miwani and Muhoroni, there are high levels of male labour migration. The socio-economic and demographic patterns that are a product of migrant labour tend to create a situation that is conducive to high risk sexual behaviour. Thirdly, research reports in Kisumu and Nyanza province in general indicate a high prevalence of premarital maternity and extramarital relations (Ocholla- Ayayo and Muganzi 1985;; Ocholla-Ayayo, Wekesa and Ottieno 1993b). It is against this background that this study seeks to generate data to help in assessing the risk of this epidemic in Kisumu and Western Kenya in general.
The other reason for selecting this research site was the presence of both rural and urban populations whose sexual networking could be compared. I included people from both regions and interviewed only Dholuo speaking informants and respondents to eliminate ethno-cultural differences and hence enable me to draw generalisations on the Luo.

3.3 Exploration

The field work began with an exploratory phase which involved talking to various people about my study and its feasibility. This phase comprised of unstructured, explanatory interviews which aimed at obtaining information that was of interest to this study and for the modification of my survey questionnaire which I had designed before going to the field. The pre-fieldwork questionnaire was written in English but was later translated into Dholuo before being pre-tested in a small-scale survey, with a random sample of about 50 respondents. The pre-test revealed problems in the wording of the pre-fieldwork questionnaire, hence changes were made to enable collection of reliable data. During this exploratory phase I managed to establish good rapport with key individuals and acquaintances throughout the research sites.

3.4 Sample selection for quantitative data

The survey involves one urban and one rural population and it was conducted in two conveniently selected sites because of limited financial resources, time and scope of the study. The samples selected in the two sites included men and women of contrasting socio-demographic and economic background. Kabando village in Nyahera Sub-location was purposely selected to represent the rural population, and one urban suburb in Kisumu town to represent the urban population. An initial household census was carried out in the two selected sites to enlist households. In Kabando village, 500 households were enlisted, with 1025 individuals eligible for selection (aged 15 and above). The 500 households were assigned numbers and divided into five strata; out of each stratum 40 households were randomly selected. From each selected household, one individual aged 15 or above, living in that
household, was randomly selected for interview. A total of 154 males and females were interviewed in Kabando, with a participation rate of about 86 per cent.

The selected urban area, Nyalenda, is densely populated and cosmopolitan, with other non-Dholuo speaking people living there. Nyalenda is generally a low-income suburban area, although there are middle income earners living there. It was easier, less time consuming and less costly to recruit respondents, focus group participants and informal interview informants. Thus, Luo households were conveniently listed in selected sites in area. A total of 523 households, with 1576 individuals eligible for selection were listed. Households in each suburb (estate) were divided into five strata and one of them was selected. Out of each five clusters, 40 households, with 184 eligible individuals were selected. A total of 158 males and females were successfully interviewed. The participation rate was 86 per cent, which was identical to that for the rural area.

Thus, in total, 312 respondents were interviewed. This survey sample size was considered appropriate for a small-scale explanatory survey and adequate for obtaining data on behavioural patterns in the population. A large sample would have been more representative but would not have enabled me to collect detailed in-depth ethnographic information on sexual networking and behaviour in the population within the given time frame for this study. The sample was almost equally composed of men and women, and urban and rural dwellers.

In sum, the data reported in this study relate only to these two rural and urban communities, in an area bordering Lake Victoria. Many of the cultural traits of the Luo of Nyanza Province as reported by other researchers are also widely prevalent in these two communities of Kisumu District (Ocholla-Ayayo 1976; Potash 1978; Parkin 1978; Cohen and Odthiambo 1989). This study does not claim to be representative of the rest of the population of Kisumu District or of Kenya but it offers an opportunity to explore sexual activity and networking in the study population. There are no other available quantitative data on sexual behaviour or lifestyles in Kisumu District and therefore there is no means of assessing the extent to which the sample population is representative of the district's population. Nevertheless, the results of this study are
compared with those obtained in other studies conducted in Kenya and elsewhere in Africa.

3.5 Collection and processing of survey data

3.5.1 Research assistants

A one-week training course was conducted for three research assistants, which covered objectives of the study, confidentiality of responses and mock interviews. The questionnaire was administered by one female and two male interviewers who had a minimum of ordinary level certificate education (completed secondary school education) and were well conversant with the local language Dholuo. Three languages are used in daily communication in Kisumu town, and other public places where people from different ethno-linguistic backgrounds interact with one another: Dholuo, Swahili and English. Most of the conversations among Luo people are carried out in Dholuo while Swahili and English are used in communication with non-Dholuo speakers. In the rural areas, Dholuo is more widely spoken than any other language. During the exploratory stage, informants were asked to state explicitly the terms used in describing sexual experience, intercourse, type of partner etc. These terms were used during interviews to minimise misunderstanding of questions.

3.5.2 Pre-test

The original baseline questionnaire was written in English but was later translated into Dholuo. It was pre-tested and adjusted before being administered to respondents. The pre-test questionnaire contained questions on demographic characteristics of the respondent, such as age, sex, marital status, sexual history, knowledge and use of contraceptives, knowledge about and infection with STDs/AIDS, and treatment.

3.5.3 Questionnaire administration

In both urban and rural areas, the selected persons were approached and informed about the study, and their consent was sought for interview. If the person agreed a date
and place were set for the interview. In most cases, the face-to-face interviews, in which questionnaires were administered, were conducted a day or two after the respondents were notified. The survey questionnaire was first administered to rural dwellers and then to urban dwellers. The interview sessions were carried out in a variety of settings and in privacy: in a house in the absence of other members of the household, in a playing ground, or under a tree shade. Rural interview sessions were relatively undisturbed compared to urban areas where household setting and living arrangements tended to interfere with some of the interviews.

Before the interview, respondents were assured of the confidentiality of their responses. The interview session began with a general statement about health and the AIDS epidemic and an explanation about the importance of the study in order to emphasise the importance of collecting data. The questionnaire was divided into four sections: Section 1 of the questionnaire elicited information on the respondent’s socio-demographic characteristics such as age, marital status, religion, education, residence, migration, while Section 2 had questions about childbearing, contraceptive knowledge and use. The third section of the questionnaire contained questions on sexual behaviour, notably attitudes towards premarital virginity, extramarital sex, and beliefs and practices relating to widow inheritance (levirate marriage). This section also obtained information on respondents’ own sexual behaviour, with questions on age at first intercourse, early sexual experiences, life-time number of partners, number of partners for various time intervals, sexual relations outside marriage and sexual contact with prostitutes. The final section contained questions pertaining to knowledge and attitude towards STDs and AIDS, experience with STDs including AIDS, and ways to prevent these diseases.

During the course of the survey, I personally supervised the research assistants who were administering the questionnaire in face-to-face interviews and constantly made spot-checks on interviewers.
3.5.4 Data quality control

Quality control measures used during data collection involved supervision of interviewers in the field. Random check-backs were made to selected households and questionnaires were carefully edited to check for any incorrect or inconsistent information. Any inconsistencies detected during editing were followed up by making call-backs to the respondent. Coding of questionnaire data was done by two trained coders. I cross-checked the work to ensure that the right codes were entered. Once editing was completed, the data was entered into SPSSPC/DE computer package and cleaned for errors made during the entry process.

3.6 Potential sources of bias affecting response for the survey

Various researchers have pointed to the problems encountered when studying sexual behaviour (Caldwell and Caldwell 1993b). These problems relate to reliability and validity of the reported personal behaviour. The first source of bias is the difficulty in establishing whether people gave honest responses about their own sexual behaviour and practices. The second source of bias of the survey pertains to the presence of the interviewer which may have affected the validity of responses. Some of the behaviour the respondents were asked about was personal, sensitive and socially unacceptable, such as prostitution, and STDs infection. Respondents were guaranteed confidentiality of their responses to ensure truthfulness and accuracy; however, in the course of the interview they were constantly reassured about confidentiality whenever they felt uncomfortable about certain questions. The third source of bias which may have affected the responses is related to the introductory comments (concerning HIV/AIDS and sexual behaviour) that were made at the beginning of each interview session.

The third source of bias stems from possible inaccuracy in recalling past behaviour. The data on individual sexual behaviour presented in this study is based on the memories of respondents. Some respondents may have forgotten past behaviour which occurred a long time ago. However attempts were made during the designing of the questionnaire to place questions in a way that might facilitate easier recall. The
questions reflected a number of life stage periods thus providing informants with a framework to recall past experiences.

3.7 Collection of Qualitative data

In addition to survey questionnaires, three qualitative methods of data collection were used; in-depth interviews, focus group discussions and participant observation. Table 3.1 shows the percentage distribution of informants in in-depth interviews and focus group discussions by selected background characteristics.

Table 3.1 Selected background characteristics of respondents in in-depth interviews and focus group discussions (%).

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<tr>
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<th>Females</th>
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</thead>
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<td>Urban</td>
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<tr>
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<tr>
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<tr>
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<tr>
<td><strong>Total No.</strong></td>
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<td>33</td>
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</tbody>
</table>
3.7.1 In-depth interviews

Informants for in-depth interviews were selected with bias, mainly for their knowledge and ability to shed light on a wide range of issues of interest in this study. Informal interviews with Luo elders highlighted customary sexual and marriage norms and beliefs, and past practices pertaining to premarital and extramarital sex. In-depth interviews with key-informants elicited information on sexual terminology (terms people use to refer to sexual intercourse, sexual partners), sexual decision making or negotiation (e.g. who decides when to have sexual intercourse in a relationship), extramarital relations, prostitution, knowledge and beliefs about STDs. Some information on the informant’s sexual history was collected, from first sexual intercourse to the time of the interview. Informants were asked to narrate their past sexual relationships and experiences in detail. Interviews were conducted either in Dholuo or Swahili depending on the informant. Interviews were tape recorded and responses were transcribed later. Some of the interviews lasted as long as forty five minutes and some were as short as twenty minutes depending on the availability of the informant.

3.7.2 Focus group discussions

Fourteen focus discussion groups were held from January to April 1994. Among both urban and rural dwellers. The focus groups consisted of discussions with unmarried but sexually experienced men and women, married men and women and one group with both married and unmarried participants. Each group consisted of an average of five participants. A total of 50 individuals with different socio-demographic and economic backgrounds participated.
Table 3.2 Information about focus groups

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<th>Rural Age Range</th>
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</tr>
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<td>Married men</td>
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<tr>
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<td>30-44</td>
<td>7</td>
<td></td>
<td>30-37</td>
</tr>
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<td>5</td>
<td>Married women</td>
<td>17-26</td>
</tr>
<tr>
<td></td>
<td>32-49</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>19-30</td>
<td>7</td>
<td>Single men</td>
<td>14-17</td>
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<td>- Out of school and</td>
<td></td>
<td></td>
<td>- Out of school</td>
<td></td>
</tr>
<tr>
<td>wage earners</td>
<td></td>
<td></td>
<td>and wage earners</td>
<td></td>
</tr>
<tr>
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<tr>
<td>Single women</td>
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<td>wage earners</td>
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<td>- Secondary school</td>
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<tr>
<td>students</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.7.3 Recruitment of focus group participants

In both the urban and rural area, respondents were recruited individually, sometimes with the assistance of the social networks of friendship established in the research site in the course of fieldwork. Individual recruitment was preferred because it limited curiosity and public attention, which would have been otherwise impossible if participants were recruited from public places such as a baraza (public meeting in the village), church, school, or market place.

A number of steps were adopted in the recruitment of participants: first the potential participant was approached and briefed about the study, and its importance. Afterwards, consent for participation was sought and if the individual accepted he or she was briefed about the focus group session, including date, time and venue. I recruited and supervised all focus group discussions.
3.7.4 Conducting discussions

Two trained moderators and facilitators guided the discussions; all moderators and discussants were drawn from the local community and were trained before the exercise. Mock discussions were conducted before the actual discussions were undertaken. In the rural area, all the discussions were held under a tree in a school compound while those in the urban area were held in a classroom at a school which was conveniently located for the participants. Most of the sessions took place during the weekend to avoid interfering with the work activities of the participants.

Each of the focus group discussion sessions began with an introductory overview of the study, highlighting its objectives and importance. The discussion began with introductory questions and as the discussion progressed, further questions were asked. All participants were encouraged to participate in the discussions by asking the questions about their opinions regarding issues raised. Attempts were made to limit outspoken participants from dominating discussions. At the end of each session, the major issues raised in the discussion were summarised by the moderator and participants were asked to give further views. Participants were thanked at the end of each session and rewarded with a bottle of soda. Each session lasted about one and a half hours.

3.7.5 Topics covered

The discussion groups covered a wide range of topics; although participants were divided into three groups (married, unmarried, married and unmarried), the topics covered were more or less similar. The main topics covered included premarital and extramarital sexual relations, sexual experience, commercial and transactional sex, sexually transmitted diseases including HIV/AIDS, and condom use.

The proceedings of each discussion group were transcribed (in Dholuo, later translated into English) immediately after each session. This facilitated identification of topics not well covered in previous discussions to be pursued in detail in following
discussion groups sessions. The transcribed data was analysed, through content analysis to establish patterns of frequently mentioned issues.

3.7.6 Participant observation

In addition to the above methods, I managed to observe and participate in various events and occasions. Throughout the fieldwork period, I attended several social events such as funerals, weddings, dances, AIDS education seminars, and cultural festivals, and also talked with people in bars, restaurants and market places where people congregate for business and recreation. These occasions provided an opportunity to make salient observations of social interaction. I made recordings of proceedings and talked with people of various backgrounds. I also developed a network of informants in both urban and rural areas with whom I had informal discussions on various issues of concern to the research. I sometimes visited these informants at home or at work but as many of our discussions were public, they were limited to general issues and did not involve discussion of personal experiences unless the informants provided such information.

My original field notes were taken in a mix of English, Swahili and Dholuo. Interviews and discussions in Dholuo were conducted with the assistance of a translator, where circumstances demanded. They were tape recorded, transcribed verbatim and checked as correct translations by native Dholuo speakers. In some of the interviews, research assistants made on-the-spot translations into either Swahili or English. For purposes of analysis, the qualitative data were entered into the ASII files (see Text Collector, 1995 O’Neill Software, Seattle WA) for analysis software in order to generate accounts of the central issues discussed with my informants.

3.8 Comparison of survey population with the KDHS 1993 data

This section provides a comparison of various socio-economic characteristics of the survey population and those recorded in the 1993 Kenya Demographic and Health Survey (KDHS), in order to assess and validate the representativeness of the survey population in relation to the rest of the population in Kenya; a more adequate
assessment would have been obtained by using the 1989 Census data but the results are not yet available. Table 3.2 displays distribution of survey respondents, by percentage, in comparison with the 1993 KDHS results for selected background characteristics. The table shows consistency between the two surveys on various aspects. First, education levels attained by the survey respondents were similar to those of the 1993 KDHS. Secondly, the people surveyed in both studies were predominantly Christian, belonging to various denominations, with a large proportion professing to be Protestants.

There are also certain distinctions between the Kisumu survey population and the KDHS respondents. First, the Kisumu survey had almost equal proportions of males and females, and rural and urban residents. In contrast the KDHS had more rural than urban residents, probably because the KDHS covered a much larger sample than the Kisumu study.

The results indicate that unmarried males and females were represented in greater numbers in this survey than in the KDHS. The KDHS did not cover males in the age group 15-19 or females aged 50 and above, and this possibly explains the difference in the proportion of single respondents in the two surveys.

About six per cent of KDHS respondents were living together with their de facto spouses. In the Kisumu survey about three per cent of the total respondents reported that they were living with a de facto partner. Among the Luo a man and a woman may be living together in a marriage-like relationship but this is not regarded as marriage because it is not sanctioned by payment of bridewealth and performance of marriage rites (Ocholla-Ayayo 1976). Such relationship is regarded as por or elopement, and this may last for many years. If pregnancy occurs the man may be compelled to perform traditional marriage rites. Although such relationships often last for a long time and sometimes become full marriages, the data suggests that a significant number of people who reported being single or separated/divorced were probably living with their de facto at the time of interview. In both the Kisumu survey and the KDHS, the proportion of respondents who were either divorced or separated was almost identical, with more females than males separated or divorced.
The level of education attained by survey respondents was similar to that of the KDHS survey. The results showed a strong difference in education between males and females, and urban and rural residents. More than half of the KDHS and survey respondents had completed primary education and above, with more males than females with secondary education. Urban residents were better educated than rural residents, for instance, the KDHS reported that rural residents were generally more than twice as likely as urban dwellers to have never attended school, with 18 per cent of rural males compared to seven per cent of urban males, and 29 per cent of rural females compared to 14 per cent of urban females, having never attended school (KDHS 1993:12). In the Kisumu survey less than 10 per cent of males and about 13 per cent of female urban dwellers had no education compared with about 18 and 20 per cent of rural males and females respectively. The high levels of education reported in the survey were probably a result of over-representation of both urban residents and young people in comparison with the KDHS population. Urban residents and younger people tend to be better educated than rural residents and older people.

Almost two-thirds of the Kisumu survey respondents were aged between 20 and 34 compared with about 52 per cent of KDHS respondents. The survey population was therefore younger than that of the KDHS which had about a third of its respondents in the age group 35 and above. This also probably explains the high proportion of people with secondary education in the survey. Over 80 per cent of both the survey and KDHS respondents belonged to various Christian denominations, with more Protestants than Catholics. Unlike the KDHS, there were no Muslims in the Kisumu survey, probably because there is very little Muslim influence in the Lake region of Kenya.
Table 3.3 Characteristics of survey population in comparison with KDHS 1993 data

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<tr>
<th></th>
<th>Survey Males n=157</th>
<th>Survey Females n=155</th>
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<th>KDHS Males n=2336</th>
<th>1993 Females n=7540</th>
<th>Total N=9876</th>
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Source: Kenya Demographic and Health Survey 1993 and Kisumu survey results.
Table 3.4 Characteristics of survey population by sex and residence (%)  

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<tr>
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<th>Urban Males</th>
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<td>18.4</td>
<td>35.4</td>
<td>25.0</td>
<td>30.2</td>
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<td>39.2</td>
<td>39.6</td>
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<td>-</td>
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<td>-</td>
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<td>32.9</td>
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<td>10.1</td>
<td>1.4</td>
<td>5.7</td>
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<td>6.4</td>
<td>5.7</td>
<td>3.8</td>
<td>3.9</td>
<td>3.8</td>
<td>4.7</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>No education</td>
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<td>12.8</td>
<td>10.9</td>
<td>17.7</td>
<td>19.5</td>
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<td>27.6</td>
<td>29.7</td>
<td>25.1</td>
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<tr>
<td>Primary complete</td>
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<td>35.9</td>
<td>34.4</td>
<td>27.8</td>
<td>35.8</td>
<td>31.8</td>
<td>33.1</td>
</tr>
<tr>
<td>Secondary +</td>
<td>39.2</td>
<td>29.5</td>
<td>34.3</td>
<td>22.7</td>
<td>17.1</td>
<td>19.9</td>
<td>27.1</td>
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<tr>
<td><strong>Occupation</strong></td>
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<td>Paid employment</td>
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<td>29.1</td>
<td>38.1</td>
<td>9.0</td>
<td>5.3</td>
<td>7.2</td>
<td>22.6</td>
</tr>
<tr>
<td>Farmer/fisherman</td>
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<td>8.9</td>
<td>9.5</td>
<td>56.4</td>
<td>30.3</td>
<td>43.4</td>
<td>26.5</td>
</tr>
<tr>
<td>Housewife</td>
<td>-</td>
<td>7.6</td>
<td>3.8</td>
<td>-</td>
<td>28.9</td>
<td>14.4</td>
<td>9.1</td>
</tr>
<tr>
<td>Self-employed</td>
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<td>16.5</td>
<td>18.9</td>
<td>13.8</td>
<td>3.9</td>
<td>8.8</td>
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<td>11.9</td>
<td>13.2</td>
<td>12.5</td>
<td>10.1</td>
</tr>
<tr>
<td>Unemployed/other</td>
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<td>29.0</td>
<td>22.1</td>
<td>9.0</td>
<td>18.4</td>
<td>13.7</td>
<td>17.9</td>
</tr>
</tbody>
</table>

54
3.9 Characteristics of survey respondents

3.9.1 Age

Table 3.4 displays the distribution of respondents in the survey by selected background characteristics. The median ages for the urban and rural male residents were similar, at 21.9 years and 20.7 years respectively.

The median age of female respondents of 23 years was identical for both urban and rural residents. Over 60 per cent of the respondents were aged 30 years and below. Female respondents were on average younger than male respondents. Over 50 per cent of the female respondents were aged 15-24 compared to over 30 per cent of males in this age category. The age distribution of the survey respondents is typical of many populations in Kenya, characterised by high fertility and a larger proportion of the population in younger age groups than in the older age groups. This is also evident in the smaller proportions of older age groups represented in the survey.

3.9.2 Marital status

About 39.6 per cent of the respondents were single compared to 43.9 per cent who were married, with more males than females being married. Less than three per cent of the respondents were living with a de facto but the large proportion of respondents who reported that they were married may also have included some people who were living with de facto partners and whose marital unions were not formalised or registered. About 13 per cent of the respondents were either widowed, separated or divorced, with more women than males in this category.

Overall, over three quarters of all marriages were monogamous unions but the proportion of urban respondents in such unions was higher than in rural areas (see Table 2.4). Over 20 per cent of females were in polygynous unions and rural women were strikingly more likely than urban women to be in polygynous unions. More than a fifth of the marriages in the survey population were arranged and some or all of the bridewealth payments had been made. More than three-quarters of the marriages were
not arranged. In these marriages the spouses either met on their own or had known one another for some time before marriage. Rural males were also likely to report having married more than once and having more than one spouse.

Table 3.5 Marital characteristics of currently married respondents by sex and residence (\%)

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
<td>Urban</td>
</tr>
<tr>
<td>Marriage union</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Monogamous</td>
<td>89.5</td>
<td>71.4</td>
<td>80.0</td>
<td>92.3</td>
</tr>
<tr>
<td>Polygynous</td>
<td>10.5</td>
<td>28.6</td>
<td>20.0</td>
<td>7.7</td>
</tr>
<tr>
<td>Manner in which</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>marriage was</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>contracted</td>
<td>Arrange</td>
<td>16.4</td>
<td>18.3</td>
<td>17.3</td>
</tr>
<tr>
<td></td>
<td>Met on our own</td>
<td>67.6</td>
<td>74.8</td>
<td>71.2</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>16.0</td>
<td>6.9</td>
<td>11.5</td>
</tr>
<tr>
<td>No. of times ever</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>married</td>
<td>One</td>
<td>73.7</td>
<td>45.2</td>
<td>59.5</td>
</tr>
<tr>
<td></td>
<td>Two</td>
<td>21.1</td>
<td>28.5</td>
<td>24.8</td>
</tr>
<tr>
<td></td>
<td>Three or more</td>
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<td>26.1</td>
<td>15.7</td>
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<tr>
<td>No. of wives</td>
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<td>One</td>
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<td>45.2</td>
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<tr>
<td></td>
<td>Two</td>
<td>10.5</td>
<td>35.7</td>
<td>23.1</td>
</tr>
<tr>
<td></td>
<td>Three or more</td>
<td>-</td>
<td>19.1</td>
<td>9.6</td>
</tr>
<tr>
<td>Total no. of cases</td>
<td>38</td>
<td>42</td>
<td>80</td>
<td>26</td>
</tr>
</tbody>
</table>
3.9.3 Religion

Over 80 per cent of respondents belonged to various Christian denominations. Half of all respondents belonged to Protestant affiliations; only 5.4 per cent had no religious affiliation.

3.9.4 Education

Table 3.4 also displays differences in levels of education between males and females and urban and rural residents. In general, two-thirds of respondents had completed basic primary education and above and about 28 per cent had secondary education or higher. There was however, an urban-rural differential. Urban residents were better educated than rural residents. More males than females had secondary education or higher, and males in the urban area were twice as likely as rural males to have attained secondary education. This could probably be explained by male dominated migrant labour that attracts educated men into towns seeking employment.

3.9.5 Occupation

Twenty-two per cent of the respondents were in paid employment, 13.8 per cent were self employed, 10 per cent were still in school and 18 per cent were either unemployed or engaged in other activities. Over a third of urban respondents were in paid employment compared with only 7 per cent of rural respondents. Nearly half of the urban males were in paid employment while the majority of the males in rural areas and a third of the women were engaged in farming or fishing. The primary occupation of respondents in paid employment included civil servants, teachers, policemen, bank workers, draughtsmen, mechanics, clerks, health care workers, clergymen and those in service industries such as catering and transport etc. Those who were self-employed were operating small businesses, as retail traders in shops and kiosks, tailors, artisans, and craftsmen. However, some of the people in paid employment were also engaged in either urban/peri-urban or rural farming or had small businesses such as retail shops. There was a higher proportion of rural than urban female respondents were
reported to be housewives (more than 28 per cent). This again reflects migrant labour patterns in the survey population; males migrate to towns for wage employment and women are left in rural areas to manage the farm.
CHAPTER FOUR

COURTSHIP AND MARRIAGE PATTERNS

This chapter discusses three related issues; courtship traditions and marriage customs; forms of Luo marriages; and rituals pertaining to widowhood and inheritance. It also explores changes in courtship and marriage, and the factors which account for these changes.

4.1 Courtship in the past

It is difficult to describe typical Luo courtship patterns today because of the enormous changes which have occurred in the political and socio-economic regimes of the Luo people in the late nineteenth and the twentieth centuries. However, it is important to explore recent patterns of courtship to understand contemporary courtship behaviour of young men and women. Courtship is referred as sero in Dholuo and it occurs between unrelated partners as dictated by the rule of clan exogamy (Ocholla-Ayayo 1976). Hence, young men court and marry women from other clans, residing either within their locality or in a distant locality. There is evidence in the literature that traditionally young marriage-aged men usually received female visitors in their simba or boys’ dormitory (Evans-Pritchard 1950; Ocholla-Ayayo 1976; Potash 1978; Cohen and Atieno Odthiambo 1989). While describing this practice, Evans-Pritchard (1950:132) asserted that

Youths arrange with girls to visit them there at night, and when the youth is visited by one of his sweethearts the other young men of the home sleep elsewhere. He plays with the girl and has intercourse between her thighs and they sleep together. He must not penetrate her—this is regarded as shameful and it will be known on the day of her marriage.

The non-penetrating sexual encounter is referred to as chode while the visits are referred to either as wuowo, tero obudha or ‘hi simba. These visits took place between noon and midnight but sometimes the visitors could stay for a night or two, especially if they came from distant villages (Evans-Pritchard 1950; Ocholla-Ayayo 1976). In some cases the girl was accompanied by a friend or two and they were expected to
inform their grandmothers of the visits, while the men informed their parents through one of their sisters. Sometimes, the young man hired a harpist to entertain the girl and his friends. The young men would also sing love songs and dance, reciting their virtues and prowess. Ocholla-Ayayo (1976) further emphasises that women were not expected to approach a man but had a choice of whom to establish a relationship with. Hence, girls could have several lovers whom they visited from time to time and this could continue right up to their marriage. Evans-Pritchard (1950) has emphasised that in the past, a girl’s parents and her brothers would not interfere in her love affairs. However this seems to have changed in the 1960s and 1970s as suggested by a number of studies (Parkin 1978; Cohen and Odthiambo 1989). It is important to observe that in traditional Luo courtship, a man’s parents play a central role in selecting their daughter-in-law: they may select a wife for their son but if the son chooses one their approval is paramount. Parkin (1978) writing about the Luo of Kaloleni, Nairobi, observed that both parents and relatives, mainly brothers, are concerned about their daughters’ or sisters’ love affairs and they tended to protect them from men whom they viewed as unreliable.

A girl’s brothers are as concerned as her father and mother that her marriage should not only suit her particular preference and emotions but should also be someone able to honour bridewealth obligations (Parkin 1978:77).

He noted that a woman’s brothers were concerned about whom she was courting and they closely monitored her and her suitor. The brothers’ concern partly stemmed from the need to maintain family dignity and partly the fact that part of the bridewealth payments received for a sister went towards the payment of their own bridewealth. Parkin (1978) also stressed that Luo girls living in Kaloleni were not expected to have many suitors.

It was apparent from interviews that traditional courtship has almost disappeared. Nowadays young unmarried men and women get involved in sexual relationships at very early age. In six focus group discussions, many informants asserted that traditional Luo norms are no longer observed by young unmarried people and that there is no fuss about premarital sex. Both young men and women may be involved in
a series of ‘steady’ relationships before they decide to get married. Chapter 6 describes in detail the premarital sexual behaviour and relationships of young men and women.

However many informants felt that parents are nowadays more concerned with their daughters’ sexual behaviour than that of their sons because of the consequences that arise from their daughters’ involvement in sex such as premarital pregnancy and abortion. Hence young men have some freedom in their sexual activity; for instance parents covertly approve of their sons bringing girls to spend the night at home, while girls are not allowed out at night. Two female focus group participant observed:

My parents do not allow me and my sister to stay out late in the night. When we visit friends or relatives we have to be home before it gets dark...my mother is always very concerned and she quarrels if I come home late. But the situation is different for my brothers; they can stay out late in the night... they go to dances till late in the morning....my parents are not concerned (Rural female 18 years old).

Boys are treated differently...I have two brothers who have girlfriends...they can bring them home even when my parents are at home but I am not allowed to bring my boyfriend (Urban female 19 years old).

However, some respondents agreed that unmarried women who are in ‘steady’ and serious relationships sometimes have covert approval of their parents, especially if the young man presents himself to the family as this is seen as a sign of seriousness and reliability. Hence, parents may accept their marriageable daughters having steady premarital relationships which are committed to marriage. However, parents tend to more strongly disapprove of teenage relationships than those of their marriageable daughter and sons; teenagers are discouraged from sexual activity by their parents, who attempt to intervene and stop the relationship when they discover that their teenage daughter is having sexual intercourse.

A number of factors which have contributed to changes in courtship behaviour may be grouped under the rubric ‘modernisation’. They include urbanisation, education, Christianity and participation in wage labour and cash economy. The effects of late nineteenth and twentieth century colonialism included adoption of new institutions such as Christianity, modern formal education and health care, and provided new
sources of accumulating wealth such as migrant wage labour and participation in cash crop farming. All these factors undermined traditional normative structures of authority and control. An increasing number of young men and women participate in formal or informal wage employment, hence are economically independent of their parents; thus they have a choice of their sexual partners or spouses. Migrant labour also makes it easier for young men to engage in casual sex or seek sex from prostitutes than before while females can engage in casual or commercial sex without fear of retribution.

4.2 Marriage customs

It is impossible to describe typical Luo marriages because the patterns and ceremonies surrounding marriage have changed fundamentally over time. There have been several studies describing Luo marriage patterns and customs (Evans-Pritchard 1950; Ocholla-Ayayo 1976; Parkin 1978, 1980; Potash 1978; Cohen and Odhiambo 1989). Evans-Pritchard (1950) described various types and ceremonies surrounding marriage that occurred in the early 1900s. Literature that has emerged on Luo marriage from the 1960s to the 1980s shows that while the major phases of marriage ceremonies described by Evans-Pritchard (1950) are still prevalent, there have been substantial changes in the procedures and ceremonies pertaining to marriage.

According to Potash (1978) Luo marriages are exogamous within the maximal lineage. Thus men marry women from non-genealogically related lineages either from their own locality or from clans residing in distant locality (Pritchard 1950; Ocholla-Ayayo 1976). Upon marriage a woman moves to live amongst her husband’s kinsmen, mainly into the husband’s father’s home. She continues to cook in her mother-in-laws hut until after the birth of her first child when her husband has set up his house.

Literature seems to suggest that in the past, and to some extent today, marriages among the Luo were arranged through an intermediary or the jogam (Evans-Pritchard 1950; Parkin 1978; Potash 1978). This was first suggested by Evans-Pritchard in his account of Luo marriage in early 1900. Recently, for instance Potash (1978:381) has emphasised this custom:
A young man wishing to marry will ask a jogam or intermediary to find him a wife for him. The jogam is usually a ‘father’s sister’, a ‘father’s sister’s son’ or a ‘mother’s brother’, all of whom reside in communities other than that of the bridegroom; or the jogam may be a ‘brother’s wife’ who has links with her natal community. This jogam will approach the girl’s family and her parents. If they are agreeable, the jogam will arrange a meeting between the prospective bride and groom. In the past usually one meeting was sufficient before the young man approached the girl’s parents. Today several meetings may take place. If the father agrees to the match, bridewealth will be negotiated.

Ocholla-Ayayo (1976) has noted that in the past some marriages were also arranged by parents if they preferred that their son marry a girl from a family which they liked. However, nowadays, as is the case throughout much of Kenya, there is greater choice of marriage partners among the Luo. The majority (see Table 5.1) of currently married men and women in the survey reported that they entered into their marriages by their own choice but parents and relatives were involved in the arrangements. More than a fifth reported that their partners were selected and marriages arranged by either their parents or relatives. The majority of respondents who reported arranged marriages stated that they selected their wives but initial and subsequent marriage negotiations were arranged by the jogam and their parents. However, a few women reported that they were persuaded, manipulated or even coerced into marriage by their parents or relatives.

Sometimes, a woman does not have much choice. Her parents or relatives could make arrangements to marry her off to a man of their choice against her will...relatives try to persuade her to accept the marriage, especially if the man is rich or comes from a wealthy family...eventually she gives in (female, FGD, 34 years old, urban area).

It was apparent in focus group discussions and informal interviews with unmarried men and women that arranged marriages are less desirable today, especially where brides are forcefully captured or abducted against their will by strangers and declared wives. Many young people frequently expressed the desire for personal choice of their partners. Indeed, some respondents view forced marriages as unworkable.

In the past parents or relatives could choose spouses and arrange marriages for their children. But today things have changed and there is more freedom...arranged marriages are not good because
the partners do not know one another and may not even like one another...they just don’t work...I would prefer to marry a man of my choice. I will involve my parents ...but they can’t force anyone on me (Urban female 21 years old).

Luo marriage involves the participation of family and clan members on both sides in negotiations and the exchange of gifts in the form of bridewealth. Bridewealth confers to the husband uxorial rights and genetical rights over his wife and the children (Potash 1978; Parkin 1978). Ideally, the payment of bridewealth begins immediately the bride’s father consents to the marriage and continues over an extended period of time payment continuing sometimes after children of the marriage are grown up. In the past bridewealth was paid in the form of livestock, mainly cattle, but nowadays it is increasingly being supplemented with cash (Parkin 1980; Cohen and Atieno-Odhiambo 1989). Today, many men who work in towns and cities for wages use cash earned to make marriage or bridewealth payments. Sometimes both cattle and cash are paid. Some researchers have suggested that the payment of bridewealth in cash seems to have shortened the period of payment (Shipton 1989). Thus, a marriage is not considered customarily legitimate if bridewealth payments are not made or negotiations initiated.

Because clans are exogamous, women move to live their married lives among their husband’s kinsmen but only as partial members of their husbands’ kin-group, hence are regarded as strangers among inter-related men (Shipton 1989). A man sets up his house in his father’s homestead and his wife cooks and farms with her mother-in-law until the time when he sets up his own homestead. In polygynous families, wives keep separate houses within the same homestead and they cultivate separate fields.

4.3 Forms of marriage:

Various forms of marriage that are part of Luo traditions are recognised, particularly bride capture or abduction, levirate and sororate marriage (discussed below). There are two types of bride capture or abduction. The first type is the ceremonial bride ‘ambush’ or ‘abduction’ which occurs after the girl’s father has given consent to the marriage. In this case the bridegroom and other unmarried male relatives organised a ceremony to abduct the bride (Evans-Pritchard 1950; Potash 1978). The second type
of bride abduction involves an element of coercion; for instance in cases where a girl objects to the marriage arrangement or her father demands substantial bridewealth payments before she leaves his home, the groom may resort to abduction (Potash 1978). Bride capture or abduction still continues to be prevalent today and young unmarried women are abducted against their will and married off to strangers. Cohen and Odthiambo (1989) reported that in rural Luo communities in Siaya there were men who were known for forcibly abducting girls and taking or sending them to their male kinmen working in cities, towns and other distant places. From the few cases of bride abduction in this study it was apparent that this practice is still prevalent; for instance a female respondent reported that she was abducted from her rural village and taken away to the city by a stranger who kept her against her will before he declared her a wife. However, despite her displeasure, her parents accepted money and other bridewealth payments. Another female was apprehended by a stranger at a dance in her aunt's village and detained for a week and then declared a wife. Evans-Pritchard (1950) noted that in the past, a man would deflower and detain a woman in his *simba* for several days and declare her his wife, although this was followed by bridewealth negotiation. In this study it was apparent from interviews with key informants that the incidence of bride capture has declined over the years.

Partners may also establish a marriage by elopement or cohabiting and may produce children. Partners in such relationships consider themselves 'married' and refer to one another as 'husband' and 'wife'. Informal non-sanctioned marriages, although not recognised customarily or legally, are common. Cohabitation may occur permanently or intermittently over a period of time without any further formal commitment, such as payment of bridewealth or formal wedding to legitimise the marriage. Thus in some cases it is difficult to differentiate between conjugal, concubinage and cohabiting relationships. However, for some couples in such relationships or marriages there is always pressure from both the spouses' relatives to formalise the union through payment of bridewealth. In some cases, the women press their husband to pay bridewealth and have ways of doing so such as returning back to their natal home.

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1 Interview with female respondent aged 43 years, rural area
I got married to my husband more than seven years ago...we started by living together...but after eight months he sent a jogam to my parents to inform them that we were married...they did not object and they started negotiating for bridewealth...he is still paying for it slowly (female 27 years old, informal interview, urban area).

Marriages are also formalised through Christian Church or civil weddings. Compared to civil or Church marriages, elopement or cohabitation are less desired forms of marriage. However, it is important to observe that nowadays civil marriages have become an easy way of legitimising marriage for many couples who do not want to undergo the rigorous marriage procedures and ceremonies.

4.4 Age at first marriage

The mean age at marriage was 26.5 years for males and 19.2 years for females. None of the males had married below the age of 20 and it is only in the age group 25-29 and above the age of 30 that a majority of men are married. It is common for men to delay marriage until their late twenties or early thirties in order to accumulate cash for bridewealth or wedding payments or because they have to support their parents, siblings and other relatives.

In accordance with Luo customs of seniority, the oldest son marries first and then is followed by his younger brothers in their order of seniority. It is believed that if the young brother marries before his elder brother, they should not share food from the same bowl and the eldest brother is prohibited from eating any food prepared by the sister-in-law. It is believed that if these rules of seniority are violated chira might afflict them or the family.

The early age at marriage for women may be attributed to a number of factors such as premarital pregnancy, school drop-out and economic insecurity. It is also important to note that men may delay marriage until later ages but women’s chances of marriage diminish after their mid-twenties. For men readiness to marry is reflected by the fact that men no longer consider themselves young. Readiness to marry may also be
influenced by pressure from parents, siblings and other relatives, and marriage of peers.

4.5 Marriage patterns in the survey population

This section describes marriage patterns in the survey population; it focuses on the characteristics of currently married respondents on the basis of selected background characteristics. Table 4.1 displays characteristics of currently married survey respondents before marriage.
4.1 Background characteristics of currently married survey respondents before marriage

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>Both husband and wife had similar age*</td>
<td>34.1</td>
</tr>
<tr>
<td>Husband is five years than wife</td>
<td>63.0</td>
</tr>
<tr>
<td>Wife is more than five years older than husband</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>Both have no education</td>
<td>26.8</td>
</tr>
<tr>
<td>Both husband and wife have not more than two years</td>
<td>16.7</td>
</tr>
<tr>
<td>difference in education</td>
<td></td>
</tr>
<tr>
<td>Husband has more than two years education than wife</td>
<td>50.7</td>
</tr>
<tr>
<td>Wife has more than two years education than husband</td>
<td>5.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>First marriage for both husband and wife</td>
<td>65.9</td>
</tr>
<tr>
<td>Only husband married more than once</td>
<td>21.0</td>
</tr>
<tr>
<td>Only wife married more than once</td>
<td>8.0</td>
</tr>
<tr>
<td>Both married more than once</td>
<td>5.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
</tr>
<tr>
<td><strong>Manner in which marriage was arranged</strong></td>
<td></td>
</tr>
<tr>
<td>Arranged by relatives</td>
<td>33.2</td>
</tr>
<tr>
<td>Met on our own</td>
<td>56.7</td>
</tr>
<tr>
<td>Other</td>
<td>10.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
</tr>
<tr>
<td><strong>Home of origin</strong></td>
<td></td>
</tr>
<tr>
<td>Both husband and wife are from same rural village</td>
<td>20.3</td>
</tr>
<tr>
<td>Neither husband nor wife are from same rural village</td>
<td>79.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
</tr>
<tr>
<td><strong>Total No.</strong></td>
<td>138</td>
</tr>
</tbody>
</table>

* Similar age is defined as husband not more than five years older than wife and wife not more than five years older than husband

In general, survey respondents differed in selected socio-economic characteristics before the marriage. Most of the currently married respondents were in different age groups before marriage. On average husbands were 5.6 years (not shown in the table) older than their wives. Men tend to marry younger wives. However the age difference
between spouses was more pronounced among respondents aged 40 and above (average of 10 years difference). In the majority of married respondents, husbands had more education than their wives; on average men had two to four years of education more than their wives. The majority of the respondents were in their first marriage, although the proportion of men with more than one marriage was more than twice that of women. More than half of currently married respondents stated that they had met on their own but involved family and relatives in making marriage arrangements. About a third of marriages were arranged by relatives, with most of them involving ‘ambush’ or abduction of the bride.

Regarding residence before marriage, as was noted elsewhere, men marry women from distant villages among non-relatives. In this study, the majority of currently married men and women did not marry spouses from their own locality. About a fifth of the currently married respondents married spouses from their locality but from a non-related clan. Upon marriage couples usually set up their household in the same compound as parents or nearby. In this study, the majority of couples interviewed in the rural area lived together with members of the extended family in the same compound. However some men had moved away from their parents or relatives once they had accumulated cash to purchase their own land or set up their own homestead.

4.5.1 Levirate marriage

In Sub-Saharan Africa, several customs relating to widowhood have been identified as having profound effects on sexual relations (Okeyo and Allen 1994; Ntozi 1997). The two most important customs are sexual cleansing and remarriage (or inheritance) after the death of a spouse. These practices have been described as widely prevalent in many Sub-Saharan African communities such as the Luo, Gusii and Iteso of Kenya (Evans-Pritchard 1950; Ocholla-Ayayo 1976; Park.n 1978; Levine 1994; Okeyo and Allen 1994), the Banyankole, Lugbara and Baganda of Uganda (Batembya and Konings 1992; Ntozi 1997), Zambians (AIDS Analysis 1994) and Zimbabweans (Amstrong 1993). In recent studies, widow inheritance has been implicated in the spread of AIDS in parts of East Africa but there is little information on the cultural significance of the practice. This section presents data obtained during fieldwork on
widow inheritance among the Luo of Kisumu District. It begins by looking at the practice of widow inheritance and investigates the prevalence of this custom practice within the survey population.

4.5.2 Widowhood among the Luo

It is customary for a Luo widow to observe a mourning period of about one year after her husband’s death. In the period immediately following the husband’s death before his burial, the widow shaves her head as a mark of respect to the deceased. She may also wear her late husband’s clothes as a sign of mourning. During this initial mourning period, the widow does not bath or mix with other people. She does not leave the home and is considered unclean.

After the burial the widow sleeps besides her husband’s grave for four days. There are two cleansing ceremonies which are performed to chase away the ghost of the deceased person, namely tipi wich’ (performed a few days after burial) and tero buru which is performed a year later. The latter marks the end of the mourning period and the widow is free to choose one of her deceased husband’s kin to inherit her although in some cases clan elders decide who is to take her over. Evans-Pritchard (1950) notes that usually a widow is taken over by one of her brothers-in-law but if she chooses another close relationship her decision is respected. A man’s eldest son is his heir and in some cases, especially in polygynous families, a newly married and young wife may be taken over by one of her husband’s older sons (by a different wife). However, this is not encouraged and does not occur very frequently. A female in-depth interview informant observed:

On the night of tero or inheritance, alcohol is brewed and food is prepared. In polygamous unions the food must be consumed on the senior (first) wife’s (widow) doorstep...all the sons must be present during this occasion...if co-wives (widows) choose the same new husband, he must sleep in every house that same night...the senior or first wife is first to be inherited (have intercourse with the new husband) and then others follow in order of seniority...but in case the co-wives have chosen different new husbands, the first or senior wife must be inherited first...if her new husband fails to ejaculate (thowe ofono Kongo otamore chiek), she stands at her door step and reports to the other co-wives that the home has not been opened hence
they should not have sexual intercourse with their new husbands (Female aged 47, rural area).

However, before a widow is inherited, she is required to have sexual intercourse with either an insane person, a senior bachelor or jamwa (a stranger is from outside the clan or Luo community) to cleanse her husband’s ghost which is believed to come back and haunt the family if this is not performed.

At the end of the mourning period when the widow has been inherited, the property of the deceased is distributed among his sons and male relatives (mainly brothers). The property is distributed among the males by a clan head. One respondent observed that:

After tero or remarriage all properties of the deceased are distributed (keyo nyinyo). Alcohol is brewed and a bull is slaughtered. The meat is eaten according to clans and age. All clothes of the deceased are spread out and distributed: sons take some and the rest are taken by brothers and jater (heir/new husband). However property like cattle and land are not distributed...they are wealth...to help the widow and children (Rural male, 56 years old).

Widows do not receive a share of their deceased husband’s property and have no control over their children. They are looked after by their sons or if they inherited are taken care of by the inheritor. Normally the inheritor is given guardianship rights over the children and can continue reproducing on behalf of the deceased relative although the children conceived belong to the deceased.

It is important to note that the situation is quite different for widowers. In polygynous unions males have other wives, hence sexual partners, with whom they continue marital life. Survey respondents and in-depth interview informants noted that monogamous males can acquire another wife soon after bereavement but there is a cultural provision which requires that the parents of the deceased wife replace her with a sister, mainly to look after children and reproduce. This practice has also been reported in other communities such as the Baganda and Banyankole (Ntozi 1997). Widowers are also not required to undergo the elaborate cleansing rituals that are performed on widows before they are inherited.
4.5.3 Prevalence of widow inheritance

The practices described above are still prevalent in Kisumu as suggested by recent studies (Okeyo and Allen 1994). For instance, Okeyo and Allen found that over 50 per cent of widows they interviewed in Kisumu had already been inherited and about 37 per cent were planning to be inherited. In this survey there were 23 widows and of these 11 had already been inherited by men who had other wives, and had then had children with the inheritor. Five respondents who had been widowed the previous year were planning to be inherited. Only 7 of the widows had refused to be inherited because of the fear of contracting HIV/AIDS. Seven males, all in polygynous marriages, reported that they had inherited their brother’s widow. In general there were a higher proportion of females than males who were currently widowed, possibly because widowers tend to remarry more frequently than widows.

The survey questionnaire included questions on whether widow inheritance is practised, the reasons why men inherit the widow of a deceased relative, whether they know any one who had inherited a widow (and if so, who this person was) and whether a widow can refuse to be inherited. The responses to these questions are displayed in Table 4.2 and are tabulated by sex and residence.
4.2 Percentage distribution of responses to questions about widow inheritance

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban Rural</td>
<td>Both</td>
<td>Urban Rural</td>
<td>Both</td>
<td>Urban Rural</td>
<td>Both</td>
</tr>
<tr>
<td>Is widow inheritance practised among the Luo?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>97.5</td>
<td>97.4</td>
<td>97.4</td>
<td>91.1</td>
<td>97.4</td>
<td>94.2</td>
</tr>
<tr>
<td>No</td>
<td>-</td>
<td>2.6</td>
<td>1.3</td>
<td>5.1</td>
<td>2.6</td>
<td>3.9</td>
</tr>
<tr>
<td>Other</td>
<td>2.5</td>
<td>-</td>
<td>1.3</td>
<td>3.8</td>
<td>-</td>
<td>1.9</td>
</tr>
<tr>
<td>Do you know any one who has inherited a widow?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>72.2</td>
<td>79.5</td>
<td>75.8</td>
<td>57.0</td>
<td>65.8</td>
<td>61.3</td>
</tr>
<tr>
<td>No</td>
<td>27.8</td>
<td>20.5</td>
<td>24.2</td>
<td>43.0</td>
<td>34.2</td>
<td>38.7</td>
</tr>
<tr>
<td>If yes, who is inherited?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>11.1</td>
<td>14.5</td>
<td>12.8</td>
<td>14.4</td>
<td>13.0</td>
<td>13.7</td>
</tr>
<tr>
<td>Sibling</td>
<td>6.3</td>
<td>14.0</td>
<td>10.2</td>
<td>10.5</td>
<td>17.7</td>
<td>14.1</td>
</tr>
<tr>
<td>Other relative</td>
<td>28.3</td>
<td>30.9</td>
<td>29.6</td>
<td>33.6</td>
<td>22.6</td>
<td>28.1</td>
</tr>
<tr>
<td>Neighbours and other</td>
<td>47.1</td>
<td>33.2</td>
<td>40.1</td>
<td>35.3</td>
<td>31.0</td>
<td>33.1</td>
</tr>
<tr>
<td>Self</td>
<td>7.2</td>
<td>7.4</td>
<td>7.3</td>
<td>6.2</td>
<td>15.7</td>
<td>11.0</td>
</tr>
<tr>
<td>Total No.</td>
<td>79</td>
<td>78</td>
<td>157</td>
<td>79</td>
<td>76</td>
<td>155</td>
</tr>
</tbody>
</table>

About 95 per cent of the respondents stated that widow inheritance is practised among the Luo while 75.8 per cent of males and 61.3 per cent of females knew of either a widower who had inherited or widow who had already been inherited. Both survey and in-depth interview respondents observed that widow inheritance is still very common nowadays among the Luo. The major reasons why widows are inherited which were frequently cited in the survey, focus groups and informal interviews include cultural beliefs, social and economic support, reproduction and need to prevent the widow from straying with other men. Among the Luo there is the belief that bad luck or omens, such as the loss of wealth and children, may befall the family if a widow does not undergo the ritual cleansing and inheritance. It is believed that the deceased ghost will also come back and haunt the family. A vast majority of respondents claimed that widows are inherited because of the need to provide moral, economic and social support to the widow and her children. Some respondents also mentioned that in cases where the widow is young, inheritance ensures continuation of
reproduction: the inheritor or new husband fathers children on behalf of the deceased relative. The new husband or inheritor has an obligation to sire children who are regarded as belonging to the deceased.

About two-fifths (40.1 per cent) of the survey of males and over a third (34.8 per cent) of females reported that a widow can refuse to be inherited (not shown in table). Respondents mentioned that in some cases widows from staunch families or those who are capable of supporting themselves refuse to participate in cleansing rituals and inheritance. In cases where a widow refuses to be inherited or decides to return to her natal home or even remarry outside her late husband’s clan or lineage, she is not allowed to take the children because they belong to her husband and his patrilineage.

Sometimes, the widow may take young children if there is no-one in her deceased husband’s family who can take the children but she has to return them to her late husband’s family when they grow up.

Sometimes, the widow may take young children if there is no-one in her deceased husband’s family who can take the children but she has to return them to her late husband’s family when they grow up.

If a widow refuses to be inherited and decides to marry someone else, she is not allowed to take children...children don’t belong to women but their father...they have to be left behind with the deceased relatives...but in cases where she takes the children eventually they (especially the sons) return to their deceased fathers home when they grow up because they inherit from their father (Male, 42 years old, urban area).

A few writers have commented that the fear of losing their children tends to discourage many women from opting out of unstable marriages or refusing to be inherited (Potash 1978; Ntozi 1997). Widows who refuse to be inherited are regarded as disrespectful to the deceased husband and his family, and they are often despised and shunned by their in-laws. In some cases they may even be refused any assistance or be dispossessed of their deceased husband’s property by his relatives. In this study three of the seven widows who had refused to be inherited had moved away from their in-laws and had set up independent female-headed households.

It is important to note that the AIDS epidemic has raised questions in the Luo community regarding the practice of widow inheritance. A few survey respondents and in-depth interview informants acknowledged the risk posed
by this custom in the spread of AIDS. Hence some respondents in the survey and focus groups viewed it as an outdated and dangerous custom which they strongly felt should be discouraged or abandoned because of the threat posed by AIDS. A few men claimed that AIDS was being spread by reckless widows while others felt that some men are reckless:

There are some men who have specialised in cleansing widows...they move from one to the other...others inherit widows even when it has been established that their husband died of AIDS...these are the people spreading AIDS.

Another male disagreed:

I think that widows who don’t get inherited are the ones spreading AIDS...they roam around with men because there is no one to take care of them.

It is evident that in Luo culture, sexual intercourse is an important component of widow inheritance. The ritual of inheritance involve sexual cleansing of the widow with a stranger and then performing sexual intercourse with the new husband or jater. This custom may therefore be a risk in transmission of STDs including AIDS because of the possibility of infected partners engaging in multiple sexual relationships.

4.6 Summary and conclusions

This chapter has examined traditional Luo courtship and marriage customs. It has also highlighted various forms and patterns of marriage in the survey population. It has been shown that traditionally, sexual encounters during young women’s visits to male dormitories were restricted to non-penetrative sexual acts. Young women could have several lovers without much interference from parents and relatives but were expected not to engage in sexual intercourse. The main concern for this was the risk of premarital pregnancy and the shame a deflowered girl brought to herself and her family at her marriage. Parents and close kinsmen played a central role in courtship since they were key players in selecting their future daughter-in-law.
However, traditional Luo courtship has disappeared; people are no longer concerned about Luo customs regarding premarital sex. Today, as noted in Chapter 6, young men have a ‘steady’ or ‘main’ girlfriend whom they expect to marry but may also have other women with whom they have sexual relations without any commitment for marriage in the future. Young women may also have several boyfriends in order to enhance their marriage chances. Several cultural changes account for changes in courtship or partnership behaviour, including urbanisation, education, wage employment and exposure to different cultures. In the past, parents and other traditional structures of authority exerted considerable control over the behaviour of young people. Cultural changes have diminished parental control of young people’s behaviour; this has enabled them to freely engage in sexual relations.

Among the Luo there are various forms of traditional marriage that are still practised today, including ambush or bride abduction, por or cohabitation, and levirate marriage. In the past, and to some extent today, marriages were arranged through an intermediary or jogam although sometimes parents and relatives selected their daughter-in-law. However, in some arranged marriages the bride is married off to strangers against her will or abducted by the bridegroom and declared a wife. Among the Luo, marriages are sealed by substantial payments of bridewealth which are made over a prolonged period. However, changes have occurred in bridewealth payments; unlike in the past when cattle were exchanged, today payments are increasingly made in cash over a short period.

The study found that there is more freedom in selection of marriage partners; only a third of the ever-married respondents reported that their marriages were arranged. Because of rules of exogamy men marry women from distant un-related clans residing in other localities. Most of them choose their own partners but involve their relatives in marriage negotiations and arrangements. As expected, most women marry at an earlier age than men who tend to delay marriage until their late twenties or early thirties. Women, especially those from poor families and single mothers, are pressed by poverty to marry early. Men delay because of their inability to raise enough to pay for bridewealth and for setting up their own households. Others also delay because
they lack a suitable partner. Traditional beliefs and rules of seniority prescribe that the eldest son should marry first, followed by his younger brothers.

The study found that the practices of widow inheritance and ritual cleansing are common in Luo Nyanza. Widow inheritance is accompanied by elaborate cleansing ceremonies which culminate in the widow being taken over by a close relative of her deceased husband. Ritual cleansing involves the widow having sexual intercourse with a jamwa or stranger in order to be cleansed from the negative effects of death. Many people in Luo Nyanza view the practice of widow inheritance as essential because it provides guardianship and material and emotional support to the widow and her children. However, widow inheritance and ritual cleansing have the potential to spread HIV/AIDS. The AIDS epidemic has raised a lot of concern among the Luo regarding the importance of these practices; some people felt that they should be discarded or discouraged.
CHAPTER FIVE

SEXUAL BEHAVIOUR OF MEN AND WOMEN

This chapter is devoted to the sexual behaviour of men and women; it focuses on behaviour before marriage, within and outside marriage. Descriptive statistics are used to show the general trends in sexual networking, in addition to qualitative data on sexual behaviour in general.

5.1 Introduction

The first section of this chapter examines premarital sexual behaviour, beginning with a brief overview of traditional Luo customs, particularly norms regarding premarital sex, mainly normative patterns. This is followed by examination of attitudes towards premarital sex, and premarital sexual activity among ever-married respondents. The third section looks at age at first intercourse and marriage, reasons and context of first sexual relations, while the fourth section focuses on sexual networking, mainly the number and type of sexual partners and extramarital relations, and male contact with prostitutes.

5.2 Premarital sexual behaviour

It has been reported that in the past, sexual behaviour among the Luo was controlled through a normative moral code, which permitted certain sexual practices and prohibited others. Luo customary sexual and marriage codes strictly prohibited premarital sex and placed emphasis on the importance of virginity at marriage (Evans-Pritchard 1950; Ocholla-Ayayo 1976; Potash 1978; Parkin 1978). Ocholla-Ayayo, Wekesa and ottieno (1993b) observed that in the past, chastity was highly emphasised among the Luo and Luhyia of western Kenya:

It was an honour for an adolescent (girl) to avoid sex before marriage since a girl who maintained chastity until the evening of the marriage, would be rewarded by her mother by being given some goats and even
cash. This was witnessed by her Aunts who had to find whether there was blood on the bed sheets, implying the breaking of the hymen during the first mating with the husband. (Ocholla Ayayo et al. 1993:368).

It is often claimed that a girl who has many lovers or who becomes a mother before marriage has devalued status as a prospective bride and is likely to become an older man's second or subsequent wife. (Parkin 1978:78)

Girls were not allowed to have sex before marriage. They were afraid that if they did so and got pregnant, they would be married off to an old man. Such a woman was not given the respect due to a wife. So even if a girl had a boyfriend courting her, she was supposed to be strict and not agree to have sex with him until she was married. (Woman, 65 years old in rural area, married in a polygynous union).

Cultural morality tended to confine sexual activity and reproduction to marriage unions. Premarital pregnancy and childbirth were undesirable because they brought shame to both the girl and her entire family. A deflowered girl suffered shame which remained a stigma throughout her life (Ocholla-Ayayo 1976). Premarital pregnancy not only ruined a girl's reputation but also jeopardised chances of a good marriage. Thus parents, especially mothers and grandmothers, protected their daughters and restricted their movements to ensure they did not engage in sexual activity before marriage (Cohen and Odthiambo 1989). On the other hand, young men were not subject to restriction in their premarital sexual relations, even though a boy who impregnated a girl could be forced to marry her or pay heavy fines (Ocholla-Ayayo 1976). Available literature shows that in many cultures in Africa, virginity was valued and a source of pride for the bride's parents and her relatives (Konde-Lule 1991). Konde-Lule (1991) notes that among the Baganda of Uganda, the groom rewarded the virgin bride and her parents with gifts, some of which were shared with their relatives. However, he notes that the fact that gifts were offered to parents of a virgin bride implied that virginity was not universal: some women were not virgins at marriage.

In the past, young unmarried males and females were provided with sexual outlets, particularly by the traditional practice of Chode which involved the performance of non-penetrative sex (Ocholla-Ayayo 1976; Caldwell et al. 1994b). A similar practice called Ngwiko has also been reported among the Kikuyu of Kenya (Kenyatta: 1938;

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1 This is a form of erotic play without full vaginal penetration which was performed by newly initiated
Ocholla-Ayayo, Wekesa and Ottieno 1993b; Ahlberg 1994). Girls were allowed to have as many boyfriends as they wished but not have sexual intercourse. *Chode* used to take place during courtship when girls visited their suitors in their *Simba* or boys’ dormitory. During such visits sexual advances were made but the girl was expected to resist even if she spent the night in the *simba*. A boy who indulged in sexual activity was regarded as promiscuous and unworthy to of marriage while a girl who did so was seen as loose and not fit to become a good wife (Ocholla-Ayayo 1976; Atieno-Odhiambo 1989). Ocholla-Ayayo (1976) noted that the traditional institutions of education such as *doul* and *siwindhi* (girls dormitory) inculcated in young people societal values and norms. In the past, girls were taught how to protect themselves from pregnancy, and what to do when they got pregnant. This knowledge was provided by *pim*, an old woman, usually referred to as grandmother, who could talk freely with young girls about anything. A similar observation has been made among the Kikuyu by Ahlberg (1994), where social values were imparted to young men and women through a long process that culminated in initiation ceremonies which involved long periods of seclusion.

In the past four or five decades, however, there has been a great impact on Luo culture from urbanisation, education, and other forces of modern lifestyles. These have contributed to the erosion of traditional systems governing premarital sexual relations. The strongly conservative attitude towards female sexual fidelity has weakened because people no longer follow traditional norms regarding premarital sexual activity. There is widespread recognition that premarital sexual relations do take place and are common among unmarried young men and women (Ocholla-Ayayo and Mугanzi 1985; Ocholla-Ayayo, Wekesa and Ottieno 1993b). Nowadays, it is common for people to have had a series of sexual relationships with different partners before marriage. Virginity at marriage is neither highly valued nor strongly emphasised. For instance, Parkin (1978:77) notes that among the Luo living in Kaloleni, Nairobi, the concept of virginity at marriage is not held with the esteem it used to be accorded:

Virginity is no longer expected among Luo and such cultural concept has taken a new

young men and women for the purpose of achieving sexual satisfaction.
direction. There is now certainly a concept of relative chastity: a Luo girl is not expected to be a virgin at marriage but nor is she expected to have many lovers.

Even though Parkin's reports were based on an urban population, the same generalisation can be made about rural areas, as this study confirmed. Society tends to now be more tolerant of the premarital activity of young unmarried people. It is now considered fashionable for unmarried young men and women to have sexual partners. A boy or a girl who is not sexually active is considered by peers to be a novice and is always looked down upon. Males are expected to be adventurous and to have many sexual partners before marriage, while girls are expected to have relations with one man. Many young people do not consider it morally wrong to have sex before marriage as long as such a relationship has a prospect of future marriage. These views were often expressed in in-depth interviews and focus group discussions:

Western civilisation has come and changed a lot of things. Nowadays, it is very common to find very young girls, even as young as 14 years, who become pregnant and bear children. I can tell you that there are very many here in this neighbourhood. All this is caused by the school because it is very difficult for parents to monitor the behaviour of their children at school. They get exposed to immoral behaviour at school. Some of them tell their parents they have gone to school but they haven't. They go to meet their lovers. Some even sneak out at night when their parents are asleep to meet their boyfriends. So because of this it is very hard to find girls who are virgins (Married woman, 48 years old, urban area).

Children copy what they see on television, videos and movies. They watch immoral things which in the past they would never have been allowed to see, like a man sleeping with a woman (having sex). In the past these things were only for grown up people and they did not do them in front of their children. Now things have changed, children watch people doing some things which they would never have been allowed to know about and then they go and practise it with the friends. This is why virginity is uncommon today (53 years old, urban male).

It is difficult to find women who have not had sex before they get married. A woman who has never had sex is a novice and inexperienced. Men want women whom they can have sex with. It is the only way that a girl can prove to her lover that she loves him (24 year urban single male).

Modern education, rural-urban migration, urbanisation and exposure to new ideas through the media have facilitated the breakdown of traditional norms and diminished family control over the behaviour of young people and thus resulted in a more relaxed attitude toward premarital sex. This has increased the freedom of unmarried males and
females to engage in premarital sex more than before. Ahlberg (1994) has observed that among the Kikuyu, Christian missionaries and modern education destroyed cultural beliefs and practices which imparted to young men and women discipline in sexual matters, and hence led to the demise of such practices as Ngwiko. Ahlberg (1994) further notes that nowadays many young people embrace the ‘romantic love’ regime in which sexual activity is regarded as acceptable as long as the couple is in love. Thus, many young people are involved in a succession of quick love relationships with people of the same age group and older partners.

5.3 Attitudes towards virginity

The survey questionnaire included questions aimed at eliciting attitudes towards female virginity at marriage. Respondents were asked whether women should be virgins at marriage; whether virginity is necessary today; whether their daughter should be a virgin at marriage; and for those who were currently married whether they were virgins at marriage. Table 5.1 summarises the opinions of the respondents concerning female virginity at first marriage.

The table shows that the attitude towards female chastity has changed and that many people tend to be sexually active by the time they get married. It reveals however, that there is widespread belief among respondents (over 70 per cent) that women should remain chaste until marriage. However, when asked if virginity at marriage is important, only 57 per cent considered virginity to be necessary today, with fewer men than women reporting greater emphasis of virginity in contemporary society. A few women who emphasised the importance or necessity of virginity at marriage mentioned Christian beliefs and the need for protection from AIDS.
5.1 Opinions regarding virginity at first marriage by sex and residence (%).

<table>
<thead>
<tr>
<th>Question</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Should a woman be a virgin at marriage?</td>
<td>Yes</td>
<td>74.7</td>
</tr>
<tr>
<td>Is it necessary today for a woman to be a virgin at marriage?</td>
<td>Yes</td>
<td>45.6</td>
</tr>
<tr>
<td>Was your partner a virgin at marriage?</td>
<td>Yes</td>
<td>4.3</td>
</tr>
<tr>
<td>Do you expect your daughter to be a virgin at marriage?</td>
<td>Yes</td>
<td>59.5</td>
</tr>
<tr>
<td>Total No.</td>
<td>79</td>
<td>78</td>
</tr>
</tbody>
</table>

It is good for a woman to be a virgin at marriage because it does not put her at risk of getting AIDS. Many young girls who have died of AIDS lost their virginity and became sexually active very early. I will remain a virgin until I find the right man for me because I do not want to get AIDS (woman 17 years, single, secondary school student, rural area).

There are very many strange diseases that one can contract from having sex. Nowadays it is even worse because of HIV/AIDS and other venereal diseases. The only way a woman can avoid contracting AIDS is to remain a virgin. It is hard to avoid getting diseases once you start sleeping around with men....I will try my best never to have sex until I get married to a good man whom I trust (woman 16 years, single, secondary school student, rural area).

About 58 per cent of the respondents wanted their daughters to be virgins at first marriage. Despite the strong emphasis on female virginity at first marriage, there is a significant difference between the expected or ideal behaviour and the reality. All ever-married male respondents reported having premarital sexual relations, and only five per cent reported that their spouse was a virgin at first marriage. This may be a reflection of change in attitudes towards female premarital chastity as virginity is no longer valued very much. The concern over premarital sexual activity centres on the
issues of pregnancy and family honour. Many respondents stressed that it is difficult for a woman to retain virginal status in the contemporary world.

The study also examined the incidence of premarital sexual behaviour by looking at the sexual behaviour of currently married survey respondents. The respondents were asked about the number of sexual partners they had before marriage and the relationship they had with these people. The main reason for eliciting this information was to understand the behaviour of people before marriage.

Table 5.2 Type of sexual partners before marriage of currently married respondents (%)

<table>
<thead>
<tr>
<th>Type of partner</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Never had sex before marriage</td>
<td>3.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Had sexual relations with spouse only</td>
<td>2.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Had sexual relations with regular partner e.g. boy or girl friend.</td>
<td>14.6</td>
<td>26.7</td>
</tr>
<tr>
<td>Had sexual relations with casual partners</td>
<td>20.0</td>
<td>23.0</td>
</tr>
<tr>
<td>Had sexual relations with both regular partner and casual partners</td>
<td>32.8</td>
<td>31.4</td>
</tr>
<tr>
<td>Had sexual relations with regular partner, casual partners, prostitutes or paying partner</td>
<td>27.2</td>
<td>14.0</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total No.</td>
<td>38</td>
<td>42</td>
</tr>
</tbody>
</table>
Table 5.2 shows the distribution by percentage of type of sexual partners before marriage of currently married respondents. Less than three per cent of males and about nine per cent of females who were currently married had never had sex before marriage. A greater proportion (nearly 40 per cent) of currently married women report having a sexual relationship with a stable partner in comparison with men (approximately 21 per cent). More females than males also reported having sexual relations only with their current spouse before marriage. Nowadays, it is common for people to have sexual intercourse and even children during courtship before they get married.

Respondents were asked about the number of partners they had before they married for the first time. Table 5.3 displays the distribution by percentages of number of sexual partners before marriage of currently married respondents.

**Table 5.3 Number of sexual partners reported before marriage of currently married respondents (%)**

<table>
<thead>
<tr>
<th>Number of partners</th>
<th>Males</th>
<th></th>
<th></th>
<th>Females</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
</tr>
<tr>
<td>1</td>
<td>2.4</td>
<td>8.5</td>
<td>5.4</td>
<td>13.8</td>
<td>18.4</td>
<td>16.1</td>
</tr>
<tr>
<td>2-3</td>
<td>23.5</td>
<td>47.8</td>
<td>35.7</td>
<td>42.7</td>
<td>53.4</td>
<td>48.1</td>
</tr>
<tr>
<td>4-5</td>
<td>51.8</td>
<td>25.9</td>
<td>38.8</td>
<td>35.0</td>
<td>23.0</td>
<td>29.0</td>
</tr>
<tr>
<td>6+</td>
<td>22.3</td>
<td>17.8</td>
<td>20.1</td>
<td>8.5</td>
<td>5.2</td>
<td>6.8</td>
</tr>
<tr>
<td>Total No.</td>
<td>38</td>
<td>42</td>
<td>80</td>
<td>26</td>
<td>32</td>
<td>58</td>
</tr>
</tbody>
</table>

A greater proportion of respondents reported engaging in multiple sexual relations before first marriage. More females (15 per cent) than males (5 per cent) reported having a single sexual partner before marriage. Urban respondents were less likely to have had only one partner before marriage: about 14 per cent of urban females compared with over 18 per cent of rural females, and about 2 per cent of urban men
compared with over 8 per cent of rural men. For these respondents the premarital partner was more likely to be their current spouse.

The table shows that the incidence of premarital sexual networking is high, particularly among males, over 90 per cent of whom, irrespective of residence, had had two or more premarital sexual partners. As expected, females reported fewer sexual partners than males, with older women reporting fewer partners than younger ones (not shown in this table).

Most males reported multiple partners before marriage; for instance over 40 per cent of rural men and two thirds of urban males reported four or more sexual partners before marriage. This level of sexual networking certainly has implications for infection and spread of sexually transmitted diseases, including AIDS.

5.4 Age at first sexual intercourse:

The first sexual intercourse is an event of great importance since it marks debut into sexual activity and has serious health implications because, if unprotected, it carries the risk of pregnancy and infection with STD. Most people in Kenya begin sexual activity prior to marriage while others delay it until marriage. Collecting data on first sexual intercourse is particularly important in Kenya where teenage pregnancy, abortion and single parenthood are issues of great concern (Khasiani 1985; Maggwa 1987; Lema 1987; Ajayi 1991; Kiragu and Zablin 1993; Ocholla-Ayayo, Wekesa and Ottieno 1993b).

The occurrence of the first sexual intercourse is of interest in this study; questions were asked in the survey to elicit information on early sexual experiences and age at first sexual intercourse. Respondents were also asked who their first partner was, the nature of their relationship and the circumstances surrounding the event. Respondents who reported that they had never had sexual intercourse were not interviewed about their sexual history. The age at first sexual intercourse was measured in complete years. Table 5.4 shows the distribution percentages of age at first sexual intercourse by current age of respondent.
Table 5.4 Age at first intercourse by current age of respondent (%).

<table>
<thead>
<tr>
<th>Age at first intercourse</th>
<th>15-24</th>
<th>25-34</th>
<th>35+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
</tr>
<tr>
<td>&lt;15</td>
<td>28.6</td>
<td>37.0</td>
<td>32.6</td>
</tr>
<tr>
<td>15-19</td>
<td>71.4</td>
<td>63.0</td>
<td>67.2</td>
</tr>
<tr>
<td>20-24</td>
<td>a</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>Total no.</td>
<td>21</td>
<td>27</td>
<td>48</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>15-24</th>
<th>25-34</th>
<th>35+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females (n=155)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15</td>
<td>45.2</td>
<td>59.5</td>
<td>52.3</td>
</tr>
<tr>
<td>15-19</td>
<td>52.4</td>
<td>37.8</td>
<td>45.1</td>
</tr>
<tr>
<td>20-24</td>
<td>2.4</td>
<td>2.7</td>
<td>2.6</td>
</tr>
<tr>
<td>Total no.</td>
<td>42</td>
<td>37</td>
<td>79</td>
</tr>
</tbody>
</table>

a No cases

The majority of those interviewed for the survey were sexually active; only 3.2 percent had never had sexual intercourse and these people have not been included in the analysis in Table 5.4. The mean age at first sexual intercourse for males and females was 15.4. The lowest age at first intercourse reported for males was 11 years and for females it was eight years (not displayed in table). Females tended have first sexual intercourse two years earlier than males, with mean ages of 14.8 and 16.1 respectively. Women also tended to experience first sexual intercourse with men who were slightly older. Over half of the females had first sexual experience when under the age of fifteen compared to about a third of males. Another striking pattern that emerges from the table is the distinct difference in age at first intercourse between respondents aged 15-24 and those aged 35 and above. The younger respondents had first sexual intercourse earlier than those born a decade or two before them (those aged 25-34 and 35 and above). A third of males aged 15-24 had first intercourse below the age of fifteen compared to a tenth of those aged 35 and above. The mean age at which young
respondents aged 15-19 experienced first sexual intercourse was about five years earlier than respondents in the older age groups of 40+.

The age at first intercourse has declined progressively through each age group, but not uniformly so. The fall is marked from the young age groups into the older age group. The findings of the Kisumu survey are consistent with other studies conducted in Kenya and elsewhere in Sub-Saharan Africa that show a trend towards decline in age of coital debut for many young people and high levels of sexual activity (Khasiani 1985; Lema 1987; Maggwa 1987; Ajayi et al. 1991; Meeker and Gage 1994). The 1993 KDHS observed within Kenya, that Nyanza province, where Kisumu is located, had the lowest median age at first intercourse, especially for women. It reported a median age at first intercourse of 15.5 among females aged 20-49 in Nyanza province (KDHS 1993). This may be attributed to early marriage of women in this region and high levels of polygyny. Ajayi et al. (1991) found that over 50 per cent of adolescent respondents in a survey in Kenya were sexually active, having initiated sexual intercourse around the age of 13. Maggwa (1987) found in a survey of 1434 students in Machakos, Kenya that the mean age at first sexual intercourse was 14.8 for girls and 13.2 for boys. Recently, Kiragu and Zablin (1993) reported in a survey of 3000 adolescents that the mean age at first sexual intercourse was between 12 and 13 for boys while for girls it was between 13 and 16. In sum, many young people in Kenya initiate sexual activity at very early ages and evidence from in-depth interviews and case studies supports this observation:

I became sexually active at the age of 16 while in secondary school. My first sexual intercourse was with a girl from my village whom I was introduced to by my cousin at my eldest brother’s wedding ceremony. We fell in love at first sight. I asked her to accompany me to my brother’s wedding party that evening. At the party, we danced the whole night and drank beer even though I was not allowed to drink at the time. We sneaked away from the festive crowd at the party and went to a nearby bush. We kissed and cuddled but did not have sexual intercourse that day. Through the passage of time we became intimate and one day I invited her to our home. I took her to the boys’ simba. That day we enjoyed ourselves and shared some good time. We slept together that night and had sexual intercourse for the first time. The girl I had sex with was not a virgin and I found out later that she had been sleeping around with some boys in the village (Single rural male aged 20 years, first sexual intercourse in 1990).
I had my first sexual intercourse at the age of 15 when I was in primary school. I think I was in class eight. My first sexual partner was a girl who went to the same school. We met one evening after night-study at school and had sexual intercourse in the school compound. I felt like a real man after that and continued having sex with other girls in my school and neighbourhood (Single man aged 22, in rural area, first sexual intercourse in 1987).

I had my first sexual intercourse at the age of 17 with my girlfriend. I had known her for a long time, maybe since childhood. It was during the school holidays and I invited her to my simba one evening and asked her if we could have sex. I was not sure she would accept because I had tried it before. To my surprise she agreed. We slept together that night and I escorted her home early in the next morning (Single rural man, aged 30 had first sexual intercourse in 1981).

I had my first sexual intercourse at the age of 16 with my first boyfriend. I did not want to have sex because I did not want to get pregnant like other young girls in the neighbourhood. It would have been a great shame to my family and a waste of my parent’s school fees. I wanted to wait until I finished school and got married to someone. Then on Christmas Day 1990 I went out with my boyfriend to celebrate in town. I drank beer for the first time and danced a lot. We left the night club very late and lodged in a boarding house because I could not go home. My boyfriend wanted to have sex but I refused initially. He insisted, so I eventually gave in. He promised that he would marry me and take care of all responsibilities if I got pregnant (Single female aged 18, became sexually active in 1991.)

Ojwang is a single university graduate 26 years old. He completed his Bachelor of Arts degree a year ago and is looking for a job. He is the eldest son in a family of seven of his mother's children. Apart from his mother, his father has three other wives. He attended the University of Nairobi but now lives in Manyatta, Kisumu, with his cousin who supports him financially. He became sexually active at the age of 17 while in school. His first sexual intercourse was with a girl in his neighbourhood whom he had known for some time. It was after a party which he had attended with two of his friends. They drank some chan'gaa (local illicit brew). He met the girl at the party and after the party she accepted to accompany him to his friend’s place. They had sex for the first time. After this encounter they had sexual intercourse on many occasions until she moved to live with a relative in Nairobi.

Ojwang said that he had sexual relations with four other girls in his village after his first sexual partner (girlfriend) while he was in high school. Most encounters took place during school holidays because he was away from home most of the time in boarding school. He said that his sexual partners were just friends and they were in no serious relationship. When he joined university, he slept with prostitutes on a number of occasions (five or six times). He and his friends used to go drinking in a bar popular among university students and they would end up taking home prostitutes from the club. He paid them between Ksh 150 and 200 (about A $3-$5). He
claimed that many students used to pick up girls in the city and take them home whenever they went out drinking. Many of them, like him, did not have a steady girlfriend. *(Single urban male, aged 26 yrs).*

### 5.5 Sources of knowledge about sex

Evidence obtained from this study and many others in Sub-Saharan Africa shows that many young people are sexually active: however, very little has been written about how young people obtain information about sex. This section investigates the different sources from which survey and informal interview respondents first received information about sexual matters.

It has been observed in the literature that in the past, young men and women were taught or instructed about sexual matters by their grandparents and older relatives (Ocholla-Ayayo 1976; Cohen and Odthiambo 1985). Literature suggests that in many communities in Kenya, and in Africa in general, grandparents played a central role in the formation of individual character (Kenyatta 1962; Ndeti 1972; Ocholla-Ayayo 1976). For instance, Cohen and Odthiambo (1989) have highlighted the special role played by *pim* (an older woman who traditionally helped bring up young children in the household) in instilling not only social values into young girls, but also knowledge regarding sexuality, marriage and childbirth.

In modern formal education, young people are taught about sex during their sixth year of school. The information they receive is related to male and female anatomy, menstruation, contraception and childbirth. Recently there has been increased pressure on the government to introduce family life education in primary and secondary school although the Roman Catholic Church is opposed. However, there have been a few pilot projects on family life education in a few secondary schools. From the information obtained during fieldwork in Kisumu it was evident that young and older respondents learnt about sex from different sources. Younger respondents were more likely to have learnt about sex from peers and friends while older respondents (aged 40 and above) were likely to have learnt from parents or other senior relatives. Most of the female respondents aged 35 and above reported that they received information about sex from older women of the *dala* or homestead. Women were taught about
menstruation, childbirth and how to behave towards men and their husbands. Men were taught by senior relatives such as grandparents and uncles. The information received from grandparents and senior relatives always emphasised proper conduct.

In this study, all sexually experienced respondents were asked how they came to learn about matters relating to sexual relations and what type of information they received. Table 5.5 shows the percentage distributions of sources of information about sexual relations reported by respondents by sex and residence.

<table>
<thead>
<tr>
<th>Sources</th>
<th>Males Urban</th>
<th>Rural</th>
<th>Both</th>
<th>Females Urban</th>
<th>Rural</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>53.2</td>
<td>55.4</td>
<td>54.3</td>
<td>53.6</td>
<td>60.2</td>
<td>56.9</td>
</tr>
<tr>
<td>Books, magazines, films</td>
<td>30.4</td>
<td>13.7</td>
<td>24.5</td>
<td>34.0</td>
<td>14.7</td>
<td>24.4</td>
</tr>
<tr>
<td>Parents and other seniors relatives and teachers</td>
<td>14.1</td>
<td>19.2</td>
<td>16.7</td>
<td>8.5</td>
<td>20.1</td>
<td>14.3</td>
</tr>
<tr>
<td>Other</td>
<td>2.3</td>
<td>6.7</td>
<td>4.3</td>
<td>3.9</td>
<td>5.0</td>
<td>4.4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total No</td>
<td>77</td>
<td>75</td>
<td>152</td>
<td>77</td>
<td>73</td>
<td>150</td>
</tr>
</tbody>
</table>

The main sources of information on matters relating to sex were friends, films, newspapers, scientific books and magazines featuring stories on sexual matters. Overall, about 54 per cent of respondents (50.9 % of males and 56.9 % of females) reported that they received information about sex from friends, mostly from peers and slightly older friends whom they had known for some time. Usually discussions took place amongst a network of trusted friends. Many female respondents mentioned that during early adolescence, they were introduced to the concept of sex by older and
more experienced girls. However, sometimes this information was vague and inaccurate. For instance, a female respondent reported:

When I was about 8 years old my sister told me a story she had been told by an older girl. The girl told my sister that her friend had sex with an older boy and she had got pregnant with a child. I could not understand how such a thing could happen and I was puzzled for some time. A few months later an older cousin explained to me how it happens (Rural female 22 years old).

I learnt about sex from my friends...we used to talk about which girl was beautiful...we talked about girls who were having sexual relations...who was ‘loose’...beautiful and so forth (Urban male 25 years old).

When we were young, say about seven years, we played many children’s games with girls...‘hide and seek’...‘mum and dad’... during such occasions, some of the older boys used to play around with girls...do things which grown up people do...like sleeping together (Rural male 18 years old).

Boys are free with each other...they talk a lot about the girls they would wish to go out with or sleep with...which girls are easy to get in the village and so forth (Rural male 19 years).

The second most important source of information mentioned by the respondents, was magazines, newspaper columns, books and films. About 39.1 per cent of males and 24.4 per cent of females mentioned these as their primary sources of knowledge about sexual relations. Men were more likely than females to obtain information about sex from this source. In in-depth interviews and focus group discussions, a number of informants and participants explained that they learnt about sex from magazines featuring stories on romance and relationships, and from scientific books or movies. At school, students are taught about anatomical differences between men and women, menstruation, and conception in general science or biology classes.

Most of the respondents reported that they had learnt about the anatomical differences between men and women when they were young children but they got more detailed information from stories in books, and magazines featuring sexual matters, reproduction and romance. The information received from magazine and newspaper columns and books could be factual but difficult to interpret:
As far as I can remember my earliest consciousness about sex was at about 8 years old. I found a magazine in my elder brother’s bedroom. It had many pictures of men and women, all nude and some had genitals exposed...they were lying in bed...I did not understand what they were doing, so I later asked my brother and he told me. I think this was the first time I realised that men and women have sex (23 years old, male, Urban area).

I learnt about matters pertaining to sex from love magazines and books. My elder brother used to buy True Love and Drum magazines every month and I read them a lot (Urban male aged 29).

Some male respondents recollected their past experiences when they first began to feel attracted to girls.

When I was 10 years old in class four, I remember being attracted to one girl in my class. I just liked to see her a lot and sometimes I used to share food with her at lunch time...the other boys in my class knew it and they used to tease me (Rural male, 19 years old).

Another male respondent described his experience:

I remember when I was about eight years old, my older brother got whipped by my mother.... I think he said something sexual to a girl in my village and her mother informed my mother. She was very furious with my brother....from that day I realised that certain things are not said in public (Urban male, 28 years).

As in many other African communities, discussion between parents and their children of matters regarding sex is taboo. In this study, parents were not a major source of information about sex with only 16.7 per cent of males and 14.3 percent of females reporting having learnt of matters relating to sex from parents. People in the older generation were more likely than younger ones to have learnt about sex from parents, grandparents and other senior relatives. In more traditional times, sex education was provided by grandparents. Girls were taught about menstruation, pregnancy and childbirth by their grandmother or by pim and other older women within the home stead, who protected them and participated in selecting their future spouses. On the other hand males received instructions from their grandparents and other older close male relatives. Sometimes the instructions they received was in fables and proverbs and did not directly refer to sex. Most young men and women contend that parents...
avoid discussing matters pertaining to sex with them. However, some parents complained that they can spend very little time with their children because of work and schooling.

The main concern of most parents is centered around pregnancy and girls are frequently cautioned against 'running around with boys'.

Married women are particularly concerned about their daughters' sexual behaviour because they will be blamed if their daughters get pregnant. This was frequently reported in in-depth interviews, with some female respondents saying 'when we were young my mother used to tell us not to play with boys because we will get pregnant'.

When my younger sisters were young my mother and other older women in the village warned us not to 'play' around with boys because we could get pregnant...we were afraid of boys and avoided playing with them, but it all changed when we grew up. This is how I learnt about sex (Married female, 23 years old, rural area).

5.6 Age at first sexual intercourse by selected background characteristics

Respondents were distributed according to demographic characteristics in order to demonstrate variability in the population. Table 5.6 displays percentage distribution of respondents who experienced first sexual intercourse under the age of 18 years, by various demographic characteristics.
Table 5.6 Age at first sexual intercourse under the age of 18 by selected background characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>67.5</td>
<td>83.5</td>
<td>79.7</td>
</tr>
<tr>
<td>Married</td>
<td>99.0</td>
<td>92.5</td>
<td>86.0</td>
</tr>
<tr>
<td>Widowed</td>
<td>100.0</td>
<td>60.1</td>
<td>65.4</td>
</tr>
<tr>
<td>Separated/divorced</td>
<td>-</td>
<td>80.0</td>
<td>71.0</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>75.1</td>
<td>84.1</td>
<td>79.6</td>
</tr>
<tr>
<td>20-24</td>
<td>60.1</td>
<td>85.1</td>
<td>72.6</td>
</tr>
<tr>
<td>25-29</td>
<td>73.5</td>
<td>80.6</td>
<td>77.0</td>
</tr>
<tr>
<td>30-34</td>
<td>42.8</td>
<td>61.3</td>
<td>52.0</td>
</tr>
<tr>
<td>35-39</td>
<td>73.4</td>
<td>77.7</td>
<td>75.5</td>
</tr>
<tr>
<td>40-44</td>
<td>52.9</td>
<td>60.0</td>
<td>56.4</td>
</tr>
<tr>
<td>45-49</td>
<td>36.4</td>
<td>50.0</td>
<td>43.2</td>
</tr>
<tr>
<td>50+</td>
<td>37.5</td>
<td>40.0</td>
<td>38.7</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>36.0</td>
<td>94.0</td>
<td>65.0</td>
</tr>
<tr>
<td>Primary Incomplete</td>
<td>45.8</td>
<td>69.0</td>
<td>57.4</td>
</tr>
<tr>
<td>Primary Complete</td>
<td>61.7</td>
<td>76.5</td>
<td>69.1</td>
</tr>
<tr>
<td>Secondary +</td>
<td>80.1</td>
<td>64.5</td>
<td>72.3</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>63.3</td>
<td>67.2</td>
<td>65.2</td>
</tr>
<tr>
<td>Rural</td>
<td>46.4</td>
<td>77.4</td>
<td>61.9</td>
</tr>
<tr>
<td>Religion Affiliation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>71.1</td>
<td>88.3</td>
<td>79.7</td>
</tr>
<tr>
<td>Protestant</td>
<td>88.1</td>
<td>83.2</td>
<td>86.0</td>
</tr>
<tr>
<td>Traditional</td>
<td>50.0</td>
<td>80.9</td>
<td>65.4</td>
</tr>
<tr>
<td>No religion/Other</td>
<td>82.0</td>
<td>60.0</td>
<td>71.0</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid employment</td>
<td>63.4</td>
<td>64.7</td>
<td>64.0</td>
</tr>
<tr>
<td>Farming</td>
<td>52.5</td>
<td>56.7</td>
<td>54.6</td>
</tr>
<tr>
<td>Housewife/work</td>
<td>-</td>
<td>74.7</td>
<td>74.7</td>
</tr>
<tr>
<td>Student</td>
<td>86.3</td>
<td>53.5</td>
<td>69.9</td>
</tr>
<tr>
<td>Self-employed</td>
<td>58.2</td>
<td>70.9</td>
<td>64.5</td>
</tr>
<tr>
<td>Unemployed/Other</td>
<td>81.4</td>
<td>56.0</td>
<td>68.7</td>
</tr>
<tr>
<td>Total No</td>
<td>152</td>
<td>150</td>
<td>302</td>
</tr>
</tbody>
</table>
The table shows that over three-quarters of never married respondents and over 85 per cent of married and formerly married respondents had first sexual intercourse under the age of 18 years. Many men and women experience sex before they get married and have several sexual partners before they settle down for marriage.

An urban-rural differential in age at first sexual intercourse is also shown in the table. A higher proportion of urban than rural respondents began sexual activity early. This may be explained by the fact that urban respondents are more exposed than rural respondents to potential sexual partners and to modern influences. Another factor is that sexual norms are more relaxed in urban than rural areas.

The findings of this study show a greater proportion of rural women had experienced first sexual intercourse before the age of 18 years, than urban females and all males. Over three-quarters of rural women had experienced first sexual intercourse before age of 18 compared to 67 per cent of urban females and less than half of rural males. In general, urban males tended to experience sex earlier than their rural counter-parts.

The results also showed that education is closely related with age at first sexual intercourse; the higher the level of education attained by male respondents, the more likely they were to have experienced first sexual intercourse before the age of 18 years. In contrast, the higher the level of education for females, the less likely they were to have first sexual intercourse before the age of 18. However, the proportions of educated women who reported sexual debut before the age of 18 are also quite high (around 65%). There are three main explanations which may account for the early sexual debut of respondents with higher education. First, education has undermined parental control and other traditional institutions of social control and has led to relaxation of socially valued normative patterns (Kiragu 1989; Ocholla-Ayayo, Wekesa and Ottieno 1993). Education exposes young people to Western values, and thus educated respondents tended to have a more modern outlook on life and relaxed sexual mores (Gage and Meekers 1994).

Secondly, it is also difficult to control the sexual behaviour of young people who are still in school because of reduced parental supervision, increasing the chances of
students engaging in sexual activity in such circumstances. During fieldwork in Kisumu, informal interviews with elderly people revealed that parents no longer have control over the behaviour of their children because the children spend most of their time with their teachers at school. Modern education seems to have undermined traditional structures and the parental responsibility for inculcating moral values into children, especially to those children who are in boarding school. It emerged from interviews and focus group discussions that the breakdown of parental control has greatly contributed towards such behaviour as greater teenage sexual freedom and premarital pregnancies.

Finally, education exposes individuals to a wide range of potential sexual partners. Females with no education may experience first sexual intercourse early because they tend to get married earlier and because they come from poor families and are more likely to engage in transactional or commercial sex as a survival strategy. In sum, differential levels of education are important here as they reflect potential risk groups that are vulnerable to HIV/AIDS and other STD infection.

5.7 Age at first sexual intercourse and age at first marriage by sex and age group

Table 5.7 illustrates the difference between the age at first intercourse and the age at marriage, by sex and age group. The age at first intercourse and marriage differ across the survey population. The table shows that a majority of men and women experience their first sexual intercourse before marriage. Women in the older age groups were more likely to have experienced their first sexual intercourse in a marriage union; for the age group 50 and above, the age at first sex was similar to the age at first marriage. However, this could be attributed to the under-representation of women in the older age groups (39 and above) in the survey.
Table 5.7 Distribution of sexually active respondents by age at first intercourse and age at first marriage by sex and age-group.

<table>
<thead>
<tr>
<th>Age at first sexual intercourse (years)</th>
<th>Age at first marriage (years)</th>
<th>Difference between mean age at first sexual intercourse and age at first marriage (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>15-19</td>
<td>11.7</td>
<td>11.6</td>
</tr>
<tr>
<td>20-24</td>
<td>15.7</td>
<td>15.0</td>
</tr>
<tr>
<td>25-29</td>
<td>16.2</td>
<td>15.4</td>
</tr>
<tr>
<td>30-34</td>
<td>17.6</td>
<td>15.6</td>
</tr>
<tr>
<td>35-39</td>
<td>16.0</td>
<td>15.7</td>
</tr>
<tr>
<td>40-44</td>
<td>17.0</td>
<td>17.0</td>
</tr>
<tr>
<td>45-49</td>
<td>18.1</td>
<td>17.6</td>
</tr>
<tr>
<td>50+</td>
<td>17.3</td>
<td>17.0</td>
</tr>
<tr>
<td>Total</td>
<td>16.3</td>
<td>14.8</td>
</tr>
</tbody>
</table>

a No cases

The difference between the age at first intercourse and age at first marriage is quite considerable for men, especially for males aged 40 and above. The average age difference between first sexual intercourse and first marriage is nine years for males compared to three years for females. This is not unique, given that traditionally Luo men tended to delay marriage until later ages when they had accumulated enough to pay for bridewealth (usually paid in the form of cattle and cash). There is also a tendency for polygynous men to marry younger wives.

However, there is now a decline in age at first marriage for males, with younger males marrying earlier than older males. Nowadays, consensual unions have become common and are widely accepted in both urban and rural areas, though traditionally such marital unions were accorded lower status. Today, young couples living in consensual unions formalise their marriage with the passage of time, birth of children and accumulation of financial capital for bridewealth transfers. Unlike that of men, the age at first marriage for women has increased by between two and three years, though
not uniformly. This may be attributed to rising levels of female education which delays marriage.

5.8 Relationship with first sexual partner

Table 5.8 displays the distribution of the nature of relationship the respondents had with their first sexual partner.

Table 5.8 Nature of relationship with first sexual partner by sex of respondents (%)

<table>
<thead>
<tr>
<th>Nature of relationship</th>
<th>Males No.</th>
<th>Males %</th>
<th>Females No.</th>
<th>Females %</th>
<th>Both No.</th>
<th>Both %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known for long time but not in steady relationship</td>
<td>40</td>
<td>25.5</td>
<td>69</td>
<td>19.4</td>
<td>129</td>
<td>22.4</td>
</tr>
<tr>
<td>Sexual partner who later became boyfriend or girlfriend</td>
<td>60</td>
<td>38.2</td>
<td>30</td>
<td>44.5</td>
<td>70</td>
<td>41.3</td>
</tr>
<tr>
<td>Spouse</td>
<td>11</td>
<td>6.9</td>
<td>11</td>
<td>7.1</td>
<td>22</td>
<td>7.0</td>
</tr>
<tr>
<td>Prospective spouse/engaged</td>
<td>13</td>
<td>8.3</td>
<td>14</td>
<td>9.0</td>
<td>27</td>
<td>8.7</td>
</tr>
<tr>
<td>Met for the first time/stranger</td>
<td>20</td>
<td>12.7</td>
<td>a</td>
<td>a</td>
<td>37</td>
<td>11.9</td>
</tr>
<tr>
<td>Prostitute (men only)</td>
<td>7</td>
<td>4.5</td>
<td>a</td>
<td>a</td>
<td>7</td>
<td>2.2</td>
</tr>
<tr>
<td>Relative</td>
<td>6</td>
<td>3.8</td>
<td>4</td>
<td>2.6</td>
<td>10</td>
<td>3.2</td>
</tr>
<tr>
<td>Coerced (females only)</td>
<td>a</td>
<td>a</td>
<td>10</td>
<td>6.4</td>
<td>10</td>
<td>3.2</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100</td>
<td>150</td>
<td>100</td>
<td>302</td>
<td>100</td>
</tr>
</tbody>
</table>

a no cases

The study found that a majority of people in the survey had their first experience of intercourse in an established relationship. For more than a third of males and over two-fifths of females in the sample, the event took place with someone with whom they had a steady relationship, but to whom they were not married or engaged.

It was uncommon for first intercourse to occur within marriage or with someone to whom marriage was planned. This is reflected in the data, in that less than seven per
cent of the respondents had first sexual intercourse with either wife or husband. The first sexual intercourse generally occurred with someone who the respondent knew for a period of time, even though the partners may have had no established relationship. Over a quarter of males and almost a fifth of females were in this category. It was common for first sexual intercourse to occur with a friend of a similar age; this may be a class or school mate, a neighbour's daughter or a friend who had been known for some time. Girls tended to have sexual partners in higher school classes, while boys have partners in lower classes. The initial stages of a relationship between a boy and a girl may have involved correspondence through love letters (especially among those in boarding school), dating and visiting each other at home in the absence of parents and guardians. Partners may have been introduced by friends, siblings or relatives. As intimacy developed intercourse occurred; at home, on the way to school or at a friend's place in the absence of parents and guardians. Most of my informants had their first sexual intercourse while still at school. Schools offer young people an opportunity for sexual contact and experimentation. Social events such as dances, parties and other social occasions marked by festivity also offer opportunities to meet a potential partner, flirt or engage in sexual intercourse. The sexual relationships in which most young people engage involve a single sexual episode ('one night stand' as is common in most recreational sexual relationships) or the partners may have an on-and-off relationship depending on opportunity.

In the survey, women were more likely than men to report a steady relationship with their partner at first sexual intercourse, 44.5 per cent for females and 38.2 per cent for males. The difference in the proportion of females and males reporting first intercourse with a stranger or someone they met for the first time was almost the same. Overall, more than a tenth of respondents reported a stranger as their first sexual partner.

First sexual intercourse was less likely to occur with prostitutes; fewer than five per cent of males reported having a prostitute as their first sexual partner (the term prostitute here is used to refer to a partner whom the respondent paid in cash for sexual intercourse or services). However, the term should be used with caution because in Kisumu there are many relationships which involve exchange of cash and
other goods that people do not categorise as prostitution. Thus some men who may have reported having sexual relationships with people they knew but were not in a stable relationship with, may have paid or offered some material incentive for sexual favours. Such liaisons in many instances are not regarded as prostitution by many men and women who are involved them. Studies in other parts of Africa have shown that transactions involving the exchange of money and other material support are a common phenomenon in many sexual relations (Caldwell, Caldwell and Quiggin 1989).

5.9 The context of first sexual intercourse

Respondents were asked to explain the context or circumstances surrounding first sexual intercourse. The selection of this question was based on the assumption that respondents could recall this event. The question was based and guided by earlier studies conducted in Africa and elsewhere (Anarfi 1993b). However it is necessary to be cautious because the responses given may have been a rationalisation after the event had occurred and may not reflect the true circumstance. Tables 5.9 shows per cent distribution of factors that influenced respondents’ first sexual intercourse.

Table 5.9 Factors influencing first sexual intercourse.

<table>
<thead>
<tr>
<th>Factors</th>
<th>Males</th>
<th>Females</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fun/enjoyment</td>
<td>31.6</td>
<td>25.3</td>
<td>28.5</td>
</tr>
<tr>
<td>In love</td>
<td>8.6</td>
<td>28.0</td>
<td>18.3</td>
</tr>
<tr>
<td>Curiosity</td>
<td>34.2</td>
<td>16.7</td>
<td>25.5</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>18.4</td>
<td>13.3</td>
<td>15.8</td>
</tr>
<tr>
<td>Offered or received money/gifts</td>
<td>7.2</td>
<td>11.7</td>
<td>9.4</td>
</tr>
<tr>
<td>Coercion</td>
<td>-</td>
<td>5.0</td>
<td>2.5</td>
</tr>
<tr>
<td>No of cases</td>
<td>152</td>
<td>150</td>
<td>302</td>
</tr>
</tbody>
</table>
Factors most commonly associated with first intercourse were fun and enjoyment (mentioned by almost a third of men and a quarter of women), and curiosity. For females the most important factor was that they were in love and did it as an expression of their emotional commitment to their partner, with more than 28 per cent citing this as the main reason for having first intercourse. Some of them reported that they succumbed because they feared losing their partner. For men, however, less than 10 per cent cited love as the factor which influenced their first sexual experience.

Social pressure, particularly from peers has been cited in various studies as a reason for young people having intercourse for the first time (Ocholla-Ayayo, Wekesa and Ottieno 1993b). Table 5.9 shows that males were more likely to be influenced by their peers to have sexual relations. Some respondents mentioned that they did it 'because most people in my age group were doing it' and therefore they wanted to experiment with sex. Ocholla-Ayayo, Wekesa and Ottieno (1993b) reported that in Kisumu, older girls tended to influence the sexual behaviour of each other because they go dating together (Ocholla-Ayayo 1985). During such dating the young girls are introduced to men with whom they later have sexual relations.

5.10 Premarital sexual relationships

There are various forms of sexual relationships among young people during adolescence and early adulthood. One of them I have categorised as ‘boyfriend-girlfriend’ relationship and the other as ‘friendship’. However, this distinction can sometimes be difficult to make. There are also various terms used by adolescents and young men and women to refer to their sexual partner. The most common terms used to refer to boyfriends and girlfriends is chotna. Sexual relationships generally occur among peers, but some unmarried women have older well-off men as sexual partners. These ‘sugar daddies’ are wealthy men such as businessmen, highly placed executives and bureaucrats who own property and lead comfortable lifestyles. In urban areas the young girls who go out with such men are referred to as ndogo ndogo : ndogo is a Swahili word which means small.
Boyfriend-girlfriend relationships are said to be characterised by deep affection and emotional commitment which is sometimes manifested through financial and material support of the female partner, usually in the form of gifts such as clothes, cosmetics, food and entertainment. Young people state that this type of relationship is based on love and romance. Boyfriend-girlfriend relationships develop over a long period and they involve partners scrutinising and sizing one another up for the possibility of establishing a long-term relationship and even marriage. From women’s perspective the ideal partner is one who is trustworthy and gentle and can provide for her and (if married) her children. From men’s perspective the ideal partner should be obedient, faithful, respectful and well-behaved, and have a good reputation. Boyfriend-girlfriend relationships are rarely acknowledged by the older generation and adolescents tend to be secretive about such relationships to avoid parental disapproval.

In contrast ‘friendship’ relationships are usually casual and are based on the exchange of money and various other forms of gifts. These relationships may occur on and off over a period of time and are easy to terminate.

Several male respondents emphasised that some young women get pregnant in order to prove their fertility and enhance their chances of getting married to their partner. However, some female respondents also claim that their boyfriends pressure them to have children so that they will marry them. Nevertheless, pregnancy in many premarital relationships does not necessarily lead to marriage. Single mothers find it difficult to marry other men if the father of their child refuses to marry them. Indeed in informal interviews, the majority of unmarried men frequently stated that they would be unwilling to marry a woman who has a child by another man. Many single mothers interviewed in informal interviews raised the point that potential suitors may not like their child hence they conceal it from them until later stages of the relationship. One female informant stated:

You can be lucky to find a man who likes you and wants to marry...but most men run away as soon as they discover that you already have a child with someone else (Single mother, 18 years old, rural area).
In interviews with informants it was frequently acknowledged that many young men have more than one girlfriend simultaneously. For instance, it is common for young men who work in Kisumu town to have a ‘permanent’ or ‘main’ girlfriend in the rural village whom they see once or twice in a month when they visit their rural homes. However, while in Kisumu town they are involved in less stable relationships with other women, including prostitutes. These other partners are typically referred to as ‘friends’.

Young men have a main girlfriend and others at the side...spare ones whom they just have fun with (Rural female respondent, 24 years old).

Interviewer: What is the difference between a main girlfriend and the other girls?

Respondent: The main girlfriend is the one you prefer most and are committed to...I mean you love most...with others there is no love but you are just with them for enjoyment (Urban male respondent, 27 yrs old).

Men usually have many girlfriends but among them there is one that they love most and are more committed to (Rural female, 20 yrs old).

I don’t bring all my girlfriends home...my main girlfriend is the only one known by my parents and relatives...she comes to our home and I visit her anytime without any problems. She is also close to my mother and sisters (Urban male, 24 yrs old).

The above statements indicate that men distinguish between main girlfriends to whom they are committed and others about whom they are not serious. There is more emotional attachment to the main girlfriend and men envisage having a long-term relationship with them which may lead to marriage. The relationships with other girlfriends are kept secret and can be easily terminated. Thus young men distinguish between women with whom they can commit themselves for a serious relationship and possibly marriage, and those for whom no form of commitment is expected. Young men expect their ‘main’ or ‘permanent’ girlfriend to remain faithful irrespective of their own fidelity. This seems to set the pattern for married life in which men have extramarital affairs while women are expected to be faithful.
Various studies have shown that adolescents and young unmarried people are motivated by various factors to enter into sexual relationships. The data obtained in this study indicate that respondents entered into such relationships to attain sexual experience and sexual satisfaction, for curiosity and financial and other gains. Others enter a relationship to find a marriage partner.

In in-depth interviews it was frequently claimed by both men and women that many premarital sexual relationships have an economic component. They emphasised that some young women have relationships with several boyfriends simultaneously because the men offer them things such as money, gifts and clothes or they pay for entertainment in the form of drinks, and food, and take them out to discotheques. For some young men and women one-night stands are also common. However, a few respondents stated that some young men also have sexual relationships with ‘sugar mummies’ although such relations are rare.

Young women who have children out of the wedlock go around with men because they need cash to feed and clothe their children...they also need to send their children to school to get a better education (Rural female, 38 years old).

The cases below show that some women engage in relationships which involve cash exchange for various reasons including poverty, the need to attain or maintain a certain lifestyle, emotional stability and social security.

Case 1

Alice is 21 years old and lives with her parents in Kisumu town. She completed her secondary school education two years ago, and is currently training as a secretary in one of the colleges in the town. She became sexually active at 16 years of age with a boyfriend who was slightly older than her. Alice has had short-lived sexual relationships with three men, two of whom she describes just as ‘friends’. In the last two years, she has had a steady relationship with her boyfriend, John, whom she sees every fortnight when he returns from college to Kisumu town. However, in the last year Alice entered a sexual relationship with an older man whom she describes as a close friend. He is married with five children, rich, has a well-paying job and drives a good car. He has promised to find her a job once she completes her secretarial training. He takes her out for drinks and dances in night clubs on the outskirts of Kisumu town. He also gives her money and buys her gifts. Alice says
she likes him because, unlike her steady boyfriend who is unemployed, he is able to provide for her financially and take her to 'big' places.

Case 2

Selina is 21 years old. She was born in Nyakach and moved to Kisumu town to live with her aunt after she dropped out of school at class eight because of her parents' inability to pay her school fees. She works as an attendant at Uchumi supermarket and lives with two friends in Nyalenda. She had sexual relationships with two boyfriends while living in Nyakach. Currently she has a boyfriend, Otti, whom she met at the supermarket. Otti is married with three children and his wife and children live in his rural home. Selina and Otti saw each other for a month before they started sleeping together. They see each other every evening after work and weekends. They spend the night together two or three times a week. Otti takes her out to nightclubs, discos and helps her out in paying rent and other necessities.

Case 3

Jacob is 28 years old and was born in Siaya. He works for an insurance company in Kisumu town. He is well paid and supports his parents and younger siblings in paying school fees and providing other necessities. He has a steady relationship with a girlfriend whom he says he loves a lot and is committed to marry in future. His girlfriend is training as teacher at a teacher training college. He visits her twice a month in college and they see each other every day when she is on vacation. Jacob pays for her fees at college, clothes and other necessities. Her mother is aware of this arrangement but says nothing about it.

Case 4

Pauline is 23 years old and lives with her parents and eight siblings in the exclusive suburb of Kisumu town called Milimani. Her father is a prominent businessman in Kisumu town and her mother is a teacher. She completed secondary school education in 1992 and then trained in a secretarial college in Kisumu town. Pauline works as a secretary at the Kenya Breweries plant in Kisumu town. She has a steady relationship with a boyfriend, Ken, whom she considers her 'permanent' boyfriend. However, she also has a sexual relationship with another man whom she met at a party. She has been seeing him for the last six months. He is much older, rich and drives a nice car. He is also married with children. He takes her out to 'big' hotels and clubs in the outskirts of Kisumu town. He pays for everything including food, drinks and entertainment. Pauline say that she likes her 'permanent' boyfriend more than her lover because he is honest and faithful. She expects to get married to him in future.
Some young women have relationships with older wealthy men, not only for economic need but also because of the emotional stability they derive from such relationships.

Young men have many girlfriends and you cannot trust them...They make false promises, such as marriage but they are just after sex and then they run away to the next woman...they do not make any effort to keep you comfortable but it is different with ‘sugar daddies’. They treat you with respect and care for you. They make an effort to maintain the relationship unlike young men (Urban female, 22 years).

However, young men disagree with this sentiment and assert that women have relationships with older and wealthy men because of economic gains. Others argue that these older men make fewer sexual demands.

Nowadays girls like to go out with men who have money and can afford to buy them gifts. It is difficult to find a girl if you don’t have any money...I find it easy to get girls when I have money. At the end of the month when I get my salary there are many women all over me but when the money runs out they disappear until the next pay day (Urban male, 26 years old).

Unlike women, young men assert that they engage in sexual relations for sexual satisfaction hence they always try to find girls to have a sexual relationship. Young men claim that it is difficult to have a long-term relationship with girls, especially in town, because they run away with men who have money.

5.11 Sexual networking

In the absence of protective measures such as condom use, one of the principal behavioural components that affects the risk of infection with an STD, including AIDS, is the number of sexual partners. Patterns of sexual partner vary widely across individuals, groups of people and societies (Ocholla-Ayayo et al. 1993a). There is abundant literature about Africa that has shown that individuals are involved in different kinds of sexual partnerships at varying stages of their life (Caldwell, Caldwell and Quiggin 1989; Setel 1995). Studies on sexual networking conducted by other researchers since the emergence of the AIDS epidemic in Africa provide
evidence of marked differences in the number of partners reported by individuals at different moments of time (Anarfi and Awusabo-Asare 1993a). The following section reports on the number of sexual partners reported by survey respondents for different time intervals and attempts to provide some explanation for the variation.

Respondents were asked the number of heterosexual partners they had had over a series of time intervals. The term “heterosexual partners” here refers to all the partners with whom the respondent had penetrative sex, whether once, a few times or numerous times. Those who reported never having had sex were not asked this question. In order to capture the variability of sexual behaviour, and to assess patterns of partner change, questions were asked on the number of sexual partners over three different time intervals: three months; six months; one year and over. The data are restricted to a short period of one year to avoid recall bias. However, there may be recall bias in data on lifetime partners stemming from recall error problems, especially for older respondents who have to remember distant sexual activity.

5.11.1 Number of lifetime sex partners by selected background characteristics

Table 5.11 shows the distribution by percentages of number of sexual partners in a lifetime by age group of men and women. ‘Lifetime partners’ here refers to all those partners with whom the respondent had ever had sexual intercourse, irrespective of whether they had an established relationship or whether the encounter was a single sexual episode.

The majority of men reported having had more than one sexual partner in their lifetime. Fewer than 20 per cent of males aged 15-29 had had a sexual intercourse with only a single partner. About 30 per cent of males aged 15-29 reported six or more lifetime partners while 53 per cent of males aged 30 and above reported six or more lifetime partners. The difference between the younger males and the older males in the number of partners may be influenced by two factors. First, the youngest age-group is only starting sexual activity and hence reported fewer partners, but in future they may venture into a series of sexual relationships, sometimes concurrently, before establishing a stable relationship. Secondly, the higher proportion of sexual partners
reported by older men is because men generally have a long period of high sexual activity before marriage and they continued having sexual relations with other partners even after marriage.

Table 5.10 Lifetime number of sexual partners of respondents by current age (%).

<table>
<thead>
<tr>
<th>Lifetime no of partners</th>
<th>MALES 15-19</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30.0</td>
<td>17.2</td>
<td>8.8</td>
<td>a</td>
<td>a</td>
<td>a</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>2-3</td>
<td>38.8</td>
<td>22.8</td>
<td>20.5</td>
<td>19.6</td>
<td>20.0</td>
<td>11.6</td>
<td>19.3</td>
<td>12.8</td>
</tr>
<tr>
<td>4-5</td>
<td>12.5</td>
<td>31.4</td>
<td>29.4</td>
<td>39.0</td>
<td>26.7</td>
<td>17.7</td>
<td>21.0</td>
<td>47.2</td>
</tr>
<tr>
<td>6+</td>
<td>19.5</td>
<td>28.6</td>
<td>41.3</td>
<td>41.4</td>
<td>53.3</td>
<td>70.7</td>
<td>59.7</td>
<td>40.0</td>
</tr>
<tr>
<td>Total no.</td>
<td>11</td>
<td>32</td>
<td>37</td>
<td>21</td>
<td>16</td>
<td>20</td>
<td>8</td>
<td>7</td>
</tr>
</tbody>
</table>

FEMALES

<table>
<thead>
<tr>
<th>Lifetime no of partners</th>
<th>MALES 15-19</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45-49</th>
<th>50+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>28.4</td>
<td>37.3</td>
<td>59.2</td>
<td>53.8</td>
<td>61.1</td>
<td>63.0</td>
<td>66.5</td>
<td>73.3</td>
</tr>
<tr>
<td>2-3</td>
<td>61.3</td>
<td>47.6</td>
<td>12.3</td>
<td>16.9</td>
<td>24.2</td>
<td>27.6</td>
<td>25.2</td>
<td>21.6</td>
</tr>
<tr>
<td>4-5</td>
<td>10.3</td>
<td>10.1</td>
<td>19.2</td>
<td>17.5</td>
<td>14.7</td>
<td>9.4</td>
<td>8.3</td>
<td>5.1</td>
</tr>
<tr>
<td>6+</td>
<td>0.0</td>
<td>5.0</td>
<td>9.3</td>
<td>12.1</td>
<td>a</td>
<td>a</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>Total no.</td>
<td>28</td>
<td>46</td>
<td>23</td>
<td>27</td>
<td>12</td>
<td>2</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

a No cases

Consistent with many other surveys on sexual behaviour (Ocholla-Ayayo et al. 1993a) men of all ages reported higher numbers of sexual partners than women. Almost half the women reported one lifetime sexual partner, with women in the older age groups reporting fewer lifetime sexual partners. This may be explained by generation differences between young and older women; older women tend to be more conservative than younger women in their sexual behaviour, and many reported having spouses as their only sexual partners. Many young women enter sexual relationships with one or more partners as an economic strategy that is central to their ability to support themselves and their children. On average, 29 per cent of sexually active females aged between 20 and 34 reported four or more partners. However, it is possible that women were under-reporting and concealing their sexual behaviour. It
clearly emerged from informal interviews and group discussions that women who have many partners are regarded as loose and not capable of making good wives. Table 5.11 shows the distribution by percentages of number of lifetime partners by marital status and level of education.

Table 5.11 Lifetime number of sexual partners by current marital status and highest level of education attained (%).

<table>
<thead>
<tr>
<th>Lifetime partners</th>
<th>Never married</th>
<th>Married</th>
<th>Separated</th>
<th>Widowed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>1</td>
<td>5.2</td>
<td>11.7</td>
<td>0.0</td>
<td>3.3</td>
</tr>
<tr>
<td>2-3</td>
<td>32.5</td>
<td>46.7</td>
<td>20.2</td>
<td>65.0</td>
</tr>
<tr>
<td>4-5</td>
<td>26.1</td>
<td>21.6</td>
<td>28.3</td>
<td>13.3</td>
</tr>
<tr>
<td>6+</td>
<td>36.2</td>
<td>20.0</td>
<td>51.5</td>
<td>18.4</td>
</tr>
<tr>
<td>Total No.</td>
<td>69</td>
<td>60</td>
<td>82</td>
<td>60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>No education</th>
<th>Primary incomplete</th>
<th>Primary complete</th>
<th>Secondary and above</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
<td>Female</td>
</tr>
<tr>
<td>1</td>
<td>0.0</td>
<td>6.3</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>2-3</td>
<td>13.0</td>
<td>31.3</td>
<td>17.2</td>
<td>38.1</td>
</tr>
<tr>
<td>4-5</td>
<td>20.0</td>
<td>25.0</td>
<td>20.3</td>
<td>31.2</td>
</tr>
<tr>
<td>6+</td>
<td>67.0</td>
<td>37.4</td>
<td>62.5</td>
<td>30.7</td>
</tr>
<tr>
<td>Total No.</td>
<td>25</td>
<td>16</td>
<td>24</td>
<td>26</td>
</tr>
</tbody>
</table>

a no cases
10 missing cases not sexually active.

The majority of married and unmarried males had sexual experience with more than one partner in their lifetime. Among the unmarried respondents, women were twice as likely as men to report having a single lifetime sexual partner. There is a difference in the number of lifetime partners according to marital status. Among men, married males report more lifetime partners with more than three-quarters reporting five or more lifetime partners compared with two-thirds of unmarried men. This may be a reflection of past sexual activity or regular contact with women other than the wife. However the opposite can be said of women, in that never-married women reported
more lifetime sexual partners than married women. About two-fifths of never-married women reported having more than four lifetime partners compared to about a third of married women. The explanation for this may be that young married women, like men, move into a series of relationships, with some being very unstable and others running concurrently, before they settle in a stable relationship. Women who were divorced, separated or widowed reported a high proportion of life-time sexual partners. About 85 per cent of separated, divorced or widowed women reported five or more partners. This may be attributed to their reliance on multiple sexual relations as a survival strategy. Studies on sexual behaviour in Africa have reported that many formerly married women enter into a series of relationships as a way of securing necessary resources (Ulin 1992; Rutenburg, Blanc and Kapiga 1994).

Similarly, the results for education groups show that there are differences in sexual experiences according to level of education. The proportion of males and females with four or more lifetime partners decreases with level of education, with 87 per cent of men with no education reporting four or more partners, in comparison with 58 per cent of men with secondary or higher education. For females, over 60 per cent of those with no education and less than 0.5 per cent of those with secondary or higher education report this number. Generally, less educated men and women were more likely to reported higher numbers of sexual partners. Males with no education and those with incomplete primary education were more than twice as likely to report six or more partners as those with secondary education or higher.

5.11.2 Sexual networking of survey respondents in different periods of time

One of the primary goals of this study was the enumeration of sexual partners and the determination of sexual networking among survey respondents. The previous analysis of lifetime partners has already touched on this. This section focuses on the total extent of sexual networking over different periods of time. It examines responses to a series of chronological questions on the number of sexual partners the survey respondents had within several time intervals preceding the survey, notably, a year, six months, and a month. The findings are summarised in Table 5.11.3 and they show a
marked variation in the number of partners reported by men and women, and across
the age groups, for all the various periods that were asked during the interviews.

Table 5.12 Number of sexual partners at different periods by sex and current age
of respondent (%).

<table>
<thead>
<tr>
<th>Current age of respondent</th>
<th>15-24</th>
<th>25-34</th>
<th>35+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Both</td>
</tr>
<tr>
<td>Previous Year None</td>
<td>15.4</td>
<td>7.7</td>
<td>11.6</td>
</tr>
<tr>
<td>1</td>
<td>29.1</td>
<td>81.4</td>
<td>55.3</td>
</tr>
<tr>
<td>2-3</td>
<td>43.4</td>
<td>7.3</td>
<td>25.3</td>
</tr>
<tr>
<td>4+</td>
<td>12.1</td>
<td>3.6</td>
<td>7.8</td>
</tr>
<tr>
<td>Previous six months None</td>
<td>10.3</td>
<td>6.3</td>
<td>8.3</td>
</tr>
<tr>
<td>1</td>
<td>47.3</td>
<td>88.8</td>
<td>68.1</td>
</tr>
<tr>
<td>2-3</td>
<td>42.4</td>
<td>4.9</td>
<td>23.6</td>
</tr>
<tr>
<td>4+</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Previous one month None</td>
<td>10.3</td>
<td>7.6</td>
<td>8.9</td>
</tr>
<tr>
<td>1</td>
<td>77.5</td>
<td>88.3</td>
<td>82.9</td>
</tr>
<tr>
<td>2+</td>
<td>12.2</td>
<td>4.1</td>
<td>8.2</td>
</tr>
<tr>
<td>Total No.</td>
<td>45</td>
<td>74</td>
<td>119</td>
</tr>
</tbody>
</table>

As expected, males generally reported a greater number of sexual partners than
females; for instance in the year preceding the survey, over 80 per cent of women
reported having had a single sexual partner compared with less than a fifth of sexually
active males. Those who reported a greater number of partners were likely to be living in urban areas. There were also differences by age; younger males and females aged 15-24 reported fewer partners than the older age groups aged 25 and above. The proportion of respondents (both male and female) reporting no partner decreased by age; younger respondents aged 15-24 reported fewer partners, but the proportion for males was higher. For the most recent period of one month, females aged 35 and above were twice as likely as those aged 15-24 to report no sexual partner, but for males those aged 24-34 were least likely to report no partner.

Although the figures for lifetime sexual partners reflect a great deal of sexual networking, the proportion of multiple relations tended to decline in recent periods. While over 90 per cent of sexually active respondents reported more than one lifetime partner, less than half of the males and less than a third of females reported multiple relations in the previous one year (not shown in table). The proportions declined further in the month preceding the survey; less than a fifth of males and less than a tenth of females reported multiple partners in the previous month.

5.12 Extramarital relations

It has been found in a number of studies in Sub-Saharan Africa that married people have sexual relations other than with their spouses (Karanja 1987; Caldwell, Caldwell and Quiggin 1989; Anarfi 1992, and 1993a). These studies show that extramarital relations are more common among men, especially in urban areas. Unprotected sexual contacts between infected and uninfected people outside marriage have implications for the spread of sexually transmitted diseases, including AIDS. The following section examines the sexual behaviour of married men and women outside marital unions. It begins by exploring attitudes towards extramarital relations and their implication for female sexual rights. The data presented here were obtained through survey questionnaires, focus group discussions and in-depth interviews with key informants.

There is extensive evidence in the literature that shows that extramarital relations for women were strictly prohibited (Ocholla-Ayayo 1976; Potash 1978; Parkin 1978). These studies show that the Luo community has strongly condemned women’s
extramarital sexual relations but those of men are treated leniently. Among the Luo, a woman is expected to have sexual relations with one man, her husband. Punishment takes the form of beating and in some cases separation and divorce if the offence is persistent. It has also been observed that in the past there was a widely held belief that adultery could result in *chira*, a mysterious fatal disease (Ocholla-Ayayo 1976; Parkin 1978; Caldwell et al. 1994a). Parkin reported that adultery with a married woman with children might result in *chira* affecting both the man and the woman's children and even his patrilineage (1978:140-141). However, adultery is not the only cause of *chira* in that there are other causes such as incest, sex with prohibited persons and violation of rules of seniority (Ocholla-Ayayo 1976). But there were circumstances in which sexual relations within the extended family were condoned and not regarded as adultery, such as cases where a man who was not capable of impregnating his wife could arrange for his brother or close kinsman to beget children who were regarded as his own (Ocholla-Ayayo 1976).

Extramarital relations involving married women are often not publicised, but they do occur as this study has confirmed. One rural in-depth interview informant said:

> Nowadays things have changed....with the prevailing hard economic conditions it is hard for some women to remain faithful because a woman has very many responsibilities to support the family, especially their children when their husband is in town working. Sometimes she can not meet all these needs and of course they start having affairs with rich men or those who give them money and other things (School teacher, 41 years old, rural area).

Interviewer: Do married women have sexual relations with other men

Respondent 1: Some women do have secret lovers but this usually happens if the husband is not there or when he is not capable of performing his sexual duties properly...but they do it secretly behind their husband’s back...it is hidden.

Respondent 2: The only time in our custom that a woman is allowed to have sex with another man other than her husband is when the husband is not capable of fathering children, she is allowed to have sex with his brother to beget him children...these children are regarded as his and have his own blood. Otherwise she is expected to remain with her husband and not run around... those who run around end up being thrown out by their husbands.

Respondent 3: Some women who are married to very old men have sex with younger men secretly....these old polygynous men have five to ten wives, they cannot sexually satisfy them all. This is one of the reasons why Luo homesteads have two gates; the main one or *rang'ach* and the smaller one *rot*. Husbands enter their homes through the
front gate and always whistle or talk loudly so that if any of his “brothers” are around, they can leave quickly through the smaller gate. These sexual relations are kept secret because if the husband finds out the wife is severely punished (Group discussion, rural area).

There is much secrecy surrounding such relationships because the woman faces serious consequences if she is found out. Luo men take it seriously when their wives stray with other men because it leads to loss of respect and honour among kinsmen and friends. A man whose wife strays is seen as weak and hence not respected, sometimes he may be ridiculed by peers. It brings shame and embarrassment to the husband when such relations become publicised, and the woman is always blamed for tainting her husband’s honour. Parkin (1978) found among the Luo living in Nairobi that:

To lose a wife through desertion or to be cuckold reflects severely on a man’s honour...for most Luo, adultery by a woman is always tantamount to divorce, for it is not normally reckoned that a marriage can survive the dislocation of a husbands’ honour (Parkin 1978:161)

The strong attitude against female adultery was expressed in focus group discussions, especially among the elderly males:

Interviewer: Do married women have sexual relations with other men?

Respondent 1: Yes...some of them have secret lovers. These types of women are unsatisfactory wives...they are not worth marrying because they always cause problems. One day they go with this person and tomorrow they are with someone else...they are like prostitutes.

Respondent 2: Like he said, some of them do that...but men don’t take it lightly when their wives run around with someone else...she belongs to her husband and he is the only one who should have sex with her otherwise why did she marry him.

Respondent 3: Some of the young girls who get married nowadays are not faithful...they have lovers...they do not have respect for their husbands...if a woman has sex with someone other than her husband it shows he is weak and other men will ridicule him.

Respondent 4: A woman who sleeps around with other men betrays her husband and this is a very good ground for her husband to throw her out of his house (Group discussion, men aged 50 and above, rural).

Some men hold the view that adultery at least on the part of the wife is unquestionable grounds for divorce. It is expected that when a woman commits adultery and her
husband finds out, the relationship between her and her lover should break up, but if she continues with the affair, the husband has good grounds for divorce. When asked if adultery is ground for divorce, one male informant responded that 'adultery is equivalent to betrayal! And that is that!'. In the past, women's adultery was considered sufficient ground for marriage dissolution. It is common among the Luo that when marriages are dissolved, children, especially males, remain with their father because by virtue of his having paid bridewealth they belong to his lineage (Potash 1978). Many females interviewed in focus group discussions concur that the fear of being thrown out by the husband because of adultery discourages many women from extramarital sexual relations.

Interviewer: Does the fear of being thrown out by the husband scare women not commit adultery?

Respondent 1: Some women commit adultery, but this is rare because the husband may find out...brothers, sisters or even parents and relatives will tell...people also start gossiping about it. When the husband finds out she can be beaten or sent back to her parents if she persists with running around.

Respondent 2: Yes, many women fear it...men can take other women because their wives would do nothing if they found out. If a woman is found out, she is thrown out of her husbands’ house and she has nowhere to go...she even loses her children. I think that not very many women here in this village have lovers.

Respondent 3: Not only the fear of losing children...a nyasigogo (a divorced or separated woman) is not respected...such a woman cannot easily get married...maybe only among people who don't know her well, or as a second wife (Focus group discussion, rural females aged 50 and above).

The same rigorous code of morality is rarely applied to men's sexual behaviour outside marriage. Men's extramarital sexual relations are more tolerated and seem to be tacitly accepted. It has been suggested that polygyny tends to promote multiple sexual relationships (Anarfi 1993b; Caldwell et al. 1993b; Talle 1995). The Luo marriage system provides for men to have multiple sexual relationships through the practice of polygyny hence, the majority of men who tend to rationalise extramarital sexual relations with the argument that it is a Luo custom to marry more than one wife. Thus, such relations are regarded as precursor to a second or even third marriage. However this is a rationalisation because in may such relations there is no prospect of a marriage.
It was mentioned by young and elderly people in in-depth interviews that it is common for married men to have sexual relations other than with their wives but there is no prospect of a marriage being sought.

Some rich married men here in Kisumu are very wicked...they have corrupted many young girls with money. You see them going to bars and nightclubs. Most of the girls who go with such men do so because they are poor and want money.

As women get old they stop having sex because they lose the interest. So the husband gets tempted to get a girlfriend whom he keeps as a lover, or he marries a second wife. Nowadays you even see a man going with very young girls the same age as his daughter.

Most men when they go to work in towns, they don't go home regularly to see their wife or children. Some of them disappear in town and get other women whom they spend all their money with. I know of men in this village who have gotten lost in the city (Nairobi) and they rarely come home. Their wives have been forced to seek help from relatives as though they have no husband to support them.

In the rural areas, male extramarital relations occur with married and formerly married women whom the men have known for some time or even grew up with. In urban areas, men who leave their wives in rural areas for work reasons, tend to take girlfriends and other lovers in the places of work or where they reside.

Respondent 1: Yes, men take lovers when they have the chance...they go to prostitutes or other free women.

Respondent 2: When men go to town and leave their wives behind in the village they take girlfriends who cook, wash their clothes. Some of them go with prostitutes.

Respondent 3: Some men have very strong sexual drives. They cannot be satisfied with one woman...that is why some men take lovers or marry second or third wives.

As noted elsewhere, the common characteristic of labour migration in Africa is for the husband to leave his wife in the rural area to do the agricultural work while he seeks wage employment in towns or agricultural plantations. Some men are also engaged in occupations which make them highly mobile such as fishing, trade and transport. Studies in other parts of Africa show that married migrant workers and transients are usually involved in a wide sexual network that places them at risk of contracting STDs and HIV and later transmitting it to their wives (Karanja 1987, Caldwell, Caldwell and Quiggin 1989; Larson 1989). They engage in sexual relations with prostitutes, mistresses and other women in the places where they work or visit. The
‘sugar-daddy’ phenomenon of relationships between relatively affluent married men and young women has been widely documented (Van de Walle 1990).

Even though wives might know about their husbands’ extramarital affairs there is little that they can do to change their husbands’ behaviour. The following two cases of women with husbands engaged in extramarital affairs clearly illustrates the difficulties women face in marriage.

Case 1
The first case involves Atieno, a woman aged 36, married into a relatively well-to-do family. She had seven years of primary education. She has four children who live with her. She lives in Nyabera while her husband lives and works in Kisumu. Her husband also has a small retail shop in her local market centre which she manages on his behalf. Atieno’s husband visits his rural area once a month and she also pays him a visit in Kisumu town occasionally. During one of her visits to town she discovered that her husband had a girlfriend whom he was keeping in his house. When she asked him about it they had a big quarrel and he threatened to beat her. Since then things have not been all right between them. He now rarely visits his family and remits money to his family infrequently. Atieno has complained to her parents-in-law and relatives about her husband’s behaviour. They have tried to talk to him but he remains stubborn and says he intends to marry the girl as a second wife. Asked whether she intended to leave her husband, Atieno said that there is nothing much she could do because leaving her husband means that she leaves her children behind.

Case 2
The second case involves Muganda, a woman aged 24 years old from Homa Bay. She is married to a man who is much older than her. They have three children, all of them girls. He is a jua kali (an artisan in the informal sector) and they leave in Kondele. Their first few years of marriage were happy until he started drinking chang’aa a lot and going out with other women. They always have quarrels when he is drunk. He tells her that she is useless because she has not born him a son. He also does not give her adequate support and spends all the money that he earns, drinking with friends and prostitutes. Muganda says that sometimes her husband doesn’t come home for days at all. She says that he has girlfriends and goes around with prostitutes. She knows some of the girls whom her husband runs around with and has confronted them on a number of occasions. He denies it when she complains to him about his bad behaviour and mistreatment. She informed her own relatives and her husband’s relatives about his waywardness. They talked with him and he complained that he does what he does because Muganda cannot bear him a son. They told him to take care of his wife or take a second one if he seriously needed one but he ignored what they told him. She however does not consider leaving her husband because of fear of losing her children and her parents wouldn’t want to take her back or repay her husband’s bride wealth. She would have nowhere to go because she does not have a good education to get a job. People will also look down at her for deserting her husband.
The above cases show that women have very limited control over their spouses’ extramarital sexual activities and the risk of infection with STDs that results. Although these women may want to leave their unstable marriages, they are unable to do so because they have limited economic resources to support themselves independently, and they risk losing their children.

5.12.1 Sexual relations outside marriage

It has been reported elsewhere in Africa that extramarital relations are more common among men than females. Karanja (1987) has reported about informal polygyny in which men have ‘outside wives’, especially in urban areas. Enel and Pison (1992) also report that in Mlomp, Senegal, 20 per cent of males had extramarital relationships. To assess sexual networking outside marriage the questionnaire asked all ever-married respondents if they had ever had sexual relations other than with their spouse, who their partners were, and how many times they had ever had sex with someone else other than their spouse and in the year preceding the survey.

Table 5.13 displays the distribution of percentages of currently married respondents who had ever had sexual intercourse other than with their spouse and the type of partners they ever had by sex and residence.
Table 5.13 Currently married respondents who ever had sexual intercourse with partners other than spouse and type of partners by sex and residence (%).

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Ever had sex other than with</td>
<td>52.6</td>
<td>28.8</td>
<td>9.2</td>
<td>21.9</td>
</tr>
<tr>
<td>spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of other partner ever had</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sex with</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse only</td>
<td>47.4</td>
<td>61.9</td>
<td>80.8</td>
<td>78.1</td>
</tr>
<tr>
<td>Spouse and casual partners only</td>
<td>18.4</td>
<td>16.7</td>
<td>19.2</td>
<td>21.9</td>
</tr>
<tr>
<td>Spouse and prostitutes only</td>
<td>10.5</td>
<td>14.3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Spouse, prostitutes and casual</td>
<td>23.8</td>
<td>7.1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>partners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of other partners ever</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>had</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>35.0</td>
<td>58.3</td>
<td>60.0</td>
<td>57.1</td>
</tr>
<tr>
<td>2-3</td>
<td>40.0</td>
<td>25.0</td>
<td>40.0</td>
<td>28.6</td>
</tr>
<tr>
<td>4 +</td>
<td>25.0</td>
<td>16.7</td>
<td>-</td>
<td>14.3</td>
</tr>
<tr>
<td>Total No.</td>
<td>38</td>
<td>42</td>
<td>26</td>
<td>32</td>
</tr>
</tbody>
</table>

As expected, more males than females report ever having sexual contact with other partners. Almost 40 per cent of all currently married respondents reported ever having had sexual intercourse with a partner other than their spouses, although almost half of the proportion reporting were urban males. For females 15 per cent reported having ever had sexual relations outside their marital union but more rural females reported this than urban ones. Males in monogamous unions were more likely to report having ever had sexual contact with partners other than their spouse. About 18 per cent of males report ever having contact with casual partners; three-quarters (not shown in table) of their partners are women (mostly single or formerly married women) whom the men had known for some time or had previously had a sexual relationship with such as former girl friends. A few men mentioned that they had sexual contact with a
married woman with whom they had a relationship previously. About 28 per cent reported that apart from their wives they had sexual engagement with both casual friends and prostitutes. A majority of the women who reported having ever had another partner other than spouse were in polygynous unions and their sexual partner was a married man whom they knew very well.

It has been reported that extramarital sexual relations in Sub-Saharan Africa tend to have an economic component; Orubuloye, Caldwell and Caldwell (1992) reported that in Ondo town, Nigeria, the majority of male extramarital relations involve the exchange of money, gifts and other economic support. All male respondents who mentioned ever having extramarital relations were asked whether they gave any assistance to their partners and what kind of assistance it was. Table 5.14 shows the per cent distribution of the responses to these two questions.

**Table 5.14 Responses of men to questions about the nature of extramarital transactions (%).**

<table>
<thead>
<tr>
<th>Question</th>
<th>Urban</th>
<th>Rural</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you give any help or assistance?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>85.6</td>
<td>73.1</td>
<td>79.4</td>
</tr>
<tr>
<td>No</td>
<td>14.4</td>
<td>26.9</td>
<td>20.6</td>
</tr>
<tr>
<td>What kind of assistance did you give?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money</td>
<td>58.2</td>
<td>68.4</td>
<td>63.3</td>
</tr>
<tr>
<td>No money but gave other assistance e.g.</td>
<td>26.8</td>
<td>11.3</td>
<td>19.1</td>
</tr>
<tr>
<td>food, rent, fees .</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other favours e.g. employment</td>
<td>15.0</td>
<td>20.3</td>
<td>17.6</td>
</tr>
<tr>
<td>No. of cases</td>
<td>38</td>
<td>42</td>
<td>80</td>
</tr>
</tbody>
</table>

About 80 per cent of males reported having given some help or assistance to their partners, but it was more common for males in urban areas to do so. Over 60 per cent of men's extramarital transactions involved money while more than 19 per cent
involved other assistance such as paying for the woman's accommodation, food, drink and entertainment. Other forms of assistance which were reported included paying school fees, and buying clothes and other presents for the extramarital partner. The following case shows that extramarital relations involve some degree of economic support.

Dolly is 21 years old and was born in Sondu. She has form four level education and is currently attending a secretarial course in Kisumu town. She lives with her aunt and her three children. She began dating and having sexual intercourse at the age of 14 with an older boy from her primary school. Since then she has had another four sexual partners. Her present boyfriend is a university student in Nairobi. She says that they see one another every three to four months and communication between them is difficult.

Eight months ago she began dating Andrew, to whom she was introduced by a former school mate. However, three months after they started dating she heard rumours that he was married with two children. At first, she did not believe it because she thought her friends were jealous of her. He brushed the issue aside when she asked him and always avoids talking about it.

Andrew is rich and owns several houses in Kisumu and matatus (public transport vehicles). He lives with his wife and children in one of the affluent suburbs in Kisumu town. He takes her out to night clubs, restaurants and bars for entertainment. He also buys her clothes (she dresses fashionably) and food and gives her cash, and three months ago he started paying her college fees.

5.12.2 Women’s attitudes to men’s extramarital sexual relations

The survey questionnaire contained questions aimed at exploring the attitudes of married women to men’s extramarital affairs. Respondents were asked whether married men have sex with other women, whether husbands visit prostitutes, whether husbands have a right to have extramarital affairs without their wives’ interference and whether a wife has a right to disapprove of husband’s extramarital activities. Responses to these questions are displayed in table 5.15.
Table 5.15 Responses of currently married to questions on married men’s extramarital sexual relations by residence (%)

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do married men have sex with other women?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>73.1</td>
<td>81.2</td>
</tr>
<tr>
<td>No</td>
<td>26.9</td>
<td>18.8</td>
</tr>
<tr>
<td>Do married men go to prostitutes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>38.5</td>
<td>46.9</td>
</tr>
<tr>
<td>No</td>
<td>61.5</td>
<td>53.1</td>
</tr>
<tr>
<td>Do married men have a right to extramarital affairs without their wife’s interference?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>32.6</td>
<td>27.8</td>
</tr>
<tr>
<td>No</td>
<td>67.4</td>
<td>72.2</td>
</tr>
<tr>
<td>Do wives have right to disapprove their husbands extramarital affairs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18.5</td>
<td>28.3</td>
</tr>
<tr>
<td>No</td>
<td>81.5</td>
<td>71.7</td>
</tr>
<tr>
<td>Total No</td>
<td>26</td>
<td>32</td>
</tr>
</tbody>
</table>

There are differences between rural and urban women with regard to responses on men’s sexual behaviour. More than three quarters of urban and rural women affirm that married men have sexual relations with women other than their wives. However, less than two-fifths of urban women and almost half of rural women believed that married men go to prostitutes. When asked whether their own husbands visited prostitutes, only five per cent of all currently married women reported that they knew that their husbands visited prostitutes. This may be attributed to the fact that married men are more secretive about their sexual relations with prostitutes than with non-prostitute partners.
The majority of currently married women believed that husbands do not have a right to extramarital relations without their wives’ interference. However, many emphasised that although they have a right to intervene in their husbands’ extramarital relations, that there is very little that a wife can do to stop them from having extramarital affairs. The concern of many married women is with the preservation of their marriage. Some emphasised that as long as husbands are discreet, there is no problem. More than a third of urban females and more than a quarter of rural women believed that husbands have a right to extramarital affairs without their wives’ disapproval, with the main reasons being ill-health of the wife, barrenness and pregnancy.

5.13 Perceptions about male and female sexuality

5.13.1 Men’s attitude towards sex

In the survey, attempts were made to explore men’s attitudes to sex through several questions including, whether one woman is sufficient for a man, whether men need more than one woman, and whether males are different from women in their need for sex. All sexually active male respondents were also asked the reasons for their responses. Table 5.16 displays percentage distributions of responses to these questions.
Table 5.16 Men’s attitude to sex, male respondents

<table>
<thead>
<tr>
<th>Question</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is one woman sufficient for a man?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>51.9</td>
<td>48.0</td>
</tr>
<tr>
<td>No</td>
<td>48.1</td>
<td>52.0</td>
</tr>
<tr>
<td>Total No.</td>
<td>77</td>
<td>75</td>
</tr>
<tr>
<td>If yes, why can a man be satisfied with one woman?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To avoid STDs and AIDS</td>
<td>62.5</td>
<td>52.8</td>
</tr>
<tr>
<td>Avoid marital/relationship problems</td>
<td>25.0</td>
<td>22.2</td>
</tr>
<tr>
<td>Maintain respect and dignity in the community</td>
<td>7.5</td>
<td>13.9</td>
</tr>
<tr>
<td>Religious reasons</td>
<td>5.0</td>
<td>11.1</td>
</tr>
<tr>
<td>Total No responded ‘yes’</td>
<td>40</td>
<td>36</td>
</tr>
<tr>
<td>If no, why can’t men be satisfied with one woman?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for sexual variation</td>
<td>24.3</td>
<td>17.0</td>
</tr>
<tr>
<td>Men have insatiable sexual drive</td>
<td>40.5</td>
<td>41.5</td>
</tr>
<tr>
<td>men are polygynous by nature</td>
<td>32.4</td>
<td>31.7</td>
</tr>
<tr>
<td>Psychological satisfaction</td>
<td>2.8</td>
<td>9.8</td>
</tr>
<tr>
<td>Total No. responded ‘no’</td>
<td>37</td>
<td>41</td>
</tr>
</tbody>
</table>

When asked whether one woman is sufficient for a man, slightly more than half of urban males and less than half of rural males believed this was correct. Younger and more educated males were more likely to state that a man can be sexually content with one woman than those in the older generation and those who were in polygynous marriages. The main reasons given why men can be satisfied with one woman included the desire to avoid STDs and AIDS and to avoid marital problems. Some respondents mentioned the need to maintain respect and dignity in the community. A man who ‘moves around’ with many women has no time for his wife and family, hence is not respected. The fact that STDs and AIDS were mentioned as major reasons to be monogamous indicates a rise in the levels of awareness about the
dangers of multiple sexual relations and the AIDS epidemic. A few staunch Christians maintained that for religious reasons men should not have other partners.

About two-fifths of both urban and rural males believed that one woman is not sufficient for a man. It was emphasised in informal interviews that men have a constant insatiable sexual drive and hence need more than one woman. About 24.3 per cent of urban males and 17 per cent of rural males believed that men need sexual variation. In urban areas younger males were more likely to give this response while in rural areas it was given by polygamous married men. About one-third of both urban and rural males who stated that one woman is not sufficient for a man, believed that men are polygynous by nature. The male quest for multiple partners was justified by one married male respondent who stated that:

Men are by nature polygynous and promiscuous. Whether a man is married or not does not matter...it is expected that men will always sleep with many women. Some men may reduce the number of other partners after they get married...but marriage will not stop them from having other women on the side.

The responses to the questions regarding multiple relations indicate that the traditional Luo belief that a man can have more than one partner is still very strong in the community. It also confirms the findings of other studies in Africa which show that there is a strong belief across the Sub-Saharan African region that men have an insatiable sexual appetite (Anarfi and Awusabo-Asare 1993a on Ghana; Orubuloye, Caldwell and Caldwell 1997 on Nigeria).
### Table 5.17 Men’s sexual needs, male respondents (%)

<table>
<thead>
<tr>
<th>Question</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are men different from women in their sexual needs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>75.3</td>
<td>82.6</td>
</tr>
<tr>
<td>No</td>
<td>24.7</td>
<td>17.4</td>
</tr>
<tr>
<td>Total No.</td>
<td>77</td>
<td>75</td>
</tr>
<tr>
<td>If yes, why?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men have stronger sexual drive</td>
<td>46.3</td>
<td>53.1</td>
</tr>
<tr>
<td>Cultural or tradition</td>
<td>27.7</td>
<td>30.0</td>
</tr>
<tr>
<td>Need for sexual variety</td>
<td>17.0</td>
<td>10.9</td>
</tr>
<tr>
<td>Men are polygynous by nature</td>
<td>9.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Total No.</td>
<td>58</td>
<td>62</td>
</tr>
</tbody>
</table>

About 75 per cent of urban and 83 per cent of rural males claim that men and women have different sexual needs. A large proportion of urban (46.3 %) and rural (53.1 %) men believe that men and women have different sexual needs because men have a stronger sexual drive. About a third of urban and rural males emphasised that the differences between men and women in their sexual needs is supported by culture. Those who responded negatively believe that men and women have similar sexual needs. They emphasise that in Luo culture men can have more than one partner but women are expected to have only one sexual partner. About 17 per cent of urban and 11 per cent of rural males report desire for sexual variation as the reason why men and women have different sexual needs. In summary male sexuality is characterised by the number of female partners a man can have and his performance of the sexual act. Indeed among the younger generation, men who report their sexual encounters to peers receive positive reinforcement in return.
5.13.2 Women’s attitudes to men’s’ sexual behaviour

A number of questions were asked to explore women’s attitudes to the sexual behaviour of men. These questions include whether there are any differences between men and women in their sexual needs, whether men need more than one wife, and whether a man can be satisfied with one woman or wife. The responses to these questions are displayed in Table 5.18.

Table 5.18 Women’s attitude towards men’s sexual behaviour, female respondents (%)

<table>
<thead>
<tr>
<th>Question</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any differences between men and women in their sexual needs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>58.1</td>
<td>63.4</td>
</tr>
<tr>
<td>No</td>
<td>41.9</td>
<td>36.6</td>
</tr>
<tr>
<td>Do men need more than one sexual partner/wife?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24.7</td>
<td>43.5</td>
</tr>
<tr>
<td>No</td>
<td>75.3</td>
<td>56.5</td>
</tr>
<tr>
<td>Do you think that a man can be satisfied with just one sexual partner/wife?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>66.7</td>
<td>57.4</td>
</tr>
<tr>
<td>No</td>
<td>33.3</td>
<td>42.6</td>
</tr>
<tr>
<td>Total No. of respondents</td>
<td>77</td>
<td>75</td>
</tr>
</tbody>
</table>

About 58.1 per cent of urban women and 63.4 per cent of rural females claimed that there are differences between men and women in their sexual needs. These proportions contrast with responses to a similar question as shown in Table 5.18. Rural females (43.5 per cent) were more likely than urban females (24.7 per cent) to state that men need more than one sexual partner or wife. The main reasons for men
needing more than one partner include the need for additional help in farming or business activities, reproduction (especially if the wife is barren) and sexual variation. Women who had secondary level education and those in monogamous marriages were more likely to be strongly against men having more than one sexual partner than those with no education or primary education.

5.14 Commercial sexual transactions

Sexual contact with prostitutes\(^2\) has been shown to be common in urban areas of sub-Saharan Africa (Little 1973; Nelson 1987; Larson 1989; White 1990; Pickering and Wilkins 1993). In Sub-Saharan Africa, high bridewealth payment, labour migration and late marriage of men have been identified as factors that contribute to commercial sexual transactions and consequently, as risk factors for HIV (Carael et al. 1987). Other factors mentioned elsewhere in this paper which have been associated with prostitution include the lack of education and employment opportunities which leave women without support and with little alternative to selling sexual services in order to survive (Bujra 1975; Standing and Kissekka 1989; Larson 1989). The concern in this section is with sexual relations which directly involve the exchange of money, thus it does not include other forms of sexual-economic exchange relations which involve some degree of continuous moral, material or economic support (money for food, rent and other basic necessities).

The development of prostitution in Kenya, particularly Nairobi, has been widely documented and it is closely linked to migrant labour and the development of the cash economy (White 1990). There is also abundant information that indicates that prostitution flourished in towns and work sites (such as during the construction of the Kenya-Uganda railway line) that sprung up during the colonial period.

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\(^2\) For the purposes of this study prostitution was defined as a short-term relationship in exchange for payment in cash. The term prostitute is used here to refer to women who make their livelihood from the commercial sale of sexual services to multiple partners. They include itinerant hookers who solicit in city or town streets, high priced hotels and nightclubs. There are also others who make nightly rounds in inexpensive bars to solicit men while others sit in their outside rooms.
Prostitution is illegal in Kenya even though it is openly practised in certain places such as bars, hotels, night clubs and brothels or at home. There is extensive literature which shows that both single and married men have sexual contact with prostitutes in Kenya, even though they may have other stable and established relationships (Nelson 1987; White 1990). However, the evidence shows that prostitution has various facets, ranging from women who sell sex to any man for a standard price, to free women who exchange sex for money or other assistance as a means of survival.

White (1990:13ff) distinguished between three types of prostitution practised in colonial Nairobi, Kenya. These include *watembezi* type women who openly solicit men in public places such as bars, restaurants and streets and the *malaya*, women who stay in rented rooms and wait for men to come to them for sex (White 1990:15). These women operate independently from their landlord who does not control the money they earn. The third category is the *wazi wazi* women who sit outside their rented rooms and call out for men to come to them. Some of these women have established relationships with boyfriends but provide other males with sexual services (White 1990:19).

A more recent form of institutionalised prostitution, though illegal, has been reported in Nairobi and the coastal town of Mombasa. This occurs in established institutions such as illegal brothels and massage parlours. The majority of these institutions are operated by foreigners and offer different sexual services, specifically by young illegal immigrants from countries such as Thailand, Russia, China and some European countries (*Sunday Standard* 14 April 1996:1). These brothels are generally patronised by affluent African males and tourists, and they operate secretly. The sexual services offered by the brothels are very expensive, charging between Ksh 1500 and Ksh 10,000 shillings (between about A$30 and A$200) depending on services rendered and are thus beyond the reach of many Kenyans.

In Kisumu, all women who receive cash payments for sexual services are lumped together under the term *malaya* or *Ochot* in Dholuo. Prostitution is more common in Kisumu town and surrounding small peri-urban centres such as Kondele, Manyatta, Oton’glo, and Dunga and the like. The *malaya* in Kisumu do not carry out their trade
in any fixed establishment or rented accommodation such as a brothel but rather concentrate their activities in bars, hotels, restaurants and in the streets especially at night.

Many women who work as bar-maids combine their work with prostitution, offering sexual services to the customers who patronise bars and night clubs. A study in Namanga border post on the Kenya-Tanzania border also found that bar workers not only sell beer to bar patrons but also provide sexual services to bar patrons (Talle 1995a). Kisumu town is the largest town in Western Kenya. With bustling activity, it is home to many people from various different ethnic groups. It is also characterised by high mobility of people in transit (to other parts of the country and neighbouring countries) and temporary encounters with people. In most of the towns and small market centres there are bars, lodging and guest houses. In-depth interviews confirmed that commercial sex transactions are more likely to occur in town and small rural market centres where there are bars, hotels and nightclubs.

There are malaya women (prostitutes) in Kisumu town and market places, especially at bars and night clubs. Here in the village it is hard to find a malaya unless you go to the local market centres...(Are there no women in the village who take money for sex?) ....aah of course, there are women who would take money for sex but they are not malaya like the ones who go to bars to solicit for men. They don't do it openly like in town...it is easier to find a malaya in town...people there do not care about what others do...in the village people would gossip about it (45 year old rural man).

When men go drinking with their friends in bars they meet ndogo ndogo (meaning young girls) and "malaya" and get carried away...some of them are very beautiful and the men can't resist...you know they get very drunk and forget everything and cannot control themselves. (34 year old married woman, urban area).

Most women when they complete their education or drop out of school go to town to look for jobs... but jobs have become very hard to find nowadays so for them to survive they start selling themselves to provide for their daily needs...I don't blame them because they are human beings and have stomachs which have to eat. Some of them have children and families to support and they have to earn a living (24 year old man, rural area).

Most girls don't stay at home - they complete their education or drop out of school because they get pregnant. Most of them go to town...Nairobi,
Kisumu or the other big ones to look for work. But nowadays it is difficult to find a job if you do not have a good education, so they find it difficult to survive because they do not have any job. Some of those who are not lucky enough to find a man to provide food for them become *malaya*, others are forced to engage in different relations with different men for their survival...others find some to live with and they become their concubines (Rural married man, retired school teacher, aged 56).

Talle (1995) found in a study of bar workers at Namanga post on the Kenya-Tanzania border that besides selling alcohol to bar patrons, many female bar workers also offered sexual services to their customers as way of supplementing their meagre salary. He observed that beer consumption and commercial sexual activities are related. Most men visit bars to drink, eat roast meat (*nyama choma* in Swahili) relax, and also to socialise with their friends. Thus bars provide both prostitutes and men who go to drink with the opportunity to meet potential sexual partners.

Most women who offer sexual services in Kisumu come from outside the region, with some from as far as Uganda and Tanzania, far away from their relatives or families. More than three-quarters of women who offered sexual services who were interviewed during the course of this research, came from outside Kisumu District and some of them had been staying in Kisumu for a short time, usually less that a year.

This may be attributed to the fact that a lot of stigma is attached to prostitution thus most women who practise prostitution do so away from their families of origin, where they are anonymous and do not have to fear their family and relatives. It has been found that women involved in prostitution congregate in towns where there are very many men who do not live with their wives or have no steady partner, as well as transients and travellers who may be prepared to pay for sex (Caldwell et. al. 1994b).

In-depth interviews with some of the women who acknowledged engaging in commercial sex showed that most were single or formerly married women, who were poorly educated and offered sexual services as a means of survival. In Africa, women who are pressured into prostitution by their social and economic conditions, unlike in Asia and parts of North America, where women may be coerced by pimps or sold into virtual sex slavery.
CASE 1

Alice is 27 years old. She is the first child in a nine-child family. She was born in Busia but now lives in Kisumu. She attended primary school up to class seven but could not continue her education because her parents could not afford to pay for her secondary education. After dropping out of school she lived with her parents for a year helping them on the family farm.

Alice became sexually active at the age of 13. Her first sexual intercourse occurred with a boy whom she had known for some time before they started having sex. Thereafter, she had sexual relations with four other boys from her village. In 1983, at the age of 16 she got pregnant to a married man from her village. He refused to acknowledge paternity and after her parents learned about it they were very angry with her for shaming them. She moved to live with her aunt in Siaya and gave birth to her first child, a daughter, in 1984. Thereafter she took her daughter to her parents and moved to Kisumu to look for work. She first got a job as a housemaid but after eight months she quit because she got pregnant again. She moved out of her employer’s house to live with friends in Otong’lo market and delivered her second child, a son. She continued living with friends while she was looking for another job.

However, the jobs that she wanted were not forthcoming because she was poorly educated, but she finally got a job as a bar maid. She has worked as a bar-maid in several towns in Western Kenya, including Eldoret, Kakamega, and Maseno. Currently she works in one of the popular bars at Otonglo market. She says that the money she earns is very little and so she has to find other means of earning a living and supporting her two children. She combines her job with prostitution; sleeping with men for money. She is paid between 150 and 250 shillings a night and her partners are men who frequent the bar. Usually the man buys her drinks and food, and pays for accommodation in guest houses. She says that she is selective of her partners and avoids going with strangers. She uses condoms with men whom she does not know very well even though sometimes they refuse to use them, insisting on paying more cash.

CASE 2

Petronilla is 35 years old. She is the fourth child in a family of ten children. She is Gusii by tribe and was born in Kitutu. She had three years of primary education but her mother could not afford to pay her school fees after her father passed away when she was about ten. Her mother was then inherited by her father’s brother. Petronilla became sexually active at the age of 15 and got married a year or two later. She gave birth to two children with her first husband. After the birth of their second child she moved to Kisumu to live with her husband who was working there. However, her husband became a chan’gaa drunkard after some time, and stopped supporting the family financially. He also started beating her accusing her of infidelity. In 1984, she ran away, and left the children with him and lived in the sprawling Manyatta slums in Kisumu town. She began selling vegetables in the local market centre.

Petronilla got re-married to a Luo man in 1986 and gave birth to another two children. Unfortunately her husband died in a road accident three
years later. She started a small second hand clothes or *mitumba* business with the little money that her husband left behind but it soon collapsed. Petronilla is now a *chang’aa* brewer and sells the liquor from her two-bedroomed house in Kondele. The money she earns is not enough for rent, food and supporting her children. She has sexual relations with many different men who go to her place to drink. They give her money for food and other necessities whenever they have sexual relations. Apart from these other men she has two married men with whom she frequently has sex. These men do not live with their wives. She says that she would like to save enough money to buy a plot of land and educate her children.

**CASE 3**

Kabenza is a 21 year old single mother, from Busia District. Her parents are peasant farmers. She had six years primary education. Kabenza had her first sexual intercourse at the age of 15 with her boyfriend. Thereafter, they had sexual relations for about a year until he moved to Nairobi in 1990. She met her second boyfriend in 1991 and had sexual relations with him for about ten months until she got pregnant later that year. He refused to accept paternity when she told him about it. Her parents were very angry when they found out she was pregnant. She was so ashamed that she ran away from home to Kisumu. There she stayed with friends from her village who assisted her financially until she gave birth to a son. After several months she went back to her rural home with her child, but found it uncomfortable and stayed for only a month. She left her son with her parents and moved back to Kisumu to seek work. However, jobs were hard to find, due primarily to her poor education. She has no job at the moment but survives by offering sexual services to men who want to have sex with her. She and her friends move around the bars in Kisumu town in the evening and at night looking for men who want their company. These men usually buy them drinks, food and pay for accommodation in the lodgings where they spend the night. The men pay some money in the morning after they have had sex. She gets between a hundred and two hundred shillings depending on the time of month when people are paid. Most of the men she has sex with are strangers, mainly people visiting the town. The money she earns from this is spent on food, rent and clothing, and the rest is sent home to her parents and child.

**CASE 4**

Rosemary is 31 years old and is the eldest child in a family of nine of her mother’s children. Apart from her mother, her father has three other wives. She had ten years of schooling but dropped out after she got pregnant. She followed friends from her village to look for work in Nairobi. She decided to do this because she wanted to support her child and poor parents. She felt that since she was the eldest child, she had the responsibility of looking after her mother and her child. She could not find a job in Nairobi and thus she returned to her rural village.

Rosemary got married at the age of 18 years to a man from Nyakach and he left her in the village to look after his land and aging parents. They had three children together before her husband moved to work in Nairobi. In his six months in Nairobi, he used to visit once a month and made regular money remittances to assist her and the family. However, things started changing slowly and he stopped visiting and made irregular remittances.
After some time she decided to go to Nairobi to find out what was going on. She discovered that he was living with another woman. She and the other woman quarrelled and fought and her husband decided to sent her away from his house without her children. She was very disappointed and felt ashamed to go back to her village. She decided to go to Kisumu and look for a job. There she found her job as a barmaid which she still has to this day. She has a steady boyfriend who lives with her from time to time when he is in Kisumu (his job involves travelling to different parts of the country). However, apart from him there are other men whom she has sexual relations with for money. These men usually pick her up from the bars, which she and her friends frequent, after work, and they have sex in lodgings or guest houses in town. They also buy her drinks, food and pay her for having sex. Neither her boyfriend or relatives know about these other men. She reported that she has sexual relations with between four and seven men in a week. She contends that this is the only way to earn extra money to survive since her job as a barmaid pays very little. Rosemary intends to save enough money to build a house or set up a small business in her rural home.

CASE 5

Audrin is 20 years old and was born in Rusinga Island on Lake Victoria. She had six years of primary education and dropped out of school because her parents could not afford to pay her school fees. She had her first boyfriend and sexual intercourse at the age of 15. After school her parents sent her to work for a relative in Siaya but she ran away to get married to her second boyfriend who was much older than her. They were married for two years and had two children, two girls. Her husband used to drink heavily and she discovered that he had other women. He became violent when she asked him about his extramarital affairs. Four months after the birth of her second child her husband threw her out of the house and she returned to her parents who were not happy with her. She left her children with her mother and went to Siaya to look for work. She worked briefly as a waitress but left to work in a bar after being lured by the owner. She met a boyfriend who was a regular customer in the bar where she was working, but she also had other sexual partners who used to patronise the bar. However, her boyfriend broke up with her after three months when he discovered that she had other men.

Audrin has also lived and worked as a bar worker in several other towns in Nyanza province. She moved to Kisumu about a year ago but has not found any work and had to find a way of surviving. She goes with men whom she meets, mostly in bars. She says that on average, she goes with between four and six men a week. They pay her between Ksh 200 and 500 a night in addition to food and drink. Sometimes she uses condoms with men she goes out with depending on whether they want to use them or not.

She occasionally sends some money to her parents who are taking care of her two children. She wishes that she could meet a man to marry but sees her chances as very slim because few men would want to marry someone who already has children. She wants to accumulate enough money to educate her children and set up a small business.
The cases above illustrate that most women who engage in prostitution in Kisumu are young, single or divorced and have little education. Some of the women who were interviewed had once been married while others were single mothers. The main reason for engaging in prostitution seems to be to earn a living. Indeed, most of the women come from poor families and are driven by economic necessity into prostitution; they are involved in prostitution to assist their children and other members of their families of origin. Of the fifteen prostitutes who were interviewed, six stated that they were the sole breadwinner in their families of origin. Most of them stated that they wanted to accumulate money to educate their children and save for their future. A few of the women had been forced into prostitution because their marriages had broken down so they had to earn a living to support their children. Women who are involved in commercial sex are geographically mobile; they have travelled widely and most come from outside Kisumu District. The majority of these women reported that their families of origin do not know that they are engaged in prostitution; they would not want them to know because prostitution is perceived negatively, so they prefer to move far away from their relatives.

5.14.1 Men’s experience with prostitutes

This section explores men contact with prostitutes. It explores the extent and frequency of this contact. The survey questionnaire included questions that asked men whether they had ever paid for sex with a prostitute or malaya, how many times they had done so and whether they had had contact with a prostitute in the previous year before the survey. Table 5.19 shows the percentage distribution of males who had ever paid for sex with a prostitute in their lifetime and those who had done so in the year before the survey.
Table 5.19 Commercial sex experiences by age and marital status of male respondent.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Urban</th>
<th>Rural</th>
<th>Both</th>
<th>Urban</th>
<th>Rural</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever paid for sex</td>
<td>36.7</td>
<td>23.1</td>
<td>29.9</td>
<td>17.7</td>
<td>11.5</td>
<td>14.6</td>
</tr>
<tr>
<td>15-24</td>
<td>24.1</td>
<td>38.8</td>
<td>31.4</td>
<td>47.6</td>
<td>53.8</td>
<td>50.7</td>
</tr>
<tr>
<td>25-34</td>
<td>41.4</td>
<td>50.0</td>
<td>45.7</td>
<td>33.4</td>
<td>30.8</td>
<td>32.1</td>
</tr>
<tr>
<td>35+</td>
<td>34.5</td>
<td>11.2</td>
<td>22.9</td>
<td>19.0</td>
<td>15.4</td>
<td>17.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Urban</th>
<th>Rural</th>
<th>Both</th>
<th>Urban</th>
<th>Rural</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>39.5</td>
<td>71.5</td>
<td>34.0</td>
<td>61.9</td>
<td>69.2</td>
<td>65.6</td>
</tr>
<tr>
<td>Married</td>
<td>60.5</td>
<td>28.5</td>
<td>66.0</td>
<td>38.1</td>
<td>30.8</td>
<td>34.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No of times ever paid for sex</th>
<th>Urban</th>
<th>Rural</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>24.7</td>
<td>47.9</td>
<td>36.3</td>
</tr>
<tr>
<td>2-3</td>
<td>14.6</td>
<td>31.8</td>
<td>23.2</td>
</tr>
<tr>
<td>4+</td>
<td>60.7</td>
<td>20.3</td>
<td>40.5</td>
</tr>
</tbody>
</table>

Overall, over 30 per cent of male respondents reported ever paying for sex with a prostitute, with about 14 per cent having had contact with a prostitute in the previous year. Older males aged 35 and above were less likely to have ever had contact with a prostitute, More urban than rural males reported having ever had contact. Males in the age group 25-34 were more likely than any other males to report ever having paid for sex; over half of rural respondents who reporting paying for sex were in this age group. When compared by marital status, single males in both urban and rural areas were least likely to report ever having paid for sex.

However, the experiences of males in the previous year were quite different. Younger males aged 15-24 were more likely to have had sexual contact with a prostitute; over
half of all males who reported having had intercourse with a prostitute in the last year were in this age group. There was also a differential by marital status; about two-thirds of males who reported contact with a prostitute were single males.

The Table 5.19 also displays striking urban-rural differences in the number of times men reported ever paying for sex. In general, urban males were more likely than rural males to report paying for sex; males in rural areas were more likely to report a single encounter with a paid partner and least likely to report four or more encounters. Most rural males who sought prostitutes reported that they went to towns or market centres as it was less common for prostitution to occur in the village. A considerable proportion of urban males (about 60 per cent) had four or more episodes with paid partners compared to only 20 per cent of rural males. For the year preceding the survey, three-quarters of males who reported contact with a paid partner had a single encounter, while more urban males than rural males were likely to have had two or more encounters.

In-depth interviews with men who had liaisons with prostitutes showed that the majority had lived and worked away from their homes of origin and regular sexual partners or spouses.

I think I was about 21 when I first had sex with a prostitute. I had just got a job in Kisumu town in one of my uncle's companies. I went celebrating with friends in one of the big night clubs in town. We met some girls in the night club and drank a lot of beer. I asked one of the girls to go home with me. She insisted that I should first give her some money. I gave her one hundred shillings and we went to a boarding house. I gave her some more money for breakfast in the morning...I cannot remember how much it was. I have also had sex with prostitutes in Nairobi and Nakuru (26 year old, urban male).

A few years ago I went out with a prostitute when I was working in Nairobi. I had a girlfriend at the time but she was still in boarding school. I had not been having sex at the time and felt starved. That time, I was paid my mid-month salary and went drinking with friends in town. I met one girl in the bar and bought her a few drinks and food. We talked and I expressed my interest in her but she demanded that if I go to sleep with her that I should pay her some money. We slept in a lodging house and in the morning I gave her two hundred shillings (34 year old, rural male).
5.14.2 Reasons for recourse to prostitutes

Several reasons were given by men in in-depth interviews and focus group discussions as to why men have sexual relations with prostitutes. Some men suggested that they pay for sex with prostitutes because they provide them with sexual outlets without any obligations. For them, it is easier to pay for sex with a prostitute than to commit themselves to a woman in a stable relationship. They do not ask for anything elaborate in the sexual services when they pay for sex but only want sexual pleasure. This emerged from focus group discussion with males in urban area:

Moderator: Why do men have sexual relations with prostitutes?

1st respondent: They do it for sexual pleasure and for fun...I did that with some friends some years ago but I stopped when I got married.

2nd respondent: Some men say they do not get satisfied with their girlfriends or wives...so they go with prostitutes...they know how to satisfy a man.

3rd respondent: When men go drinking to have fun with friends...picking up a prostitute is part of the way men have fun.

4th respondent: Some men seek prostitutes because it is easy for them to get their sexual desires satisfied...all you need is a few shillings and the job is finished (Male focus group discussion, urban area).

I go with prostitutes because I want to satisfy my sexual desires. I like the detachment that is involved with a prostitute...I do not have to worry about her the following day. Everything is finished the moment you have sex and pay her...there is nothing beyond that (28 year old, single male, urban area).

Another reason for having sexual relations with prostitutes was that prostitutes provide men with a sexual outlet in the absence of their regular partner or spouse. Some men who have sexual relations with a prostitute do so because they live away from their stable partners, such as wife or regular partner, for work reasons and they may spend long time apart before they are reunited. For such men prostitutes are a major outlet for their sexual deprivation in the absence of their regular partner.

Many married men go to work in big towns and leave their wife behind in the village. They do not have wives to cook for them or do their laundry and other housework, so they befriend other women who do their house chores...such as washing, cooking...but this is not done free...they give them money and other assistance...they also have sexual relations with them. There are many men who have got lost in the city because of these.
women...they have forgotten they have wives in their villages (48 year old married woman, rural village).

I have a wife and children who live in the village...she is not always here to satisfy my sexual desires...I lived with her here after we got married for about a year but she went to the rural area to look after my small farm. I visit her once a month. I cannot stay without having sex and this is why I have to seek prostitutes (38 year old, married male, urban area).

The other reasons that were commonly cited by informants include problems with a wife or regular partner and the need to have sex with a variety of different women; one young man asserted that ‘A man can not eat ugali (the local staple food) all the time...he needs to eat something of different taste’. Others say that they lose control of themselves when they get drunk and forget themselves and so end up paying for sex. Men who go social drinking with friends often end having sexual relations with prostitutes, barmaids and other free women who frequent bars.

5.15 Summary and conclusion

The primary objective of this chapter was to describe sexual behaviour and patterns. It has highlighted patterns of sexual behaviour in the past and present, and the differences in patterns of behaviour among subgroups of the population in Kisumu. It has also examined various forms of sexual relationships that occur both among married and unmarried people. The summary of this chapter is divided into four parts, including premarital sexual relations, extramarital sexual relations, commercial sexual relations and sexual networking.

5.15.1 Premarital sexual relations

Most of the relevant literature on the Luo and the findings of this study suggest that premarital sexual relations, especially for females, were uncommon in the past. Female chastity at marriage was highly valued. However, cultural values and norms which restricted people’s behaviour have disappeared or lost their effectiveness. The forces of modernisation have undermined structures of authority which previously restricted the sexual behaviour of young people. It has become socially acceptable for unmarried people to be in sexual relationships. In this study, the majority of currently
married respondents had sexual relations before marriage. This contrasts with the general expectation that Luo women should remain chaste until marriage.

On average, females in the survey had experienced sexual intercourse two years earlier than males. The age at first intercourse varied between rural and urban respondents; rural respondents had their sexual debut earlier than urban respondents. There was also discrepancy between the age at first sexual intercourse and the age at marriage of men. Men delay marriage until their late twenties or early thirties while females marry at a younger age. Social and economic pressure cause young men and women to be sexually active before marriage and to have multiple partners. Some women believe premarital sex and pregnancy increase their chances of marriage.

5.15.2 Extramarital sexual relations

Among the Luo, women’s extramarital relations are strongly condemned but those of men are condoned. Whereas female extramarital sex is considered adultery, men are considered polygynous by nature; there is a cultural prescription for a man to have more than one wife. Formal polygyny has declined but men have adopted informal polygyny: one formal wife and one or more mistresses.

Extramarital sexual relations are common, especially among urban males. More than half of urban males and about one-fifth of rural females reported extramarital sexual relations. The majority of males who had extramarital relations were monogamously married and lived away from their spouses for work reasons. Females who reported extramarital relations were in polygynous unions. Most extramarital relations involve the exchange of cash, gifts or other material support for sex. The reasons for men’s have extramarital relations included the need for variety, marital instability, separation from spouse due to work and belief that women tend to lose interest in sex as they grow older. Most married women wished to control their husband’s sexual behaviour but felt they could do very little.
5.15.3 Sexual contact with prostitutes

Prostitute patronage has widely been reported in Kenya. Prostitution became widespread during the colonial period and continues to thrive. Both single and married men go to prostitutes even though they may be in stable relationships. Prostitute patronage is common in town and market centres where there are nightclubs, restaurants, lodging houses, hotels and bars. Prostitutes are driven into prostitution by social and economic conditions; most come from poor families, have broken marriages or relationships and low education. Many prostitutes in Kisumu town and other major centres come from outside district; they live away from their families to avoid the stigma attached to prostitution.

Overall, almost a third of male and nearly a fifth of female respondents in the survey reported ever engaging in commercial sexual transactions. Fourteen per cent of men reported that they paid for sex in the twelve months preceding the survey. Males in urban areas were more likely to report paying for sex than those in the rural areas. A number of reasons were cited by men for prostitute patronage; prostitutes provide men with sexual outlet without any form of commitment or obligation in the absence of a stable partner or spouse. It is also common for men who live and work away from their spouses or regular partner to seek sexual relief with prostitutes. Other reasons given included need for a variety of different women, marital instability, lack of control after drinking and peer pressure. Prostitution has been closely linked to the spread of STDs. This has a consequence beyond the prostitutes and their clients because most men who patronise prostitutes also have other non-prostitute partners, and many do not use condoms consistently.

However, the exchange of cash and gifts for sexual services is not confined to prostitution. Many non-marital relationships have a transactional component involving gifts, cash and other material support to women. Case studies illustrate the importance of exchange of material and non-material support in male-female relationships. The economic component of marital and non-marital relationships varies: in relationships involving ‘sugar daddies’ money and gifts are central while in
stable relationships they are marginal. Nevertheless, the transactional nature of many relationships makes it difficult to distinguish them from various forms of prostitution.

5.15.4 Sexual networking

The nature of sexual networking and the way sexual relations are conducted in Kisumu have a potential to spread HIV/AIDS. Multiple sexual partnerships were common, especially among men, in the study population. Many men and some women have more than one sexual partner simultaneously. Irrespective of marital status, men report significantly more sexual partners than women. Although young men aged 15-29 reported slightly fewer partners than the age groups above, they acquire more partners as they grow older.

About two-thirds of men reported having five or more lifetime partners and more than a half reported two or more partners in the 12 months preceding the survey. In contrast, less than half the women reported five or more partners and less than a third had two or more partners before the survey. Among both men and women, a higher level of education corresponded with a lower number of sexual partners. Although rural respondents reported slightly fewer partners than urban respondents, risky sexual behaviour was still common, contrary to the popularly held view that people in urban areas are more sexually promiscuous than people in rural areas.

The high levels of sexual networking among men in this study are supported by social perceptions about male behaviour. Traditionally, sexual notions rest on dichotomous images of male and female sexuality: men are in constant need of sex and initiate sexual relations while women are expected to suppress their sexuality and not openly express it. It is generally believed that men have greater need for sex and a variety of sexual partners, and hence are promiscuous and polygamous by nature. In contrast, women are expected to confine themselves to one partner and to restrain their sexual desires and behaviour. Those who openly express their desires or have many sexual partners are looked down upon as being loose. These dichotomous sexual ideals have not changed and they continue to influence sexual behaviour of men and women.
CHAPTER SIX

SEXUALLY TRANSMITTED DISEASES

6.1 Introduction

It was mentioned in Chapter 2 that sexually transmitted diseases are a significant co-factor in the transmission of HIV in Kenya and other Sub-Saharan African countries (Kreiss et al. 1986; Simonsen et al. 1988; Greenblatt et al. 1988; Green 1992). Data are unavailable on the incidence and prevalence of these diseases in the general population, so estimates are based on clinical studies. This chapter presents both qualitative and quantitative information on sexually transmitted diseases, including AIDS. It is divided into two sections; the first section provides detailed information on survey respondents' knowledge of various types of STDs, their transmission, and respondents' beliefs about their cause. It also details survey respondents' experience with STDs, risk aversion measures (STD prevention), and treatment-seeking behaviour. The second section focuses on knowledge, beliefs and attitudes towards HIV/AIDS, including respondents' knowledge of modes of transmission and means of prevention. The data presented were obtained using the survey questionnaire method, in-depth interviews and focus group discussions with particular categories of informants, for instance, traditional medical practitioners, health workers and key informants.

The survey questionnaire contained questions on knowledge, attitudes and aetiological beliefs and history of infection with STDs. In-depth interviews were conducted with key informants, including traditional healers: specifically herbalists, diviners, traditional birth attendants. The in-depth interviews and focus group discussion schedules had various questions relating to STDs, such as types of disease, their aetiology and symptoms, perceived outcome of infection and treatment of these illnesses. Interviews were held with seven traditional healers, including two traditional
birth attendants. Ten in-depth interviews with key informants and two focus group discussions (each with six members) were conducted covering these topics.

6.2 STD knowledge in survey population

The survey questionnaire included questions that asked respondents whether they knew of any diseases which are spread through sexual intercourse and if they did, which STDs they did know about, and how these are transmitted. Responses to these questions are displayed in Table 6.1.

Table 6.1 Knowledge about STDs (%)

<table>
<thead>
<tr>
<th>Question</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever heard of any nyach (STD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Urban 98.7</td>
<td>Rural 97.4</td>
</tr>
<tr>
<td></td>
<td>Both 98.1</td>
<td>Urban 98.7</td>
</tr>
<tr>
<td></td>
<td>Rural 96.1</td>
<td>Rural 97.4</td>
</tr>
<tr>
<td>Which nyach (STD) do you know?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>40.6</td>
<td>46.4</td>
</tr>
<tr>
<td></td>
<td>43.5</td>
<td>43.1</td>
</tr>
<tr>
<td></td>
<td>41.4</td>
<td>42.3</td>
</tr>
<tr>
<td>Syphilis</td>
<td>10.3</td>
<td>8.2</td>
</tr>
<tr>
<td></td>
<td>9.3</td>
<td>9.0</td>
</tr>
<tr>
<td></td>
<td>11.8</td>
<td>10.4</td>
</tr>
<tr>
<td>AIDS/Ukimwi</td>
<td>30.4</td>
<td>27.0</td>
</tr>
<tr>
<td></td>
<td>28.7</td>
<td>30.4</td>
</tr>
<tr>
<td></td>
<td>34.2</td>
<td>32.3</td>
</tr>
<tr>
<td>Chancroid</td>
<td>6.3</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>4.4</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td>1.3</td>
<td>1.8</td>
</tr>
<tr>
<td>Nyach</td>
<td>12.4</td>
<td>15.8</td>
</tr>
<tr>
<td></td>
<td>14.1</td>
<td>15.1</td>
</tr>
<tr>
<td></td>
<td>11.3</td>
<td>13.2</td>
</tr>
<tr>
<td>Total No.</td>
<td>78</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>154</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>73</td>
<td>151</td>
</tr>
</tbody>
</table>

NB: Only the first type of STD mentioned by respondent was recorded.

Table 6.1 shows that knowledge of the existence of STDs was almost universal; over 97 per cent of the respondents knew about STDs. Three respondents refused to answer the question while two others did not know of any STD. In general, urban males and females had heard more about STDs than their rural counterparts. Among the Luo community, all types of STDs are referred to by one general term, namely nyach.
There are no specific names for various STDs; however, they are known or recognised to have debilitating effects on the reproductive system. When asked which STDs they knew, the majority of respondents mentioned gonorrhoea more frequently than any other STD, with over two-fifths of men and women mentioning this when they were asked this question. The next most common responses were AIDS (28.7 % of males and 32.3 % of female respondents), and syphilis (9.3 % of male and 10.4 % of female respondents). Knowledge of other sexually transmitted diseases was quite limited; for instance less than five per cent of males and females mentioned chancroid spontaneously when they were asked which STDs they knew. About 14 per cent of males and 13 per cent of females stated that STD they knew of was nyach, which refers to all STDs in general.

In-depth interviews with traditional healers, mainly herbalists and traditional birth attendants (TBAs), provided more detailed information about aetiology, symptoms, treatment and outcome of infection with these diseases classified as nyach. The main reason for interviewing these specialists was that they were more knowledgeable on various health issues and hence more capable than most lay men of providing detailed information on health problems affecting the population. According to most traditional healers whom I interviewed, various types of nyach are believed to occur as a result of having sexual intercourse 'with someone who is infected', promiscuity or 'running around with many partners'. These diseases affect both men and women and can also be also be acquired by children through congenital infection. The most common symptoms of nyach illnesses that were mentioned by traditional healers and traditional birth attendants include penile and vaginal discharge, lower abdominal pains, genital ulceration and weight loss. According to traditional healers who were interviewed, if untreated these diseases can have severe debilitating effects in both men and women, such as infertility, congenital infection, ectopic pregnancy, and foetal wastage.

6.3 Perceived modes transmission of STDs

The following section is devoted to examination of what people perceive to be the causes and modes of transmission of STDs. The survey questionnaire included a
question about the causes of sexually transmitted diseases. The responses to these question are displayed in Table 6.2 which shows the percentage distribution of perceived modes of transmission of STDs.

Table 6.2 Perceived mode of transmission of STDs by sex and residence (%)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Males</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
</tr>
<tr>
<td>Sex with prostitutes</td>
<td>20.3</td>
<td>14.1</td>
<td>17.2</td>
<td>24.4</td>
<td>12.0</td>
<td>18.2</td>
</tr>
<tr>
<td>Sexual promiscuity or indiscriminate sex</td>
<td>50.5</td>
<td>44.9</td>
<td>47.7</td>
<td>41.7</td>
<td>43.7</td>
<td>42.7</td>
</tr>
<tr>
<td>Casual contact e.g. with infected urine, towels, clothes, dirty toilets</td>
<td>16.0</td>
<td>17.7</td>
<td>16.8</td>
<td>12.7</td>
<td>22.6</td>
<td>17.6</td>
</tr>
<tr>
<td>Poor genital hygiene</td>
<td>8.9</td>
<td>10.5</td>
<td>9.7</td>
<td>12.9</td>
<td>9.3</td>
<td>11.1</td>
</tr>
<tr>
<td>Supernatural e.g. witchcraft/sorcery</td>
<td>2.0</td>
<td>5.1</td>
<td>3.5</td>
<td>4.1</td>
<td>6.7</td>
<td>5.5</td>
</tr>
<tr>
<td>Don't know</td>
<td>2.3</td>
<td>7.7</td>
<td>5.0</td>
<td>4.2</td>
<td>5.7</td>
<td>4.9</td>
</tr>
<tr>
<td>Total No.</td>
<td>78</td>
<td>76</td>
<td>154</td>
<td>78</td>
<td>73</td>
<td>151</td>
</tr>
</tbody>
</table>

7 missing cases (4 refused to answer question and 3 did not know any STD).

The most frequently cited mode of transmission was sexual promiscuity or having sexual relations with many partners. It is believed that STDs result from having sexual intercourse with someone who has the disease, an 'unclean' person, a stranger or a prostitute. Thus men and women who 'sleep around' with many partners are more vulnerable to contracting STDs. These views emerged from in-depth interviews and focus group discussions. One herbalist commented:

These illnesses are caused by sleeping (having sex) with someone who has the disease. Some men and women have many sexual partners who also have other partners, like prostitutes malaya. Men who sleep around with prostitutes get infected and spread it to their other partners...their wives and other lovers get infected without knowing and it takes them a long time to find out (Male traditional herbalist, 56 years old).
About 17 per cent of males and 18 per cent of females believed that STDs can be contracted by having sexual relationships with prostitutes. Some respondents stated that such diseases result from having casual contact with an infected person (16.8 % of men and 17.6 % of females). For instance, contact with a person’s urine, especially in a dirty toilet, for example stepping barefoot in an infected person’s urine or sitting on a bathing stone used by an infected person. They also stated that STDs could be contracted by sharing underclothing or towels with an infected person and children can get the disease from adults if they sit on an infected person’s lap.

Moderator: Are there any other ways that these diseases can be transmitted?
1st Respondent: Yes, even children catch these diseases when they touch or sit on the laps of someone with the disease; they get it from the open ulcers.

2nd Respondent...Sometimes the child might get the disease from the mother in the womb before birth.

3rd Respondent: Someone can get gonorrhoea from a toilet used by an infected person...it happens in public toilets, like in bars...if you are not careful and urinate or step barefoot on an infected person’s urine, then you get infected...(How?)...I don't know but if there is infected urine then infection is possible.

4th Respondent: People get the diseases by sharing clothes with an infected person...nowadays some people, especially teenagers and women like to borrow clothes from one another...people also buy mitumba (second hand clothes) and they don't even know the people who wore them...people get strange diseases from clothes worn by someone with the disease (Female focus group discussion, Urban area).

Poor genital hygiene was also identified as a cause of sexually transmitted disease; almost ten per cent of males and 11.1 per cent of females stated that failure to clean genitals properly, especially after sexual intercourse and during menstruation can result in infection with a sexually transmitted disease. For males, failure to clean the penis foreskin is believed to result in infection which makes the foreskin difficult to unroll.

The belief that disease or other misfortune can be sent through sorcery, witchcraft or 'remote control' (as some of the in-depth interview informants put it) is also found
among the Luo of this study (Ocholla-Ayayo 1976; Parkin 1978). Witchcraft and sorcery are less frequently cited by survey respondents as causes of STDs (3.5% of males and 5.5% of females). However, it emerged from interviews and discussions with informants that sexual intercourse can provide a common point of contact with magical spells that cause illness, sterility or even death. For instance, two in-depth interview informants elaborated:

Diseases can be contracted through many different ways...through the air, water, sharing clothes, eating certain foods and even sex...and many other ways. For example, a stomach ache, headache and other illnesses can be contracted through sex. (Interviewer: How?) Simply through witchcraft. A man can get magical spells from a diviner or ajuoga to protect his wife from other men. If she has intercourse with a lover, he will fall ill...he may start complaining of stomach ache or some other illness...his penis may get swollen and fall off. If he does not go to a diviner to find out what is wrong he will continue having problems...he can even die of the illness (*Rurai male, key informant, over 70 years old*).

Some men protect their wives with magic spells....it happens among the Luo, Kamba and other communities...(Interviewer: How?) They get medicine (meaning magical spells) from a medicine man and if another man sleeps with their wife he falls sick sometimes they get stuck until the husband comes and ‘opens’ them (performs magical act)...the man may also get a disease but his wife remains symptomless ...he can even die (*49 year old rural woman*).

Similar beliefs about sexually transmitted diseases and witchcraft have also been reported in other African communities, such as the Tswana of Botswana (Ingstad 1990: 34), Swazi of Swaziland (Green 1992), Manica of Mozambique (Green 1992), Yoruba of Nigeria (Messersmith et al. 1994) and Tonga of Zambia (Mogensen, 1997).

### 6.3.1 Experience with sexually transmitted diseases

As mentioned in Chapter 2, the data on the incidence and prevalence of STDs in Kenya are limited, but evidence from clinic-based studies of women usually considered to be at low risk, such as patients at antenatal, postnatal and family planning clinics, indicates that gonorrhoea, syphilis, trichomoniasis, chlamydia and other genital ulcer diseases are common (Daly et al. 1994). These clinic-based studies of women show prevalence levels of gonorrhoea and syphilis ranging between 2 per
cent and over 10 per cent (Temmerman et al. 1992; Mati et al. 1995) but studies among prostitutes have reported infection levels of STDs ranging between 16 per cent to over 60 per cent for gonorrhoea and 35 to over 50 per cent for syphilis (D’Costa et al. 1985). This study aimed at measuring the history and prevalence of STDs for both men and women in the survey population. The survey questionnaire elicited information on whether respondents knew someone who had ever contracted an STD, whether the respondent had ever contracted an STD, which one they contracted, who infected the respondent and the treatment they sought. Table 6.3 displays percentage distribution of respondents who reported that they had ever contracted an STD by various selected socio-demographic characteristics.

### Table 6.3 Respondents ever-infected with an STD by sex and residence (%).

<table>
<thead>
<tr>
<th></th>
<th><strong>Males</strong></th>
<th><strong>Females</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Do you know friends</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>who have ever</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>contracted an STD?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>53.6</td>
<td>43.3</td>
</tr>
<tr>
<td>No</td>
<td>42.3</td>
<td>53.4</td>
</tr>
<tr>
<td>Other</td>
<td>4.1</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Have you ever</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>contracted an STD?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24.1</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>No of times ever</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>infected</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once</td>
<td>31.6</td>
<td>69.2</td>
</tr>
<tr>
<td>Twice</td>
<td>57.9</td>
<td>30.8</td>
</tr>
<tr>
<td>Three or more times</td>
<td>10.5</td>
<td>a</td>
</tr>
<tr>
<td><strong>Total No.</strong></td>
<td>78</td>
<td>76</td>
</tr>
<tr>
<td><strong>Total respondents ever-</strong></td>
<td>19</td>
<td>13</td>
</tr>
</tbody>
</table>

|                         |           |             |      |       |       |      |
| **infected**            |           |             |      |       |       |      |
| a no cases              |           |             |      |       |       |      |
The data show that more respondents knew of friends and acquaintances who suffered from STDs than had experience themselves. Overall, 40.3 per cent (48.5 % of males and 32.1 % of females) of the respondents knew of someone who had suffered a sexually transmitted disease. Overall, about 16 per cent of the respondents reported ever contracting a sexually transmitted disease in their lifetime. None of the respondents reported infection at the time of interview. The number of men reporting ever contracting a sexually transmitted disease exceeded that of women; the proportion of males reporting infection was twice that of females: 20.4 per cent of males compared to 11.6 per cent of female respondents. Males were also more than twice as likely as females to report two or more episodes of sexually transmitted diseases. About 80 per cent of females who reported STD infection reported only a single episode of STD, compared to 50 per cent of males reporting a single episode. It is important to note that females may have been under-reporting their infection because of the social stigma attached to STDs. Among the Luo, as in many African communities, the social stigma attached to STDs is greater for women than for men, so sufferers are less likely to divulge information concerning their infection status. The information that a girl or a woman has a venereal disease is taken as an indication that she has loose sexual morals and is promiscuous. In contrast, a bout of an STD may be accepted for men and sometimes it is regarded as an indicator of their sexual conquests. In fact, some men regard them as no more serious than a common cold. Such attitudes may have been a barrier to female reporting of STD infection. Another factor that may have contributed to low reporting among females is the fact that many STDs tend to be asymptomatic in women and are not easily recognised (Erwin 1993). The findings of this study are consistent with findings of other survey studies of sexually transmitted diseases in Africa, which report similar levels of STDs. For instance, Anarfi and Antwi (1995b) found that 22 per cent of respondents (26 per cent of males and 15 per cent of females) in a study of street youth in Accra, Ghana, had been treated for STDs, with males twice as likely as females to report infection. Orubuloye, Omoniyi and Shokumbi (1995) reported high levels of STDs ranging between 28 and 39 per cent among prisoners in four gaols in Nigeria, while Akinnawo (1996) reported that 24 per cent of police officers in Ondo, Nigeria, had been infected with STDs. Similar studies of students in school and higher education institutions in
Ekiti, Ondo State, Nigeria found that 12.7 per cent of urban males and 2.4 per cent of urban females had gonorrhoea, while 2 per cent of males reported syphilis (Owuamanan, 1996).

STD infection is associated with various socio-demographic variables such as age, marital status, education, residence, history of migration, and number of sexual partners. For instance Daly, Maggwa et al. (1994) found in a study of family planning clinic attendees that factors such as being unmarried and having multiple sexual partners were significantly associated with STDs. The findings of this survey show that infection was closely associated with age, marital status, residence and education. Males aged 25-34 and 35 and above were more likely to report ever contracting an STD than the younger age cohort aged 15-24, even though more respondents in the latter age cohort reported recent experience with an STD. For females, the majority of those reporting contracting a venereal disease were aged 25-34 while more than a third of them were aged 15-24. Table 6.4 shows that proportion of respondents reporting STD infection differed by socio demographic characteristics.
Table 6.4 Respondents ever-infected with an STD by selected background characteristics (%).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>12.7</td>
<td>17.7</td>
</tr>
<tr>
<td>25-34</td>
<td>47.4</td>
<td>38.5</td>
</tr>
<tr>
<td>35 +</td>
<td>39.9</td>
<td>43.8</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>42.1</td>
<td>23.1</td>
</tr>
<tr>
<td>Married</td>
<td>57.9</td>
<td>76.9</td>
</tr>
<tr>
<td>Formerly married</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>31.6</td>
<td>28.8</td>
</tr>
<tr>
<td>Primary (incomplete)</td>
<td>10.6</td>
<td>23.1</td>
</tr>
<tr>
<td>Primary (complete)</td>
<td>34.7</td>
<td>32.7</td>
</tr>
<tr>
<td>Secondary +</td>
<td>23.1</td>
<td>15.4</td>
</tr>
<tr>
<td><strong>Total respondents ever-infected with STDs</strong></td>
<td>19</td>
<td>13</td>
</tr>
</tbody>
</table>

a: no cases

Evidence obtained in this study shows that people aged 25 years and above had high levels of sexual networking (see Chapter 4). Over two-thirds of males who reported ever contracting an STD were married but a considerable proportion of unmarried males also reported ever contracting an STD. Formerly married women, mainly those who were separated, divorced or widowed, and never married women were more likely to report ever being infected than those who were currently married. For both males and females, urban respondents were more likely than rural residents to report contracting an STD. In fact, most of the rural male respondents who reported ever contracting such a disease stated that they got infected in town while living there or during short visits; this implies that STDs are probably introduced to rural populations by returning migrants and other people who have frequent contact with towns. A higher proportion of males and females with either no education, incomplete or complete primary levels of education, reported ever contracting an STD than those with secondary or higher education.
All male respondents were also asked whether they were circumcised. This question was included on the basis of evidence that the risk of STDs and HIV infection may be increased by absence of circumcision or the presence of the foreskin. It is worth noting that in most communities in Kenya, circumcision is a cultural practice that marks the transition from childhood to manhood and is accompanied by elaborate ceremonies. However, the Luo community does not practise circumcision; transition into adulthood is marked by the removal of the lower front six teeth. Of those interviewed in the survey, about five percent of urban and 2.8 per cent of rural males reported that they were circumcised (not shown in the table). All males who reported circumcision were aged 15-24 which reflects changing attitudes toward circumcision by the younger generation. None of the respondents who reported ever-infection with an STD was circumcised.

Epidemiological studies show that the combined effect of having multiple partners and contact with prostitutes increases the likelihood of contracting an STD, especially if unprotected sex occurs (Messersmith et al. 1994). Table 6.5 shows the percentage distribution of respondents who reported ever contracting an STD by number of lifetime partners and partners in the last year.
Table 6.5 Sexually active respondents ever-infected with an STD by number of lifetime partners and number of partners in last year.

<table>
<thead>
<tr>
<th>Number of lifetime partners</th>
<th>Ever infected with an STD</th>
<th></th>
<th></th>
<th>Females</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
</tr>
<tr>
<td>1</td>
<td>a</td>
<td>a</td>
<td>a</td>
<td>2.3</td>
<td>3.6</td>
<td>2.9</td>
</tr>
<tr>
<td>2-3</td>
<td>4.4</td>
<td>6.9</td>
<td>5.6</td>
<td>60.3</td>
<td>72.3</td>
<td>66.3</td>
</tr>
<tr>
<td>4-5</td>
<td>15.3</td>
<td>20.7</td>
<td>18.0</td>
<td>29.5</td>
<td>20.6</td>
<td>25.1</td>
</tr>
<tr>
<td>6+</td>
<td>80.3</td>
<td>72.4</td>
<td>76.4</td>
<td>7.9</td>
<td>3.5</td>
<td>5.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of partners in last year</th>
<th>None</th>
<th>1</th>
<th>2-4</th>
<th>4+</th>
<th>Total No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a</td>
<td>61.1</td>
<td>33.7</td>
<td>5.2</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>3.2</td>
<td>66.1</td>
<td>27.3</td>
<td>3.4</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>1.6</td>
<td>63.6</td>
<td>30.5</td>
<td>4.3</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>3.1</td>
<td>79.7</td>
<td>17.3</td>
<td>a</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>5.0</td>
<td>86.4</td>
<td>8.6</td>
<td>a</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>4.0</td>
<td>83.1</td>
<td>12.9</td>
<td>a</td>
<td>18</td>
</tr>
</tbody>
</table>

As expected, males (who had ever contracted an STD) reported more lifetime partners and greater number of partners in the last year than females. For instance, Table 6.5 shows that over 90 per cent of males in both urban and rural areas who reported ever being infected with an STD had four or more lifetime partners. More than a third of males who reported contracting a STD had multiple sexual partners in the last one year compared to only 12.9 per cent of females. Over two-thirds of males who stated that they had ever contracted an STD reported sexual contact with a prostitute, compared with 20.8 per cent who reported ever contracting an STD but who had never paid for sex with a prostitute (not shown in table). The high proportion of individuals with multiple partners who had ever contracted an STD demonstrates the relationship between sexual lifestyles and the risk of exposure to STD infection.

There is abundant literature that shows STDs, particularly gonorrhoea and syphilis, are endemic in parts of Africa (Green 1992; Daly, Maggwa at al. 1994). Saboteur (1988:68-69) notes
So common is gonorrhoea among some ethnic groups that doctors have written that its symptoms are sometimes regarded as a sign of sexual reawakening or potency.

Gonorrhoea is one of the most common and widely recognised STD, which, unlike AIDS, is less feared, especially by men. A similar view is corroborated by Cohen and Odthiambo (1989) on the Luo of Liganua, Siaya District in Kenya. In Kisumu town, some young men refer to gonorrhoea metaphorically as 'thunder', and others stated that an individual who has not contracted the disease is believed to be sexually inexperienced. One young male respondent elaborated in an in-depth interview that:

Some men do not view venereal diseases as a threat..., they consider them just as any other common illness, like flu or a minor cough. For instance having gonorrhoea is viewed as a sign of sexual experience........I mean being sexually involved. They do not care about venereal diseases (26 year old, single, urban male).

For other young men STDs are regarded as part of transition from childhood the age of sexual inexperience, into adulthood the age of sexual experience and adventure.

The risk of STD transmission also depends on the number and type of sexual partners and also on the partner’s other partners. The type of sexual partner has been found to be an important factor in the transmission of STDs; people with multiple sexual partners are more likely to contract sexually transmitted diseases than those in stable relationships (Orubuloye, Caldwell and Caldwell 1994). This study investigated these aspects of risk of infection. All respondents who reported ever contracting an STD were asked to identify the partners from whom they contracted the disease. The responses to this question are displayed in Table 6.6.
Table 6.6 Type of partner who infected ever-infected respondents (%).

| Type of partner who infected respondent | Males | | | | Fema|les | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Urban | Rural | Both | Urban | Rural | Both | | | | | |
| Spouse | a | a | a | 7.3 | 8.6 | 7.9 |
| Regular partner (boy/girlfriend) | 21.0 | 15.8 | 18.4 | 34.2 | 18.6 | 26.4 |
| Casual partner (eg. friend but not in any stable relationship) | 31.6 | 24.4 | 28.0 | 50.5 | 62.8 | 56.7 |
| Prostitute/paying partner | 47.4 | 59.8 | 53.6 | 8.0 | 10.0 | 9.0 |
| Total No. | 79 | 78 | 157 | 79 | 76 | 155 |
| Total respondents ever infected | 19 | 13 | 32 | 11 | 7 | 18 |

a no cases.

It is clear that the majority of married respondents did not report ever contracting an STD from a spouse. About eight per cent of females reported getting the infection from a spouse, while 18.4 per cent of males and 26.4 per cent of females were infected by regular partners with whom they had a stable relationship. About 28 per cent of males and over half of females reporting infection stated that they got venereal disease from casual partners whom they knew but had no established relationships with. Over half of the males reported that they contracted the disease from a paid partner or a prostitute; the proportion was higher among rural respondents than urban ones. This does not imply that prostitute use is more common in rural areas than in urban areas; most rural respondents stated that they got infected by prostitutes in towns and big market centres. About nine per cent of the women reported being infected by a partner who had offered them money or gifts for sexual relations. Clinic-based STD studies in Nairobi, Kenya have shown that prostitutes and those who engage in multiple transactional sexual relations, are major reservoirs and transmitters of STDs (Greenblatt et al. 1988; Simonsen et al. 1990; Plummer et al. 1991). These studies which focus on small samples of males attending STD clinics show that the majority of men infected with various types of STDs had contracted the disease from prostitutes.
Treatment for disease is important for the control of sexually transmitted diseases and studies in Africa show that people who get infected with an STD resort to an array of medical remedies (Green 1992; Anarfi 1995b). This study investigated whether survey respondents who reported ever getting infected had sought treatment. All the respondents mentioned that they had received medical care after they found out that they were infected. Thus, they were asked where they sought treatment and how the disease was treated. Table 6.7 shows the percentage distribution of the type of medical care the respondents reported having sought.

Table 6.7 Type of medical care as reported by ever infected respondents (%)

<table>
<thead>
<tr>
<th>Type of treatment</th>
<th>Males</th>
<th></th>
<th></th>
<th>Females</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
</tr>
<tr>
<td>Self-medication</td>
<td>20.5</td>
<td>12.5</td>
<td>16.5</td>
<td>18.2</td>
<td>28.6</td>
<td>23.4</td>
</tr>
<tr>
<td>Traditional healer</td>
<td>5.8</td>
<td>21.0</td>
<td>13.4</td>
<td>9.1</td>
<td>18.6</td>
<td>14.8</td>
</tr>
<tr>
<td>Hospital</td>
<td>68.4</td>
<td>53.5</td>
<td>60.9</td>
<td>54.5</td>
<td>38.6</td>
<td>45.6</td>
</tr>
<tr>
<td>Self-medication, then hospital</td>
<td>5.3</td>
<td>13.0</td>
<td>9.2</td>
<td>18.2</td>
<td>14.2</td>
<td>16.2</td>
</tr>
<tr>
<td>Total No.</td>
<td>79</td>
<td>78</td>
<td>157</td>
<td>79</td>
<td>76</td>
<td>155</td>
</tr>
<tr>
<td>Total Cases</td>
<td>19</td>
<td>13</td>
<td>32</td>
<td>11</td>
<td>7</td>
<td>18</td>
</tr>
</tbody>
</table>

The majority of the respondents reported that they sought treatment from a hospital and were either treated with oral antibiotics or injections (mainly penicillin and tetracycline) or a combination of both. Rural males (21%) and females (18.6%) were more likely to seek care from traditional practitioners than their urban counterparts (5.8% of males and 9.1% of females). Traditional healers treat STDs typically with decoctions of leaves and roots of various medicinal plants, which are administered orally and sometimes mixed with ber (millet gruel) at various intervals. The majority of the herbalists I interviewed knew about and used a wide variety of medicinal plants to treat different diseases, including sexually transmitted diseases. These plants are available locally and also come from outside Kisumu and Luoland, as far as the Kenyan Coastal region and Tanzania (Field notes).
Overall, females were more likely to resort to self-treatment than males. Those respondents who reported self-treatment with antibiotics had bought drugs from the chemists, street vendors and unregistered practitioners. Others were offered the drugs by friends who had previous experiences with a venereal disease. Less than ten per cent of men and over 16 per cent of women mentioned that they initially treated themselves with antibiotics and other drugs bought from the pharmacy or provided by friends, but later went to hospital when the disease got worse. Thus, self-treatment or medication is common among people infected with STDs; Cohen and Odhiambo (1989:91) writing about the Luo of Siaya, commented:

Venereal disease has been a subject of continuous concern to the young in Kenya. The prevalence of venereal disease has made penicillin a high-value commodity, often sold on the black market, and the scarcity and price of the wonder drug have made the visitor to Kenya the target of inquiry and pleading, since the foreigner is known to carry essential medical supplies wherever he or she goes.

Some studies in Kenya have shown that self treatment with antibiotics result in ineffective treatment and recurrence of the disease (Mati 1989; Cohen and Odhiambo, 1989). Several factors may explain why many people use self treatment, ranging from access to medical facilities, cost of treatment (including transport and time spent) perceived efficacy of treatment, to fear and stigmatisation. Lack of privacy and stigma attached to STDs were expressed by some respondents as reasons why infected people do not want to seek treatment from recognised health care centres. This emerged clearly in discussions with in-depth interview informants:

Nowadays to go to hospital costs money....for transport, hospital charges and on top of that you don't get free medicine from hospitals, they tell you to go and buy from the chemist/pharmacy because they have none. Sometimes you may have to go there many times before the doctor sees you (urban male 18 years old).

People tend to look at people who have STDs as promiscuous and care free......they are seen as wicked people with no sexual morals. A friend got insulted by medical assistants at 'casino' (meaning STD clinic) in Nairobi when he went there for treatment with gonorrhoea, they spoke inhumanly to him.....some even insulted and blamed him.....this makes people shy away from going to hospitals (urban male 34 year old).

People infected with STDs are regarded as morally wicked because they sleep around (promiscuous)....[Does this prevent people with
STDs seeking treatment?] Yes, many people would not want other people to know they have a disease, so they only tell close friends or keep it secret for fear of being laughed at and ridiculed. People often hide the diseases because of the opinion of others. It is very embarrassing when other people know that you have an STD (urban male 28 year old).

In fact, those who are infected with STDs are considered criminals by Kenyan law. For instance, prostitutes are frequently rounded up in many urban centres and are arraigned in court charged with spreading STDs. People who contract STDs are viewed by many people in the community as being immoral and are avoided by the community at large.

Partner notification is an important factor in treatment and control of STDs; the survey examined whether respondents who reported ever contracting an STD notified their partners who infected them with the disease. Table 6.8 displays percentage distribution of ever-infected respondents who informed their partners and the reasons why they did not inform them.
Table 6.8 Ever-infected respondents who informed their partners about the infection by sex and residence (%).

<table>
<thead>
<tr>
<th>Question</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you inform your partner you got infected?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21.1</td>
<td>46.2</td>
</tr>
<tr>
<td>No</td>
<td>78.9</td>
<td>53.8</td>
</tr>
<tr>
<td>Total cases</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td>If no, why didn't you inform your partner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashamed/embarrassed</td>
<td>26.7</td>
<td>6.6</td>
</tr>
<tr>
<td>Couldn't trace partner</td>
<td>60.0</td>
<td>42.8</td>
</tr>
<tr>
<td>Afraid of partner's reaction</td>
<td>13.3</td>
<td>28.6</td>
</tr>
<tr>
<td>Total cases</td>
<td>15</td>
<td>7</td>
</tr>
</tbody>
</table>

The majority of men who reported ever contracting a venereal disease did not inform the partners who infected them because they could neither identify their partner nor trace them: their partners were prostitutes with whom they had a 'one-night' sexual episode. However, in contrast, most of the women who ever contracted an STD informed their partner, probably because the majority were infected by people whom they knew very well even though they might have not been in an established relationship. Often this took the form of accusation that the infection had come from their partner. Those who informed their partners mentioned that their partners sought treatment afterwards. Only six women did not inform their partners because they were either embarrassed or ashamed to tell their partners or afraid of their partner's reaction. There is risk associated with the high proportion of males who did not inform their female partners who infected them, in that these women may continue having sexual relations and infecting their other partners unknowingly. Partner notification offers the
opportunity to seek treatment and is important in the control of sexually transmitted disease.

All respondents who knew about STDs were asked whether they knew how to protect themselves from venereal diseases and how they could protect themselves from contracting these diseases. The responses to these questions are displayed in Table 6.9.

**Table 6.9 Knowledge about methods of STD prevention (%)**

<table>
<thead>
<tr>
<th>Do you know how you can protect your self from STDs?</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td></td>
<td>98.7</td>
<td>93.6</td>
</tr>
<tr>
<td>No</td>
<td>1.3</td>
<td>6.4</td>
</tr>
<tr>
<td>Total No.</td>
<td>79</td>
<td>73</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How can one prevent STD infection</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero grazing (monogamy)</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td></td>
<td>32.9</td>
<td>34.2</td>
</tr>
<tr>
<td>Abstain from sex</td>
<td>18.9</td>
<td>17.8</td>
</tr>
<tr>
<td>Avoid sex with prostitutes and strangers</td>
<td>23.9</td>
<td>26.4</td>
</tr>
<tr>
<td>Use condoms</td>
<td>10.4</td>
<td>17.4</td>
</tr>
<tr>
<td>Other</td>
<td>13.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Total No.</td>
<td>79</td>
<td>73</td>
</tr>
</tbody>
</table>

About 95 per cent of the respondents reported that they knew of ways by which they could protect themselves from STDs. More than six per cent of females reported that they did not know how. The most frequently mentioned method of STD infection was being faithful in a monogamous relationship or ‘zero grazing’ which was mentioned by 33.6 per cent of men and 43.8 per cent of females. Only 13.9 per cent of males and 16.3 per cent of females mentioned condom use as a means of preventing STD infection. Other less frequently mentioned ways of avoiding STDs include abstaining.
from sexual relations (18.4 % of men, 17.3 % of women) and avoiding indiscriminate sexual relations with prostitutes (25.1 % of men and 14.2 % of women). However, there were also some misinformed beliefs about STDs; about 9 per cent of men and 8.4 per cent of overall respondents stated that STDs could be avoided, by urinating or cleaning genitals immediately after sexual intercourse.

STD case studies

CASE 1

**Background:** John is 24 years old and was born in Muhoroni, Kisumu District. He attended primary and secondary school in Muhoroni and Siaya up to Form 3 but could not complete his education because his parents could not afford to pay his fees. He now lives and works in Oton'glo market, about twelve kilometres from Kisumu town. He shares a two-bedroom rented house with three of his male friends. He is a barman in one of the popular day and night clubs in the market centre.

**Sexual experience:** John became sexually active at the age of 16 while in Form 1 in secondary school. His first sexual intercourse was with a girl in his village whom he describes as 'just a friend' who attended the same primary school he went to. This occurred after a night dance in the village. They never had sex together again after this first encounter. Thereafter, he had sexual relations with two other girls in stable relationships while he was in school. Currently he does not have a stable relationship with any woman but has sex with different women whom he happens to meet while working at the bar; these include prostitutes and women he calls friends.

**STD infection and treatment:** John has twice been infected with a sexually transmitted disease, gonorrhoea. He was first infected in June 1992, soon after he started working. He says he was infected by a prostitute whom he met in Kisumu town. He bought her drinks and food and paid for a room for the night in a boarding house. Three days after his encounter with the prostitute, he started feeling burning pain while urinating and a day later had pus in his urine. At first he did not know what to do and decided to consult one of his friends who is slightly older than him. His friend advised him to buy some capsules (antibiotics) from the chemist. He took them for two days but stopped when the symptoms and pain subsided. Soon after, the symptoms came back and he decided to go to the district hospital in Kisumu town where he got an injection and some antibiotics. The health officer who treated him advised him to use condoms. He did not take this advice seriously because he had tried to use condoms but did not like them. Seven months later he was again infected with gonorrhoea by a barmaid whom he had bought drinks and food, and later paid for having sex. Four days later he noticed similar symptoms to his first infection. This time he went to a private doctor in Kisumu town, got an injection and antibiotics. Now he uses condoms whenever he has sex with women whom he does not know well because he is scared of AIDS. He knows people who have been victims of the disease.
However he still has sex with different women, some of them prostitutes (Rural male 24 years old).

CASE 2

**Background:** Andrew is 35 years old and was born in Homa-Bay. He attended secondary school up to Form 6 and later joined Maseno college for a diploma course. He is married with three children and lives with his family in Kisumu town. He works with a state corporation and earns a good salary.

**Sexual experience:** Andrew became sexually active at the age of 18 with his first girlfriend whom he had known for about a year. Thereafter, they had sexual relations many times until she went to boarding school away from his village. Apart from his first girlfriend, he then had sexual relationships with four other girls before he got married: two of them were in stable relationships while the others were just friends whom he had known for a short time.

**STD infection and treatment:** He was first infected with gonorrhoea in 1987 while still at college in Maseno by a casual girlfriend who was a student in a secretarial college in Kisumu town. He feared telling his friends about it or seeking medical attention from the college health centre because his friends would laugh at him. So he went to a private doctor in town who gave him an injection and prescribed some antibiotics. When he told his casual girlfriend about it, she denied having infected him. Soon afterwards their relationship broke up. Andrew was infected for the second time with syphilis in 1987 by a girl he had met in a night club in Kisumu town. He had gone out with friends drinking and partying and they ended up picking up women whom they took to a boarding house in the town. He gave her some money for bus fare and breakfast the following morning. A week after that happened he noticed a boil in his genitals but decided to ignore it as something normal. He did not see any other symptoms until two months later when the boil came back. He got frightened and asked a close friend who advised him to seek medical attention immediately. He saw a doctor in a private hospital who gave him an injection and antibiotics. The doctor also conducted laboratory tests to ascertain the disease. He continued visiting the doctor until he was fully cured. He did not have sexual intercourse with any other woman during the treatment period. Andrew says that he no longer engages in casual sex since he got married. He confines his sexual activity to his wife. He is frightened of getting AIDS and cannot risk sleeping around with other women, especially in Kisumu, which he describes as a danger zone (Urban male 35 years old).

CASE 3

**Background:** Michael is 32 years old and was born in Seme, Kisumu District. He has completed O-level secondary school education and currently works as a driver in Kisumu town with a local household goods hire-purchase company.

**Sexual experience:** Michael became sexually active at the age of 17 with a girl from his village. They had a relationship for about two years; but they broke up when he discovered she was seeing another man. While he was in secondary school, Michael had sexual relations with two other girls but did not have any steady relationships. He says they were just friends he met and liked. Michael completed secondary school in 1981. 'This is when I really
started moving around with girls of all sorts’. He moved to Nairobi to seek employment and got a job as a driver. His job involved travelling to different parts of the country and he earned a lot of money. Michael says that he had girlfriends whom he used to visit while doing his job in different parts of the country such as, Nakuru, Eldoret, Narok. He also went with prostitutes in towns where he stayed overnight while he was travelling around.

STD infection and treatment: Michael has been infected three times with STDs, mainly gonorrhoea. He was first infected in 1983 by a prostitute whom he had picked up after heavy drinking with work mates in Nairobi. He sought advice from a friend who had previously been infected. The friend took him to a private doctor who prescribed some antibiotics and gave him several injections. He was also advised to drink black tea (no milk). In 1987 he was infected for the second time and went to see a doctor who gave him an injection and antibiotics and advised him to use condoms to protect himself. However, he ignored the advice and continued having casual unprotected sex. He says he tried condom once but could not get what he calls ‘real feeling’. ‘Using a condom is the same as eating an unpeeled banana’. Michael was last infected with an STD in 1992, this time with chancroid. This was immediately after he was transferred to Kisumu. He got the disease from a woman he had picked up from a bar in the outskirts of Kisumu town. The first symptoms were a large painless hard swelling in the genital area which disappeared after a while. He bought some anti-biotics (capsules) from a chemist in town. Later the disease started to manifest in the form of recurring painful ulcers in the genital area and penis. He consulted a doctor; who then ordered a laboratory test and treated him with injections and antibiotics for about a month. Since then, Michael says that he uses condoms whenever he goes with prostitutes or women he does not know very well because ‘these days things are very bad. You cannot tell who will give you a venereal disease’ (Urban male, 32 years old).

CASE 4

Background: Oscar is 18 years old and the eldest in a family of nine children. He was born in Nyahera and had primary education up to Class 5. Currently he works as a cook in a small motel in the local market centre.

Sexual experience: Oscar had his first sexual intercourse at the age of 15, with a girlfriend who was also a work mate. Thereafter, he had sexual relations with several other partners (could not remember the number).

STD infection and treatment: Oscar has been infected with a venereal disease once in his lifetime. He contracted a venereal disease from a girlfriend (had no stable relationship) in the neighbourhood. He had known the girl for about a week before they had sexual intercourse. Four days after they had sex, symptoms started to develop, mainly whitish penile discharge and also difficulty in urinating. He told his closest friends who advised him to go to the local dispensary for some antibiotics. He hesitated because he was afraid that people would know about it. His friend told other boys in the neighbourhood and within a week or so, the word had spread among the locals that Oscar had a venereal disease, and no woman wanted to go near him. The symptoms got worse and Oscar finally went to the local dispensary and was treated for
gonorrhoea. The medical assistant at the dispensary prescribed drugs, which he was to swallow three times a day. However they did not work and the pain got worse. After a week Oscar went back to the dispensary where he was advised to go to Kisumu District Hospital. He decided he wouldn’t go to Kisumu but would seek treatment from the local herbalist. When asked why he could not go to Kisumu, he replied ‘it would cost me money to go to Kisumu. I would have to go many times because I do not know anyone there who can help me get treatment. They could have told me that they have no drugs and then I would have to buy them. These are very many expenses which I could not afford’. Oscar says that he finally got treatment from a herbalist in a neighbouring village who gave him a herbal mixture (*Rural male, 18 years old*).

### 6.4 Knowledge about HIV/AIDS

The following section is devoted to AIDS; it looks at the awareness of the disease, how people have perceived it over time, and the way people comprehend the disease. The information provided here was obtained through survey questionnaire, focus group discussions, in-depth interviews and participant observation. To assess the knowledge about HIV/AIDS, the survey questionnaire included questions that asked respondents whether and when they had ever heard about AIDS, their source of information about the disease and whether they knew anyone in their locality or elsewhere who had ever been infected by the disease, and to what extent they considered themselves to be at risk of infection. The responses to these questions are displayed in Table 6.10.
Table 6.10 Knowledge about HIV/AIDS (%)

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th></th>
<th>Females</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
</tr>
<tr>
<td>Ever heard about AIDS?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>98.7</td>
<td>94.9</td>
<td>96.8</td>
<td>97.5</td>
<td>98.7</td>
<td>98.2</td>
</tr>
<tr>
<td>No</td>
<td>1.3</td>
<td>5.1</td>
<td>3.2</td>
<td>2.5</td>
<td>1.3</td>
<td>1.8</td>
</tr>
<tr>
<td>Total No.</td>
<td>79</td>
<td>78</td>
<td>157</td>
<td>79</td>
<td>76</td>
<td>155</td>
</tr>
<tr>
<td>From what sources did you get information about AIDS?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radio, television</td>
<td>31.7</td>
<td>41.1</td>
<td>36.4</td>
<td>31.6</td>
<td>30.3</td>
<td>30.9</td>
</tr>
<tr>
<td>Newspapers, magazines, posters</td>
<td>36.7</td>
<td>26.9</td>
<td>31.8</td>
<td>30.4</td>
<td>20.4</td>
<td>25.4</td>
</tr>
<tr>
<td>Other publicity</td>
<td>10.1</td>
<td>11.5</td>
<td>10.8</td>
<td>15.2</td>
<td>10.6</td>
<td>12.9</td>
</tr>
<tr>
<td>Health workers/hospital</td>
<td>11.4</td>
<td>12.8</td>
<td>12.1</td>
<td>5.1</td>
<td>13.7</td>
<td>9.4</td>
</tr>
<tr>
<td>Friends and relatives</td>
<td>10.1</td>
<td>7.8</td>
<td>8.9</td>
<td>17.7</td>
<td>25.0</td>
<td>21.4</td>
</tr>
<tr>
<td>How is HIV/AIDS transmitted?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual intercourse</td>
<td>47.4</td>
<td>42.1</td>
<td>44.7</td>
<td>44.7</td>
<td>42.9</td>
<td>43.8</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>26.5</td>
<td>29.8</td>
<td>28.7</td>
<td>20.9</td>
<td>17.5</td>
<td>19.2</td>
</tr>
<tr>
<td>Unsterilised needles</td>
<td>10.2</td>
<td>7.4</td>
<td>8.8</td>
<td>10.7</td>
<td>10.1</td>
<td>10.4</td>
</tr>
<tr>
<td>Casual contact</td>
<td>5.1</td>
<td>7.7</td>
<td>6.4</td>
<td>8.9</td>
<td>15.8</td>
<td>12.4</td>
</tr>
<tr>
<td>Foetal infection</td>
<td>8.9</td>
<td>7.7</td>
<td>8.3</td>
<td>11.4</td>
<td>6.6</td>
<td>9.0</td>
</tr>
<tr>
<td>Witchcraft</td>
<td>1.9</td>
<td>5.4</td>
<td>3.7</td>
<td>3.4</td>
<td>7.1</td>
<td>5.2</td>
</tr>
<tr>
<td>Total No.</td>
<td>78</td>
<td>77</td>
<td>155</td>
<td>77</td>
<td>75</td>
<td>152</td>
</tr>
</tbody>
</table>

Most of the survey respondents have heard about AIDS; less than four per cent of males and two per cent of females had never heard about AIDS at the time of study. The high levels of AIDS awareness observed in this Kisumu study are linked to public health education campaign and other informal information such as rumours about the disease, friendship networks, and AIDS deaths. Since the first few cases of AIDS were reported, public health campaigns have mounted, through posters, media (radio and TV), theatre or drama, musical compositions, and public lectures and workshops to educate people about the disease (Kisumu District Development Plan 1994-1996).
While the Ministry of Health and the National AIDS Control Program (NACP) remain the main primary sources of information about AIDS, there are also small locally based grassroots-level initiatives by various organisations to increase people's education about AIDS through local health and volunteer workers at the village level. There are various Christian Church organisations involved in AIDS education and prevention and HIV/AIDS features prominently in church sermons and seminars and workshops organised by various religious denominations. However, it may be observed that the AIDS education and prevention campaign in Kenya has a moralist approach and tends to emphasise change in sexual behaviour. It promotes monogamy and safe sexual practices. In the course of my fieldwork I attended many AIDS lectures, public gatherings or baraza's, and seminars both in Kisumu town and rural villages. The following statements from interviews and AIDS education lectures illustrate that the central theme of AIDS education is moralistic.

These days it is very dangerous to move around carelessly......many young people have perished because of AIDS. Many young people today indulge in sexual relations. Young women sleep with men for money....if you young people don't change your behaviour you will all perish from AIDS.....there is this girl in my village who finished school and went to town to look for work. She started to roam around with men. She caught AIDS and died.....We must change our lifestyle if we want to avoid AIDS (AIDS counsellor, lecture in rural school).

Today we have AIDS because of sin..people nowadays are very promiscuous.....young boys and girls indulge in sex. We have very many single mothers and children without fathers.....people today have no respect any more, for example prostitution is common...men go to bars for prostitutes, get disease and take the disease back home to their wife....People must change!......young people must abstain from sexual matters and married men should be faithful to their wives if they want to avoid AIDS (Priest, Catholic church, Sunday sermon).

AIDS will not spare those who do not change ...the chances of acquiring the disease are very high nowadays (Primary School Teacher).

Much of the information provided focuses on the medical framework of AIDS, depicting the disease as both a health problem and a threat to life. These efforts to educate people about HIV/AIDS have led to high levels of knowledge about the disease even in low prevalence areas (KDHS 1993).
Respondents were also asked when they first heard about AIDS and their responses are plotted in figure 6.1 which displays the cumulative percentage of AIDS awareness in the survey population in the decade preceding the field work.

Figure 6.1 Cumulative percentage of AIDS awareness by year among survey respondents

The chart shows that awareness about AIDS has been increasing over the last decade or so, from less than 6.8 per cent in 1983 to over 95 per cent in 1995. Early reports of the existence of the disease in the late 1980s were received with skepticism, suspicion and doubt; many people did not believe that the disease existed at all (Daily Nation 21 June, 1986). It is important to observe that there has been wide variation in the level of awareness about AIDS in different parts of Kisumu and at different points in time. Until recently, few people in Kisumu and Nyanza in general believed that AIDS existed or was a big problem; many people viewed it as an imaginary disease. This was collaborated by some of my informants in in-depth interviews:

We heard of AIDS before people started to die of the disease here. In the early 1980s we heard that there was an incurable disease in America that was affecting homosexuals. Then the mid-1985 we heard of a wasting disease that was affecting many people in Uganda. The
government also started warning people and it was reported that some people had died in Kenya but very many people did not believe it. It is only recently...(When?) in 1990 that people started to die of AIDS. The first person I know of was a workmate who died in 1991. People said that he had caught the disease in Uganda because he had lived and worked there for more than ten years (Urban female, 44 years old).

When people first heard about AIDS in the mid-1980s, no one believed that it would one day kill people in Kisumu. People thought it was an imaginary disease that would never come here. But, now things have changed and every one knows it exists and people gossip about it....the first case I knew of was of a young man from this village, he died in 1989. Since then AIDS has claimed more than ten people in this village. We are all afraid that AIDS is going to finish people here (Rural female, 31 years old).

A string of deaths, one person after another, has made people in this village realise that AIDS really exists...before people didn't know, there were just reports of people dying or sick but they had never seen someone with the disease. Now there are many people sick with AIDS...virtually every weekend people attend a funeral of someone who has died (Rural male, 29 years).

Nowadays very many people are dying of AIDS including very wealthy and prominent people, some of them in senior government positions and 'mwanaanchi' (ordinary people)...I don't know how many more will die (Urban male, 33 years old).

Many people, especially in rural areas, still believe that AIDS is predominantly an urban disease, mainly because most people who have contracted the disease are people who have lived in urban areas or away from their villages of origin:

All the people I know who have contracted or died of AIDS get it elsewhere or get it from partners who have lived away in town, not here in the village....They get it from towns where they lived and some returned to the village to die. We have been hearing that the disease is spread by promiscuity which is more common there than here. That is why those who are dying of AIDS are people from towns (Rural male 51 years old).

Thus to some people AIDS is a disease arising from disorder in urban life and the breakdown of core values of the society. For instance two respondents stated:

There is AIDS these days because people in towns are promiscuous and careless...it has come because people in town move around with anyone...married men and women sleep around with other
people...men have mistresses and wives have lovers...this is how AIDS is spreading (Rural female, 47 years old).

AIDS has become common nowadays because people do not follow tradition any more...they sleep around carelessly...some women do it for money because they are poor and cannot survive on their own...even young school girls go with sugar daddies...in the past this was not common...the people of today have no respect at all (Urban male, 50s years old).

At the time when early cases of AIDS occurred, there were many theories held by people about the disease. The first few cases of AIDS were local people from Kisumu who had lived and worked outside the District, in cities and towns such as Nairobi, Mombasa, Busia etc. Until recently, AIDS in Kisumu and Nyanza Province in general, was regarded as a disease of people in urban areas or those who have travelled; migrant labourers, itinerant traders, professional elites, prostitutes and people with a history of living in or near Uganda. The majority of the first cases of AIDS were people who had lived or travelled outside Kisumu; many of them died in towns or returned home in the terminal stages of the disease to die. The earliest cases of AIDS deaths in Kisumu District occurred in mid-1987. In the village (Kabando) where the fieldwork was carried out, the first cases occurred in 1988. These were deaths of two wealthy men who were successful businessmen involved in cross-border trade at Busia, on the Kenya-Uganda border. When one of them started getting sick, relatives and friends explained his sickness as resulting from witchcraft; it was rumoured that he was bewitched by business competitors. This belief was reinforced by the fact that soon after his death, his younger wife fell sick and died a few months later. As time passed, more and more local men who had lived outside Kabando village died of the disease (Field notes).

For both males and females, the important sources of knowledge were the media; mainly radio, television, magazines, newspapers and posters. The radio was the most common channel of information about AIDS. The information was received from weekly radio programs on AIDS that are broadcast all over Kenya in English, Swahili and vernacular languages (including Dholuo). Males were more likely than females to have received information about AIDS from newspapers, magazines and posters. Apart from the media, the second most important source of AIDS knowledge for men was public forums (chief’s baraza, seminars and workshops, social gathering in bars,
schools and church), and for females, friends and relatives. This shows that public forums and networks of friends and kinsmen are an important channel for information about various issues.

The survey found that majority of the respondents knew the correct details of how the disease is spread. About 44.7 per cent of men and 43.8 per cent of females knew that AIDS was transmitted primarily through sexual intercourse. Most of my informants and respondents believed that AIDS is spread by immorality or sexual promiscuity, and the following statements clearly demonstrate this:

Promiscuous women are spreading AIDS....some of them are very beautiful and they attract men and they do not care who they go with so long as they are given money (Urban respondent 19 years old).

AIDS is spread by promiscuous people...men and women who have sexual relations with many partners, such as prostitutes who sleep with six or even ten men in one day. Men who sleep with such women get the disease and give it to their wives and girlfriends (Urban single woman 23 years old).

Rich promiscuous men, some of them are old, entice young girls with money, they buy them gifts, clothes, pay for their living and give them money...these men have many partners...they get diseases and give it to these young girls. For each promiscuous person who dies, maybe ten or more follow them (Urban married woman 46 year old).

The second most important mode of transmission mentioned by respondents was blood transfusion (over a quarter of males and almost a fifth of females). Other less frequently mentioned modes of transmission were unsterilised needles and foetal infection. However, there was some misconception about AIDS, especially among females; for instance nearly seven per cent of men and 12.4 per cent of women believed that AIDS can be transmitted through casual contact such as shaking hands, eating together with an infected person, sharing clothes and toilet facilities with an infected person. Whereas the survey data confirm findings of other studies in Kenya and Sub-Saharan Africa that the level of knowledge about AIDS and means of transmission is quite high, there seemed to be a few respondents who are still misinformed about AIDS. These include those who associate the cause of AIDS with supernatural powers, witchcraft, punishment from God, and those who believe that AIDS is chira. About 3.7 per cent of men and 5.2 per cent of women attributed AIDS
to supernatural causes such as witchcraft and punishment from God. Some people believe that witchcraft can be manipulated to cause AIDS. A female informant stated that

Nowadays witches have become sophisticated because they can even send you AIDS....they have very powerful dawa or medicines which can cause diseases that look like AIDS (Married female 36 yrs old, urban area).

This belief that supernatural powers can be manipulated to cause AIDS or illness which looks like AIDS is also found in other parts of Africa, such as among the Tonga of Zambia. Mogensen (1997) notes that among the Tonga, AIDS is believed not to be caused by witchcraft, but supernatural forces such as evil spirits and ghosts which can send diseases which look like AIDS.

Some staunch or devoted Christians, especially from fundamentalist sects, view AIDS as a punishment from God; it is an example of the biblical admonition that 'the wages of sin is death' and AIDS is a punishment for man's sins.

A common theory about AIDS in the early stages of the epidemic, which still prevails in some parts of Nyanza Province, was (and is) the belief that AIDS is chira, a disease which presents symptoms similar to those of AIDS. Chira is a disease that results from violation of social norms (Ocholla-Ayayo et al. 1993a). The Luo belief in chira is closely linked to sexual pollution and personal responsibility between sexual partners (husband and wife) and towards the kinship group (family lineage) (Ocholla-Ayayo 1976). The Luo moral code places strong emphasis on sexual responsibility towards self and others. It is believed that sexual intercourse with certain persons results in transgression: for example with persons of the same agnatic lineage, a married woman, a ritually uncleaned person or widow who is not inherited widow. Sexual intercourse with these persons is to cause pollution and hence chira.

In Luo custom, a widow has to be cleansed before she can resume normal life...if a man sleeps with a widow who is not cleansed, he will get chira'...he will slim and get sores all over...in the hospital they say it is AIDS but it is chira (Urban male, 43 years).
The similarity between AIDS and chira kept recurring in some interviews and discussions with survey respondents and informal interview informants. For instance, it was not uncommon for some informants to describe AIDS as resembling chira.

AIDS and chira are just the same because they have same symptoms...slimming and sores all over the body...chira was there before AIDS but AIDS was just discovered recently...it was there just as chira...there is no difference between the two...both are caused by carelessness and failure to observe custom (Rural male 40+ years old).

AIDS is like chira. In both cases the person afflicted thins away, gets very weak and loses vitality. I have seen people with both illnesses. My neighbour was a very fat man but he suddenly started thinning away....he was very ill....people said it was chira. We later heard that the doctor said he had AIDS, the illness just ate him away. He consulted several doctors and his relatives even took him to a diviner. He was not cured and a few months later he died (Urban male 36 years old).

Before AIDS was recognised by doctors, people used to die with similar disease...they just got thinner and thinner and then died.....there was no cure for it, even in hospital, just like AIDS...we Luo call it chira (Rural male 36 years old).

In rural areas many people suffer and die of AIDS but people say it is chira....because they have similar symptoms (Urban male, 26 years old).

When people started dying of a thinning disease, most people did not know how to explain it because there was no cure...some people attributed the deaths to witchcraft while others believed that it was chira...as punishment for sexual promiscuity and failure to follow traditional customs....but we have been told that we shouldn't confuse the two (Rural male 29 years old).

In-depth interviews and focus group discussions show that some people, in certain contexts, view AIDS and chira as the identical because they have similar cause and symptoms, while others perceive them as distinct from each other. AIDS and chira have similar symptom manifestations, notably severe weight loss, general weakness and inevitable death, and also because they have no conventional medical cure. Hence, many people, especially in areas where there is little exact knowledge about the disease and low prevalence, are not able to distinguish the two diseases. This is probably the reason why many people today use the term chira to refer to AIDS.
There is abundant ethnographic information which shows that similar explanations for wasting diseases are also common in other East African communities such as the Ankole (Amakire), Tonga (Kahungo) and Luhyia (Ishira) (Parkin 1978; Obbo 1988; Mogensen 1997). These concepts refer to fatal disease that is caused by the violation of sexual taboos, especially those related to adultery during pregnancy or nursing. For instance among the Baganda of Uganda, it is believed that adultery resulted in difficult birth or the mother's death. Repeated transgression resulted in a fatal disease known as makiro. It is also believed to be a disease that is contracted by girls who sleep or roam around with different men. The Tonga of Zambia believe that a man can get Kahungo if he sleeps with an uncleaned woman who has had a miscarriage. Such a woman is supposed to undergo ritual cleansing after a period of seclusion before she can resume normal sexual relations. Among the Luo, chira, represents a classic example of an illness that occurs as a result of social transgression or infringements of the moral code; in this case the transgression of rules regarding sexual behaviour (Ocholla-Ayayo 1976; Obbo 1988:196). The Luo code tends to link sexual transgression and carelessness with destruction of families. Similarly, AIDS is viewed in the same context, as a disease that results from sexual immorality or promiscuity.

The belief that AIDS is chira or is caused by witchcraft shows the different ways in which Luo people draw on their culture to explain their experience with a mysterious disease such as AIDS. Public health education programs have not managed to totally displace non-scientific explanations about the disease and the myths surrounding it. Thus, today there are wide range of explanations and it is still common to hear accounts about AIDS being merged with traditional beliefs about health and disease. However, the medical explanation is widely respected by the majority of the population, particularly young educated people. This explanation includes the identification of the virus that causes AIDS as mdudu (Swahili for small insect) which is passed on to the partner during intercourse. In the last few years public perception of AIDS has changed from a situation of complete denial, which was not uncommon in the early and mid-1980s, to one in which people recognise AIDS as an established problem in Kisumu. From 1990 onwards AIDS has come to be increasingly associated with widow inheritance; AIDS is viewed as a disease that is being spread by and threatening this custom, which involves ritual cleansing of the widow or chodo kola.
The custom involves sexual intercourse to cleanse the widow after which she can choose an inheritor. The potential risk of spreading HIV during this ritual is high and has provoked a lot of debate since 1994 among Luo leaders, academics and sages, regarding the merits and demits of the practice. There is strong opposition to the practice among many men and women, especially those who are educated, because of the threat it poses to HIV infection. This is illustrated by the following statement from an interview female informant:

Widow inheritance has risks. There is now a plethora of sexually transmitted diseases and AIDS. Many women have been widowed by AIDS and those who succeed their husbands won’t be spared if the widows are infected......people should know that this cultural practice, especially forced inheritance, has not stood the test of time. The Luo community risks extinction through this practice because it perpetuates a vicious circle (Married female 37 years old, urban area).

Thus the AIDS epidemic has also provoked debate regarding Luo customs; some people feel that those customs that have outlived their importance should be abandoned.

Because of the increase in the toll of AIDS deaths in Kisumu and Nyanza in general, many people now perceive the disease as a threat or problem. The ways in which AIDS threatens the lives of many people in the region is illustrated by the terms used to describe the disease; AIDS is referred to metaphorically as ayaki or ayaki matieko, 'the one that finishes or kills one suddenly'. In the context of AIDS, it is a disease that finishes someone very quickly.

Caldwell et al. 1993a) note that social consciousness about AIDS is most affected by sickness or death, thus it increases as people experience the disease through the loss of a friend or acquaintance. To assess the survey respondents' experience with the disease respondents were asked if they knew anyone who had been diagnosed with AIDS and who this person was. The responses to these questions are displayed in Table 6.11. Over two-thirds of the respondents stated that they knew or had heard of someone suffering from AIDS or that there had been an AIDS death in their neighbourhood.
Table 6.11 Respondents who knew about someone with HIV/AIDS (%)

<table>
<thead>
<tr>
<th>Question</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you know any one who has been diagnosed with HIV/AIDS?</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Yes</td>
<td>66.7</td>
<td>56.9</td>
</tr>
<tr>
<td>No</td>
<td>33.3</td>
<td>43.1</td>
</tr>
<tr>
<td>If yes who is this person?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friend, neighbour, workmate</td>
<td>40.0</td>
<td>33.3</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>23.3</td>
<td>28.6</td>
</tr>
<tr>
<td>Relative</td>
<td>20.0</td>
<td>23.8</td>
</tr>
<tr>
<td>Combination of above</td>
<td>13.3</td>
<td>14.3</td>
</tr>
<tr>
<td>No response</td>
<td>3.4</td>
<td>a</td>
</tr>
<tr>
<td>Total. No.</td>
<td>78</td>
<td>77</td>
</tr>
</tbody>
</table>

a: no cases

Table 6.11 shows that more than 60 per cent of male respondents and over 70 per cent of females knew someone who had AIDS or had died of the disease. None of the respondents reported having AIDS, but a considerable proportion had seen or heard of an AIDS death in their locality. In Kabando village, it was reported that six people had died of AIDS in the year previous to the fieldwork, while many were rumoured to be suffering from the disease. Most of these people knew someone who had died or was suffering from AIDS, and of those who knew someone who had the disease, over a third of males and over a quarter of females knew a friend, neighbour or a workmate who had or died of AIDS. About 22 per cent of males and 23 per cent of females who reported that they knew someone with AIDS mentioned relatives as the victims of the disease. Over half of the females who knew someone with AIDS or who had died of the disease identified the person as an acquaintance. Over 13 per cent of males mentioned that they knew of relatives, friends or neighbours who had been diagnosed with AIDS.
The respondents were also asked questions pertaining to means of protection against HIV/AIDS infection and their perceived risk of infection. The responses to these questions are displayed in Table 6.12.

Table 6.12 Ways to avoid getting AIDS and respondent's perceived risk of contracting AIDS (%).

<table>
<thead>
<tr>
<th>Question</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>How can you avoid getting HIV/AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monogamy (zero grazing)</td>
<td>56.3</td>
<td>47.3</td>
</tr>
<tr>
<td>Abstain from sex</td>
<td>24.6</td>
<td>24.5</td>
</tr>
<tr>
<td>Use condoms</td>
<td>19.1</td>
<td>19.2</td>
</tr>
<tr>
<td>Other</td>
<td>a</td>
<td>9.0</td>
</tr>
<tr>
<td>To what extent do you think you are at risk of getting HIV/AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No risk at all</td>
<td>55.2</td>
<td>53.4</td>
</tr>
<tr>
<td>At risk</td>
<td>15.7</td>
<td>13.1</td>
</tr>
<tr>
<td>Don't know/Can't tell</td>
<td>29.1</td>
<td>33.5</td>
</tr>
<tr>
<td>Total No.</td>
<td>79</td>
<td>78</td>
</tr>
</tbody>
</table>

a: no cases

The majority of respondents stated that they knew of means to protect themselves from infection with HIV/AIDS. The most common theme in many responses was reduction in number of sexual partners. The most frequently mentioned means of prevention was monogamy, 'zero grazing' or 'sticking to one partner' (51.8 % of males, 52.5 % of females). Even though 'zero grazing' or sticking to one partner may have been accepted at the level of the questionnaire answering, it is not usually practised by many people, especially men who reported multiple sexual partners. Abstinence or 'keep to oneself' was identified as a preventive measure by 24.6 per cent of males and
29.9 per cent of females. Although knowledge of the sexual transmission of AIDS is high among survey respondents, only 19.1 per cent of men and 13 per cent of women gave the use of condoms as an AIDS prevention measure. Younger and more educated respondents were more likely than older ones to mention use of condoms for AIDS prevention.

Respondents were also asked whether they perceived themselves to be at risk of infection. Despite the fact that many respondents, especially men, reported having multiple sexual partners, the majority of respondents (54.3 % of males, 42.2 % of females) did not fear infection with HIV/AIDS. They did not consider AIDS to be a big threat to them and this is summed up in the following joke in Dholuo rwath tho gi lim dhoge, which means 'a bull dies with hay in its mouth'. This means that a bull will continue to eat even if it is to face the butcher's knife the following morning. In the context of AIDS, it means that a man will continue having indiscriminate sexual relations despite the fact that there is risk of getting infected and subsequent death.

Evidence obtained in this study on the sexual behaviour of the survey respondents showed that at least some men tried to rationalise continued risky behaviour. Two quotations from male informants during an informal conversation illustrates this:

If AIDS indeed exists and it is caught from having sexual intercourse, then it will kill very many men...the exception is only those who are eunuchs or do not get an erection (Rural male 27 years old).

People are just scared of AIDS for nothing, you can die from many other diseases of which AIDS is just one of them or even get knocked down by a car...AIDS is just one of those many misfortunes that occur (Urban male, 35 years old).

One male respondent stated that it is 'better die of AIDS (which is natural) than a road accident because an accident is caused by human errors not bad luck'. Thus, to some, AIDS is viewed as just one of the risks people face in daily life. This male carefree attitude is expressed in the following account:

Some people say that if they get the disease, they won't die alone, so they look for other people to infect. I know of a man, who, upon learning that he had the AIDS virus, left Mombasa and slept with many prostitutes in different towns while on transit to Kisumu. I hear
that he didn't want to die alone, so he purposely infected these prostitutes (*Urban Male* 33 years old).

However, a considerable proportion of respondents, notably 31.2 per cent of men and 38 per cent of women, did not know or could not tell whether they were at risk of infection or not. When asked whether they could protect themselves from AIDS, many survey and in-depth interview informants (especially women) frequently expressed fear about their vulnerability to infection because of the sexual behaviour of their partners, as illustrated by the following statements during in-depth interviews:

It is very hard for a woman to protect herself from AIDS when she has a partner or a husband who sleeps around with other women. We women are faithful to our husbands but men are not faithful, they move around with other partners who give them the disease and they take it to their wives (*Urban female* 25 years old, married).

I am very much afraid of getting AIDS because I do not know whether my boyfriend has other girlfriends. He might have other girlfriends (in the town where he works) whom he runs around with. I have asked him about it but he says there is only myself. I hope he does not get the disease and infect me. I only pray that one day we get married and we settle down together (*Rural female respondent, 21 year old*).

Men take other women when they go to town and forget their wives. They cannot be trusted, they get diseases and bring them back to their wives. Even if a woman remains faithful to her partner she can still get the disease because her husband might have other partners who have the disease (*Rural female respondent, 29 year old*).

We have been told by the health people to protect ourselves by sticking to one partner or using condoms. This may be very difficult for many women who are poor and dependent on their husbands or their sexual partner...many women who exchange sex for money do it because they are need money to survive and live in comfort...what would happen if such a woman demands that her husband or boyfriend wear a condom and he refuses? It is very hard in such a situation to use condoms or refuse sex (*Urban female, 34 years old, in-depth interview informant*).

HIV/AIDS education and prevention programs emphasise behavioural change; the main message concerns the dangers of having multiple partners. These programs assume that providing people with factual information about AIDS, such as the modes of transmission will lead to a change in their behaviour. The survey assessed behavioural change among survey respondents by asking whether they had changed
their sexual behaviour since they heard about AIDS, and, if they had, what measures they had taken to protect themselves from getting infected. Table 6.13 shows the percentage distribution of ways in which respondents had changed their behaviour since they heard about AIDS.

Table 6.13 Respondents who reported changing their behaviour since they heard about AIDS by sex and residence

<table>
<thead>
<tr>
<th>Type of behaviour change</th>
<th>Males</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
</tr>
<tr>
<td>Zero-grazing</td>
<td>32.0</td>
<td>33.7</td>
<td>32.8</td>
<td>38.6</td>
<td>50.6</td>
<td>44.6</td>
</tr>
<tr>
<td>Reduced number of sexual partners</td>
<td>17.9</td>
<td>25.9</td>
<td>21.9</td>
<td>26.3</td>
<td>13.3</td>
<td>19.8</td>
</tr>
<tr>
<td>Avoid sex with prostitutes</td>
<td>16.6</td>
<td>12.9</td>
<td>14.8</td>
<td>a</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>Have sex with known partners only</td>
<td>15.3</td>
<td>18.2</td>
<td>16.7</td>
<td>22.1</td>
<td>26.8</td>
<td>24.5</td>
</tr>
<tr>
<td>Insist on use of condoms with partners not trusted</td>
<td>12.8</td>
<td>6.4</td>
<td>9.6</td>
<td>10.4</td>
<td>4.0</td>
<td>7.2</td>
</tr>
<tr>
<td>Abstinence</td>
<td>5.4</td>
<td>2.9</td>
<td>4.2</td>
<td>2.6</td>
<td>5.3</td>
<td>3.9</td>
</tr>
<tr>
<td>Total No.</td>
<td>78</td>
<td>77</td>
<td>155</td>
<td>77</td>
<td>75</td>
<td>152</td>
</tr>
</tbody>
</table>

a: not applicable

When asked whether there had been any modification of behaviour since hearing about AIDS, the majority of the respondents reported having modified their behaviour to avoid contracting AIDS. For instance, 32.8 per cent of men and 44.6 per cent of women said that they practise 'zero grazing' or monogamy while 21.9 per cent of men and 19.8 per cent of females reported that they had reduced their number of sexual partners. Around 17 per cent of men and 24.5 per cent of women stated that they had sexual relations only with partners whom they knew very well. Strikingly, less than ten per cent of men and women mentioned that, as a protective measure, they used condoms with partners whom they did not trust, while less than five per cent reported
that they abstained from sexual relations. Qualitative data obtained in this study show that individual reactions to the disease vary. Some informants and focus group discussion members contended that a change has taken place as the following excerpt from a female focus group discussion shows:

Facilitator: Do you think that AIDS has affected the attitudes and behaviour of men and women toward sex?

1st Participant: Yes, it has affected very much the behaviour of some of the people who used to move around with different women. People are very careful about who they move with nowadays...before AIDS came some people were very reckless. Now when men go out drinking with friends or partying, they do not take prostitutes or other 'free women as they used to because they know it is risky and dangerous to do so, they know of friends or relatives with the disease or who have perished.

2nd Participant: These days men are a bit more careful...you do not see them with prostitutes and concubines in public very often....they go drinking and go home alone (urban area, female focus group discussion)

One female informant stated that 'these days, wives are happier than in the past because men have become a bit scared by AIDS, they do not spend all their money on prostitutes or mistresses as they used to'. However some focus group discussion participants and in-depth interview informants in urban areas felt that there had not been much change among some groups, such as adolescents and youth. Some men and women made allegations that it is young girls or *ndogo ndogo* who move around with rich men who are spreading the disease. This is evident in the following excerpt from discussions with a focus group of young males:

1st Participant: AIDS has not changed the behaviour of the youth in any way...many of them are promiscuous, especially young unemployed girls...they go crazy when they see men with money....if you are a man who is perpetually broke, it is hard to have a girlfriend, they like men who have money ...they forget that there is AIDS and sleep around with different men and spread the disease all over.

2nd Participant: I think AIDS has not changed the behaviour of young people, they are still promiscuous, girls are still getting pregnant and falling out of school.

3rd Participant: Some young men and girls are very promiscuous as much as before AIDS came. AIDS has not scared them and they behave as though AIDS does not exist (*Male FGD rural area*).
Some female informants felt that men are more discreet in their behaviour than in the past, but still have multiple partners. Even though some of the respondents conceded that AIDS has scared people, some still have multiple relations. In sum, there were differences in the views of both survey respondents, informal interviews and focus group discussion informants regarding the extent to which people had altered their behaviour since the AIDS epidemic broke out in the mid-1980s.

6.5 Summary and conclusion

6.5.1 Sexually transmitted diseases

This chapter has described knowledge, attitudes and beliefs about STDs including AIDS. It has highlighted beliefs regarding aetiology, treatment and prevention of STDs. It has also examined the changing attitudes towards sexual relations in the face of the AIDS epidemic.

Respondents' knowledge about STDs including AIDS was quite good. The majority of respondents in this study were conversant with the ways in which STDs retransmitted and prevented. In general, lay perception of STDs, including AIDS is closely linked to morality. Those who are infected with an STD or HIV/AIDS are viewed as sexually promiscuous and those who suffer from the disease are therefore stigmatised by the greater community.

One problem is that some respondents held erroneous beliefs about STDs. For instance, slightly more than one-tenth of males and females in the survey claim that STDs could be contracted through non-sexual physical contact or sharing clothes and other facilities such as toilets. A few respondents also claimed that witchcraft could be manipulated to cause illness in the form of STDs. It is also believed that some illnesses such as chira can occur as a result of violation of sexual rules and taboos. These prevailing myths and beliefs show lack of understanding among sections of the population about the modes through which STDs are transmitted.
More than one-fifth of males and one-tenth of females in the survey reported that they had contracted an STD in their lifetime. Half of males who had ever been infected with an STD had experienced infection more than once. The majority of males reported contracting the disease from prostitutes and casual partners while females reported being infected by husbands or regular partners. This implies that the sexual networking of men is of great risk to their spouses or stable partners. Respondents who were infected sought relief from a variety of sources with the majority seeking modern health care. However interviews and case histories of respondents who had experienced STD infection suggest that it is not rare for infected people to seek health care from different sources either simultaneously or sequentially. Some respondents first tried self-treatment or traditional herbs but when these were ineffective they sought modern care. Financial cost involved in treatment of STDs was cited as a major barrier in seeking effective treatment of STDs.

6.5.2 AIDS

AIDS emerged as a major problem in Kisumu in the late 1980s; before to this AIDS was perceived as an imaginary disease. During the early stages of the epidemic, lay perception of the disease fitted well into the early epidemiological patterns of AIDS. It was perceived to be an urban disease affecting people who had lived ‘outside’ Luoland, mainly in big towns and Uganda. Early cases of AIDS were people, such as itinerant traders, businessmen, migrant workers and professional elites, who had travelled widely outside Luoland. However, since the early 1990s there has been increased incidence of HIV/AIDS in Kisumu and Luo Nyanza. The majority of respondents in this study knew of someone who was infected or had died of AIDS.

Luo beliefs about illness and misfortune influence the way AIDS is understood. Early cases of AIDS were attributed to witchcraft while others were thought to be ‘chira’. Some people believe AIDS is chira since they have similar symptoms and occur through violation of socially acceptable norms. However, a great majority of respondents in the study believe that the AIDS and chira are distinct from one another.
Almost 60 per cent of women surveyed considered themselves to be at risk of being infected with HIV. These females expressed fear about their vulnerability to infection due to male sexual behaviour. In contrast more than half the men surveyed did not consider themselves to be at risk of infection. Some men had a carefree attitude with regard to HIV infection. Some respondents also viewed getting infected as bad luck while others argued that they face many other greater risks than HIV/AIDS in their daily lives. This attitude is can of hinder behavioural change. The AIDS education campaign should focus on encouraging men to take up responsibility for their own behaviour.

The wide prevalence of AIDS has begun to provoked some changing attitudes towards multiple partners and some Luo customs, such as widow inheritance are increasingly viewed as having the potential to spread the disease. Both men and women claimed that they are careful in selecting their sexual partners. The fear of getting AIDS is likely to lead to some reduction in risky behaviour such as prostitute patronage and, despite being inconsistent, men are increasingly using condoms with women they perceive as risky.

7.1 Introduction

The condom is one of the oldest family planning means of contraception. The use of condoms to prevent gonorrhea and syphilis has been recommended by the World Health Organisation in its treatise on Sexually Transmitted Diseases. Condoms have been found to reduce the incidence of HIV (Jellinek et al. 1988) However since the AIDS epidemic has not spread solely through the promiscuity of the woman and its use has become an acceptable method of birth control for men in many parts of the world, their use has increased. Furthermore, condoms are easy to use, safe, and non-toxic. They can also be used at any time of the menstrual cycle and by women who are lactating. A great variety of condoms are available in many sizes, shapes and colors. Some are coated and lubricated and others are uncoated.

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CHAPTER SEVEN

CONDOM KNOWLEDGE AND USE

The use of condoms is not in our [African] culture and it is still considered a strange thing....

The excuse is that condoms are unnatural or uncomfortable. Others say they are allergic to condom’s cream. The thing is it is not cultural to use them, they have never appeared in cultures before.

Ocholla-Ayayo (1993b:389)

This chapter continues the discussion of the survey and informal interview data. It focuses primarily on knowledge, attitudes and beliefs about condoms, condom use to prevent pregnancy and sexually transmitted diseases, perceptions about the efficacy of condoms in preventing STD infection, and personal experiences with condoms. The evidence provided here was mainly obtained from 302 sexually experienced respondents, 74 of whom reported ever having used a condom. Data from in-depth interviews and focus group discussions are also presented.

7.1 Introduction

The condom is one of the oldest, most reliable methods of contraception. Historical records on Imperial Rome show that men used to insert their penises into sheaths of skin-like materials such as goat bladders for intercourse (Mbizvo and Adamchak 1989). However, since the AIDS epidemic broke out in the early 1980s, the promotion of the condom and its use has become an essential component of STD/HIV prevention programs (Ngugi et al. 1988; Mbizvo and Adamchak 1989; Messersmith et al. 1994). Epidemiological and biomedical studies show that condoms are effective in
preventing or reducing the risk of STDs including AIDS (Judson et al. 1983; Conant et al. 1986; Cameron et al. 1991; Johnson 1994). For instance, Johnson (1994) using retrospective data from European couples, reported that consistent use of condoms by couples where one partner is HIV-positive reduces the risk of HIV transmission to the other partner by 69 per cent.

7.2 Condom knowledge and attitudes

This study assessed knowledge and attitudes about condoms, their accessibility and their use by survey respondents. All sexually experienced respondents in the survey were asked whether they had heard about condoms, and if they had, where they could purchase them or obtain them free. In addition, respondents were asked whether they knew of any methods of family planning, and whether they had ever used or were currently using any method of family planning to prevent pregnancy. Table 7.1 shows the percentage distribution of the responses to questions regarding condom knowledge.
<table>
<thead>
<tr>
<th>Table 7.1 Condom knowledge (%)</th>
<th>Male</th>
<th></th>
<th></th>
<th>Female</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
</tr>
<tr>
<td><strong>Ever heard of condom?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>98.7</td>
<td>96.0</td>
<td>97.3</td>
<td>98.7</td>
<td>94.6</td>
<td>96.6</td>
</tr>
<tr>
<td>No</td>
<td>1.3</td>
<td>4.0</td>
<td>2.7</td>
<td>1.3</td>
<td>5.4</td>
<td>3.4</td>
</tr>
<tr>
<td>Total No</td>
<td>77</td>
<td>75</td>
<td>152</td>
<td>76</td>
<td>74</td>
<td>150</td>
</tr>
<tr>
<td><strong>Do you know of any place you can obtain/purchase condoms?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>93.5</td>
<td>88.9</td>
<td>91.2</td>
<td>93.4</td>
<td>83.9</td>
<td>88.6</td>
</tr>
<tr>
<td>No</td>
<td>6.5</td>
<td>11.1</td>
<td>8.8</td>
<td>6.6</td>
<td>17.1</td>
<td>11.4</td>
</tr>
<tr>
<td>Total No</td>
<td>76</td>
<td>72</td>
<td>148</td>
<td>75</td>
<td>70</td>
<td>145</td>
</tr>
<tr>
<td><strong>Sources of condoms supply</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning centre</td>
<td>41.9</td>
<td>46.4</td>
<td>44.2</td>
<td>53.2</td>
<td>59.3</td>
<td>55.1</td>
</tr>
<tr>
<td>Health Centre</td>
<td>27.4</td>
<td>30.5</td>
<td>28.9</td>
<td>24.2</td>
<td>24.5</td>
<td>24.2</td>
</tr>
<tr>
<td>Chemist/pharmacy</td>
<td>11.7</td>
<td>9.2</td>
<td>10.4</td>
<td>14.5</td>
<td>7.4</td>
<td>12.4</td>
</tr>
<tr>
<td>General stores, bars,</td>
<td>16.3</td>
<td>9.9</td>
<td>13.1</td>
<td>4.8</td>
<td>5.1</td>
<td>4.9</td>
</tr>
<tr>
<td>Other*</td>
<td>2.7</td>
<td>4.0</td>
<td>3.4</td>
<td>3.2</td>
<td>3.7</td>
<td>3.4</td>
</tr>
<tr>
<td>Total No</td>
<td>71</td>
<td>64</td>
<td>135</td>
<td>70</td>
<td>62</td>
<td>132</td>
</tr>
</tbody>
</table>

* includes community health workers and condom distributors, friends, street vendors.

Table 7.1 shows that an overwhelming majority of respondents had heard about condoms and knew of at least one source where they could obtain them. Overall, nearly 97 per cent of these sexually experienced respondents stated that they knew about condoms, and of these around 90 per cent knew where to obtain or purchase a condom. Over 98 per cent of male respondents surveyed knew of at least one method of preventing pregnancy (not shown in table), with 53.5 per cent of males and 45.8 per cent of females stating that they had used some method of contraception in the past. About 22.9 per cent of males and 34.2 per cent of females were using a family planning method at the time of the survey.
In Kisumu district as well as other parts of Kenya, the term 'condom' is used explicitly but condoms are also referred to by various local terms, including *mpira* (Swahili word for rubber), *gumboots*, or by their brand names, such as *Trust* and *durex* (the most common brands of condoms). Young men also often joke about condoms by referring to them as *socks* and *bullet proof vests*. The most common places to purchase or obtain condoms known by survey respondents are family planning clinics and health centres. The Ministry of Health and some non-governmental organisations which provide health care distribute condoms free. Other sources include chemists or pharmacies, general stores and shops, bars and street vendors. Urban respondents seemed to be aware of a wider variety of sources than their rural counterparts. This may be attributed to the fact that in Kisumu district, condoms are rarely available outside the town and other major periurban centres. Rural areas are poorly serviced by health institutions and, unlike in town centres, it is uncommon to find condoms being openly displayed in rural areas or being sold in shops, open air-markets, lodging houses or bars.

In-depth interviews and focus group discussions offered informants and respondents an opportunity to express their views on obtaining condoms in health centres or purchasing them from shops. Some informants, especially females, said that they would be too shy to ask for condoms at health centres or family planning clinics or to buy them in a shop in the presence of other people. These sources are public or exposed and many people feel too shy to obtain condoms in such places. Some stated that people would 'think badly' of them. Studies in South Africa (Brouard, 1994) and Nigeria (Edem and Harvey, 1995) show that even though many men are aware of the protective capabilities of condoms against STDs, they feel uncomfortable and embarrassed about obtaining them from the largely female family planning clinics in which they are distributed or purchasing them from shops, chemists, pharmacies. This shows that there is a need to introduce condom distribution techniques which are less embarrassing and more gender-sensitive, thus making it more convenient for people to obtain condoms. Condoms need to be better distributed outside health centres, family planning clinics and other public outlets in order to reach sexually active people who want or need to obtain them. In general, the data obtained in this study show that there
are high levels of community awareness about condoms which may be attributed to AIDS education campaigns and condom promotion programs.

Generally, attitudes towards condoms vary widely among respondents, focus group discussion participants and in-depth interview informants. The majority of those who had used condoms believed that they were effective barriers against STDs and pregnancy. Both condom users and some non-users agreed that condoms are vital when engaging in sexual relations with prostitutes or partners who are not known well, especially with regard to the AIDS epidemic. However, respondents who reported using condoms tended to have a more positive attitude to condoms than non-users. One urban male respondents stated:

Nowadays it is very risky to play around with women you do not know very well......doing so is risking your own life because you can get infected with AIDS...you cannot trust these women because you do not know how many men they sleep around with... so it is better to use a condom if you cannot avoid sex (Urban male, 29 years old).

The above statement reflects some of the contradictions and paradoxes in men’s attitude to condoms and women. While some men acknowledge that it is risky to ‘play around’ without condoms, they agree to have sexual relations without condoms with women whom they know well.

Some of the survey respondents and in-depth interview informants who had never used condoms expressed mistrust with regard to the efficacy of condoms in providing protection against infection. For instance, one survey respondent stated:

It is okay for the health people to tell us to use condoms to protect ourselves from infection with AIDS, but how effective are they?...They have small pores which can allow the disease to pass through...After all, they are man-made and anything can happen (Rural male, 33 years old).

This statement demonstrates that some people perceive AIDS as a lethal and all-powerful disease which cannot be prevented by simple precautions such as having intercourse using a condom. Studies in Zaire (Irwin et al. 1991) and Uganda (Konde-
Lule 1993) report that people frequently deride the idea that something as delicate as a condom could provide protection against a deadly disease such as AIDS.

There have been other misunderstandings and scare stories about condoms in Kisumu and Kenya in general. There is a common belief among some people in Kenya and other parts of Africa that condoms are a strategy introduced to control the black African population. One male informant expressed the ear that condoms lubricant contains HIV:

How can we trust condoms in protecting against AIDS, when we hear rumours and read in newspapers and magazines that condoms that are brought to Africa are smeared with the AIDS virus. This scares people from using them (Urban male 36 years old).

This finding is echoed in other studies in Sub-Saharan Africa which show that condoms are viewed with suspicion. For instance, Schoepf et al. (1988) reported that in Zaire condom and contraception use is seen as a conspiracy by Western imperial powers to control population. Hausser (1993) found that uneducated young men and women in Burundi believed that condoms contain HIV; they viewed them as the cause of the disease. The politicisation of condoms thus has tended to impede their acceptance in parts of East and Central Africa.

Other male respondents and informal interview informants also expressed the fear that condoms could slip off during intercourse and remain inside a woman, while females told stories of women who had medical problems after condoms became stuck in their bodies. Similar findings have been reported in a survey in Guinea-Bissau and Zaire where condoms were associated with diseases, especially if they slipped and remained in the vagina (Hosborg and Aaby 1992; Schoepf et al. 1988). In summary, these misconceptions hinder the social acceptability of condoms. In this study, such sentiments were more common among condom non-users and are more prevalent in rural areas than urban areas and among the less educated respondents. This raises the need for the campaign to increase condom use to focus on discarding these misconceptions and assuring people of condom safety in terms of their health and in preventing STD/HIV infection.
In Kisumu, as in other parts of Africa, there is a negative attitude towards condom promotion and use from various religious movements. In this survey, there was also strong religious condemnation of condom promotion and use, particularly by some conservative respondents and informants, especially staunch Christians, who expressed their opposition towards the promotion of condom use in the community, especially by the young people because they 'would make them promiscuous'. The argument is that condoms will lead to sexual immorality or uncontrolled sexual activity among the youth. One female informant who disapproved the use of condoms by young people stated:

The Bible tells us that sexual relations should occur only in marriage. It is therefore wrong to provide condoms to young unmarried people because sex is not meant for them......I think giving condoms or allowing young unmarried people to use condoms is tantamount to giving them a license to engage in sexual relations.....condoms will encourage them to sleep around without fear of pregnancy occurring (Urban female 43 years old).

Condom use and promotion have been hotly debated but public health efforts to promote their use have met stiff opposition from Christian and Islamic religious movements and traditional moralists. The Catholic Church has been more outspoken, strongly opposing attempts to introduce sex education in schools and condemns the use of any form of birth control, including condoms (Friedmann 1995). For instance, the head of the Catholic Church protested by burning condoms and AIDS education material in public (Sunday Nation 1 September, 1996:1-2). Protestants have been less harsh, but also condemn premarital sex and the use of condoms. The Government remains ambivalent about condoms, mainly because of the resistance by Christian Church organisations to provision of condoms to the youth. However, these attitudes fly in the face of reality, in that many young people, including teenagers, are sexually active, and it also conflicts with a sensible attitude towards AIDS prevention. Studies conducted elsewhere indicate that sex education does not increase ‘promiscuity’ or lead to teenage involvement in sexual relations. For instance, an analysis of 35 studies on sex education programs conducted by the World Health Organization in different parts of the world indicated that sex education does not lead to early sexual activity in adolescents. Indeed 16 of the studies found that sex education tended to delay sexual debut among young people (WHO:1994 cited in Fuglesang 1997)
Despite all this, it was evident from in-depth interviews that many people, especially parents who have daughters who have had a pregnancy or are single teenage mothers, are pragmatic about the sexual activity of adolescents and young adults and the distribution of condoms to young people. In sum, condom promotion and use has been moralised by arguing that condoms engender promiscuity and marital infidelity. In two separate focus group discussions married men and women were outspoken against condoms because they would make it easier and encourage spouses to ‘cheat on each other’. For instance one female discussion group participant stated that condoms encourage men to engage in extramarital sex:

Men do not use condoms with their wives……they cannot dare to do so because their wives will suspect them of sleeping around. So, if you give them condoms they will go straight to malayas (prostitutes) and other women who sleep around (Urban female, 38 years old).

A suggestion that women should also be provided with condoms was met with outrage and condemnation in one male focus group. One married male commented:

You cannot have two cocks crowing in the same homestead, there is always one, the husband.....if you give condoms to our wives they will start behaving like their husbands and this will cause marital problems.

Condoms are also associated with ‘people who sleep around’ or those who are promiscuous, such as prostitutes. This is illustrated by the following comments from in-depth interviews:

If you tell your partner, for instance a boyfriend or a newly met boyfriend to use condom, he may think that you are a prostitute or fear getting a disease from him (Rural female 23 years old).

I have never seen or used a condom....I will never use one. [why?]....ah! Why should I?. Those things (condoms) are for people who ‘run around’ with loose women and prostitutes (Rural male, 50+ years old).

Informal discussions with both men and women revealed that men see women who want to use a condom as promiscuous or perhaps as prostitutes. One young rural male stated:
If a woman tells me to use a condom, I know that she is not a good woman....otherwise why would she refuse 'flesh to flesh'.....no decent woman would insist on a man using condoms. ('Rural male, 26 years old).

Many male and female respondents and informal interview informants recognise the importance of condoms as prophylactic against STDs and advocate condom use with partners who ‘sleep or run around’ with many partners, loose girls, strangers and prostitutes.

7.3 Condom use in survey population

All sexually experienced respondents in the survey were asked whether they had ever used condoms in their lifetime, and if so, how often they used them and whether they had used them in various time intervals (the past one year, six months, one month). They were also asked to describe the circumstances in which they used them. The question focused specifically on the partner with whom the respondent had used a condom. Responses to these questions regarding condom use are displayed in Table 7.2.
Table 7.2 Respondents reporting ever-use of condom by selected background characteristics (%).

<table>
<thead>
<tr>
<th>Have you ever used a condom?</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>38.0</td>
<td>24.4</td>
</tr>
<tr>
<td></td>
<td>62.0</td>
<td>75.6</td>
</tr>
<tr>
<td>Total No.</td>
<td>71</td>
<td>64</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes how often do you use condoms?</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every time</td>
<td>17.2</td>
<td>8.6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>37.9</td>
<td>33.7</td>
</tr>
<tr>
<td>Rarely</td>
<td>44.8</td>
<td>57.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age group</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>34.7</td>
<td>34.9</td>
</tr>
<tr>
<td>25-34</td>
<td>55.0</td>
<td>57.3</td>
</tr>
<tr>
<td>35+</td>
<td>10.3</td>
<td>7.8</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married</td>
<td>43.4</td>
<td>48.0</td>
</tr>
<tr>
<td>Married</td>
<td>56.6</td>
<td>52.0</td>
</tr>
<tr>
<td>Formerly married</td>
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<td>35.3</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>13.3</td>
<td>19.8</td>
</tr>
<tr>
<td>Primary education</td>
<td>36.4</td>
<td>34.8</td>
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<tr>
<td>Secondary +</td>
<td>50.3</td>
<td>45.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of lifetime partners</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.3</td>
<td>a</td>
</tr>
<tr>
<td>2-3</td>
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<tr>
<td>4-5</td>
<td>16.7</td>
<td>26.5</td>
</tr>
<tr>
<td>6+</td>
<td>74.6</td>
<td>69.1</td>
</tr>
<tr>
<td>Total No</td>
<td>30</td>
<td>19</td>
</tr>
</tbody>
</table>

Despite the high level of knowledge about condoms, a great majority of the survey respondents had never used a condom. The general level of condom acceptance and use is quite low. For instance only 31 per cent of males and 16 per cent of females reported ever having used a condom (see Table 7.2). Of these condom users, 11 per cent of males and 6 per cent of women had used condoms in the last year before the
survey. Males were more than twice as likely as females to report using condoms every time they had sexual relations. Those who reported consistent use of condoms were more likely to have had contact with prostitutes and a history of infection with sexually transmitted disease. However, the majority of condom users were inconsistent in their condom use; many stated that they used them occasionally during sexual intercourse.

In general, condom users differed on the basis of various socio-demographic variables, namely sex, age, marital status and education as shown in Table 7.2. In general, males in urban areas were more likely than their rural counterparts and all females (both urban and rural) to report ever using condoms, a factor which may be attributed to their high levels of sexual networking and contact with prostitutes. Condom acceptance and use decreased as age increased; with younger and more educated respondents were more likely to report ever having used condoms than older and less educated respondents. For instance, the majority of male respondents who reported ever having used condom were aged 25-34 (about 57 %), while females aged 15-24 were more likely than older females to report using condoms (about 64 %). For both males and females, there was difference in the proportions reporting ever having used condoms on the basis of marital status. For instance, the majority of those who reported ever having used condoms were married (68 % of men and 57 % of females). Married males who reported recent use of condoms indicated that they had used them for protection against STDs when they engaged in extramarital activities. A significant proportion of formerly married females (36 %) reported having used condoms.

Condom use among males was also positively associated with education and number of sexual partners. There is a remarkable increase in the proportions of males who had ever-used condoms with increase in both level of education and number of lifetime sexual partners. However, for females, the proportions of respondents who reported ever-use of decrease with increase in the number of sexual partners. Most male and female condom users had some formal education. Male respondents who had secondary level of education and above were more likely to report having used condoms (45 %) than those with primary education or no education. In contrast over half of females who reported ever having used condoms had only primary education.
It is important to note that education is not always an determining factor of condom use, for instance, Talle (1995) noted that educated men in Namanga, despite being aware of HIV/AIDS disliked and refused to use condoms with prostitutes.

Table 7.2 shows that even though condom use is low, its use among men is concentrated among those who reported risk behaviour such as multiple partners, including contact with prostitution. For instance over-two thirds of male condom users reported having more than six lifetime sexual partners, indicating high levels of sexual networking among male users. The majority of male condom users had experience with prostitutes. In contrast females who reported using condoms had fewer lifetime sexual partners, with over half of female users (about 56 per cent) reporting only three or more sexual partners.

All sexually active respondents who reported using condoms were asked to give reasons why they used condoms, and those who had never used them were asked to why they did not. Responses to these questions are shown in Table 7.3.
Table 7.3 Reasons for use and non-use of condoms (%)

<table>
<thead>
<tr>
<th>Reasons for using condom</th>
<th>Males</th>
<th></th>
<th></th>
<th>Females</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian male</td>
<td>Urban</td>
<td>Rural</td>
<td>Both</td>
<td>Asian female</td>
<td>Rural</td>
<td>Both</td>
</tr>
<tr>
<td>Prevent STDs</td>
<td>58.0</td>
<td>61.2</td>
<td>59.6</td>
<td>37.0</td>
<td>26.7</td>
<td>31.8</td>
</tr>
<tr>
<td>Prevent pregnancy</td>
<td>31.4</td>
<td>25.3</td>
<td>28.4</td>
<td>49.9</td>
<td>56.7</td>
<td>53.3</td>
</tr>
<tr>
<td>Prevent both STDs and pregnancy</td>
<td>10.6</td>
<td>13.5</td>
<td>12.0</td>
<td>13.1</td>
<td>16.6</td>
<td>14.9</td>
</tr>
<tr>
<td>Total no. of respondents who have ever used condoms</td>
<td>30</td>
<td>19</td>
<td>49</td>
<td>17</td>
<td>8</td>
<td>25</td>
</tr>
</tbody>
</table>

Reason for not using condoms

<table>
<thead>
<tr>
<th>Reason for not using condoms</th>
<th>Asian male</th>
<th></th>
<th></th>
<th>Asian female</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have faith or trust in partner</td>
<td>66.5</td>
<td>63.2</td>
<td>64.8</td>
<td>67.2</td>
<td>61.4</td>
<td>64.3</td>
</tr>
<tr>
<td>Partner may suspect infidelity</td>
<td>16.3</td>
<td>14.1</td>
<td>15.2</td>
<td>14.8</td>
<td>20.4</td>
<td>17.6</td>
</tr>
<tr>
<td>Condoms inhibit sexual pleasure</td>
<td>13.0</td>
<td>12.3</td>
<td>12.7</td>
<td>9.1</td>
<td>6.3</td>
<td>7.7</td>
</tr>
<tr>
<td>Expensive or don't know where to get them</td>
<td>4.2</td>
<td>10.4</td>
<td>7.3</td>
<td>8.9</td>
<td>11.9</td>
<td>10.4</td>
</tr>
<tr>
<td>Total no. of respondents who have never used condoms</td>
<td>47</td>
<td>56</td>
<td>103</td>
<td>60</td>
<td>65</td>
<td>125</td>
</tr>
</tbody>
</table>

Condom users in the survey stated that they used condoms either as protection against STDs, to prevent pregnancy or for both reasons. The striking feature in Table 7.3 is that men are more likely than women to have used condoms for prevention of STDs. The majority of males stated that they used condoms to protect themselves from being infected with venereal diseases, while for women the most important reason for using condoms was to prevent pregnancy. Most male respondents and informants who reported using condoms used them with unknown partners, or when they suspected their partners past sexual contacts which could infect them. This may be explained by the fact that a considerable proportion of male survey respondents reported risky behaviour, multiple sexual partners, and infection with venereal diseases, and hence were more likely than women to report using condoms for STD prevention. For women, pregnancy may be a more ‘real’ fear than infection with an STD, while men probably do not worry as much about pregnancy because it does not happen to them. Men tend not to use condoms for prevention of pregnancy because they expect their partners to use one of the many other available methods of preventing conception.
Fertility studies in Kenya show that many men place the responsibility for pregnancy prevention entirely on women because they are the ones involved in childbirth and care (Muganzi 1994). About 28 per cent of males reported that they had used a condom with their partner to prevent conception, while about 32 per cent of women used them to prevent getting infected with a STD. A further 12 per cent of males and 15 per cent of females stated that they had used condoms both to prevent pregnancy and as protection against sexually transmitted diseases.

Of the survey respondents who stated that they did not use condoms, the majority said that they knew their partners well; for instance, about 64.8 per cent of male and 64.3 per cent of female condom non-users stated that they did not use condoms because they trusted that their partners did not have other partners. The majority of these respondents believed that their partners were safe and free from diseases, and hence did not perceive that they could get venereal diseases from them. Condoms are less likely to be used in a stable relationship, such as that with a husband or wife or regular partner. This may be explained by the fact that many people associate condoms with promiscuity (which is probably partly engendered by the AIDS education campaign) and hence detest using them. Some informants in in-depth interviews stated that asking a partner to use a condom is almost tantamount to admitting their own promiscuity or accusing one’s partner of promiscuity. For many people, risky sex does not necessarily mean sex with multiple partners, but sexual relations with someone such as a prostitute, a partner who is not well known or a stranger. Indeed, most respondents and interview informants who had used condoms mentioned that they used them with paid partners and partners whom they did not know very well. Many people do not consider condoms appropriate to use within marriage or with a regular partner such as a regular boyfriend or girlfriend. Two urban male in-depth interview informants stated:

I have never used a condom with any of my girlfriends because I know them very well and believe they do not cheat me...I have used them several times with other women, I mean those that I 'pick up' in night clubs and bars. You never know who sleeps with them, so I have to take precautions.....When I sleep with other women, I wait for a few days before I have sex with my girlfriend just to be sure that I do not infect her with an STD (Urban male, 31 years old).
If you are happily married and are faithful to one another, then what is the reason for using a condom?. I do not see any reason why I should use one with my wife (40-year-old, urban male survey respondent).

The evidence obtained in this study shows that there are categories of people or sexual partners with whom people in Kisumu are more or less likely to use condoms. Condoms are consistently used by men with partners other than wives or steady girlfriends who are likely to be infected with sexually transmitted diseases and whom they do not trust. The following case studies from interviews clearly demonstrate this.

Case 1
Maxwell is a 32 years old male from Nyakach Division, Kisumu District. He has had secondary school education up to Form Four. He lives in Kisumu town and is unmarried. He became sexually active at the age of 18, with a girlfriend from his village. Since then he has had regular relationships with five girlfriends, including his present girlfriend. He has also had sexual relations with casual friends and prostitutes. Maxwell says he uses condoms every time he has sexual relations with women whom he does not trust because ‘you can never know who is going to give you ukimwi (or AIDS)’. He began using condoms about a year ago after he realised that AIDS was rampant in Kisumu. He has never been treated for an STD but says that he once took some antibiotics after he had sex with a prostitute whom he suspected had a venereal disease. He says that even though he uses condoms, they make sex unpleasant and uncomfortable both to him and the partner. He does not use condoms with his current regular girlfriend because he believes that she is faithful and does not have other lovers.

Case 2
Anne is a 28-year-old female who was born in Kendu Bay. She comes from a big family and has 10 siblings and her parents are peasant farmers. She completed her primary school education but could not continue because her parents couldn’t afford the school fees. She became sexually active at the age of 16 years and has had several regular boyfriends with whom she has had three children (the children live in her rural home with her aging parents). Currently she works as a barmaid in one of the popular bars in Kisumu town patronised by middle-income earners. She has several men with whom she occasionally has sexual relations; they pay her in cash, drinks or food, and take her out when she is not on duty. She says that before she heard about AIDS she never knew about condoms but now she uses condoms with men she does not know well. Some men are reluctant to use them and they even promise to increase their payment to have unprotected sex. On several occasions the condoms have split or slipped out of her vagina. Anne has a regular boyfriend whom she sometimes stays with. He knows her occupation and does not mind her going with other men so long as she does not do it openly. They do not use condoms because she believes he has no other girlfriend.
About 17 per cent of females and 15 per cent of males stated that they did not use condoms because it would be an indication of lack of trust in their partner's sexual behaviour; in other words it would raise suspicion regarding partners' fidelity. Usually condoms are associated with STDs and multiple partners, hence the assumption is that someone using a condom has an STD. Female informants and respondents considered that to ask their regular partner to use a condom would be taken as an accusation that the partner has other lovers. Three female respondents and one male respondent stated:

I think it is a bit hard to tell my boyfriend to use a condom unless I am menstruating. He may think that I do not trust him (Rural female, 19 years old).

I can tell my boyfriend to use a condom to prevent pregnancy...that he will do without any problem. But it is another thing to use condoms for disease prevention (Urban female, 23 years old).

If I ask my boyfriend to use a condom, he will think that I am very loose or suspect him of having other lovers or even being infected with a disease (Urban female 23 years old).

If you have sex with your girlfriend or wife with a condom it is an indication of lack of trust and faithfulness (Urban female 22 years old).

I do not see why I should use a condom with my girlfriend...it is not normal in a relationship where partners trust one another (25-year-old urban male respondent).

Thus within stable relationships and marital unions, condom use for reasons other than contraception engenders lack of trust. In such contexts, condoms are viewed as symbols of unfaithfulness by raising the suspicion that one has been deceiving his or her partner. Negotiating for condom use in such relationships can risk ruining the relationship by introducing mistrust and acknowledging that one has other partners.

Lack of condom acceptance and use is also attributed to the fact that condoms tend to inhibit sexual pleasure during intercourse. About 12.7 per cent of male and 7.7 per cent of female condom non-users stated that they do not use condoms because they interfere with the enjoyment of sexual intercourse. Respondents were more likely to state that condoms make sex less enjoyable if they had ever used them than if they had no experience of condom use. In both rural and urban areas, three-quarters of men
who had ever used condom, stated that doing so made sex unpleasurable (not in table). Condom users in the informal interviews and focus group discussions also agreed that condoms reduce sexual enjoyment during intercourse. The excerpts from in-depth interviews with male informants illustrate this.

When you have sexual intercourse with *mpira* (condom), you don't get real satisfaction because it is not natural...I think flesh to flesh is much more enjoyable (19 year old urban male survey respondent).

There is no satisfaction in having sex with a condom because you cannot feel it...it is like eating an unpeeled banana or a sweet with its wrapper on (Rural male, 27 years old).

Condoms make sex unenjoyable and uncomfortable, there is no feeling at all...the rubbing that occurs during intercourse when having sex with a condom can harm both the man and the woman. There is no need to use it if there is trust and faithfulness between partners...people have to enjoy having sex (Rural male, 23 year old).

I have used condoms several times but I do not like them because I didn’t enjoy having sex with them...there is no real taste. It takes a long time to reach the climax or even satisfy your partner (Urban male 34 years old).

The above statements show that men dislike condoms because they interfere with sexual satisfaction by reducing sensitivity. Most men associate sexual satisfaction with the number of achieved ejaculations and a man who achieves many ejaculations is considered strong and potent. Both male and female users of condoms complained that condoms interfere with sexual performance because they reduce the number of ejaculations achieved. This is demonstrated by the following statement.

A man cannot satisfy his partner with a condom properly because it takes too long to ‘come’ (ejaculate)...he keeps going on and on but ends up just tiring himself....only for one or two rounds.....so, it is hard to perform well in bed and fully satisfy a woman with a condom (Rural male, 33 years old).

These views are also common in other studies on family planning and sexual behaviour in Africa (Fournet et al. 1990; Ahmed and Kheir 1992; Preston-White 1994). For instance, Preston-White (1994) reports in a study of teenagers in Kwazulu/Natal, South Africa, that many males who used condoms for the first time disliked them because they did not enjoy intercourse with a condom and some experienced
difficulties such as pain caused by constriction and inability to reach a climax. Kashindo (1996) also found among prostitutes in Blantyre, Malawi, that their clients did not like condoms because they reduced sexual excitement and some clients opted to pay more for unprotected sex. Mnyika et al. (1995b) also report that men in Tanzania dislike using condoms because they reduce sexual enjoyment and those who disliked them for this reason were less likely to use condoms on a regular basis than those who gave other reasons for not using condoms.

About 7 per cent of males and 10 per cent of females reported that they did not know where they could obtain free condoms or purchase them, with the proportion of rural respondents reporting this being higher than that of urban respondents. At the time of the study, condoms were primarily offered free at family planning clinics and health centres, but some respondents, especially women, felt shy and embarrassed at being seen getting condoms at a clinic. Condoms are otherwise sold at pharmacies, shops, bars and by street vendors for approximately A $0.30 per packet of three condoms. Some respondents found that this cost prohibitive considering the harsh economic conditions:

When AIDS came we used to receive free condoms from health centres and hospitals...you could get as much as you wanted, but now it is different...we have to buy them if you can't get free ones. Not very many people can afford ten shillings to buy a packet of three condoms...money is a big problem for people who are poor (Rural male, 39 years old).

Some respondents and interview informants referred to lack of awareness about condoms before the outbreak of the AIDS epidemic. Two interview informants stated that:

Before AIDS started, not very many people knew about condoms, there was nothing to fear.....but nowadays, many people have been scared by AIDS, and some of them are using them to protect themselves from getting the disease (Rural male 26 years).

Not very many people knew about condoms, let alone even seeing one...very few people had used them before AIDS came, but now people are afraid to sleep around because of AIDS, so some use condoms (Urban female 32 years).
7.4 Discussion

Overall, the majority of respondents had not used condoms either for prevention of pregnancy or sexually transmitted disease. Only 24 per cent of the survey respondents reported that they had used condoms, but the general pattern of use is low and inconsistent. Whilst most people are aware of the prophylactic importance of condoms in preventing STDs, they use them, if at all, in certain specific relationships. In a socio-demographic sense, most condom users are distinct in that they are younger people who reside in urban areas and have had a formal education. In general, males were more likely than females to report having ever used a condom for prevention of sexually transmitted disease or for contraception.

Research in other parts of Sub-Saharan Africa corroborates the finding that condom use is low and inconsistent in most sexual relationships (Preston-White 1991; 1993; Vos, 1993). In many countries, condoms receive low priority even within family planning clinics which promote other methods of contraception, such as the pill and diaphragms. In studies conducted in Sub-Saharan Africa (including fertility-based Demographic and Health Surveys), involving samples representative of the general population, it has been reported that the use of condoms as a family planning method is quite low. The 1993 KDHS shows that condoms are the least used method of family planning with only 11.8 per cent of all men and 0.9 per cent of women reporting current use of the condom for the prevention of conception. WHO/GPA surveys on sexual behaviour in nine African countries, Burundi, Guinea Bissau, Tanzania, Kenya, Cote d’Ivoire, Lesotho, Togo, Central African Republic and Zambia, have shown condom use ranging between 14 per cent in Tanzania and 36.3 per cent in Zambia (Cleland and Ferry, 1995). It is imperative to observe that condom use for the prevention of STDs, is not usually assessed in Demographic and Health Surveys.

The review of literature on condom use presented in Chapter 2 indicates that in many parts of Africa, the general pattern and rates of condom use are irregular or inconsistent, and vary from one country to another and within populations in a given country. This conclusion is borne out by studies in Zimbabwe (Mbizvo and Adamchak, 1989; Wilson and Lavelle 1992), in Kenya (Kiragu, 1991 and Kiragu and
Zabin 1993), Nigeria (Messersmith et al. 1994), and Tanzania (Kapiga et al. 1995; Mnyika et al., 1995) among many other countries.

Consistent or regular use of condoms depends on a number of inter-related factors, such as the number and type of sexual partners, knowledge about STDs and their prevention, and easy availability of condoms. Previous studies in sub-Saharan Africa have attempted to measure consistency of condom use by analysing coital events over a period of time such as lifetime, previous year or month, (Lule and Gruer 1991; Kasprzyk et al. 1992; Mnyika et al 1995; Kapiga et al. 1995). In a survey of Ugandan students, Lule and Gruer (1991) reported that 35 per cent of men and 24 per cent of females had used condoms but only 9 per cent of men and 11 per cent of females were using them regularly. Kasprzyk et al. (1992) found inconsistent use of condoms among men and women aged 18-63 in Zimbabwe; only 7 per cent of men and 8 per cent of women had used condoms regularly in their last ten sexual encounters preceding the survey. Kapiga et al. (1995) and Mnyika et al. (1995) obtained similar results to these other studies, showing that many people do not use condoms regularly despite the fact that they have sexual relations with multiple partners over their lifetime.

Regular condom use may be influenced by the type of sexual partners: condoms are associated with a certain type of partner. The majority of condom users and non-users in this survey and in informal interviews, perceived condoms to be appropriate to use in relationships with prostitutes, newly met partners, strangers and casual friends, rather than with spouses or regular partners, such as a steady boyfriend or girlfriend. Most respondents and interviewees were not motivated to use condoms because they did not perceive that they or their partners were at risk of contracting a disease. This implies that condoms are more likely to be used when people perceive that they are at risk of infection from a particular partner. It is worth to note that some of these short-term loose or casual relationships with prostitutes, strangers and newly met partners can sometimes become steady, and condom use may be suspended or stopped all together. Bledsoe (1991) has observed that stopping using condoms depicts a transformation of a relationship from loose emotional attachment to one that a woman and her partner wish to uphold.
Previous studies in sub-Saharan Africa have also obtained results similar to those reported above (Schoepf et al. 1988; Piripiri et al. 1989; Agyei 1992; Akande 1994). Schoepf et al. (1988) observed that in Zaire condoms tend to be socially acceptable to men who purchase commercial sexual services but there are problems surrounding their use with regular partners and spouses. Piripiri (1989) found that despite very low levels of condom use, married men were more likely to use condoms in extramarital affairs with prostitutes and casual partners in order to prevent STD infection, including HIV/AIDS, than to use condoms with their spouses. Akande (1994) reports that Nigerian and Zimbabwean university students did not regard condoms as appropriate to use in sexual encounters involving a regular partner. Some studies report that condoms are more likely to be used in a regular partnership for prevention of pregnancy rather than for STD prevention. For instance, Akinnawo (1996) found that in Nigeria, married men were more likely to use condoms with prostitutes, women friends and strangers in order to prevent STDs but used them with their spouses to prevent unwanted pregnancy. Renne (1993) found that married men in Ondo State, Nigeria, also used condoms with their wives during postpartum abstinence to avoid pollution of the mother’s milk during lactation and to maintain an appearance of postpartum abstinence.

Lack of condom use may also be influenced by the context and the unpredictability and context of intercourse. The use or non-use of condoms may be determined by the circumstances in which intercourse occurs. In a large number of sexual encounters, intercourse is unplanned, and thus at the time of coitus a condom may not be available. For instance, many respondents and informants stated that they did not use condoms because they did not have a condom at the time of intercourse. People do not always carry condoms on them and doing so can be problematic, especially if a girlfriend or a wife discovers them. Some respondents in interviews mentioned that they did not use condoms because they acted on the spur of the moment, while others gave intoxication as a reason for not using condoms. One male respondent commented:

Nowadays, whenever men go out drinking they carry condoms just for emergency......but some of them do not use them....they forget about the disease (AIDS) and they don’t use them after getting drunk (Urban male, 29 years old).
Indeed alcohol consumption has been found to be counter productive to condom use. For instance, Talle (1995a) observed that bar women and their clients in Namanga, on the Kenyan-Tanzania tended to give drunkenness as a reason for not using condoms during casual sexual relations.

Lack of knowledge about condoms, and difficulty in obtaining condoms or lack of access to condoms (Bertrand and Makani, 1989; Ajayi et al. 1991; Frame and Ferrinho et al., 1991) are important factors in attempting to understand condom use and non-use. Mbizvo and Adamchak (1989) found a close relationship between lack of knowledge about condoms and condom non-use; a large proportion of males in their study had never used condoms because they did not know about them. Other studies have also shown that lack of condom use corresponds to lack of knowledge about them and their effectiveness in providing protection against disease (Okeyo and Allen 1994). The results of the Kisumu study suggest that there is high level of awareness about condoms among respondents and informal interview informants but a low level of actual use. Similar findings have also been reported elsewhere in Africa. Agyei et al. (1992) reported from a survey of teenagers and young adults that there was very high level of knowledge or awareness about condoms (78.2 % of males and 56.6 % of women) but only 12.7 per cent of males and 0.4 per cent of females reported current use of condoms. Knowledge about condoms or other disease prevention is not sufficient to motivate condom use, but such knowledge is important in effecting behavioural change.

Some researchers have also drawn attention to the fact that negotiating for use of condoms is always difficult, particularly for women, because of power and socio-economic imbalances, and cultural expectations (Ulin, 1992; Preston-White 1995; Maggwa et al., 1995). Maggwa et al. (1995) reports that many women find it difficult to persuade their partners to use condoms. The decision to use condoms always requires the cooperation of partners, but is difficult for example for a girl or a woman to raise the issue of using condoms or even to negotiate other safer sexual practices with a partner who is hostile. Condom use by women is totally dependent on the understanding and co-operation of their male partners. Men often view women who propose using condoms as indecent. Against this background, it is therefore not
suprising that only a small proportion of women in this survey reported use of condoms.

Recent studies have shown that condom social marketing programs have been successful in increasing condom acceptance and use among people at risk of HIV infection, such as prostitutes, truck drivers, youth, and STD clinic patients (Ngugi et al. 1988; Asamoah-Adu et al. 1994; Laga et al. 1994). Ngugi (1988) reported that AIDS education and condom promotion among 300 Nairobi prostitutes of lower socio-economic status resulted in an increase in condom use, leading to a threefold reduction in the rate of HIV infection. After 12 months, over half of the prostitutes were making their clients use condoms whenever they had sexual intercourse. Esu-Williams (1995) obtained similar results from a study of prostitutes in Cross River State in Nigeria. The percentage of prostitutes who had never used condoms decreased from 62 per cent at the time of the baseline study to 16 per cent at the time of the follow-up study, with the percentage of those consistently using condoms increasing substantially. Rygnestad et al. (1994) found in a study of a rural STD clinic in Zimbabwe that condom use increased among men from 31 per cent to 48 per cent and for women from 8 per cent to 23 per cent during the 1989-1992 study period. Although in Africa condom use seems to be highest among prostitutes and their clients, sometimes prostitutes face refusal by clients and this is shown in examples from Malawi (Kashindo 1996) and Ghana (Neequaye et al. 1991).

There is also evidence that condoms are increasingly becoming acceptable in many premarital and extramarital sexual relationships. This has been achieved through condom distribution in various community and population-based programs. Hess (1993) reported that 2.3 million condoms were distributed in the first six months of a program involving condom promotion among half a million couples in Guinea. In Zaire, a population-based program involving 13 million young people and their parents resulted in an increase in condom sales from 100,000 in 1987 to 18 million in 1991. The program involved sale of condoms at subsidised prices and marketing through non-traditional outlets to reach the target population (Population Services International 1994). These studies indicate that condom use and acceptance have been increasing gradually among certain sections of the population at risk of infection. This
increased acceptance of condoms may be attributed to the community mobilisation, participation of targeted groups, such as, prostitutes in the education campaign, and increased availability and improved access to condoms. The increase in condom use reflects risk minimisation and reduction in chances of STD/HIV infection. Although condom use is still sporadic, the fact that men and women negotiate their use serves to intensify and broaden the social discourse on safe sexual practices (including condom use).

The conclusion that can be drawn from the data presented above is that condom use is quite low but diverse among users, and is influenced by several factors noted above. Most people use condoms with certain specific partners whom they do not know well or suspect of being infected with a disease. Some of the problems associated with condom use in Kisumu include loss of pleasure; association with disease and promiscuity; availability and access. Thus, the attitudes, level and patterns of condom use observed in this population are not different in any way from those found in other settings in Sub-Saharan Africa.
CHAPTER EIGHT
RESPONSE TO PEOPLE WITH HIV/AIDS

8.1 Introduction

While the main focus of Chapter 6 was on community response to the AIDS epidemic in Kisumu, this chapter examines the attitudes, perception and behaviour of people with HIV/AIDS, their perception of the attitudes of their relatives and the community in general towards them, and their sexual behaviour after they were diagnosed. It also examines the reaction of family members of people with AIDS towards the disease.

In Chapter 6 it was shown that many people are now aware of the existence of AIDS; they have either seen people with the disease or have relatives, neighbours and friends who have been victims of the disease. There is extreme paucity of data relating to how individuals, families and communities react to and cope with HIV/AIDS. A handful of studies in Eastern Africa (Uganda) and West Africa (Ghana) have been conducted to assess reaction to HIV/AIDS (Anarfi 1992; Barnett and Blaikie 1992; McGrath et al. 1992; Ankrah 1993). These studies in Africa show that the appearance of AIDS led to fear, stigma and rejection of people with HIV/AIDS and their families. Many people still fear and avoid contact or sharing clothes, utensils or toilets, and shaking hands with infected people.

The data used in this study are derived from informal discussions and in-depth interviews with 51 key informants, of whom 31 had AIDS-related illnesses and 20 were relatives of AIDS sufferers. Family members who were interviewed included spouses, parents, siblings and children. Interviews were conducted over a seven-week period in various parts of Kisumu District, including Kisumu town, Seme, Kibos and Maseno town. Twelve of the informants with AIDS complications were recruited from the District Hospital. These informants were approached and asked to join in the study during their visit to the hospital. A further 13 informants were recruited at The Association of People With AIDS in Kenya (TAPWAK) Kisumu hospice and the
remaining six were recruited through personal contacts with friends and acquaintances.

Interviews were conducted by two trained AIDS counsellors. It was easier to use AIDS counsellors because of their access and familiarity with the AIDS patients. Patients were more willing to discuss issues with them than with strangers. It is imperative to observe that research in this area is difficult mainly because AIDS is a stigmatising disease which is not publicly discussed. Hence it was not easy to identify and approach individuals for interview. It is for this reason that the study population was not randomly selected. However, AIDS counsellors, health personnel, traditional practitioners and TAPWAK assisted with the identification of people with HIV and AIDS patients who were willing to discuss their condition. Each person was given a detailed description of the study and, once consent was obtained, details of the nature and type of information required were given to the respondent. In some cases it was necessary to request the family’s permission to speak to people with AIDS. Three of the respondents would not allow contact with members of their family. Most of the interviews were conducted at home while others were conducted at a health facility or at TAPWAK’s Kisumu town hospice. In cases where the respondent was too ill, discussions and interviews were extended over several days. During visits, the research assistants made observations of patients’ interaction with family members. Interviews were also conducted with their relatives, AIDS counsellors, health officials and local opinion leaders such as church leaders, village elders and key informants.

8.2 Characteristics of respondents with HIV/AIDS

The semi-structured questionnaire contained questions about the respondents’ socio-demographic characteristics, sexual behaviour before and after HIV diagnosis, response to HIV diagnosis, treatment, and knowledge about AIDS, and perception of their relatives’ and the wider community’s reaction to their illness. Table 8.1 displays the socio-demographic characteristics of respondents.
Table 8.1 Background characteristics of study subjects (n=31)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>(%)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>16</td>
<td>(51.6)</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>10</td>
<td>(62.5)</td>
</tr>
<tr>
<td>Rural</td>
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<td>(37.5)</td>
</tr>
<tr>
<td>Age</td>
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<td></td>
</tr>
<tr>
<td>Single</td>
<td>10</td>
<td>(62.5)</td>
</tr>
<tr>
<td>Married</td>
<td>6</td>
<td>(37.5)</td>
</tr>
<tr>
<td>Separated/widowed</td>
<td>a</td>
<td>(20.0)</td>
</tr>
<tr>
<td>Education</td>
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<td></td>
</tr>
<tr>
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<tr>
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</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>(6.3)</td>
</tr>
<tr>
<td>Religion</td>
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<tr>
<td>Catholic</td>
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<td>(31.2)</td>
</tr>
<tr>
<td>Protestant</td>
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<td>(50.0)</td>
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<tr>
<td>Other</td>
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<td>(18.8)</td>
</tr>
<tr>
<td>Total No.</td>
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<td>(100)</td>
</tr>
</tbody>
</table>

In all, 16 men and 15 women with AIDS-related disease were interviewed using a semi-structured questionnaire, with a sex ratio of almost one male to one female. Over two-thirds of the respondents (21 men and women) lived in urban areas, mainly Kisumu town and surrounding peri-urban areas. Of the 21 urban residents, eight had lived in rural areas and moved to town to live with relatives while seeking better medical care. All rural seropositive persons had previously lived in other towns before and had returned to the villages to live with their natal families after they fell ill. The over-representation of urban respondents arises from the fact that many were seeking
better health care and services for people with AIDS which are overwhelmingly located in towns.

The majority of people who were seropositive were aged 25-39 years among males, and 15-29 years for females. The sex and age patterns of infection observed in this study are similar to those observed nationally (NACP, 1994). The majority of the seropositive males (n=10) were single, while females were either married (n=7), separated or widowed (n=3). Two men had more than one wife while three women were in polygynous unions. Two female respondents were widowed and they reported that their spouses had died from the same disease. More than three-quarters of the informants had some education: 14 had primary education while ten had secondary or higher education. Twenty-four of the respondents were Christians, of whom the majority were Protestants, while the rest belonged to traditional religious groups. Two-thirds of the infected respondents (n=24 respondents) were unemployed at the time of interview although all had been engaged in various economic activities before they fell ill. At the time of interview, some of the informants were physically unable to perform any economic activity because of their poor health.

8.3 Reaction of seropositive respondents to diagnosis

All respondents were asked several questions about HIV/AIDS diagnosis, their reaction to their serostatus, whether they informed family relatives and friends, and their perception of the reaction of their relatives. They were also asked about the type of treatment and health care they sought after diagnosis. The frequency distributions of responses to these questions are displayed in Table 8.2.
Almost all respondents were diagnosed with HIV in a health facility; 19 persons were
told by medical officers and nine were informed by HIV/AIDS counsellors in the
hospitals where they sought treatment for AIDS-related illness. Only three
respondents learnt about their HIV status after they had donated blood for relatives
who required emergency transfusion. In the early stages of the epidemic, people were
tested for HIV without their consent or knowledge and sometimes were not informed
by medical officers of the result. Today all blood donations are screened and those
found to be infected are rejected but the donors are not informed of the test results
unless they want to know. Interviews with survey respondents show that many people
do not want to donate blood for fear that they will discover their HIV status. Indeed, in
the last fifteen years, there has been 50 per cent decline in blood donation in Kenya
(East African 13 October 1996). This decline is attributed to fear by donors that they
would discover their HIV status when tests are carried out on their blood.
Twenty three of the seropositive respondents had full-blown AIDS while eight were HIV positive. It is imperative to observe that in Kenya most people with AIDS are diagnosed when they present themselves for treatment in the later symptomatic stages of the disease. Most of the respondents had been diagnosed with HIV/AIDS two to six months before to the interview. Caldwell et al. (1993a) note that in Africa, many families do not know the HIV status of asymptomatic family members or the nature of their illness.

The most common initial reaction reported by seropositive persons about their diagnosis was shock (n=12), afraid and sad (n=8), disbelief (n=9) while two respondents were indifferent. Of the five persons who expressed disbelief, three sought further blood tests in other health institutions. The following statement illustrate some of the reactions of seropositive persons to their diagnosis:

Interviewer: What was it like to hear that you had AIDS?

Respondent: I was very scared and it affected me very much...I was depressed for a very long time and thought about death.....and the pain that comes with the disease... it shattered my hopes about the future (Male 29 years old).

I was very shocked when the doctor told me that I had AIDS, I felt very angry with myself because I was not very careful with women....maybe if I was married this would not have happened.....I keep wondering who gave me this disease..Now I am going to die without a wife and children of my own (Male 26 years old).

Those who expressed disbelief about the diagnosis denied having AIDS and attributed their illness to witchcraft. One male stated:

....you know this disease was sent by my enemy.....he is my workmate.......I got ill after we quarrelled at work....He got very envious when I got promoted and he started undermining me...now he wants to finish me completely...I have been to a witchdoctor who told me that he is the cause of my illness (Urban male 37 years).

This could be attributed to the fact that there is a tendency among medical professionals not to inform or explain to the patients or their relatives details about the nature of their illness and treatment. Interviews and discussions with people with AIDS, their families, medical officers and AIDS care givers indicate that infected
persons suffer from considerable emotional distress because of fear of stigma, death and uncertainty about the future. Six seropositive respondents mentioned that they had contemplated and even attempted suicide after they were diagnosed with AIDS.

When the doctor told me I had AIDS I was very shocked...I had seen a workmate who had died of the disease and did not want to go through the same painful death....I seriously thought about taking my life but changed my mind after receiving a lot of counselling.

Some people who test positive for HIV cannot live with it.....there is one young man who recently....(When?) late last year (1993).......he committed suicide after he found that he had AIDS.....no one could believe that he could have such a disease. He left a note explaining why he took his life.

Table 8.2. shows that the majority of the respondents had informed at least one person about their HIV status. Five seropositive respondents informed all members of the family. Of the 13 married seropositive persons, only seven informed their spouse, three informed their parents while three told everyone about the nature of their illness.

Three, all single males and females, informed their parents only about their diagnosis. Among those who informed all or some family members (n=18), the mother and siblings were most likely to be informed. Males were more likely to inform their brothers while females informed their mother and sisters.

A striking feature of Table 8.2 is that a great number of seropositive persons had not informed anyone that they had HIV/AIDS. Thirteen seropositive respondents withheld information about their diagnosis from their family, relatives and friends. Such behaviour may be risky because seropositive individuals may deliberately or accidentally infect other people, such as their sexual partners and care givers. It was evident from open-ended interviews with people with HIV/AIDS, members of their family and key informants, that people who are diagnosed with HIV and their families are reluctant to disclose the nature of their illness to other people because of the fear of being stigmatised. The following statements clearly illustrate this.

Many people have suffered and died from AIDS in this town...there is a workmate of mine who died recently. He was very sick for a long time. When he died people said it was AIDS, but he did not tell anyone at work that it was AIDS...he said it was TB... I think it was
easier to say that he had TB than AIDS...AIDS is a venereal disease which is difficult to talk about to people (Male 29 years old urban area).

Interviewer: Have you told your neighbours that he has AIDS?

Respondent: We haven't told anyone that he has AIDS...because people will gossip and say very bad things about him... people associate AIDS with promiscuity (Female 29 years old, married to seropositive male aged 38, rural area).

Only my family knows about my illness (AIDS)...I have not told any one else...some of my friends and neighbours say I have AIDS (Female, 27 years old, urban area).

We have not told anyone in the neighbourhood that he has AIDS...even close relatives do not know....AIDS is a bad disease which people associate with sexual promiscuity...if people know they will start gossiping and saying bad things about him (wife of male aged 36 years, rural area).

The major reasons given for not informing family members of their illness include worry, and fear of stigmatisation and rejection or isolation.

I could have told my wife and children that I have AIDS long ago when the doctors told me, but I did not know how they would react......they know it is a bad disease. If I tell them they will be worried and sad. I am not going to tell anyone, only the doctor can know (Male aged 40s, rural area).

Some of the patients who failed to inform their family about their illness expressed fear that they would be rejected. Two female respondents feared they would be thrown out of their homes if their husbands found out that they were suffering from AIDS. The following statements illustrate this.

I have not told anyone in the family what I am suffering from...even my husband does not know...I fear that if he finds out he will throw me out...AIDS is a very bad disease and he would not want anything to do with me (Female aged 25, urban area).

I am afraid of telling my husband that I have AIDS. What would he think about me?...we married only two years ago...if he knows he will leave me. He wouldn’t want to live with me any more because I am going to die (Female aged 23 years urban area)
There is evidence from studies in Africa that people diagnosed with AIDS and their relatives are reluctant to inform other people about the disease (McGrath et al. 1992; Termmerman et al. 1990; Ankrah 1993). Anarfi (1995a) noted that HIV/AIDS seropositive individuals go through considerable stress in making the decision whether or not to inform their family about their illness. This difficulty in confiding their HIV/AIDS status reflects the way people perceive the disease as shameful and resulting from behaviour that is not condoned by the society. Awusabo-Asare (1995) emphasises that divulging information about HIV/AIDS status to other members of the family depends on the perception of their reaction.

Other reasons for not telling family members include feeling that they would divulge the information to non-relatives (two respondents) and that they would not understand the nature of their illness (one respondent). In general, respondents had varying reasons for not disclosing their diagnosis to family members. For example one man told his wife, but not other family members because he felt it was their own domestic problem which she could better understand than other members of the extended family.

8.4 Reaction of others to seropositive patient’s diagnosis

All seropositive persons who informed someone of their diagnosis and their family members were asked about their initial and subsequent reaction to the illness. The most common initial responses of the family members who were informed of the nature of the illness were shock (n=7), fear (n=4), and disbelief (n=5). Two seropositive females reported that their spouses and regular partners were angry and outraged when they informed them of the nature of their illness.

When asked about the current response of family members towards their illness, the majority of the respondents who had informed their relatives about their illness reported that they were sympathetic and understanding. They mentioned that in addition to daily care and nursing, family members also contributed financially in meeting medical bills.
However, a considerable number of the relatives and seropositive respondents denied that they or their relative had the disease. Five seropositive respondents and ten relatives of people with HIV/AIDS had refused to accept the HIV diagnosis which had been made in hospital. During open-ended interviews with relatives of people with AIDS and key informants, many spontaneously mentioned witchcraft as cause of illness. For instance, two female informants who were taking care of terminally ill family members stated:

People are saying that he has AIDS, but I don’t think so........this disease was sent to him by someone who does not wish him well........he has very good education and money........many people are jealous and envious about what he has achieved. You know people don’t wish you well when they see you doing well........someone has bewitched him (female aged 50s, in household of male aged 28 yrs, urban area).

Since she returned here (home), we have taken her to many doctors but they can’t cure her.... we have also tried traditional healers.....if we can find out what this disease is we can cure it (Female aged 48 yrs rural area, in household of female aged 24 years rural area)

Previous studies show that denial is a common initial response towards AIDS and many people with the disease continue to deny their condition, despite it being clinically proven and their showing the symptoms. Many subscribe to alternative explanations which are not scientifically valid. As mentioned in Chapter 6, witchcraft plays an important role in the explanatory models of AIDS in this population. These perceptions partly stem from the fact that AIDS is a disease which presents itself in a plethora of unusual symptoms which people do not clearly recognise and hence suspicions of witchcraft and sorcery are widespread. The reluctance to inform relatives about the diagnosis may also explain the prevalence of such beliefs. Among the Luo, disease is not an isolated event; any prolonged disease with no known cure is thought to be brought by evil spirits, ill-wishers or witchcraft. Usually accusations of witchcraft are leveled at enemies or rivals either at work or in business, or at relatives and neighbours in the village. Thus, even in cases where people are diagnosed with AIDS in hospital, they doubt it and it is not uncommon for them and their families to seek alternative explanations and remedies for the disease. Because the illness is attributed to witchcraft there is high utilisation of traditional healers, mainly diviners, to find the cause of the illness.
Because AIDS manifests itself in the form of other known diseases it is often confused with these diseases. When asked about the illness their relative was suffering from, some family members mentioned other illnesses, such as TB, cancer, liver disease, cerebral malaria and typhoid (the latter two are common diseases in the Lake Victoria region). This may be due to fear of stigma, inability to recognise symptoms of the disease or the fact that they were not informed by the patient or medical personnel about the nature of their illness. However, most respondents and informants recognise at least one of the common symptoms of AIDS such as weight loss or slimming, diarrhoea and hair loss.

A few respondents who were HIV-positive reported that they had experienced isolation from some of their relatives and friends since they fell ill. Three terminally ill seropositive respondents were kept by their families in separate rooms away from visitors. Eight respondents mentioned that some of their relatives had withdrawn physically and emotionally after they learnt about the nature of their illness. A male relative of a seropositive respondent stated:

Before he became sick, our relatives and neighbours used to come here often but now they no longer come here....even our closest relatives don’t come because they know he has a bad disease...they have left us alone with our patient (male 24 years old seropositive respondent in household of male aged 44 years, urban area).

Family members and relatives may withdraw socially or physically from seropositive patients because they perceive their illness to be shameful and thus do not want to be associated with them. Previous studies have found that people harbour negative attitudes towards people with AIDS and hence discriminate against them (Quam, 1990; Farmer, 1990). For instance, two urban seropositive respondents who lived in plots with shared amenities reported that they had been denied access to the communal toilets and bathroom because they were suspected of having AIDS. The following cases show how some people with AIDS are subjected to stigma and prejudice.

Mary is 32-year-old widow who lives in Kabando, Nyahera with three of her children. She had previously lived with her husband in Kisumu town before his death in December 1994. Mary’s husband fell ill in June 1994 and was hospitalised twice with pneumonia and once with TB before he died. While her husband never told her that he had AIDS, Mary was informed by a relative of the nature of his
disease. Mary’s husband was dismissed from his job and the family evicted from the company house when Mary’s husband’s employer found out that her husband had AIDS. *(Female 32 yrs, rural area).*

John is 28 years old and lives in Kisumu town. He had previously lived and worked in Nairobi before falling ill. He married two years ago and has two children. His wife owns a small market stall in town. He was sociable before he fell ill; engaging in social activities such as drinking and dancing. He was relatively healthy until June 1994 but was surprised when he began to lose weight and feel fatigued. He started having recurrent bouts of diarrhoea and pneumonia. He sought help from a private practitioner who saw him for about a month and then referred him to the National Hospital. In November 1994 his illness was diagnosed as AIDS and he was counselled about the nature of his illness. Since then his health has continued to deteriorate slowly. John is lonely and depressed. He says that family members and his close friends have difficulty dealing with his illness. He never informed them about his illness but they suspect he has AIDS. They avoid him and have very little contact with members of his family.

Ankrah (1993) and McGrath et al. (1993) remark that ostracism and rejection are historically common reactions to those suffering from illness that are considered contagious or those that result from a perceived violation of taboos and accepted or valued norms. In hospitals and other health institutions AIDS patients are secluded in rooms or wards away from other patients.

In this study, only two cases, both females, were encountered during field work where individuals with HIV/AIDS had been rejected and abandoned by their families.

Case 1: Female respondent aged 31 and twice married.
At the time of interview the respondent had been discharged from hospital with AIDS-related illnesses. She had initially been brought to hospital by her mother from Senghor. Aside from her mother and sister, her other relatives rarely visited her. She could not afford to pay the hospital bill and had been detained for a number of days. She remarked that her family and relatives no longer cared about her because she had become a burden to them.

Case 2: Female respondent aged 25 and single parent.
At the time of interview the respondent lived with her mother and four year-old daughter in the village. Before she fell ill, she had been living with her boyfriend at Busia border post but her boyfriend left her when she began falling ill. Due to the deterioration of her health, she was forced to stop working and moved back to stay with her mother. Her father was very angry when she returned home sick. He did not want anything to do with her. Her mother had recently been
informed at the District Hospital that her daughter had AIDS. Since then she had been kept in her own room and been given her own eating and cooking utensils. She remarked that her mother was ashamed of people seeing her so she spent most of the time in her room asleep.

Informal interviews with seropositive respondents show that their infection or disease had weakened or strained their relationship with spouses, neighbours and friends. Three married women became estranged from their husbands following revelation of their condition and five single men and women broke their relationships with their regular partners after they told them their HIV/AIDS status. Previous studies have shown that HIV/AIDS infection has a profound impact on marital unions and sexual relationships. For instance, Temmerman et al. (1990) found that seropositive women in Nairobi have a higher divorce rate than seronegative women. Barnett and Blaikie (1992) reported that some young wives of seropositive men left them after they found out they had AIDS and married other men. Some respondents reported that they had socially withdrawn from those activities, such as attending meetings or appearing in public, that brought them in contact with other people; consequently they had much less contact with relatives and non-relatives, such as workmates, than they had before their diagnosis or the onset of their illness. This resulted partly from their poor health and fear of being stigmatised.

Since I fell ill with this disease, I now have less contact with people.....I am more reserved because I feel that people will know that I have AIDS....I feel embarrassed when people stare at me and ask irritating questions.... I rarely appear in public places (Male 37 years old, urban area).

Some of the respondents observed that people are still afraid of sufferers from AIDS. One respondent noted that

Many people are still very ignorant about HIV.....they think they can get it by touching or being near you.....people who suffer from AIDS are treated like outcasts (Male 34 years old, urban area).
Most respondents reported that neighbours and close friends had been supportive since they became ill, however some respondents had not informed neighbours or friends that they had HIV/AIDS.

Our neighbours have been understanding and sympathetic.....they come here to see him.....we hold prayers together for his recovery (Female respondent, 40+ years old, in household with male suffering AIDS, rural area).

A number of reasons may explain why people are sympathetic and supportive to people with HIV/AIDS. First, some respondents had not informed their relatives, friends and neighbours that they had HIV/AIDS, and they were therefore in a positive relationship. Secondly, relationships between relatives and neighbours may be close, since most Luo clans are territorial and relatives tend to reside in the same locality; and thirdly, so many people have died from AIDS or AIDS-related illness that many people are familiar with AIDS.

However, a few survey respondents (who did not have HIV/AIDS or relatives with the disease) have negative perceptions and attitudes towards people with AIDS. They perceived people with HIV/AIDS as not deserving any sympathy because their illness emanates from immoral behaviour or surreptitious sexual practices. For instance two respondents stated that people with HIV/AIDS should be confined or quarantined to avoid infecting other people.

Some people who get AIDS spread it deliberately to unsuspecting partners.....they do not want to die alone.....so they sleep with as many people as they can (Urban male, 34-years-old survey respondent).

People with AIDS should be confined......some of them endanger other people's lives....as soon as they learn that they have the disease they go on rampage...they deliberately spread the disease (Rural area, 27-years-old female survey respondent).

There have been reports in the press that some clergymen demand proof of not being HIV positive from prospective couples who want to wed in church while others refuse
to conduct funeral prayers for people suspected of having died of AIDS (*Sunday Daily Nation*, 16 March 1997).

8.5 Care of people with HIV/AIDS

8.5.1 Care by families

In agreement with previous studies (Barnett and Blaikie 1992; Awusabo-Asare 1995), it was also apparent in this study that it is usually immediate family members who take the responsibility of caring for family members with AIDS, with very limited assistance from other relatives. Many of the respondents were living with family members, especially those in rural areas: many of them had returned to their natal families after they had fallen sick. Over half of the respondents were being taken care of by family members, notably spouses (n=7), parents (n=5), siblings (n=4), and children (n=3). Of the married respondents, six men were being taken care by their wives while only one husband was caring for his wife. Women, notably wives, mothers and sisters, were the principal care-givers. The care and support provided by family members ranges from psychological support and health care decision-making to paying hospital bills and hands-on care, such as preparing food, washing, changing clothes, and giving regular medication. Six respondents received assistance from relatives in the form of providing transport to hospitals, paying hospital bills, and purchase of drugs. A further five respondents were taking care of themselves; of these, three had been abandoned by relatives and two had kept away from their families to avoid upsetting them.

8.5.2 Care by hospital and non-governmental organisations

Some of the respondents (n=13) had been hospitalised at least once in the two months before the interview. They had been discharged after their condition improved and were visited at least once a week by either an AIDS counsellor, a clergyman and or a local medical officer. It is important to note that owing to the effects of Structural Adjustment Programmes (SAPs) within the health system in Kenya, many hospitals are unable to cope with the large numbers of AIDS patients and the great expenses
associated with treating these patients, and so they discharge them for home care. It is estimated that 60 per cent of hospital beds at the Kisumu District and New Nyanza Provincial Hospitals are occupied by people with AIDS-related illnesses (Daily Nation 28 June 1996). Very few hospitals have expanded beyond offering in-patient care. Eight seropositive respondents who had been admitted to public hospitals complained of overcrowding and lack of essential drugs while others complained that nurses ignored them. At the time of interview, seven of the seropositive respondents were under the care of hospitals and hospices.

Some hospitals, churches and non-governmental organisations (such as TAPWAK) also provide home-based care programs which entail home visits by health workers and AIDS counsellors in Kisumu town and surrounding rural villages. These home-based programs involve the supply of necessary medications and the counselling of patients and their relatives. Clergymen also visit AIDS patients in their homes to provide counselling, spiritual and pastoral care. In total, sixteen seropositive respondents reported that they were regularly receiving health treatment, counselling and pastoral care at home.

8.6 Sexual behaviour of seropositive persons after diagnosis

The sexual behaviour of seropositive respondents was examined by asking questions regarding respondents’ behaviour before and after diagnosis with HIV. Respondents were asked how many sexual partners they had had in their lifetime, the type of sexual partners they had, and whether they had paid their partners or received money or gifts from them for sexual intercourse. Respondents were also asked whether they had had sexual intercourse with anyone since they were diagnosed and, if they had, whether they had protected their partners. The responses to various questions regarding their behaviour are displayed in Tables 8.3 and 8.4.
### 8.3 Seropositive respondents' sexual behaviour

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</tbody>
</table>

More than half of the seropositive respondents reported having five or more lifetime sexual partners with males reporting more partners than females. Two of the sixteen males stated that they had too many lifetime partners to remember. None of the males had only engaged in monogamous sexual relations with a regular partner compared with two females. When compared with males and females in the general survey (n=312), seropositive male respondents reported having had more lifetime sexual partners. Seropositive respondents had a median of 8.0 compared with 6.0 lifetime partners for survey respondents (not shown in table). However, seropositive females reported almost the same sexual partners as females in the survey (4.0 and 3.8 lifetime partners respectively). Over half of the male seropositive respondents had had sexual relations with casual partners and prostitutes while a third of females had had relations with partners who had paid them. The majority of males (n=13) reported that they had ever had sexual relations with prostitutes and a few women (n=5) reported being paid money or gifts for sexual relations (see Table 8.4).
### 8.4 Respondents who had paid for sex and had intercourse since they were diagnosed with HIV/AIDS

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ever paid or received money for sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13 (81.2)</td>
<td>5 (33.3)</td>
<td>18 (58.1)</td>
</tr>
<tr>
<td>No</td>
<td>3 (18.8)</td>
<td>10 (66.7)</td>
<td>13 (41.9)</td>
</tr>
<tr>
<td><strong>Have you ever had sex since you were diagnosed with HIV/AIDS?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7 (43.7)</td>
<td>5 (33.3)</td>
<td>12 (38.7)</td>
</tr>
<tr>
<td>No</td>
<td>9 (56.3)</td>
<td>10 (66.7)</td>
<td>19 (61.3)</td>
</tr>
<tr>
<td>Total</td>
<td>16 (100)</td>
<td>15 (100)</td>
<td>31 (100)</td>
</tr>
<tr>
<td><strong>If yes, did you protect your partner?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1 (14.3)</td>
<td>1 (20.0)</td>
<td>2 (16.7)</td>
</tr>
<tr>
<td>No</td>
<td>6 (85.7)</td>
<td>4 (80.0)</td>
<td>10 (83.3)</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

More than a third of the respondents (7 men and 5 women) reported having had sexual relations after their diagnosis with HIV. Their partners were spouse (n=5), boyfriend/girlfriend (n=4), casual partners (n=2) and prostitute (n=1). Three males and two women had sexual relations with more than two partners after they were diagnosed with HIV/AIDS. The majority of those seropositive respondents who reported having sexual contact did not inform their partners of their serostatus (some did not believe that they had HIV/AIDS). Only two respondents stated that they had protected themselves and their partners from infection by using condoms. Thus over 83 per cent of the seropositive respondents had knowingly put other people at risk of infection by engaging in unprotected sexual relations.
This chapter shows that the effects of HIV infection go beyond mere infection. The outbreak of AIDS in Kisumu and Nyanza in general has provoked strong emotions and various reactions to the disease in those who are infected with HIV, their family members and the community at large. Most people infected with HIV/AIDS undergo enormous psychological stress. On learning about infection the most common immediate reaction of people infected with HIV/AIDS and their families include shock, disbelief and denial. People with HIV/AIDS and their relatives tend to be secretive about the illness for fear of stigma. Infection with HIV/AIDS brings shame and stigma to both the infected persons and their family. Among the Luo, illnesses that result from behaviour that is not socially accepted, such as promiscuity or breaking sexual taboos, are stigmatised.

The study found that, like other diseases with no known cure, AIDS is given a social interpretation. Although many people may acknowledge the natural theory of the cause of the disease, questions are raised about why the disease occurs or affects a particular person. In this study it was not uncommon for people infected with AIDS and their families to attribute the illness to witchcraft. In an attempt to find answers traditional healers, mainly diviners, were consulted to find the cause. In Kenya, as in many other African countries, there are a number of traditional healers who claim to cure AIDS. Some people including HIV-infected persons believe that traditional healers can cure or relieve the suffering caused by the disease. Thus many people with AIDS and their families search for a cure despite the fact that a cure is elusive.

Most of the HIV infected persons learn that they have the disease in its late stages; usually at hospital when they present themselves with complications. Family members and close relatives are sometimes not informed by patients that they have the disease.

Because the clinical manifestation of AIDS is similar to other known diseases such as tuberculosis, cancer, and chira, some people confuse it with these diseases. Thus, it is not uncommon for people infected with AIDS and their relatives to claim that they suffer from these other diseases.
CHAPTER NINE

SUMMARY AND CONCLUSION

9.1 Introduction

Since its outbreak more than a decade ago, AIDS has emerged as a major problem with health, social, economic and psychological implications. Although both governmental and non-governmental organisations have mounted education and prevention campaigns throughout Kenya, the scourge continues to spread unabated throughout all sections of the population. Currently Kenya is the leading country in Africa in terms of number of reported AIDS cases (Ntozi 1997).

In order to control the spread of the disease it is essential to factors, such as sexual behaviour, which predispose people to infection with HIV/AIDS. It is especially important to understand why people engage in risky behaviour such as serial or concurrent multiple partnerships. This study examines the social and cultural factors that influence sexual behaviour among the Luo of Western Kenya in relation to the AIDS epidemic. The data were obtained through a combination of quantitative and qualitative data collection methods over a ten-month period between August 1994 and May 1995. A survey comprising 312 respondents was conducted in one rural village and an urban area. The results of this study suggest that, despite the ethical issues and secrecy surrounding sex, the use of quantitative and qualitative data collection methods can help to obtain valid data on sexual behaviour and networking. The small sample used in this study provided the researcher with the opportunity to observe behaviour and obtain detailed information, which would have been difficult with a much larger sample. A much larger sample can be used in future to validate the general observations made in this study. This chapter summarises the findings on sexual behaviour and response to HIV/AIDS. This is followed by suggestions for future research and recommendations.
There is general consensus in literature on the Luo and among respondents in this study that before the colonial period, premarital sexual relations were less common. In the past there was a strong emphasis on strict adherence to norms and moral codes of sexual conduct. There was more rigid control of the sexual behaviour of young unmarried people by traditional structures of authority. Unmarried women were expected to remain chaste until marriage when they could gain sexual experience. The traditional institution of *chode* provided unmarried men and women with the opportunity for sexual outlet and to gain some sexual experience during courtship but without any actual penetration. Premarital sex and pregnancy brought shame to the girl and her family and it reduced her chances of marriage.

The was also strict control of women’s sexual activity within marriage; adultery by women was strongly condemned and punished. The Luo sexual culture has double standards because the cultural prescription of polygyny allows men to have multiple partners but expects female monogamy. Men’s extramarital sexual relations are treated differently from those of women: they are treated leniently or casually while those of women are strongly condemned.

Since the beginning of the twentieth century, several socio-economic factors that accompanied colonialism and the commercialisation of the economy changed the way sexual relations were conducted and promoted multiple sexual relations. Migrant labour and colonial policies restricting or discouraging women from migrating to urban areas led to the increase in prostitution in urban centres. The introduction of modern formal education, Christianity and wage employment undermined traditional structures of authority and consequently led to their breakdown. Although in varying degrees, both men and women have more economic and social independence from traditional authorities, such as clans, elders and parents, in that they are less accountable to them for their behaviour than in the pre-colonial period. Nowadays many young men and women become sexually active before marriage and at an early age. Although women are not expected to be sexually experienced before marriage the data obtained in this study indicate that they do not abstain from sex until marriage. On average women experience their first sexual intercourse, and marry, earlier than men.
The results of this study also suggest that there is variation in sexual behaviour among different subgroups of the study population. Men, irrespective of their age and marital status, tend to report more sexual partners than women (except for formerly married women). There are also differences in the sexual behaviour patterns of rural and urban residents. Rural residents report fewer partners than urban residents; married urban males are more likely than their rural counterparts to report multiple partners. Males in monogamous marriages, especially those living away from their spouses for work reasons, and females in polygamous unions are likely to report extramarital sexual relations.

Prostitution is widely prevalent in Kisumu town and other small rural towns and market centres in the district. It became widespread in the colonial period and has developed into various forms of direct and indirect prostitution. Both urban and rural men patronise prostitutes in bars, restaurants and lodging houses. More than a tenth of men reported having sexual contact with prostitutes in the last year before the survey. However, the exchange of cash and gifts is not confined to prostitution because there are many other non-prostitute sexual relationships which have an economic component. Data obtained in this study suggest that many premarital and extramarital non-prostitute sexual relationships also have an economic component but the degree of its importance in the relationships varies from one form of relationship to another. Poverty, the need for emotional comfort and social security are some of the factors that impel women into relationships that involve the exchange of sex for cash and other material support.

9.2 Sexual relations and the AIDS epidemic

In the early 1980s when the first AIDS cases were reported in Kenya among high risk groups such as prostitutes, STD clinic patients and truck drivers, few people, especially in the rural areas, were aware of the existence of AIDS. In Kisumu and many parts of Nyanza, AIDS was perceived as an imaginary disease or some of early cases were thought to be chira. However, since then there has been tremendous increase in awareness of AIDS due to the information and education campaign which was launched in the mid-1980s and intensified in the 1990s.
The current high awareness levels in the study population may lead some men to reduce the number of sexual partners or be selective of their partners. The results of this study indicate that many men still engage in risky behaviour. For instance, almost a fifth of men and less than a tenth of women reported multiple partners in the last month before the survey. About one-tenth of men reported sexual contact with prostitutes in the last year before the survey. Although men engage in risky behaviour they use condoms inconsistently; about a fifth of men and one-tenth of women reported condom use in the last one year prior to the survey. Men tend to use condoms more consistently with prostitutes and partners they perceive as being capable of infecting them with STDs, including HIV/AIDS. Condom use is very inconsistent in marriage and regular or steady relationships in which partners trust one another. More than half the women felt that they were at risk of getting AIDS but a majority of men did not believe so. Many women feel vulnerable to HIV/AIDS because of the sexual activities of their partners.

However, it was apparent from this study that attitudes towards multiple sexual relations are beginning to change and perhaps this may lead to changes in behaviour in future. People have increasingly become aware of the danger of multiple sexual relations and respondents in this study reported changing their sexual behaviour since they learnt about AIDS. People are aware that AIDS is a fatal disease with no known cure. The change in attitudes towards multiple sexual relations may partly be attributed to the AIDS education campaign and partly to the exposure of the Luo community in general to people with HIV/AIDS. Many people have seen family members, relatives and friends suffer from the dreaded disease. As a result some people no longer regard AIDS as a myth or imaginary disease but as a reality that threatens the entire community. However, erroneous beliefs about the disease are still an obstacle to changes in sexual behaviour, as is the fact that some people, especially men, still do not perceive themselves to be at risk of contracting HIV/AIDS.

The study found that traditional beliefs about disease and misfortune influence the way people interpret STDs, including AIDS. Both other standard STDs and AIDS are sometimes attributed to witchcraft and sorcery. AIDS is a mysterious and fatal disease, and many people who suffer from the disease and their relatives resort to
supernatural explanations. The study also found that the local discourse on AIDS frequently alludes to the similarities between AIDS and *chira* a condition that results from violation of sexual rules and norms of seniority.

9.3 Contribution of this study to knowledge

Information obtained in this study not only reflects levels of sexual networking but also yields important information on the way sexual relationships are conducted and the meaning of sexuality. The data obtained in this study describes prevalence and levels of sexual networking in urban and rural Kisumu, providing vital insights into the way men and women express their sexuality.

Before the emergence of the AIDS epidemic, sexual behaviour among the Luo people was rarely studied. The focus of many studies was on marriage customs, fertility and norms regarding sex. None of these studies provided any detailed information on the actual behaviour within and outside marriage. Many studies on sexual networking have examined sexual behaviour from a narrow point of view by only focusing on numbers of sexual partners without looking at the context within which the behaviour occurs. This study provides detailed information on marital and non-marital sexual relations, variety of sexual relationships and factors that motivate people to engage in multiple sexual relations, issues which have never before been highlighted together.

The study has also revealed various significant issues pertaining to local meaning and cognition of AIDS which is vital in understanding the epidemic. It has also highlighted the way local belief systems influence people’s interpretation of the disease. AIDS is conceptualised and fitted into existing models of causes of disease and illness; for instance some people frequently allude to its similarity to *chira* while other believe that AIDS is *chira*. 
9.4 Suggested interventions

9.4.1 Improvement of the quality of information and education campaigns

There is need to ameliorate the quality of education to dispel myths, rumours and other inaccurate beliefs about AIDS. This study found various beliefs regarding the aetiology of AIDS and its similarity to chira. Some of the respondents in the survey, and people with HIV/AIDS and members of their families attributed the disease to witchcraft. Others believe that HIV/AIDS can be spread through casual contact. It was also apparent that some people, especially men, believe that they are not at risk of becoming infected with HIV/AIDS. The existence of such erroneous beliefs seems to suggest that the AIDS education campaign has not fully succeeded in reaching all people and dispelling incorrect beliefs about AIDS.

These beliefs present a considerable obstacle to AIDS prevention campaigns and therefore, the efforts towards effective AIDS education and information should be intensified through all channels such as radio, drama and peer groups. This could be done through the establishment of a network of peer groups, village educators (especially in rural areas) and volunteers who are respected people in the local communities.

9.4.2 Counselling on matters pertaining to sexual relations

This study found that there is high prevalence of premarital sexual and multiple sexual relations among young people. As noted elsewhere, in the past grandparents and other elder relatives provided young men and women with counselling on matters related to sex. Young girls were instructed by their grandmothers or by other older women in their homesteads on matters sex and marriage. However, nowadays many young people spend time away from traditional authorities and sources of information about sex, either for education or wage employment. Many parents fear that sex education actually increases the likelihood that young people will become sexually active. Parents prefer that their children are kept ignorant of sex. As a result, young people seldom receive any advice or guidance in partner selection or any counselling
regarding sexual relations either at school or from their own parents. Thus many young people have no one to discuss and counsel them on sexuality, safe sexual practices, sexual relationships and marriage.

9.4.3 Change in attitudes of men and women with regard to sexual behaviour and safe sex

In this study it was apparent from interviews with respondents that men are perceived to have an insatiable sexual drive and thus can have many sexual partners. There is need for men to change the attitudes which encourage them to indulge in multiple sexual relationships. The AIDS education campaign emphasises monogamous relations or ‘zero-grazing’; however from this study it is evident that some men may ‘zero-graze’ or confine their sexual network to several women whom they do not perceive as a risk capable of infecting them with STDs/AIDS, however many do not see ‘zero-grazing’ as a viable option. While the AIDS education campaign needs to continue to encourage both men and women to have monogamous relationships, there is also a need to provide detailed information on how men and women can be sexually satisfied in monogamous relations or through ‘zero-grazing’. Many men have negative attitude towards condoms: some claim that condoms diminish sexual pleasure while others associate them with promiscuity. There is a need to encourage people to use condoms by providing more knowledge on how men and women can enjoy sex with condoms. Probably, the provision of better-quality condoms might help in overcoming this problem.

The AIDS education and information campaign should also discourage cultural practices such as widow cleansing and inheritance which enhance the risk of infection. The study revealed that attitudes towards these practices are beginning to change, especially among educated people. In addition to attitudinal changes, there should be ways to assist widows (and their children) in finding alternative means of support, in order to discourage widow inheritance.
9.4.4 Introduction of family life education and sex education in schools

It has been observed in Chapters 5 and 6 that there have been pilot projects and attempts to introduce sex education in the education curriculum, but there has been very heated opposition by parents, Church organisations and other pressure groups for fear that such a move would encourage adolescents and young people to be promiscuous. However, studies in various parts of the world show that sex education does not lead to increased involvement of young people in sexual relations. Thus sex education is vital in enabling young people to acquire more detailed and accurate information about their sexuality and sexual relations in general. Indeed, sex education should not only provide information on sex but should offer emotional and psychological support. Sex education should be geared towards providing young people with information and counselling on sexual relations rather than advocating indulgence in sexual intercourse.

9.4.5 Long-term AIDS and other STDs prevention

The AIDS education campaign promotes safe-sex practices and monogamous relationships as the only real long-term solution to curb the spread of AIDS, but there appears to be a problem in adopting these preventive measures. The promotion of condom use encourages men to continue engaging in multiple sexual relations and prostitute patronage because it gives them false security. Men tend to use condoms with prostitutes and partners perceived as risky but not with stable partners or partners whom they trust. In addition, cultural practices, such as polygyny and widow inheritance, and gender ideologies encourage men to freely engage in multiple sexual relations. Nevertheless, the solution to AIDS is to encourage men to refrain from multiple sexual relations and confine themselves to monogamous unions.

Several studies have shown that poverty is a major factor fuelling the AIDS epidemic in Africa (Larson 1989). Poverty has pressured many poor women, with low education and lack of access to economic resources, to engage in prostitution and other casual relationships. The patrilineal structure of most Kenyan ethnic groups, gender ideologies and discriminatory policies tend to marginalise women with regard to
access to economic resources and property. The implementation of Structural Adjustment programs in the mid-1980s to 1990s seem to have exacerbated poverty, thus increasing pressure on economically vulnerable groups to engage in risky behaviour as a survival strategy. Poverty makes it very difficult for women to say ‘no’ to unprotected sex or refuse sex with a promiscuous partner. Because of this there is need to adopt measures and set up programs aimed at alleviating poverty, and addressing gender imbalances in access to economic resources and good health. This could be done by improving women’s education and enhancing their legal right to property. However, these efforts can only have a significant effect if they are accompanied by economic independence. There have been several efforts in Kisumu to set up poverty alleviation programs that are aimed at alleviating poverty and discouraging risky behaviour. An example of this is the UNICEF-funded Manyatta Youth Rescue Group which aims at rehabilitating and assisting prostitutes. The project promotes safe sex practices and treatment of STDs, and has set up a pharmacy to generate income for members with the ultimate aim of discouraging them from prostitution.

9.4.6 Suggestions for further research

Many studies in Africa focus on multiple sexual relations but pay little attention to how these relationships develop and are maintained. This study has highlighted sexual relations within and outside marriage and some of the factors that motivate people to engage in such relations. However, it lacks detailed information on partners in multiple relations and their sexual networks. Thus it is essential to find out who these partners are and describe their characteristics and sexual behaviour.

This study found multiple sexual relations are common, especially among men, but some men and women confine their sexual activities to monogamous relationships with their spouses or stable partners. It is important to find out the factors that motivate these men to confine their sexual relationship to monogamous unions. It is vital to find out their attitudes if we are to understand sexual behaviour.
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Appendix A: Questionnaire

Survey of Sexual Networking and Response to HIV/AIDS among the Luo of Kisumu District, Kenya

Vincent Muange
N.C.E.P.H.
The Australian National University

Questionnaire No. ............
Date of Interview ..........
Interviewers name ..........

Instructions to interviewer

1. Select a private and quiet place for the interview.
2. Keep interviews short (no more than 45 minutes).
3. Circle the choice of answer provided by the respondent. If the answer provided is not available describe answer in OTHER.
4. Ask questions in order as listed and DO NOT ask questions together.
5. After completing interview, go through the questionnaire. Check whether the right answers are written. If not all questions are completed, you need to reinterview the respondent to complete the questionnaire.
6. If the respondent is not available, you need to revisit the same household. Do not select people from another household for replacement. Cancel the interview after three visits.

Introduction to any adult at the selected household.

Hello, my name is.............I am working for Mr. Vincent Muange who is a PhD student at the Australian National University. He is studying sexual behaviour of people in Kisumu District. We would like to interview about 400 people. The
information collected from you will be very useful in our understanding of personal habits and sexual behaviour so that we can help in improving the prevention of sexually transmitted diseases, especially HIV/AIDS. Vincent Muange has informed your local Chief and sub-Chief about the survey and has formal permission from the Office of the President of the Republic of Kenya (If necessary show respondent research clearance permit). The study will include males and females aged 15 and above in all selected households.

During the interview we would like to talk to the selected person in private because some of the questions are personal and sensitive. Now I would like you to give me some information about all people who live in this household. [complete the household listing form on the first page of the questionnaire].

**Introduction to selected respondent**

You are aware that diseases are spread through several means. We may get diseases from insects such as mosquitoes, contaminated water and from the environment. Recently diseases spreading from one person to another are on the increase and therefore it has become necessary to understand some personal behaviour so that we can offer advice on how to prevent them. I would like to talk to you for about 45 minutes about your health and sexual behaviour. I must say that some of the questions are personal and private but I will ensure all the answers are confidential. The responses are for purposes of this study only and would not be linked to your identity in any way. Your cooperation is required and I would like to reiterate once more before we start the interview that your responses will be confidential.
HOUSEHOLD LISTING FORM

Village name ...........
Household No ...........

1. How many people live in this household? ...........
   No. of men ...........
   No. of women .........

USUAL RESIDENTS OF THE HOUSEHOLD

<table>
<thead>
<tr>
<th>Coding for relation with head of HH</th>
<th>No.</th>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Marital status</th>
<th>relationship with HH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Household head</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Husband/Wife</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Son/daughter</td>
<td>3</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>4. Parents of self</td>
<td>4</td>
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<td></td>
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<td></td>
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<tr>
<td>5. Grand parent</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Brother/sister</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. In-law</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Other</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Go through the list and count the total number of eligible men and women (those aged 15 and above). The total number of eligible persons is ............ persons.
RESULTS OF THE INTERVIEW

<table>
<thead>
<tr>
<th>Coding for results</th>
<th>No.</th>
<th>First Visit</th>
<th>Second visit</th>
<th>Third visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Date</td>
<td>Date</td>
<td>Date</td>
</tr>
<tr>
<td>1. Completed</td>
<td></td>
<td>Result</td>
<td>Result</td>
<td>Result</td>
</tr>
<tr>
<td>2. Refused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Not at home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Socio-economic characteristics of survey respondents

1. Sex
   1. Male [ ........ ] 2. Female [ ........ ]

2. How old are you?
   Age [............] years

3. What religion do you belong to?
   1 Christian (Catholic)
   2 Protestant
   3 Muslim
   4 Traditional
   5 No religion
   6 Other

4. Have you ever attended school? What level did you complete your education?
   1 Never in school
   2 Primary 1-4
   3 Primary 5-7
   4 Secondary 1-2
   5 Secondary 3 4 5 6
   6 University/college
   7 Other

5. What is the main kind of work you do?
   1 Professional (specify)
   2 Farmer/fisherman
   3 Housewife
   4 Self employed/petty trade
   5 Student
   6 Not working

6. Where were you brought up most of your life?
   1 Urban
   2 Rural
   3 Small town
   4 City
7. After the age of 15, have you ever migrated to live in a province other than Nyanza?

1 Yes
2 No

8. How many siblings do you have who are still alive

1 Brother(s) ...........
2 Sister(s).............

9. Have you ever been married??

1 Never married (go to Q. 16)
2 Married (go to Q. 10)
3 Separated/divorced (go to Q. 10)
4 Widowed (go to Q. 10)

10. How many times have you been married?

No. of times ..........

(Men) How many wives do you have? .............

(women) How many wives does your husband have including your self? ........

11. How old were you when you first married and how old was your husband/wife?

1. Respondents age at marriage ........
2. Spouses age at marriage ........

12. How long have you been married?

No. Years ........ Months ........
13. What level of education did your spouse complete?
   1 Never in school
   2 Primary 1-4
   3 Primary 5-7
   4 Secondary 1-2
   5 Secondary 3 4 5 6

14. Does your spouse(s) live in the same house as you?
   1 Yes (go to Q. 16)
   2 No (go to Q. 15)

15. How often do you meet your spouse?

   1 Every day
   2 At least once a week
   3 At least once a fortnight
   4 At least once a month
   5 Other

16.a (Ask never married, separated, divorced and widowed respondents)
   Do you have a regular partner?

   1 Yes (go to Q. 17)
   2 No (go to Q. 19)

17. How many regular partners do you have?

   No. of regular partner(s) .......

18. How long have you been with this partner (longest one)?

   Months ........... Years ...........

   (Ask women only Q. 19-21).
19. Have you ever given birth?

1 Yes
2 No.

20. How many living children do you have? ...........

21. How old were you when you had your first child? ........

**Attitude to virginity**

V1. In some communities, a woman is expected to be a virgin at marriage. Is this true of the Luo?

1 Yes
2 No
3 Don’t know

V2. Should a woman be a virgin at marriage?

1 Yes
2 No

V3. Is it necessary today for a woman to be a virgin at marriage?

1 Yes
2 No

V4. Was your partner a virgin at marriage?

1 Yes
2 No

V5. Do you expect your daughter to be a virgin at marriage?

1 Yes
2 No
Sexual experience

B1. Who can you talk to about sex?

1 No one
2 Spouse, boyfriend/girlfriend
3 Friends
4 Other

B2. From what source of information did you learn about sex?

1 Magazines
2 Movies
3 TV/radio
4 Books
5 Friends
6 Parents and other relatives.

B3. Have you ever had sex?

1 Yes
2 No (go to Q M1)

B4. How old were you when you had your first sexual intercourse?
Years .......... months ........

B5. What was the circumstance? .................................................................
........................................................................................................
........................................................................................................

B6. Who was this person?

1. Boyfriend/Girlfriend
2. Spouse (wife/husband)
3. Friend
4. Stranger
5. Other

B7. How long did you know this person?
Years ....... Months .........
B8. (Ask only ever married respondents Q B8 & B9)

Did you have sexual intercourse before or after marriage?

1 Before marriage (go to Q. E1)
2 After marriage

B9. How many partners did you have before marriage? .......... 

(Ask all sexually active respondents Q. B10)

B10. How many partners have you had sex with in the last one month? How about in the last one year? How about in your whole lifetime?

1 .......... Last one month
2 .......... Last one year
3 .......... Lifetime
4 Can’t remember
5 Too many to count

Extra marital relations

E1. Have you ever had sex partners other than your husband/wife?
1 Yes
2 No

E2. If yes who was this partner?

..............................................................
..............................................................

E3. How many other sexual partners have you ever had since marriage?

Number of partners .......... 

E4. (Ask male respondents only)

Did you give them any assistance?

1 Yes
2 No

E5. What kind of assistance did you give?

1 Money
2 Gifts
3 Other .......... 

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Male and female attitudes to sex

(Ask male respondents only Q. M1-M6)

M1. Is one woman sufficient for a man?

1 Yes
2 No

M2. If yes, why can a man be satisfied with one woman?

........................................................................................................................................................................................................................................................................................................................................................................................................

M3. If no, why can’t a man be satisfied with one woman?

........................................................................................................................................................................................................................................................................................................................................................................................................

M4. Are men different from women in their sexual needs?

........................................................................................................................................................................................................................................................................................................................................................................................................

M5. If yes why?

........................................................................................................................................................................................................................................................................................................................................................................................................

M6. If no, why not?

........................................................................................................................................................................................................................................................................................................................................................................................................

(Ask female respondents only Q. M7 to M14)

M7. Are there any difference between men and women in their sexual needs

1 Yes
2 No
3 Other

M8. Do men need more than one sexual partner?

1 Yes
2 No
M9. Do you think a man can be satisfied with one sexual partner?

   1 Yes
   2 No

M10. Does a woman whose partner has had other sexual partners have a right to refuse sex?

   1 Yes
   2 No

M11. If yes, why?........................................................................................................................

M12. Can you refuse to have sex with your partner if he has other partners?

   1 Yes
   2 No

M13. Have you ever refused sex with your husband or partner?

   1 Yes
   2 No

M14. If yes, what are the reasons for refusing sex with your partner?

   ............................................................................................................................
   ............................................................................................................................
   ............................................................................................................................

Widow inheritance

(Ask all respondents)

W1. In some communities a widow is inherited by her deceased husband’s brother or relative. Is this true of the Luo?

   1 Yes
   2 No

W2. If yes, why?..................................................................................................................

W3. Have you ever known someone who has inherited a widow?

   1 Yes
   2 No
W4 If yes, who is this person?

1 Parents
2 Sibling
3 Relative
4 Self
5 Other ...........

W5. Can a widow refuse to be inherited?

1 Yes
2 No

W6. If no, why not? ..............................................................
...........................................................................

Sexual contact with prostitutes

P1. (Ask male respondents only) Have you ever had sexual intercourse with prostitutes or a woman that you gave something in exchange for sex?

1 Yes
2 No (go to Q. C.1)

P2. (Ask female respondents only) Have you ever been paid or received something in exchange for sex?

1 Yes
2 No (go to Q.C1)

P3. (Ask males only) How much did you pay when you last had sex with a prostitute?

Cost...........Ksh
P4. When was the last time you paid for sex with prostitutes?

Week.......Month.......year

P5. Do you often use condoms with prostitutes?

1 Yes
2 No

Condom knowledge and use

C1. Do you know what this is? (show a condom)

1 Yes
2 No (go to Q. S1)

C2. Have you ever heard of condoms (use local name if appropriate)?

1 Yes
2 No

C3. What are they used for?

(if respondent answers 'sex', probe with 'why are they used during sex?)

1 Prevent diseases
2 Prevent STDs
3 Prevent pregnancy
4 Prevent HIV/AIDS
5 Prevent STDs including HIV/AIDS and pregnancy.
6 Other

C4. Do you know of any places to buy condoms?

1 Yes
2 No (go to Q. 7)
C5. Where would you get condoms if you wanted them?
1 Hospitals, health centres and family planning clinic
2 Pharmacy/Chemist/drugstore
3 Friends
4 Bar/hotel
5 Supermarket/retail shop
6 Other

C6. How much do condoms usually cost?
1 Free
2 .......... K.sh per packet
3 Don’t know.

C7. Have you ever used a condom any of your partners?
1 Yes
2 No (go to Q. 10)

C8. How often do you use condoms?
1 Every time
2 Sometimes
3 Rarely

C9. If yes, what are the reasons you used a condom?
1 Prevent pregnancy
2 Prevent STDs
3 Prevent AIDS
4 Prevent pregnancy, STDs and AIDS
5 Did not trust partner
6 Partner wanted to
7 No reason
8 Other

C10. If, no, what are the reasons you have not used a condom?
1 Not having sex
2 Cannot obtain them
3 Don’t like them
4 Partner won’t use
5 Are dangerous
6 Trust partner
7 Against religion
8 Using other birth control methods
9 Other
Sexually transmitted diseases

S1. Do you know of any sexually transmitted disease?
   1 Yes
   2. No

S2. If yes, which ones (list all STDs mentioned).
   ............................................................................................................................
   ............................................................................................................................
   ............................................................................................................................

S3. How are STDs transmitted?
   ............................................................................................................................
   ............................................................................................................................
   ............................................................................................................................

S4. Do you know friends who have contracted an STD?
   1 Yes
   2 No.

S5. Have you ever been infected with an STD?
   1 Yes
   2 No (go to Q. S12)

S6. If yes, who was the partner who infected you?
   1 Girlfriend/boyfriend
   2 Spouse
   3 Prostitute
   4 Other ...........

S7. How many times have you ever been infected with an STD?
   Number of times ...........

S8. When were you last infected with an STD?
   Exact year ...........
S9. Did you get any treatment? Where?

1 Yes
2 No

1 Hospital
2 Private clinic
3 Self treatment
4 Traditional healer, herbalists etc.
5 Other

S10. Did you tell your partner that you were infected with an STD?

1 Yes
2 No.

S11. If no, why did you not inform your partner.

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

S12. Do you know of ways to prevent STDs?

1 Yes
2 No

S13. If yes, how can one avoid getting infected with an STD?

(List all ways mentioned)

.............
.............
.............
.............

S14. If you found out that you had an STD would you inform your partner?

1 Yes
2 No
Knowledge about AIDS

K1. Have you ever heard of a disease called AIDS?

1 Yes
2 No

K2. When did you first hear about AIDS?

1 Last one month
2 Last one year
3 ....... exact year
4 Can’t remember

K3. Where did you first hear about AIDS?

1 Newspapers
2 TV, video
3 Radio
4 Health Worker
5 Hospital/clinic
6 Church
7 Friends/other people
8 Posters and stickers
9 Books
10 Other

K4. Do you know of the way(s) through which AIDS is spread from one person to another person?

(List all modes of transmission mentioned by respondent)

................................................................................................................................................
................................................................................................................................................
................................................................................................................................................
...........................................

K5. Have you ever known someone personally who has been diagnosed with HIV/AIDS?

1 Yes
2 No
3 Heard rumours of someone in community.
K6. If yes who is this person?
1. Family member
2. Other relative
3. Friends/Neighbour
4. Other

K7. Who can get AIDS?
1. Anyone
2. People with many partners or promiscuous people
3. Young people
4. Prostitutes
5. Adults/grown ups
6. Foreigners
7. Other

K8. How can one get AIDS?
1. Sex
2. Shaking hands
3. Sharing clothes, utensils and other commonly shared facilities
4. Blood transfusion
5. Sharing contaminated needles
6. Witchcraft
7. Kissing and touching
8. Punishment form God
9. Other

K9. Do you think you can get AIDS?
1. Yes
2. No
3. Not sure
4. Other

K10. If yes, why? ........................................................................................................................................

K11. If No, why? ....................................................................................................................................

K12. If not sure, why? ..............................................................................................................................
K13. What can people do to prevent getting AIDS?
   [Code in order mentioned]
   
   1 Abstain from sex
   2 Use condoms
   3 'Zero grazing' or staying in monogamous relationships
   4 Remain faithful
   5 Choose partners carefully
   6 Avoid promiscuity
   7 Avoid sex with prostitutes.
   8 Other

K15. Is there anything you personally could do to prevent getting AIDS?]
   
   1 Yes (go to Q. K16)
   2 No (go to Q. K17 )

K16. If yes, What could you do?
   
   1 Abstain from sex
   2 Use condoms
   3 Remain faithful to partner
   4 'Zero grazing' or staying in monogamous relationship.
   5 Choose partners carefully
   6 Avoid sex with prostitutes
   7 Use clean needles
   8 Other

K17 If no, why not?
   
   1 Faithful to partner
   2 Choose partners carefully
   3 Not at risk
   4 Don't know how to prevent it
   5 Have no control
   6 Other
   7 Bad luck
Appendix B: Life histories of people with HIV/AIDS

CASE I

George is a married man, aged 26 years who has a child aged two years. He is the second born child in a family of eight children. He was born and brought up in a village in Muhoroni where he lived with his parents. His parents have five acres of land, used as a sugar plantation. He attended primary school in his village and later attended high school in a neighbouring District. He joined the University of Nairobi to study a Bachelor of Arts degree but dropped out in the third year. He is currently living with his wife and child in Mayatta, Kisumu town. His wife is a nursery school teacher. Even though George appeared frail, he was in good spirits and was willing to talk about his condition.

George had his first sexual experience at age 17 with a girl he had known for some time. They were not in a stable relationship. Thereafter, he had sexual relationships with two other girlfriends in stable relationships. He says that his real experience in sexual relations began when he joined the University because he had money to spend on having fun and drinking. He had sexual relations, both with casual friends (in short-term relationships) and with prostitutes (mostly one-night-stands). He often picked up girls in night-clubs and bars in the city, especially after getting paid his ‘boom’ (student living allowance). He did not use condoms regularly except with women whom he suspected could pass on an STD to him. He has experienced five STD infections, including gonorrhoea and chancroid.

When he got married two years ago, George stopped having casual sex with casual girlfriends and prostitutes. He also cited his last STD infection, which caused painful ulcers around the penis and groin area, as a reason for changing his behaviour. In December 1993 he began falling ill with severe headaches, heavy sweating, fever, and chest pains. He also had no appetite and lost weight. He first went to a general practitioner a number of times but was later referred to the Kisumu District hospital. He was examined and given a prescription. However his problem persisted and he was referred to the Kenyatta National Hospital in Nairobi. The doctors requested a thorough medical check-up and blood test. He tested positive for HIV and was informed after being counselled. He says that he was very shocked and could not believe that someone like him could contract the virus. He went for two further tests which were also positive. He was depressed and refused to tell his wife. He contemplated committing suicide but dropped the idea after counselling. It took him two months to tell his wife about his HIV status. When he told her, she was very shocked and couldn’t believe it. She and their young son went for HIV tests; his wife was also found to be HIV positive but their son tested negative. His wife has not yet developed any symptoms of AIDS. His parents and siblings were also shocked when he informed them.

In February 1994, George opted to drop out of university because his deteriorating health meant that he could not concentrate on his. He moved to Kisumu town to live with his wife who takes care of him. He opted to stay in Kisumu town to avoid embarrassment from his rural kinsmen and neighbours. He says that people gossip a lot
in the rural areas. He has been in and out of hospital three times. His wife takes care of him and is sometimes assisted by his sister. A brother takes him to hospital whenever it is necessary. He says that his parents sold an acre of land (for more than Ksh 30,000) to cater for his medical bills. He says that while family members and close kinsmen understand his diseases, and a few close friends visit him, he has lost contact with most of his friends. He also receives weekly visits from an AIDS counsellor and a local priest.

CASE 2

Clementine is a formerly married woman aged 31 years. She was born and now lives in Kano Plains, Kisumu District, with her mother. She has had incomplete primary school education; she dropped out in class six to help her parents look after the family. She lived in the village with her parents until she got married at age 17. She says that she was married to a man from Siaya for a year and a half. She had her first child, a daughter with him. Her marriage ended when he deserted her for another woman. After her marriage ended, she moved back to her parents home. She later moved to Nairobi where her brother had found a job for her in a knitting factory. Initially she stayed with her brother but she later moved out with a friend.

Clementine experienced the first sexual intercourse at the age of 15 with a boyfriend in her village. They had a regular sexual relationship for a year but it ended when she got married. She did not have any extramarital affairs while married. However, since her marriage ended, she has had sexual relations with four men in Nairobi, two of whom were married. Her last regular partner was a truck driver from Rwanda whom she lived with periodically. They had one child together. He used to pay for her rent, food, clothing, and give her cash for living expenses. He also helped her start a small retail business. She describes their four year relationship as stable; she did not have other sexual partners during their relationship. However, she says that her boyfriend may have had other sexual partners elsewhere because he used to travel from one country to another, and regularly travelled to Mombasa and back driving trucks. He had told her that he was once married in Rwanda. They lived together for about two years until he fell ill. In January 1993, her boyfriend began falling sick. He had stomach and chest problems and also began to lose weight. He stopped working and returned back home in Rwanda for a few weeks. When he returned, he was very frail and weak. He died a month later at the District hospital. He never told her what he was suffering from. She only heard rumours from their friends that he had AIDS but she did not believe them.

Clementine has never had any STD infection, but is now sick with AIDS. She was diagnosed with HIV six months ago (May 1994) after she began falling ill. It started with diarrhoea and stomach problems. She became very weak and could not work. She went for treatment in a private clinic but after a week she was sick again. She was under medication for some time before she decided to see two other physicians, however her problem still persisted. She began to suspect that she had been bewitched. A friend took her to a traditional healer ‘mganga’ who told her that an envious business rival had bewitched her. He performed a ritual and gave her some herbal medicine. She was better for about a week but then began having chest problems with heavy coughing.
She went for treatment at the District hospital and was admitted. The doctors told her that she was suffering from tuberculosis. They then tested her for HIV and after counselling she was told that she had tested positive. She was very shocked and did not know what to tell her parents and other relatives. She was discharged from hospital a month later. Due to her deteriorated health she moved back home with her children to live with her aging parents. Clementine is worried about her children. She worries about who will take care of them when she is dead. She has no money left for them because she spent all her savings, the money her deceased boyfriend left her, paying her medical bills. She cannot afford to buy the expensive medicines she requires.

**CASE 3**

Raphael is 36 years old. He is married with four children, three boys and a girl. He was admitted at the District hospital with full-blown AIDS at the time of interview. He requested that the interview be conducted in the absence of his wife and relatives who were visiting him when we went to interview him. Despite being very frail and weak he was willing to talk about his disease and life history.

Raphael had primary school education up to class seven and could not continue because his father refused to pay his school fees. His father was a polygynous man and tended to favour his younger wife's children. An uncle took him to Nairobi and helped him find a job. He later left the job and started his own 'mtumba' (second-hand clothes) business in Kisumu.

He had his first sexual intercourse at age 18 with a woman he had known for about six months (she was a housemaid or 'ayah' to a relative he was living with at the time). Their relationship ended a few months later. His second sexual engagement was with a girlfriend in a relationship that lasted about a year. He had sexual relations with two other steady partners before he got married to his wife.

Raphael also has had sexual engagement with casual partners (women he describes as friends) and prostitutes. In the early eighties, he says that he had a lot of money and would go out with friends, social drinking and dancing in nightclubs. Most of the time he would take a friend (girl) with him or he would pick up a prostitute. He says that he had paid for sexual relations with prostitutes more than 20 times. He described himself and his company (friends) as being very promiscuous during those days. He was twice infected with STDs but later took precautions by taking capsules (antibiotics) before and after having sexual relations with a prostitute.

He married his wife at the age of 26 and they have had four children together. His wife also has a son from a previous marriage. After their marriage, his wife went to their rural home to manage a plot of land he had inherited from his late father. He admits that he had other sexual partners after marriage. He says he was more careful about sleeping with casual friends and prostitutes after he heard about AIDS in mid 1987. He stated that he has never used condoms because he did not see any reason to do so.
Raphael said that he began falling ill with chronic fever in December 1994. He suspected he had malaria and went to see a private practitioner who prescribed some antibiotics but they did not work. He referred him to the District hospital where several blood tests for malaria were negative. He was tested for HIV in February 1995 and was found to be positive. He was shocked by the results and did not want anyone, even his wife, to know that he had AIDS. He has never told anyone that he has AIDS because he fears that they will blame him and think badly of him.

Since testing positive for HIV his health has deteriorated considerably. He has suffered from pneumonia, chronic diarrhoea and tuberculosis. He stopped having sex with other partners after he was diagnosed with HIV but had unprotected sex with his wife two months ago.

CASE 4

Angelina is about 35 year old and is a mother with five children. She was formerly married to a polygynous husband. She was the youngest of five wives. Previously she lived in her matrimonial home in Siaya but she now lives in Koru. She is being taken care of by her aged mother and four of her children. At the time of interview, she had symptoms of full-blown AIDS. She was wasted, weak, losing hair, and had dark skin lesions. Her mother initially refused to allow the interview to take place but an AIDS counsellor managed to persuade her to agree. Angelina is kept in a separate room where she spends most of the day.

Angelina became sexually active at the age of 15 with a boyfriend from her neighbourhood. They had known one another for a month before they had sexual intercourse. They were sexually engaged for about a year before she became pregnant. She planned to have an abortion but did not have the money. She dropped out of school and gave birth to a daughter at the age of 17. Her parents were annoyed with her. Her boyfriend denied paternity and stopped seeing her. After giving birth, she stayed home helping her mother with the farm and domestic chores. A year later an aunt took her to Siaya town to work as a housemaid for a wealthy businessman. She had sexual relations with two other men in Siaya. She also had a secret sexual affair with her employer while his wives were away. She became pregnant for a second time and her employer married her as his fourth wife. They had four children together.

She says that for ten years she lived a tranquil rural life, raising her children and cultivating a plot of land that her husband had allocated to her. Her husband was very wealthy, with retail shops in Kisumu, Siaya and Homabay. She says that her husband provided for his five wives adequately (they had enough money for food, clothes and other basic needs). He visted the family every weekend. Unfortunately her husband fell ill in 1992 and died of a mysterious disease. He went to three hospitals in Kisumu and Nairobi and consulted a traditional healer but was not cured. They suspected that he had been bewitched by a business competitor.

Angelina says that her happy life ended after her husband’s death. After his burial and all death rites were performed, her in-laws and co-wives turned against her; ‘they accused me of bewitching my husband and came for the property that he had left for myself and the children. There was no mercy for myself and my five children. I
found myself thrust into a new status as a widow and single parent, with nothing to call my own’. None of her husbands relatives assisted or supported her. She says that rather than staying in the village waiting for people to help her, she boarded a bus to Kisumu with her children.

CASE 5

Patrick is a single man aged 34 years. He was born in Migori. He is the eldest child of his mother’s nine children. Patrick is a well educated man and has a diploma in management. Until 1993, he held a senior position in an insurance company in Nairobi. He was diagnosed with HIV in 1992 and is currently living with a cousin in a rented house in Kisumu town. He is an active member of the Kisumu TAPWAK and was interviewed at their premises in Milimani. He is actively involved in TAPWAK’s HIV/AIDS education out-reach program.

Patrick had first sexual intercourse at the age of 17 with a girl from his school. They were sexually engaged for six months and he broke off their relationship after he found out that she was going out with another man. He has also had regular sexual relations with three girlfriends and a on-and-off relationship with a workmate. In the previous year he had one regular sexual partner, his girlfriend. At the time he tested positive, they were arranging their wedding. He says that both their parents had met and finalised all the wedding arrangements. However, their hopes were shattered when a blood test confirmed that he was HIV positive.

In November 1993 he began experiencing severe headaches shortly after returning back to Nairobi after his annual leave in his village in Nyakach. He consulted a doctor who diagnosed Malaria and prescribed some drugs. The problem persisted and the doctor requested laboratory and blood tests. When the results came out the doctor did not tell him the outcome of the test but refered him to a specialist for further tests. The specialist did a blood test and found him to be HIV positive. He was very shocked and refused to accept the results until they were confirmed by a further blood test. He felt very guilty and was angry with himself for being careless. He tried to recall who might have infected him but could not. He says that he had always gone out with ‘clean’ women whom he would not have suspected were infected. He says that he received counselling prior to and after his first HIV blood test. Although he was living with his fiance at the time, he says that he did not have the courage to tell her about the results of his blood test. He was very depressed and over the next few weeks he pondered about what he should do. He says that he lost a lot of weight because of ‘thinking hard’.

Patrick finally told his fiance about his HIV status after receiving counselling from his doctor. His fiance was shocked and couldn’t believe it. She went for a test and was found to be negative. She was angry with him and they had a big quarrel. She blamed him of being unfaithful. She did not want to listen to his pleas that it was not his fault that he had HIV. They broke up a month later and cancelled all the wedding plans they had made. When she left him she told friends and workmates about him and then people, including some friends and neighbours, started claiming that he had AIDS. This annoyed him very much and he decided to isolate himself from them because they were blaming him and speaking badly about him. He says that he lost some of his
friends; they began to avoid any close contact with him.

In August 1993, Patrick moved to Kisumu. He had requested a transfer from his employer. He says that he wanted to settle among strangers where he would not be talked about. At the time he moved to Kisumu, his health was alright despite having lost some weight. He says he was psychologically stressed and spent much of his time thinking about death. He has been hospitalised twice with severe diarrhoea and is now getting regular treatment from a private hospital. He says he has come to terms with his condition after receiving counselling and pastoral care at the TAPWAK hospice in Kisumu town. He has also recently informed his close relatives about his HIV status and says that they have been very sympathetic. Patrick says that he has spent all his savings on treatment, paying bills and buying expensive drugs for HIV related infections. His elder brothers assists him in paying bills and also visits him regularly.

CASE 6

Ruth is a 43-year-old woman who is HIV positive but remains relatively healthy. She was born in Busia and is the second born in a family of ten children. She has secondary education up to form two and is trained a mid-wife. Before she tested HIV positive she was happily married (for 16 years), was raising her six children and was working as a mid-wife in a big hospital in Eldoret.

Ruth had her first sexual intercourse at the age of 19 with a man who later became her husband. Her strong Christian up-bringing detered her from getting involved in casual sexual relationships and her mother constantly cautioned her against playing around with boys. She and her husband married after five years, when she was aged 24. She says that she had only one life-time sexual partner, her husband. She says that she had suspected her husband was having secret sexual affairs with other women but he always denied this whenever she confronted him.

In October 1992, she fell ill with a fever that lasted a week. She did not consult a docter but got a prescription for some pills from a workmate. However, in the next two months, she was ill with fever and severe headaches. She saw a doctor who said it might be high blood pressure. She went to a private practitioner who recommended a blood test. She could not believe it when the test came out positive for HIV. She requested a re-test which was also positive. A third test at a different hospital confirmed her HIV status. She had heard about AIDS in the early 1980s and over the years had seen people suffering from the disease.

When Ruth informed her husband, he quarrelled her and beat her. He accused her of infidelity and would beat her whenever he came home drunk. Ruth says that she felt she could no longer work as a mid-wife because she would threaten the lives of patients thus she decided to inform her employer of her HIV status. Not long afterwards she lost her job at the hospital.

CASE 7

Lonah is 32 years old and was born in Nyakach. She is married with four children, three girls and a boy. She lives with her husband in Nyalenda, Kisumu. Her husband
works in a factory in the town. They were happily married for eight years, six of which they lived separately because her husband was working away from home. At the time she was living in her husband’s rural home in Karachounyo, taking care of his small rural farm and running a small retail shop in the village market centre. Her husband used to visit when on leave, over the weekend or on major holidays. Occasionally, she would visit him in his place of work when she had time. She moved to Kisumu when her husband was transferred there and her youngest daughter fell sick.

Two years ago, she gave birth to her fourth child, a girl. Eight months after the birth, her daughter started developing health problems, such as severe fever, stomach-aches and diarrhoea. She took her to various health centres and the Siaya District hospital but the problems persisted. She began thinking that her daughter had been bewitched and so she consulted a “Jouga” or medicine man. The medicine man told her that her daughter had been bewitched by a jealous neighbour. He performed a ritual and cleansed her with “mayasi” or traditional medicine.

However, the baby’s health problems continued and she decided to go to seek better health care from Kisumu where her husband had been transferred. Docters at the Kisumu Provincial Hospital insisted on testing the little girl for HIV. The tests returned a positive result for HIV. Lonah could not believe it and did not tell her husband. She had heard about HIV/AIDS on the radio and at the local health centre but could not believe that her daughter could get the virus. The doctors also tested her and found that she too was HIV positive. She returned home and finally gathered enough courage to tell her husband. When she informed him about it, they quarreled and he accused her of having been unfaithful to him when she was back in his rural home. He refused to go for a test when she insisted that he also take a blood test. Thereafter, her husband started drinking heavily, being hostile to her and threatening to throw her out. He stopped supporting her financially and he no longer cares about her and the children. Her ailing daughter condition has further deteriorated. The child has lost weight, and is now emaciated, and very weak. She regularly takes the baby to the district hospital for medical attention. Lonah is worried about all her children, but particularly the ailing one. Lonah also worries about the future. She is currently not able to support herself and the children. She is worried that she too will finally succumb to the disease and her children will be left alone.

CASE 8

Millicent is 28 years old and single. She was born and grew up in Kanyamkago, but now lives in Kisumu town. She has completed form one of secondary school education. She dropped out in the second term of form two after she became pregnant. She became sexually active at the age of 14 with a boyfriend. A year after her first sexual intercourse, she became pregnant to her second boyfriend. The boyfriend refused to accept paternity and marriage. He was still a student in form four.

In 1981, Millicent gave birth to her first child, a daughter, and thereafter she stayed home, helping her mother with house-work. A year after the birth, she left her child with her mother and went to Nairobi to seek work. She was initially accomodated by a relative but moved out with friends when she got a “kibarua” or temporary
employment, with a relative’s assistance. She also met and started having sexual relations with a boyfriend from Migori who was working in Nairobi. After a year she got pregnant again with her second child. Her boyfriend refused to accept paternity and disappeared. She moved back to Kanyamkago, her parents rural home. Her parents were not happy about her situation and they quarrelled with her. After the birth, she also left her second child, another daughter, and ran away to Kisumu. She looked for jobs but in vain but was forced to rely on friends for help, some of whom would ask for sexual favours in exchange for their help. She also started drinking and sleeping around with different men for money. The men included strangers she met in bars, night-clubs and lodging houses. She occasionaly sent some of the money she earnt back to her parents for the upkeep of her children.

In 1991, she met a wealthy truck-driver in a night-club in Kisum. He was a Zairean national. After the first night they became very intimate and he began to give her money, take her out drinking and dancing, pay her rent and buy her clothing. He would stay at her house whenever he made a stop in Kisumu on the his way to Zaire. In 1992, she brought her children to Kisumu town and with the help of her boyfriend, she started a small “mitumba” (second-hand clothing) business. Millicent had another young man whom she was seeing in Kisumu when her truck-driver boyfriend was out of town. She describes him as a friend with whom she was having a good time.

In 1993, Millicent began getting worried about her health when she started sweating severely at night, having fever and had swellings which appeared under her arms. She was also suffering bad inflammation of her tonsils. She went to a private doctor who gave her an injection and prescribed some drugs. Her health problems continued however and even new complications started to appear. She stopped working and was spending her little savings on her health-care. When her condition deteriorated, her rich boyfriend took her to Nairobi for better medical care. At Kenyatta National Hospital she was told she should take a blood test. Initially she hesitated. She had heard about AIDS and its symptoms and she feared that she might test HIV positive. After counselling, she took the blood test which confirmed her HIV positive status. Her boyfriend left her after she informed him of the test results and that she had AIDS. She has not seen him since. Her relatives were shocked when they found out that she had AIDS. Some of her friends stopped seeing her while others blamed her for her wickedness. She now lives with a married sister who takes care of her and takes her to hospital. She is growing weaker and weaker. She now regrets her past sexual lifestlye and is worried about the future of her two young daughters.

CASE 9

Elijah is about 40 years old and was born in Nyakach where he grew up. He completed primary school education but dropped out of school because his parents could not afford his school fees and needed his help to support his younger siblings. After school he was employed by a neighbour as a farm helper, herding cattle and cultivating land during the rainy season.

Elijah became sexually active at the age of 18 with a girlfriend in his employer’s village. Thereafter he had sexual relations with her and three other women in the same village. He also paid for sex during a visit to Kisumu town. At the age of 20 he
decided to seek greener pastures, so he left his job as a “shamba-boy” after saving about Ksh 1000. He moved to Busia town on the Kenya-Uganda border where he found employment, initially in a food store and later as a bar man.

He worked and lived in Busia town for more than ten years. During this period he had sexual relations with numerous women, including prostitutes. Some relationships were stable and others casual. Elijah cannot remember how many women he has had sexual relations. “There are too many to count and I can’t remember”. On several occasions, he had sexual relations with women from Uganda who were “doing business” in Busia town. He says that Ugandan women are reputable sexual partners and he preferred them to Kenyan women. He describes those days as full of good times with nothing to worry about.

Elijah married six years ago and has three children, two girls and a boy. His wife lived in the rural area with his children while he was in Busia working. She assisted his mother with farm work. He used to make regular end of month monetary remittances to them. Two years ago, he moved to Kisumu after he found a job in one of the popular night-clubs in town as a waiter. A year later his wife started having health complications, mainly fatigue, fever, weight loss, loss of appetite, vomiting and diarrhoea. She went to various health centres but the problems persisted. Elijah consulted a traditional doctor who told him that his wife had been bewitched by a former boyfriend. He performed a ritual cleansing ceremony and gave her manyasi (traditional herbs). However the problems continued and new complications started to emerge; pneumonia, severe diarrhoea, chest pains, and skin lesions. Elijah brought her to Kisumu for treatment. The doctors did a blood test and she tested HIV positive. Elijah also decided to take a test and his results were negative. He wondered how this was possible since he had slept with his wife many times prior to and after marriage. Elijah has spent a lot of money on his wife’s health care. Recently she was released from hospital and is being taken care of by one of her younger sisters who helps in cooking, washing and giving her medicine. Family friends have also been helpful; they visit and sometimes contribute towards payment of some of the expensive medical bills.