PERCEPTION OF THE YOUTH AGED 15 TO 24 YEARS ON SEXUAL DEBUT, MITIGATION STRATEGIES AND ASSOCIATED HEALTH EFFECTS IN HOMA BAY COUNTY, KENYA

BY

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DECLARATION AND APPROVAL

Declaration by student

This thesis is my original work and has not been presented for conferment of degree in any other university or institution.

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DEDICATION

This thesis is dedicated to my children and my students for them to learn that age is not a limit in acquiring knowledge and skills. I also urge them to appreciate that a person can achieve progression through commitment and self-determination.

LIST OF ABBREVIATIONS AND ACRONYM

AGYW - Adolescent girls and young women

AIDS - Acquired Immunodeficiency Syndrome

AYLWA – Adolescents and youth living with HIV

CHU - Community Health Units

HIV - Human Immunodeficiency Virus

HPV - Human Papilloma Virus

JOOUST - Jaramogi Oginga Odinga University of Science and Technology

KDHS - Kenya Demographic Health Survey

KNBS - National Bureau of Statistics

MOH - Ministry of Health

NACOSTI - National Commission for Science, Technology and Innovation.

NCPD - National Council of Population Development

PAC - Post Abortal Care

RVF - Recto Vaginal Fistula

SDG – Sustainable Development Goals

SRH - Sexual and Reproductive Health

STI - Sexually Transmitted Infections

VVF - Vesico Vaginal Fistula

VYA - Very Young Adolescents

WHO - World Health Organization

UTI- Urinary Tract Infection

ICPD – International Conference on Population and Development

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ABSTRACT

Sexual debut among the youth in the age group of 15 to 24 has been found to be on the increase globally with an upsurge in the reproductive health and social problems such as teenage pregnancy, Illegal abortions, sexually transmitted infections, HIV/AIDS and early marriages. The above issues inspired me to study sexual debut of the youth in Homa bay County where the fertility rate was 23% compared to national prevalence of 15%. Ndhiwa Sub County had the highest of 33% in the County. This study aimed to determine the perception of the youth aged 15 to 24 years on sexual debut, the mitigation strategies and the reproductive health consequences in Homa Bay County. The study was significant because it involved social and health issues in the welfare of the youth. Determining their perception was to provide insight into the understanding of the youth's sexual behavior. According to Homa Bay County demographic health survey report of 2019, Ndhiwa Sub County was number one in Teenage pregnancy and early marriage. This informed purposive choice of study site as Ndhiwa Sub County. This was across sectional study design in which quantitative and qualitative techniques were applied. The study population was youths aged 15 to 24 years stratified as single and married. The sample size was 273 and further stratified as 141 females and 132 males. The married youths who participated in the focus group discussion were sampled as 13 of either gender. Data was collected using semi structured questionnaire, interview schedule and focus group discussion guide. Data analysis was done by use of SPSS version 25.The descriptive data was summarized and frequency distributions noted. The perception of the youth on sexual debut was evaluated by inferential statistics of Chi- square test of independence to determine relationships between independent and dependent variables. $P < 0.05$ was considered to be statistically significant. The Qualitative data was thematically grouped and analyzed. The findings showed that 61% of the respondents were involved in social relationships and only 14% talked of sexual relationship. Seventy seven percent of the youths said they mainly get sexual behavior information from the peers while 26% said they get information from the media. The sociocultural factors enhancing sexual debut were reported to be peer influence and aftermath of cultural activities. Ninety four percent of the youths said parents were not discussing sexual debut issues with their children and 89% of the youths said the parents did not accept the vise. Sixty eight percent of the male youths considered sex as ordinary activity for fun. Majority of female youths accepted that the sponsor relationships of sex in exchange of gifts or favor exist but generally the youths did not agree with the practice. The mitigation strategies identified by the youth were: abstinence as per 65%, reinforcement of sex education in school as per 85% and avoidance of negative peer influence as per 36%. The youths perceived that engagement in sexual debut can result in the following consequences: Social consequences reported were: school dropout 31%, early and forced marriage 25% and family rejection 18%. The youths reproductive consequences as Criminal abortion 72%, teenage pregnancy 56%, sexually transmitted infections 35%, family planning 11% and complications during childbirth 53%. As a result of the above 99% of the youth agreed that sexual debut affect their health. The focus group discussion had the same ideas with the interviewed group and mainly strengthened adaptation of positive society norms in the prevention strategies. The study concluded that youths are getting information which does not give life skills and living values which can prevent their engagement in risky sexual behavior. The study recommendation is for the health and education departments to enhance counseling on sexual debut and sex education for positive behavior change which is subjective self-control.

CHAPTER ONE: INTRODUCTION

1.1 Background Information

Globally, youth aged 15 to 24 years' perception of sexual debut, mitigation strategies, and associated health effects is a critical area of concern for public health and social development. Sexual debut refers to the initiation of sexual activity, before individuals have reached emotional and physical maturity. Various socio-cultural, economic, and individual factors influence this multifaceted issue (Nxumalo *et al.,* 2023)

Global research has demonstrated that sex debuts among youth can lead to significant health consequences. These include a higher risk of unintended pregnancies, sexually transmitted infections (STIs), including Human Immuno deficiency Virus/Acquired Immuno Deficiency Disease (HIV/AIDS,) and emotional and psychological challenges. Additionally, early initiation of sexual activity can disrupt educational attainment, hinder economic opportunities, and perpetuate cycles of poverty and inequality (Yoosefi, *et al.,* 2023). The reproductive health consequences related to this sexual behavior are early marriages, teenage pregnancy, abortions, and sexually transmitted diseases, including HIV/AIDS (Memar & Farajkhoda, 2022). Youths in the age group of 15–24 years form more than half of the 2.3 million new HIV infections. HIV affects both sexes, with girls disproportionately affected due to their vulnerability (WHO, 2015).

Poton, Bullivant, and Soto (2020) conducted a study to examine the impact of sex education regulations on teenage pregnancy rates in developed nations. The review discovered empirical data indicating a positive correlation between the implementation of laws requiring sex education in schools and an increase in teenage conception rates. Legislation allowing parents to opt out of sex education requirements for younger adolescents may help reduce the negative consequences associated with these mandates. The projected impacts of compulsory sex education remained strong when subjected to certain specifications aimed at isolating causality; however, not all parameters yielded the same results. Altogether, changes in domestic laws related to sexual health do not explain the significant declines in adolescent pregnancy rates observed in many developed countries recently.

In Portugal, Silva (2022) found that 50.5% of young individuals initiated their sexual engagement at an average age of 18.3 years. Men exhibit greater sexual activity, starting at an earlier age, and engage in more sexual relationships than women. Participants exhibited a satisfactory level of awareness regarding STDs and contraception methods. However, analysis revealed variations in knowledge levels concerning specific STDs and contraceptive methods based on factors such as gender, age, and sexual activity. The study's findings recommend the development of targeted interventions aimed at engaging young people, communities, and healthcare professionals, highlighting the importance of putting people at the center of health policies.

Mitchelle & McKay (2020) conducted a poll in Canada and found that 60.1% of young individuals reported using a condom during their most recent sexual encounter. This phenomenon was more prevalent among those at younger ages, particularly males, and those who disclosed engaging in sexual activity with multiple partners over the past year. When questioned about their decision to not use a condom, approximately half of non-users mentioned monogamy and the use of alternative methods, such as oral contraceptive pills. Age, sex, and the number of partners were factors that influenced the reasons for not using a condom. For instance, those between the ages of 20 and 24 were more inclined to state that they did not use a condom due to personal aversion, whereas those between the ages of 15 and 17 were more likely to indicate that no condoms were accessible. Approximately 20% of those aged 15 to 24 stated that they did not use either a condom or any other form of contraception during their most recent sexual encounter. Within the last year, 10% of sexually active females have used emergency contraception. Overall, a significant fraction of young people in Canada face a considerable risk of contracting sexually transmitted illnesses and experiencing unintended pregnancies. These findings have important implications for the development of comprehensive sexual health education and the implementation of relevant policies and initiatives.

In developing countries, about 20,000 girls under the age of 18 give birth daily, with an increased risk of health and development consequences (Mayabi 2016). Adhikari et al. (2018) conducted a study in Nepal that reports adolescents engaging in risky sexual behavior, despite not recognizing the risk and accepting the behavior as normal. This research considers the theory

of planned behavior, which explores the relationship between attitude, beliefs, and intentions, as an avenue for behavior control among youths making their sexual debut. The belief that the youths are sexually active is subjective, and the youths have a will to control their sexual behavior. In Sub-Saharan Africa, up to 25% of the youths aged 15–19 have had sex before marriage. Reports indicate increasing health consequences (Ozobokeme, 2023). Despite the institutional environment providing opportunities for sex education, early sex debut remains prevalent among this age group (Arabi-Mianrood, *et al.,* 2019). This is one of the important reasons for this research: to explore youths' perceptions of their sexual behavior.

In Kenya, people aged 0–34 years constitute 78 percent of the population, and this is the category that requires developmental attention. The country's rapid population growth and high proportion of young people place significant demands on health care, education, housing, water, sanitation, and employment. Kenya is unlikely to achieve the Sustainable Development Goals or Vision 2030 if it fails to adequately address the sexual and reproductive health (SRH) needs of this age group of the population. As in many parts of Africa, young people in Kenya face considerable challenges to their health and well-being, as well as an uphill struggle to stay in school, find gainful employment, and negotiate relationships while postponing marriage and childbearing and avoiding STIs, including HIV. Some youths, due to their large population, do not get an opportunity to acquire life skills and consequently engage themselves in risky behaviors that expose them to social, economic, and adverse health events such as unintended pregnancies and life-threatening sexually transmitted diseases (MOH, 2013).

Similarly, Mudhune *et al.* (2024) conducted a cross-sectional analysis of baseline data to investigate sexual behavior among Kenyan adolescents enrolled in an efficacy trial of a smartphone game to prevent HIV. The study revealed that 15% of the adolescents exhibited sexual experience, which was associated with factors such as lower socio-economic status, food insecurity in the household, living without parents, substance use, the absence of adult conversations regarding future goals, and discussions regarding condom usage. 21.7% of those with sexual experience reported engaging in transactional sex, while 17.5% reported willing first sex. Among those with willing first sex, 60.9% reported not using condoms. Female adolescents who abstained were less likely to consider using a contraceptive during their first sexual

encounter. Young sexually active adolescents are likely engaging in unprotected intercourse and having unwanted sexual experiences, according to the study's findings. Parental monitoring, socioeconomic status, and living situation continue to be significant predictors of sexual experience among young adolescents. As such, early adolescence presents an opportunity to educate adolescents about safer sexual practices in a manner that is suitable for their age and stage of development.

Like any other developing country in the world, sex debuts among the youth in Kenya are reportedly on the rise. Research done in Nairobi among 3556 high school students revealed that 50% of males and 11% of females have had sexual intercourse at least once, with a significant proportion reporting multiple sexual partnerships (Orpinas and Kabiru 2019). Kenya's Population Policy for National Development recognizes that the rapid growth in population size is a constraint on national development. To counter this, the policy proposes a reduction in fertility levels from 5 children per woman in 2009 to 2 children per woman in 2050. This will necessitate that the women delay their sexual debut age (NCPD, 2017).

Valentine and Owuoth (2023) examined factors related to sexual debut in males and females aged 18–35 in Kisumu County, Kenya, using data from HIV incidence study screening and enrollment visits. Of the 1057 participants, 542 (51.3%) were women. The median age at study screening was 25 and 16 years at sexual debut. Five hundred and four (47.7%) reported early engagement in sexual activity. Women and those with more than primary education had lower rates of engagement in sexual activity. Early sexual debut was widespread and linked to lower levels of education and drug use. We need early interventions before 15 to boost schooling and prevent drug usage. Comprehensive sexual education and drug prevention may be effective before 15 years of age.

In Homa Bay County, Kenya, Owoko et al. (2021) examined adolescent girls' contraceptive uptake. Contraceptive knowledge was at 97.6%. School teachers (30%), classmates (17.2%), and the media provided the most contraceptive knowledge. 57.9% of adolescent girls did not practice safer sex, putting them at risk of STDs and unwanted pregnancies. Sub-counties in the Islands of Lake Victoria, such as Suba, had up to an 80% lower rate of girls utilizing contraceptives ($p <$

0.005). Fear of side effects (51.8%) and self-stigmatization (13.4%) were major obstacles. Health institutions primarily provided contraceptives (77.1%), despite the survey revealing a deficiency in youth-friendly services. Girls (39.6%) were unaware of teenage sexual and reproductive health policies and procedures. Adolescent girls in Homabay County underuse contraceptives due to misinformation, cultural beliefs, and a lack of youth-friendly services in health facilities. All health facilities need youth-friendly, comprehensive sexual health education and services, with a focus on risk reduction and policy sensitization of young girls. There should be ways to reach the "hard-to-reach" island adolescent populations.

According to the 2019 demographic health survey in Homa Bay County, 19.2% of girls between the ages of 15 and 19 have had a live birth, and 22.2% in the same bracket have begun childbearing. This demonstrates that early sexual activities and early marriages are common in the county, though some counties, such as Narok, have a higher prevalence rate (KNBS, 2019). In January 2020, at a Homa Bay County development stakeholders meeting involving departmental heads and elected leaders, the Health Department reported increased teenage pregnancy according to the County demographic survey of 2019. The education department was also concerned about the school dropout rate among girls due to teenage pregnancy and early sex debut (CDC, 2020).

1.2 Statement of the Problem

Kenya has a relatively high prevalence of early sexual activity among youth. According to the Kenya Demographic and Health Survey of 2019, approximately 21% of females and 29% of males aged 15 to 19 years reported having had sexual intercourse. The survey also indicated that the median age at first sexual intercourse was 16.8 years for females and 17.1 years for males. Early sexual activity in Kenya is associated with a high risk of unintended pregnancies. The same survey mentioned above found that 18% of females aged 15 to 19 years had begun childbearing, and 12% of these pregnancies were unintended. Unintended pregnancies can lead to various health risks for young women, including complications during pregnancy and childbirth, unsafe abortions, and limited access to adequate prenatal care (Ongwae, Okongo and Masiga, 2023).

Sexual behavior of the youth significantly impact on their overall health and wellbeing, early sexual debut often associated with arrange of adverse outcomes including high risk of sexually

transmitted infections, unintended pregnancies and negative mental health effects. Early sexual debut can also influence educational attainment and future economic activities, thereby affecting long term quality of life (Obonyo et al., 2019). Understanding the perception of young people aged between 15 and 24 years on sexual debut as well as strategies used to mitigate associated risks is crucial for developing effective public health interventions. This study aimed to investigate the perception of the youth on sexual debut, examine the strategies they employ to mitigate risks associated with early sexual activity, and explore the health effects linked to these behaviors. By gaining insight in these aspects the research seeks to inform policymakers, educators and health professionals on how to better support youths in making informed decisions about their sexual health (Kinaro,2020:Okumu et al.,2021).

1.3 Study Objectives

1.3.1 General Objective

The study aims to examine the perception of youth aged 15 to 24 years in Homa Bay County, Kenya, regarding sexual debut, mitigation strategies, and associated health effects.

1.3.2 Specific Objectives

1. To determine the socio-economic and cultural factors influencing sexual debut among youths aged 15 to 24 years in Homa Bay County.
2. To examine the perception of the youth aged 15 to 24 years on implementation of mitigation strategies for sexual debut in Homa Bay County.
3. To investigate the perceived health effects of sexual debut among youth aged 15 to 24 years in Homa Bay County.

1.4 Research Questions

1. What are the socio-economic and cultural factors influencing sexual debuts among youths aged 15 to 24 in Homa Bay County?
2. What is the perception of the youth aged 15 to 24 years in Homa Bay County on implementation of mitigation strategies for sexual debut in homa bay county?
3. What is the perceived health effects of sexual debut among youth aged 15 to 24 years in Homa Bay County?

1.5 Study Justification

The study findings can provide valuable ideas into the specific knowledge gaps, sociocultural and socio-economic factors, and opinion of the youth on mitigation strategies, and perceived health effects related to sexual debut among youth. The findings can also inform the development of evidence-based interventions, policies, and programs that are tailored to the local context, ultimately contributing to improved sexual and reproductive health outcomes for young people in Homa bay County and other regions.

1.6 Significance of the Study

The study provides insights into specific areas where information is lacking or misconceptions exist. Policymakers can use this information to support comprehensive sexual education programs that provide young people with accurate and age-appropriate information to make informed decisions about their sexual health. The study also provides insights into socio-cultural and economic factors influencing sexual debut. These can help inform community-based interventions that promote positive cultural practices and challenge harmful traditions thus fostering sexual health among the youth. By understanding the impact of poverty, limited educational opportunities, and other socio-economic factors, policymakers and organizations can use the information to develop strategies that address economic disparities, increase access to education, and create opportunities for youth to improve their socio-economic well-being. Finally this study will provide clear perspective of youths understanding of their sexual behavior and foster avenues for their controlled behavior for positive sexual health.

1.7 Definition of operational terms

Sexual debut - This is initiation of sexual activity at a young age, typically before reaching the legal age of consent or before being emotionally and physically prepared for sexual relationships.

Teenage pregnancy - Occurs when a female between the ages of 13 and 19 becomes pregnant.

Unintended pregnancy- A pregnancy that is unplanned or unwanted at the time of conception.

Adolescents - These are Individuals who are in the transitional stage between childhood and adulthood, typically between the ages of 10 and 19.

Comprehensive sexual education - This is an educational approach that provides accurate, age-appropriate, and evidence-based information about sexuality and sexual health.

Sexually transmitted infections (STIs) – This are infections that are primarily transmitted through sexual contact.

Sexuality education- This is giving young people accurate and age appropriate information about sexual and reproductive health to enable them develop and deliver positive health outcomes

Abortion - The termination of a pregnancy before the fetus is able to survive outside the womb

HIV/AIDS prevalence - The number of individuals infected with the human immunodeficiency virus (HIV) in a particular population

Cultural factors - Social, behavioral, and belief systems that are shaped by the traditions, customs, values, and practices of a specific culture or society.

Peer influence - The impact that peers or individuals of the same age group have on an individual's attitudes, behaviors, and decision-making.

Perception of the youth - This is what the youths think and feel about themselves in terms of attitude, value and beliefs.

Pornography - The depiction of erotic behavior in terms of pictures and writings intended to cause sexual excitement.

1.8 Limitation of the Study

This study focused on the perceptions of youth aged 15 to 24 years in Homa Bay County, Kenya, with respect to sexual debut, mitigation strategies, and associated health effects. The study target was confined to the age group of 15 to 24 years classified as youths by the Kenya Bureau of Statistics in 2019. The study sought permission from guardians or caregivers for those who had not reached consenting age. Due to participants desire to present themselves in a socially acceptable manner and provide honest responses related to sexual debut, the participants declined to have an audio recording of focus group discussion sessions hence note taking was done by a note taker.

1.9 Delimitation of the study

To be able to gather the required data from the subjects, the research assistance were chosen on the basis of being fluent in the Luo language and also understanding the terrain of Ndhiwa Sub County in order to cover all the sampled community health units per division. Conducive environment was created for the focus group discussion to have open discussion and the report given from the notes taken was free from any undue influence.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The section seeks to establish both the theoretical and empirical literature that will be derived from the writings and studies of the various scholars that have tried to analyze and address the issue of the perception of youth between 15 to 24 years on sexual debut, mitigation strategies, and associated health effects in Homa Bay County, Kenya. However, the study takes into consideration the limited scope to which scholars have interrogated or written about the concept of sexual debut.

2.2 Sociocultural and economic factors influencing sexual debut

A research done in Nepal showed that parenting and family and societal environment, cultural and traditional values, economic condition, school environment, peer influence, love affairs, social media are conducive factors for premarital sex. The religion of the adolescents further influences their attitudes, perception and behaviors towards the sexual behaviors. More evidence showed that the higher the age, the higher the chance of experiencing sexual activities among unmarried people. These pre-sexual activities among the adolescents may increase the likelihood of unprotected sexual intercourse, which further may result undesirable sexual outcomes like urinary tract infection (UTI), teenage pregnancy, induced abortion and its associated complications (Shrestha, 2019)

In their study, Djordjevic *et al.* (2019) evaluated the level of susceptibility to reproductive health issues among teenagers in Serbia by examining the sexual behavior of 1722 individuals aged 15-24. The study encompassed the demographic attributes of participants, such as age, gender, settlement type, and location, as well as their reproductive health characteristics, including sexual behavior, utilization of contraceptive protection, awareness and attitudes towards HIV, and safeguarding of reproductive health. Of the participants, a majority (53.5%) were sexually active teens. Out of all respondents, the largest proportion, specifically 16.6%, reported that they engaged in sexual intercourse for the first time when they were 17 years old. 53.4% of adolescents engaged in sexual intercourse with a single partner, whereas 26.4% of respondents had sexual intercourse with two or more partners. Interrupted intercourse was the prevailing contraceptive strategy, chosen by 34.7% of the participants.

In a study conducted by Son *et al*. (2020) in Korea reviewed series of studies previously done on sexual debut. It was discovered that there was no correlation between socioeconomic factors, such as occupation, income, and academic background, and the age at which females engage in early sexual activity. The 2006 study on males found that there was a correlation between the age at which they first engaged in sexual activity and their career, income, and academic background. However, the 2016 study found that the individuals' academic background was the only significant factor in determining the age at which they first engaged in sexual activity. Both the male and female studies found a positive correlation between early sexual debut age and a higher lifetime number of sexual partners. Furthermore, in both the female cohorts from 2004 and 2014, the early sexual debut groups exhibited a greater frequency of pregnancies and reports of sexual abuse. The factors that influenced early sexual debut varied over time and differed between men and women. There was no notable correlation between socioeconomic characteristics and the age at which women first engaged in sexual activity. Nevertheless, engaging in sexual activity at a young age resulted in many complications, particularly among adolescent females. Therefore, it was necessary to develop appropriate strategies to tackle these issues.

Mathews *et al.,* (2022) compared first sex experiences and wellbeing of adolescent girls and young women (AGYW) who had an engaged in sexual activity (age < 15) with those who had later sexual debut by conducting a representative household survey among AGYW aged 15-24 years in six districts in South Africa. Of 3009 AGYW who had ever had sex, 8.9% reported early sexual debut. Early sexual debut was associated with coercion at first sex and a lower average well-being score compared with a later debut. Interventions which aim to delay early sexual debut may positively affect well-being. In Ghana, female youth in urban areas and those from the wealthiest households were less likely to initiate early sexual debut. Additionally, youth resident in urban areas from rich households are less likely to initiate early debut. However, a 3-way interactive effective revealed that female youth resident in urban areas from rich households were found to be more likely to initiate early debut. The study underscored that gender-based sexual and reproductive health interventions and programs may be more appropriate for

adolescent females in rich households living in urban areas. These interventions should reach the teenagers before they start engaging in sexual intercourse (Asante *et al.,* 2022).

Ajayi and Somefun's 2019 study revealed the following findings. Out of the total of 630 participants, 17.9% reported engaging in transactional sex, where they had either given or received money, a present, or a favor in exchange for sexual activities. The bivariate analysis indicates that persons from polygamous homes had a greater likelihood of reporting engaging in transactional sexual activities, such as giving or receiving money, gifts, or favors in exchange for sex. Those with appropriate family support were 56% less likely to engage in transactions involving money, gifts, or favors in exchange for sex than those with little or inadequate family support. To summarize, the study provides evidence to support the claim that both family structure and family support serve as protective factors against engaging in transactional sex among adolescents and young adults. Future surveys need to include a larger sample in order to explore the effect of single-parent and polygamous families on transactional sex in Nigeria, where family formation is changing rapidly.

In Tanzania, Namugerwa (2022). Conducted a cross sectional study to establish factors contributing to the Sexual Debut among older Adolescents (15-19yrs) in Nyendo -Mukungwe Division Masaka District. The study revealed that a significant majority of the respondents, specifically 95%, reported having friends who were their peers. This finding suggests that peer pressure significantly contributes to the higher rates of early sexual debut among older adolescents (aged 15-19) in Nyendo Mukungwe division, Masaka district. It is likely that these adolescents receive positive reinforcement about the pleasures of engaging in sexual activity, while downplaying the associated risks such as sexually transmitted infections. The study found that a large proportion of the participants did not regularly attend religious services, and most of these individuals were not virgins. The lack of regular religious attendance was associated with increased involvement in sexual activity compared to those who attended regularly. This may be attributed to the absence of teachings that discourage sexual debutand adultery. The study recommends the implementation of strategies to reduce early sexual debut among adolescents, as

this behavior exposes them to risks such as sexually transmitted infections (e.g., HIV/AIDS) and urinary tract infections (UTIs).

In Uganda, Luwedde, Sserwanja, and Katanzi (2022) found that Islamic religion, household size, and divorce or widowhood were significant predictors of early sexual engagement. Secondary and additional schooling, blue-collar jobs, and being between 20 and 30 lowered the risk of early sexual activity. Material, behavioral, cultural, psychological, and demographic factors explained a statistically substantial portion of the early sexual activity gap between men and women. Young women have more disadvantages than young men when having their first sexual experience. The unequal allocation of resources, behavioral and cultural inequalities, mental concerns, and demographic differences between young men and women account for 96.37% of this disparity. The relationship to the household head (49%), education, occupation, number of household members, internet use and reading newspapers or magazines explained the inequality in early age at first sex between men and women youth. The study recommended for reduce inequities in education, career possibilities, and access to sexual and reproductive information via the internet, newspapers, and magazines among young men and women to address early sexual activity and its health effects. Fostering family bonds and supervising young women are also crucial.

In a case study among secondary school students in rural Kenya, Akinyi *et al,* (2022) found that 61% of pupils had engaged in sexual intercourse with mixed-day schools having a higher percentage (63.5%) than single-sex institutions (58.5 percent). Male students were more likely to have ever had sex compared to female students [OR = 1.59 (95% CI 0.83–1.85), p = 0.03]. Most of the students (89%) spent money received from their parents for pleasure with their friends and (60%) used the gifts. However, those receiving gifts from boys or girls had four times the odds of ever having sex (OR 4.04, 95% CI 1.36–11.97). On the other hand, qualitative data suggested that the need for money for both basic requirements and pleasure played a big impact on adolescent sexual debuts. Finally, the majority of Nyamira County's in-school teens had ever had sex. The majority of pupils were fed by their parents, signaling a pluralist setting in which peer pressure, cultural norms, and popular culture on social and mainstream media all played a role in

early sexual debuts. In conclusion, people perceived those with money as having power over others' autonomy, and their economic environment as influencing their decisions.

2.3 Implementation of mitigation strategies for sexual debut according to the youth aged 15 to 24 years.

Interventions aimed at reducing risky sexual behavior are considered an important strategy for averting Human Immunodeficiency Virus (HIV) infection among youth (15–24 years) who continue to be at risk of the disease. Enhancing intervention success requires a comprehensive understanding of the barriers and facilitators to interventions targeting youth (Mbengo *et al.,* 2022). In their study, the majority of the barriers fell under the context domain's characteristics (e.g., gender-biased norms). The next important group of barriers emerged within the characteristics of the end-user domain (e.g., fear of relationship breakdown). Numerous types of facilitators emerged, primarily categorized into two groups: those assisting with the implementation strategy (such as ensuring the correct execution of the intervention) and those addressing the end user's fears (such as pregnancy or STDs). The next common set of facilitators appeared within the context domain's characteristics (e.g., family support). This review identified several multi-level barriers and facilitators to HIV prevention interventions for reducing risky sexual behavior among youth (Mbengo *et al.,* 2022). To address these factors and enhance intervention success, we need multi-level and combinational approaches.

Gazendam *et al,* (2020) investigate the links between early sexual activity and individual and contextual characteristics in Canadian youth, as well as whether these differ for girls and boys. Overall, contextual factors, i.e., disrupted family structure or low family support, were the characteristics most strongly associated with early sexual activity. Among boys, there was an incremental and strong relationship between hours spent in organized sport and early sexual activity. Among girls, poorer body image, lower socioeconomic status, and higher social media use aligned most strongly with early sexual activity. In summary, persistent gender stereotypes appear to underlie differences in individual and contextual factors associated with adolescents' sexual behavior. Findings suggest that exploratory analysis may be beneficial to future researchers, policymakers, and youth care providers.

The societal norm in India is such that adolescents are expected to respect and follow traditional values and view early sexual debuts as undesirable and deviant from social morals. However, India has observed a dramatic shift in attitudes towards sex before marriage. Muhammad *et al.,* (2021) identified factors associated with an early sexual debut among unmarried adolescents. The findings showed that adolescent boys (9%) were more prone to early sexual debuts compared to girls (4%). Both boys (17.2%) and girls (6%) who were school dropouts had significantly higher chances of an early sexual debut. Boys who had frequent media exposure were significantly more likely to report an early sexual debut than those who had no media exposure. Further, the likelihood of an early sexual debut was significantly higher among boys and girls who had exposure to pornography compared to their counterparts. The odds of an early sexual debut were higher among boys and girls who had moderately severe or severe depressive symptoms compared to their counterparts. The results highlighted that Indian unmarried adolescents demand the appropriate knowledge to promote safer sexual behavior and lead a responsible and healthy lifestyle. The preventive efforts must be multifaceted, with involvement at the individual and parental levels. Interventions, in particular, appear advantageous to be parent-focused, emphasizing family life education that can prevent risky sexual behaviors among adolescent boys and girls. And public programs should focus on sexual health promotion, taking into account the physical and psychosocial changes that occur during the early years of sex life.

A study that described SRH knowledge, information-seeking, and sexual behavior of very young adolescents (VYA) showed that the majority of the adolescents get sexual and reproductive health information from the media in which the sexual content may be inappropriate. A large proportion of sexually active VYAs reported sexual risky behaviors. This study highlights the need for an accurate and more comprehensive SRH education approach for VYAs at an opportune age before the majority engages in sexual behavior (Geoffroy *et al,* 2019).

Kimeli *et al.* (2022) assessed challenges influencing access to comprehensive HIV care among adolescents and youth aged 15–24 years at Nakuru County Referral Hospital in Kenya. The study concluded that the main socio-cultural challenges faced by adolescents and youths living with HIV/AIDS(AYLWA) at county referral hospitals are stigma and frequent changes of caregivers, resulting in poor adherence to ARV medications. Moreover, no major socio-

economic challenges were affecting AYLWA at the health facilities. Furthermore, poor adherence and low viral suppression were the primary clinical challenges facing AYLWA. The study recommended the need to offer and strengthen psychosocial support to AYLWA to enable them to cope with their status and educate the caregivers on the importance of AYLWA having a consistent caregiver for continuity. For this role, hospital management should hire more trained adherence counselors. Furthermore, hospital management must strengthen youth-friendly HIV services in order to better respond to youth needs. This will enhance peer support.

A study in technical training institutions in Kenya aimed to establish the sexual behavior of the youth, the extent to which the youth are exposed to sexual content in television and the effect of the exposure on the sexual behavior of the youth. From the study findings, it was established that majority of the youth were sexually active and that they had multiple sexual partners. The study further established that the youth are exposed to sexual content on television and that they perceive the content they watch to have a negative effect on their behavior. From the study findings, it was concluded that there exists a relationship between exposure to sexual content on television and the sexual behavior of the youth (Koros, Wagumba, and Baya, 2023).

Joyce *et al.* (2022) found that socio-cultural factors affected SRH service and information use in Kenyan pastoral communities. Early marriage, youth, male-only sexuality decisions, and family dread lead to unprotected sex, whereas contraceptive myths and misconceptions affect use. The data showed that youth need to know sources, contraceptive functions, and use. The findings recommend training health care practitioners, CHVs, teachers, parents, and community leaders on adolescence, sexuality demands, and FGM's negative effects, including early marriage.

In general, 15% of all unsafe abortions globally occur among adolescents under the age of 20. In Kenya, adolescents account for 17% of the 35% of maternal deaths caused by abortion. Furthermore, Homa-Bay County is one of the 15 highest-burden counties, contributing 97% of maternal deaths in Kenya (Ruggiero *et al.,* 2023). Despite global attention to adolescents' sexual reproductive health and welfare, scanty information on their experience and understanding of their intention to procure unsafe abortion, especially for those ages 10–14, remains.

A study by Everlyne in 2023 linked only five factors to the intention to get an unsafe abortion among teens in Homa-Bay County, Kenya. Knowing that you are pregnant in the first three months was the only factor that was significantly linked to the intention to get an unsafe abortion ($p < 0.0001$). While perceived self-efficacy ($p < 0.0001$), barriers ($p < 0.0001$) to abortion, consideration that waiting time to receive care was short ($p = 0.020$), and being nulliparous ($p = 0.028$) were negatively associated with the intention to procure an unsafe abortion, The study concluded that the county and other similar counties need to adopt policies and programs that are friendly and can address determinants of intention to procure unsafe abortion among adolescents. To ease disclosure, the research recommends a well-structured information delivery system on adolescent sexual health and abortion at an early age, a strong family support system, and an empowered male partner. Lastly, the research recommended the establishment of a health system that is both responsive and free from segmentation.

2.4 The health effects of sexual debut among youth aged 15 to 24 years

Cruz-Jiménez, *et al.,* (2020) analyzed how adolescent perceptions of the risks of pregnancy for physical health and self-development are associated with five personal tools in Mexico. The findings revealed that adolescent perceptions of the risks of pregnancy were associated with personal tools regarding sexual and reproductive rights, gender stereotypes, contraceptive methods, self-efficacy, and future expectations. The study concluded that sexual education programs that emphasize sexual and reproductive rights and gender equality can help adolescents develop a habit of reflection and visualize life plans beyond motherhood and fatherhood.

Several studies in Sub-Saharan Africa have documented high and increasing sexual debut among young peoples. Some studies have shown that significant numbers of University female students are engaged in early sex debut, with risky situations (non-regular partner, after taking alcohol and non-use of condom) and suffer from its consequences (unwanted pregnancy, abortion, sexually transmitted infections and HIV/AIDS). Poor communication with parents on sexual and reproductive health issues, attending romantic videos/films and alcohol consumption were independent predictors of early sexual intercourse among female university students (Olaleye, 2021).

David, Reynolds, and Chakraborty (2023) conducted a study to determine the influence of mass media exposure on HIV stigma beliefs and unprotected sex among teenagers and young people in sub-Saharan Africa. They found that mass media exposure has a moderating impact on both behaviors. The study discovered that beliefs about HIV stigma have a negative effect and increase the likelihood of engaging in unprotected sexual activity. Secondly, contrary to previous research, individual exposure to mass media has a protective effect, reducing the risk of engaging in unprotected sexual activity. Furthermore, the negative impact of stigmatizing views is least pronounced when there is limited exposure to mass media at both the individual and regional levels. Conversely, this impact is most pronounced when there is considerable exposure to mass media at both the individual and regional levels. These findings indicate that stigma beliefs can influence the sexual practices of African T&YAs in unexpected ways. Additionally, they demonstrate that mass media exposure can have both protective and detrimental effects on this particular group.

Other studies have also reported risky sexual behaviors as a common practice among youth in Sub-Saharan Africa (SSA). Youth in this region were frequently engaged in early sex debut, with ill consequences such as unwanted pregnancy, Sexually Transmitted Infections (STIs), and HIV/AIDS. Against the well accepted cultural norms in Sub-Saharan Africa, the youth also tend to engage in having multiple sexual partners, concurrent sexual partners and unprotected sexual intercourse. Unless appropriate age and institution targeted intervention exist, certain behaviors can put the youth at a greater risk of HIV infection (Biney, Ewemooje & Amoateng, 2022).

In addition, Adimora and Enwu (2019) determined the socio-demographic factors of early sexual debut and depression among adolescents in secondary schools in Nsukka Education zone of Enugu state, Nigeria. The study revealed that age group at which respondents had their first sexual intercourse ranged between 13 to 19 years. The girls-initiated sex earlier than the boys ($p= 0.001$). Those brought up by one parent-initiated sex at an earlier age ($p= 0.000$), while age of sex initiation increased with maternal ($p= 0.000$) and paternal education ($p= 0.001$). Depressed adolescent boys and girls were more likely than their non-depressed peers to have experienced sexual intercourse. The youngest adolescents who were depressed were more likely to have experienced intercourse than the older ones who were not depressed. Respondents sharing room

with parents or adult relations of opposite sex were found to have initiated sex earlier than those staying alone or sharing room with same sex peers. The study concluded that age at sexual debut was found to be associated with younger age, gender, living with a one parent and parents' educational status.

Over the years, perceptions about sexual debut have been changing and acceptance of early sex debut is becoming more evident. Early sex debut among youth is especially alarming since about half of new HIV/AIDS infections occur among young people between the ages 15 and 24 and particularly worrying in Sub-Saharan Africa where about 43 percent of the population is less than 15 years (PRB, 2014) More than 700,000 teenagers become pregnant each year (Arthur, Agyekum & Gyamfi, 2024). One in three (34%) females became pregnant at least once before age 20. Even though, the reproductive health problems of young people are critical among both sexes: young girls are more affected because of their biological, economic and social status. (Grose *et al.,*2021).

Ogutu and Chege (2023) conducted a study to examine the factors that contribute to the occurrence of early sexual initiation among students aged 13–19 in secondary schools located in Kiambu County, Kenya. The study found that the prevalence of early sex debut among students was 60.5%, with a higher rate in males (67.9%) compared to females (39.6%). A majority of the respondents, specifically 117 individuals (69.6%), expressed the belief that engaging in sexual activity before marriage is acceptable. Out of this group, 75 individuals (64.1%) reported having engaged in sexual activity. The majority of individuals, who reported their first sexual experience, 69.9%, stated that it occurred during school breaks. The reasons for abstaining included apprehension towards guardians (49.4%) and concerns about HIV/AIDS (52.7%). However, a significant majority of individuals, specifically 71 (70.3%) of those who expressed concern about contracting HIV/AIDS and STIs due to early sexual initiation, had engaged in sexual activity. Significant associations were found between gender (P =.032), knowledge of sex (P =.025), usage of mobile phones (P =.019), peer pressure (P =.046), and poverty (P =.037) and early sexual debut. The study concluded that substantial number of teenagers in secondary school engaged in early sexual activity. Therefore, it is important for public health interventions to take

into account the wider elements that contribute to early sexual initiation, such as the ecological context in which this behavior occurs.

Premature initiation of sexual activity among teenagers and young women can increase their susceptibility to unintended pregnancies and sexually transmitted infections. In Kenya, this leads to the abandonment of education, which in turn leads to an increase in poverty? Researchers have looked at how people start sexual relationships in the context of HIV and educational programs. For instance, Kiiru, Thiongo, and Gichangi (2024) examined population and health surveys in Kenyan households to identify the factors associated with women between the ages of 15 and 24 initiating sexual relationships at an early age. Approximately 10.2% of the 3,706 women interviewed reported engaging in sexual intercourse before the age of 16, representing nearly 1 in 100 responses. The statistical analysis showed a significant correlation between early sexual initiation in Kenya and factors such as educational level, history of childbirth, contraceptive usage, and wealth position. Women who indicated that they have previously given birth had a greater likelihood of engaging in sexual activity at an early age ($p<0.005$) compared to women who have never given babies. Participants who used contraceptives were 1.4 times more likely ($p<0.001$) to have engaged in sexual activity at an early age compared to those who did not use hormonal contraceptives.

Ogweno (2020) examined how school-based sexual risk avoidance education affected Homabay County sexual behavior. The study identified high-risk sexual behavior, early sexual debut, inconsistent condom use, and various sexual activities in girls. Researchers found that individuals knew a lot about risky sexual conduct, pregnancy, and HIV/AIDS. They observed high perceptions of pregnancy and HIV/AIDS risk, as well as self-sexual efficacy. Multiple sexual partners were linked to current guardians ($P = 0.021$) and pregnancy awareness ($P = 0.036$). Not using condoms consistently was also associated with current guardians ($P = 0.033$) and sexual self-efficacy ($P = 0.011$). Pregnancy knowledge ($P = 0.006$) and risk perception ($P = 0.003$) were associated with early sexual debut. School-based sexual risk avoidance education enhanced risky sexual behavior knowledge ($P = 0.023$) and sexual self-efficacy ($P = 0.039$). School-based sexual risk avoidance education protects awareness of risky sexual conduct and sexual self-efficacy, both of which affect sexual behavior. The Ministry of Education and

partners should expand progressive sexual risk avoidance education from primary to secondary schools.

In Homa Bay, youth engaged in early sex for fear of being labeled ‘odd’ by their peers, belief (among both male and female) that ‘practice makes perfect’, curiosity about sex, media influence, need to prove if one can father a child (among male), the notion that sex equals love with some of the youth using this excuse to coerce their partners into premature sex, and the belief that sexual activity is a human right and parents/guardians should not intervene. Male youth experienced more peer pressure to have sex earlier. Female youths cited a variety of reasons to delay coitarche, including fear of pregnancy, the burden of caring for a baby, and religious doctrines. Having multiple sexual partners and intergenerational sexual relationships was common among the youth, driven by perceived financial gain and increased sexual prowess (Omanga, *et al.,* 2023). HIV prevention strategies need to address gender vulnerabilities as well as promote a protective environment; hence, the application of combination prevention methods is a viable solution to the HIV pandemic.

2.8 Theoretical Framework

This research is based on the Theory of Planned Behavior, which explores the relationship between behavior, attitudes, beliefs, and intentions. The theory suggests that individual behavior is determined by behavioral intention and perceived behavioral control that contributes to an individual's decision to engage in a specific behavior. In the context of sexual debut, attitudes can refer to the youth's beliefs and evaluations about engaging in sexual activity at an early age (Bauer *et al.,* 2023). Subjective norms include the perceived social pressures, expectations, and cultural norms surrounding sexual debut. Perceived behavioral control refers to a youth's perception of their ability to control their behavior and overcome socioeconomic and cultural barriers through life skills, living values, Society norms and reproductive health services.

Furthermore, perceived behavioral control plays a crucial role in an individual's ability to overcome barriers and engage in desired behaviors. The youths in Homa Bay County can access and utilize mitigation strategies for sexual debut which are the perceived behavioral control. This can involve understanding their knowledge and awareness of available strategies, as well as

examining the socio-cultural factors that may hinder their ability to effectively engage with these strategies, including stigma, lack of information, limited access to healthcare services, and cultural beliefs and norms (Banbury *et al.,* 2022).

Subjective norms can include the influence of peers, family, and healthcare providers in shaping youth's perceptions of the health effects of sexual debut. A study in Homa bay County investigated the attitudes of youth towards health effects of sexual debut, examining their knowledge, beliefs, and concerns. The study also examined the role of subjective norms in shaping these perceptions, such as the influence of peers, family, and healthcare providers in communicating information about the health consequences such as unintended pregnancy, HIV/AIDs, school drop outs and early marriages of early sexual activity. Additionally, the study examined the perceived physical, emotional, and social health effects that youth associate with sexual debut (Cristello *et al.,* 2023).

By applying the Theory of Planned Behavior to this study researcher can gain insights into the factors influencing youth's attitudes, beliefs, and intentions related to sexual debut, mitigation strategies, and health effects. This can provide a comprehensive understanding of the socio-economic, cultural, and perceived barriers that contribute to or mitigate early sexual activity among youth in Homa Bay County. The theory can also inform the development of targeted interventions, education programs, and policies to address the issue effectively. The figure below shows the diagrammatical presentation of the theory of planned behavior adopted from Banbury et al., (2022).

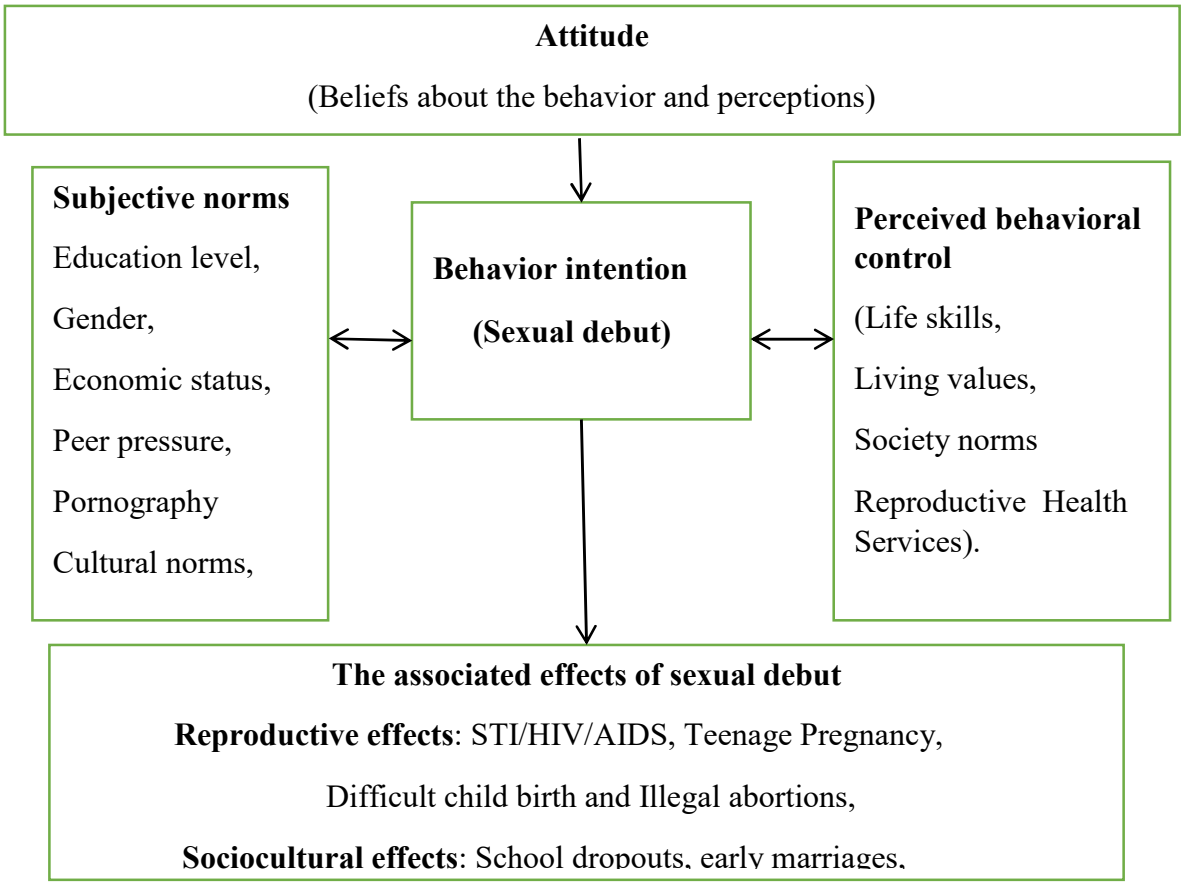

Figure 2.1: Theoretical Framework on Theory of Planned Behavior

2.9 Conceptual Framework based on Theoretical Framework

The figure 2.2 below is a conceptual framework developed from the theoretical framework above showing the relationship of the variables under study. The independent variables that include social and economic factors such as age, gender, educational status, economic, background religion, peer pressure, pornography and cultural norms which are subjective norms influence the dependent variable sexual debut which is the behavior intention. This behavior intention is generally shaped by attitude and perception of the individual. Inability to control sexual debut (behavior intention) result in early marriage, school dropout and associated health effects such as teenage pregnancy, illegal abortions, difficult childbirth and sexually transmitted infections. The

intervening variables which are life skills, living values, and peer and society norms are perceived behavioral control aspects that affect the influence of the independent variables on the dependent variable as diagrammatically shown below. In the planned behavior context the effect of the intervening variables on the dependent variable will limit the outcomes which are the effects of independent variables on the dependent variable thus achieving planned behavior change of prevention of sexual debut.

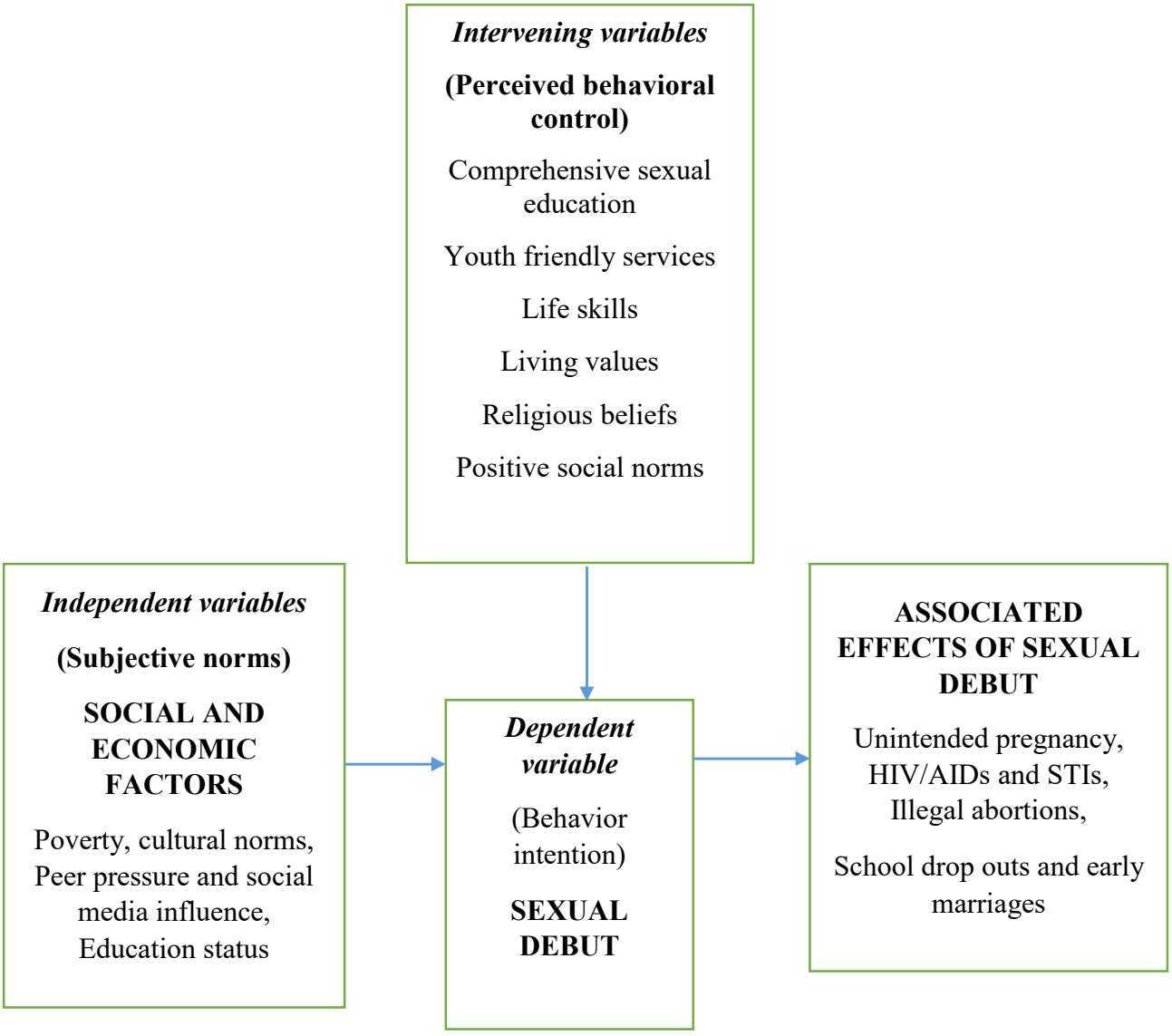

Figure 2.2: Conceptual Framework based on theoretical framework

CHAPTER THREE: MATERIALS AND METHODS

3.1 Study Area

The study was conducted in Homa Bay County, which is located in the southern part of the former Nyanza Province along the Lake Victoria region. The latitude for Homa Bay County is -0.528703, and the longitude is 34.459404 in the Southern Eastern Hemisphere. The county's economic activities are primarily fishing and agriculture, with some sub counties in sugar belt zones. The county has seven sub counties, with the county headquarters located at Homa Bay Town. The Ndhiwa Sub County was targeted for the study due to being number one in the county on teenage pregnancies and early marriages, according to demographic data for 2019. It is mainly an agricultural area located in the Southern Nyanza sugar belt with a sugar industry. The majority of the unskilled population works in the area of sugar production. Ndhiwa Sub County borders Suba North, Suba South, and part of the Nyatike area, where the economic activity is mainly fishing. There are six administrative divisions in Ndhiwa Sub County, namely Kobodo, Kobama, Riana, Ndhiwa, Nyarongi, and Pala. The divisions are further classified as four in rural areas and two in urban areas. The urban are Kobama and Ndhiwa, while the rural are Pala, Kobodo, Riana, and Nyarongi. The respondents were drawn from each division according to the stratified sample size. The map of the study area is attached in Appendix VI.

3.2 Study Design

The study employed cross-sectional study design, which was useful for describing the distribution of characteristics, identifying patterns, and exploring associations within a population at a specific time. (Hamed,2021). The design encompassed the qualitative and the quantitative aspects of the study in the behavioral context. The design was appropriate for the study because it would provide valuable insights into the prevailing attitudes and knowledge among the youth, as well as inform efforts to address sexual debut and promote sexual health in the County and beyond.

3.3 The Study Population

The study population consisted of youths aged 15 to 24 who had lived in Ndhiwa Sub County, Homa Bay County for at least six months. In the 2019 census (KEBS 2019), statistical data on this category of youth was available. The World Health Organization also categorized youths

into this age group. The total population of this category of youth in Homa bay County was 232,781.

The youths who were residents of Ndhiwa Sub County aged 15 to 24 years, according to the census, totaled approximately 43,685 people. We further stratified the youths into male and female categories, followed by single or married status. The questionnaire primarily received responses from the singles, and a sample of the married category participated in the focus group discussion.

3.4 Sample size Determination

The total population of Ndhiwa, as per the 2019 census, was 218,128. There were 103,706 males and 114,422 females. The total population of youths in the age group of 15 to 24 is estimated to be 20.2% of the total population, according to United Nations estimates. The population of youth in the age group 15 to 24 years during the last census was male 21,095 and female 22,590, giving a total of 43,685. The study population is above 10,000, thus the sample size is determined by Fisher *et al.'s* (1998) formula, which is as follows:

$n=Z^2Pq\ /d^2$

Where:

n= Desired sample size when the population is greater than 10,000

z= Standard normal deviation usually set at 1.96

p= Proportion of the target population estimated to have characteristics being measured is 20.2%.

Hence p= 20.2/100 =0.202

q= 1-p

q=0.798

d= the degree of accuracy, usually set at 0.05

$n= (1.96)^2 \times 0.202 \times 0.798 / (0.05)^2$

n=3.84x 0.202x0.798/0.0025

n = 0.61899/0.0025

n= 248

10% of the sample was added in order to account for non-response rate, the incomplete questionnaires or those with errors during data cleaning to limit sampling errors.

10% of 248= 25

Sample size = 248+25 = 273

From The strata of male and female the sample was determined by application of stratified sampling. Each stratum was allocated a random sample size as follows:

N (i) = n *P (i)

N (i) =the expected population portion from stratum (i)

P (i) = the proportion of population included in stratum i

. n = the total sample size.

The population of the male youth is 21,095 and females is 22,590

The sample for male N (i) =273 *21095/43685 =132

N (ii) for female =273 *22590/43685=141

From each division the respondents were to be male 132 divided by 6 =22

Female 141 divided by 6 = 24. The total numbers of respondents for the questionnaire per division were to be 46 people.

3.5 Eligibility Criteria

All the eligible population was determined and characteristics for inclusion and exclusion were set as per the target population.

3.5.1 Inclusion Criteria

In this study on the perception of youth aged 15 to 24 years in Homa Bay County, Kenya, regarding early sexual debut mitigation strategies, and associated health effects, the following inclusion criteria were met: youths aged 15 to 24 years who had been residing in Ndhiwa sub-county, and who are willing to participate in the study. The married people in the study population were considered for the focus group discussion. Participants in the study must have lived in Ndhiwa Sub County for more than six months.

3.5.1 **Exclusion Criteria**

Any person within age 15 to 24 years of age who was not willing to consent to the study was excluded since participation was voluntary. Persons unable to understand the study purpose, risks, and benefits and voluntarily provide consent were also excluded.

3.6 Sampling Procedure

The researcher purposively selected Ndhiwa Sub County as the study site, taking into account the demographic issues of early marriages for both men and women. Ndhiwa was leading in unintended pregnancy in Homa Bay County as per Kenya Population Census of 2019. Six divisions make up Ndhiwa Sub County, with two classified as urban and four as rural. The sampling frame included all six divisions. The study used cluster sampling to randomly select two community health units from each division. To meet the sample size of 23 youths per community health unit, stratified random sampling was used to select 11 male and 12 female respondents from each community health unit's households. Total of 46 youths from each division participated in the data collection as were available according to inclusion criteria.

Married youths from each division participated in the focused group discussion. The researcher randomly selected two participants a male and a female from each sampled community health unit where data was collected. The categorized group of married youths resulted in a total of 12 males and 12 females. The researcher added two participants a male and a female from one of the sub county tertiary institution in order to have an odd numbers which allowed for conclusive discussion. Each category had thirteen married youths, making a total of twenty-six youths who participated in the focus group discussion. Each gender was involved in group discussion separately to allow for freedom of expression.

3.7 Data Collection Instruments

The researcher developed the data collection instruments to facilitate the collection of both quantitative and qualitative data. The study used a semi-structured questionnaire with closed-ended and open-ended questions attached to Appendix III to collect both quantitative and qualitative data. The researcher used a focus group discussion guide, annexed to Appendix IV, to conduct sessions with married youths in the age category to share their previous experiences.

3.8 Pretesting of Data collection tools

Pretesting of data collection tools was done to ascertain their validity and reliability. The researcher conducted the pretesting at a community health unit in the Marindi division. The researcher randomly sampled forty-six youths from the community health unit, comprising 22 males and 24 females in the study age group, and gave them the questionnaire to complete. Trained data collection assistants helped those who could not read or write. The researcher and all research assistants analyzed and discussed the collected data to correct any sections in the data collection tools that required harmonization.

Seven males and seven females, all in the same age group but already married, participated in the focus group discussion. The focal person in charge of the community health unit assisted in inviting the participants, who gathered at Marindi Health Centre grounds. The researcher, acting as the moderator, guided each gender in their own discussions on the assigned topics. The researcher moderated a 40-minute discussion for each group, ensuring that all members were on the same page. The researcher analyzed and matched the information from each group to the discussion guide to ensure clarity for the participants.

3.9 Validity of the instruments

Validity was tested by comparing the extent to which the questions were answered and whether they all conveyed the same meaning as was intended. The researcher verified the content's validity by scrutinizing the responses. The researcher checked the construct's validity by examining the respondents' attitudes and beliefs as expressed in the subject matter. All the sampled study populations used the same data collection tools, and the pretesting verified their accuracy. The questionnaire was self-administered consecutively two groups of 23 respondents.

The researcher further analyzed the questionnaire and focus group discussion results to confirm they aligned with the measurements.

3.10. Reliability of the instruments

The researcher trained the data collection assistants to ensure they understood the tools well. The Marindi division of Homa Bay Town Sub County, which shares the same geographical characteristics as Ndhiwa Sub County, served as the pre-testing site. The researcher adhered to the inclusion criteria for the youth who responded to the questionnaire and those included in the focus group discussion. The data from pre-testing was analyzed, and the results showed that the youths were aware of predisposing factors to sexual debut and knew ways to reduce the behavior. The tool were revised appropriately to ensure reliability.

3.11 Data collection procedures

The questionnaires were distributed to the youths who could read and write to fill by self. Those not able to read and write were assisted by trained research assistants who were fluent in the dholuo, as the inhabitants were Luo community members. There were a total of twelve data collection assistants, one male and one female from each division. They were young people from local tertiary institutions, trained in data collection. Given the sensitivity of the sexuality issues, females were assigned to interview females, and males to interview males. The data collection took two days, one day per community health unit in a division.

A focus group discussion guide attached to Appendix IV was used to conduct the sessions with youths in the age category who were already married to share their previous experience and perceptions on sexual debut. To ensure homogeneity, the researcher randomly selected married youths from the community health units where the data was collected. The study divided them into male and female groups, allowing them to express themselves freely within their respective groups. The study recruited those who gave their consent to participate. The researcher identified thirteen ladies and thirteen gentlemen and arranged meeting points at the Ndhiwa Sub County Hall. The researcher moderated the discussions, clarifying the discussion guides for the participants. The researcher recorded the issues agreed on by the groups according to the items in the discussion guides. After the discussion, each group of participants gave three answers to each question in the discussion guide, which the moderator wrote down as an agreed opinion. The

groups declined the request to record their discussion hence notes were taken during the focus group discussion sessions. The discussion took forty minutes for each group.

3.12 Data management and analysis

A semi-structured questionnaire was used to collected data from the sampled youths in each community health unit in the divisions, in accordance with the determined sample size. The researcher conveniently chose the age groups based on social development, with the youth from 15 to 18 years old still in school, those from 19 to 21 years old in professional development, and those from 22 to 24 years old settling down to a career. The researcher checked the collected data for completeness, cleaned and coded it using Microsoft Excel, and then entered it into the statistical package for social sciences (IBM SPSS version 25) to analyze various variables. The study used descriptive statistics to summarize the data by variable distribution, thereby determining the frequency of occurrence in the gender-specific sample population being studied. The study used inferential statistics, specifically the chi-square test of independence, to examine the relationship between the variables and their significance within the youth population. Due to limited resources, the study used a sample size of the youth population to understand and infer the magnitude of sexual debut among them. The researcher can use the study findings to forecast necessary actions for the youth population regarding sexual debut. The researcher presented the data in the form of frequency tables, contingency tables, pie charts, and bar charts.

Thematic analysis, which coded and grouped similar responses into meaningful themes in accordance with the objectives, analyzed the qualitative data. The researcher then presented the recurring themes in a cohesive manner and quantified them into meaningful reports.

The researcher analyzed the focus group discussion report based on each gender's consensus, following the guidelines outlined in the discussion guide. The researcher grouped and reported the findings in various thematic fields. Chapter 5 facilitated discussion of the findings.

The researcher explored the interactions and relationships between the independent variables (age, gender, educational status, economic background, religion, peer pressure, attitudes and beliefs) and the dependent variable (sexual debut), with the effect such as teenage pregnancy, school dropout, early marriage, STI/HIV infections, and abortions) in order to draw conclusions.

3.13 Ethical Considerations

The JOOUST Research Ethical Committee (Appendix VII), the NARCOSTI (Appendix VIII), and the County Research Department (Appendix IX) all gave their permission for the study to proceed, as stated in the authority letter in Appendix VI from the Board of Postgraduate Studies and the letter from the Director of County Health Services in Appendix IX.

The study, which used anonymous data collection tools, maintained the respondents' privacy and confidentiality. The study only included those who gave consent, leaving out those who were not willing to participate. The researcher applied ethical principles, which include respect for individual opinions and decisions. The focus group participants declined to have their discussion tape recorded. On a written paper, the issues they had discussed and agreed upon were noted and taken for analysis.

CHAPTER FOUR: RESULTS

4.1 Introduction

This chapter contains a description of the respondents' background from different perspectives, an analysis of the dependent variable perception of sexual debut, and the independent variables in their various thematic areas. This chapter further highlights the findings regarding the thematic areas of this thesis. The sample size was 273 youths, divided into 141 females and 132 males. The respondents to the questionnaire were 256, with 139 females and 117 males; hence, the response rate was 94%. These valid questionnaires were within the predetermined sample size. The analysis reflected gender, which is applicable to comparing the perceptions of male and female youths wherever it exists.

4.2 Socio-demographic characteristics of the respondents

According to Table 4.1, the following demographic characteristics of the population were apparent: Most of the respondents, 95 (37%), were between the ages of 15 and 18. The age range between 19 and 21, occupied by 85 (33% of respondents), and the age range between 22 and 24 years, occupied by 76 (30%) of respondents, closely trail this age range.

Out of the 256 respondents, the numbers of female respondents were higher than the males, with about 54%, compared to the male respondents, who had about 46%.

The majority of respondents belonged to three major religions. Those included SDA 88 (34%), Catholic 74 (28.9%), and the Protestant group of churches 74 (28.9%). The remaining 20 (9%) respondents belonged to other religions such as Anglican, Legion, Muslim, P.A.G., and P.E.F.A.

The highest number of respondents, 120 (47%), were secondary school students, followed by tertiary college students, 64 (25%). About 41 (16%) had a primary level of education and the respondents who had not attended any educational institutions were less than 5%.

Since a person may have attended more than one category of school, the schools attended were recorded as multiple responses. The majority of respondents, 84 (33%), and 47 (18%) attended mixed-day and mixed-boarding schools, respectively. There were 2 non-responses for the type of school attended, indicating those who did not attend any school.

The respondents' economic backgrounds were as follows: those from very poor backgrounds were 36 (14%), those from less economically stable families were 128 (50%), and those from stable families were 87 (34%), while only 5 (2%) respondents came from very stable families.

Thus, 164 (64%) of the 256 respondents came from low-economic backgrounds, while 92 (36%) came from stable economic backgrounds. The respondents who engaged in various economic activities when not in school were as follows: manual work (55%), farming (23%), business (16%), driving (4%), and employers (2%)

Table 4.1: Socio-demographic characteristics of the respondents (n=256)

	Characteristics of the youth	Frequency	Percentage rate
1	**Age of the respondents**		
	15 to 18 years	95	37%
	19 to 21 years	85	33%
	22 to 24 years	76	30%
2	**Gender**		
	Male	117	46%
	Female	139	54%
3	**Religion**		
	SDA	88	34%
	Catholic	74	29%
	Protestants	74	29%
	Others	20	8%
4	**Educational Status**		
	Not attended school	8	3%
	Primary	41	16%
	Secondary	120	47%
	Tertiary	64	25%
	University	23	9%
5	**Category of Schools attended**	3234	
	Boys boarding	42	13%13%
	Boys day	15	16%
	Girls boarding	84	6%
	Girls day	47	33%
	Mixed day	2	18%
	Mixed boarding		1%
6	Economic background	36	14%
	Very poor	126	50%
	Less stable	87	34%
	Stable	5	2%
7	Economic activities involved in while not in school		
	Manual work	140	55%
	Business	41	16%
	Farming	60	23%
	Driving	11	4%
	Employers	4	2%

4.3 Socio-cultural and socio-economic factors influencing sexual debut among youths aged 15 to 24 years.

The specific objective of the study was to determine the socio- cultural and socio-economic factors influencing sexual debut among youths aged 15 to 24 years in Homa Bay County, Kenya. To address this research objective, the study carefully developed a research questionnaire for youths between 15 and 24 years, identifying the socio- cultural and socio-economic factors they perceive to influence sexual debut.

4.3.1 The socio- cultural factors influencing sexual debut among the youth

These factors included social and cultural norms, beliefs, and practices that shape individual behaviors and decisions regarding sexual activity.

4.3.1.1 Sociocultural factors that lead to sexual debut among the youth

Figure 4.1 shows the sociocultural factors that lead to sexual debut among the youth. This was an open-ended question where the youths named any two major sociocultural issues that lead to sexual debut. The youths identified peer pressure (235, 92%) as the primary factor causing sexual debut, followed by sex for favors (119, 46%), cultural practices (66, 26%), rape (48, 19%), pornographic media (41, 16%), being forced by friends (25, 10%), pleasure (32, 12%), and poverty (16, 6%).

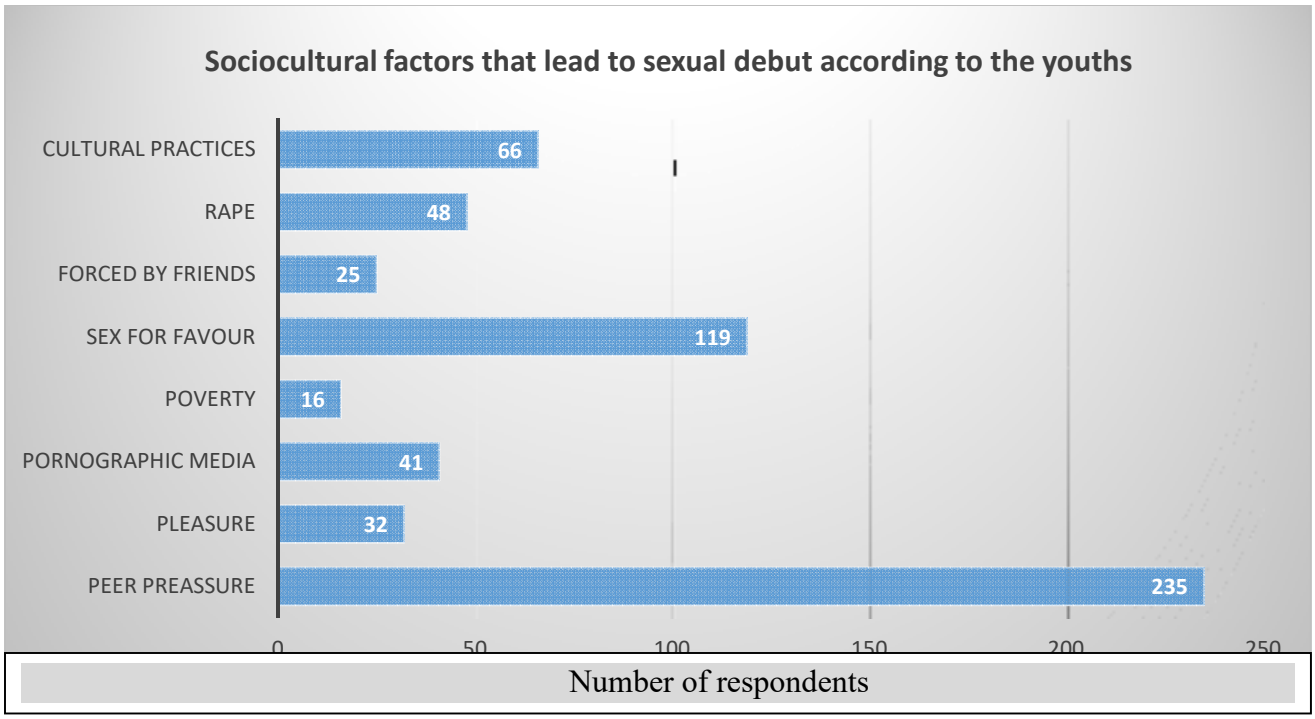

Figure 4.1: Sociocultural factors that lead to sexual debut according to the youths (n=256)

4.3.1.2 The society norms that could influence behavior change according to the youth.

Figure 4.2 describes the youth of Ndhiwa sub-county's responses to whether society norms could influence their behavior change. 114 (97%) of the male respondents agreed that society norms could influence behavior change in youths, whereas 3 (3%) disagreed with that fact. Similarly, 137 (99%) of the female respondents agreed with the fact that society norms could influence behavior change in youths, whereas 2 (1%) of the female respondents disagreed with that fact. Overall, 251 (98%) of the youths agreed that social norms could influence their behavior. According to the group discussion, the youths agreed that implementing strict rules on sexual debut in the community is important. They also said the education of the family to give support to those who have been affected could influence the behavior change of avoiding early sexual behavior.

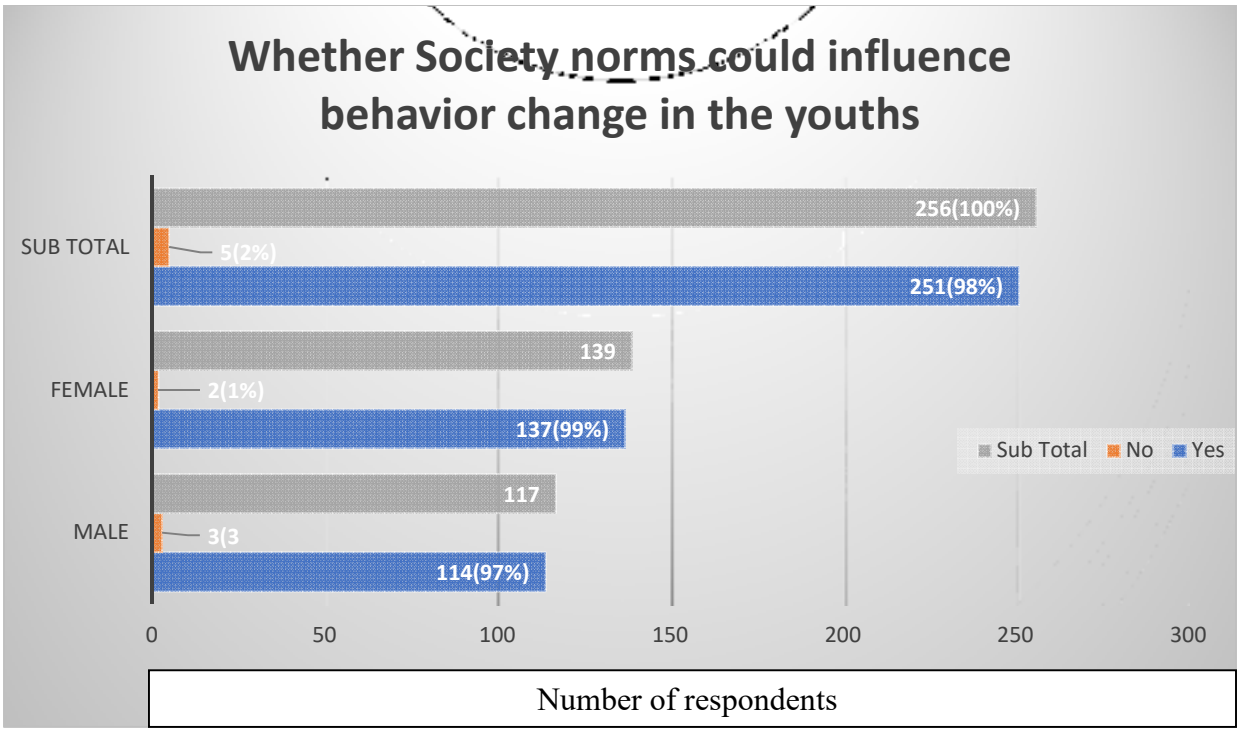

Figure 4.2: Perception of the youth on whether society norms could influence their behavior change (n=256).

4.3.1.3 Boyfriend and girlfriend relationships among the youth according to gender.
The initiation of sexual debut predominantly starts from issues of boyfriend and girlfriend relationships.

Table 4.2 illustrates that 214 (83.6%) of the respondents agreed to the fact that they have boyfriend-girlfriend relationships. Only 42 (16.4%) said they were not in a girlfriend-boyfriend relationship.

The researcher further explored the youths' responses to the question of whether they had a boyfriend or girlfriend based on gender. The observed count of female respondents saying no to the question of whether they had a boyfriend was 22 (15.8%), and the male respondents saying no were 20 (17.1%). On the contrary, the observed count of female respondents saying yes to whether they had a boyfriend was 117 (84.2%), and the males saying yes to having a girlfriend were 97 (82.9%). The researcher subjected this result to a chi-square test of independence (P value = 0.08 df= 2), which revealed a significant statistical difference in the proportion of male

and female youths who had boyfriend or girlfriend relationship. Therefore, the two variables were independent of each other at a 95% confidence level.

Table 4.2: Perception of the youth on having a boyfriend or girlfriend relationship based on Gender (n=256)

	Counts of having a boyfriend or a girlfriend			
Gender	**Response**	**No**	**Yes**	**Total**
Female	Count	22	117	139
	%	15.8%	84.2%	100.0%
Male	Count	20	97	117
	%	17.1%	82.9%	100.0%
Total	**Count**	**42**	**214**	**256**
	%	**16.4%**	**83.6%**	**100.0%**
P value =0.08 **df = 2**				

4.3.1.4 The type of the relationships the youths were involved in

Most of the respondents, 132 (61.3%), revealed that they were in social relationships, with 30 (14%) directly in sexual relationships, and 52 (24.2%) of the respondents indicated that they were involved in peer relationships. Notably, 1 (0.39%) of the respondents chose not to express their opinion on this matter.

Table 4.3: The type of relationship the youths are involve in (n=215)

Type of relationship the youths are involved in	**Number of the youths**	**Percentage**
None	1	0-4%
Peer	52	24.2%
Sexual	30	14%
Social	132	61.4%
Totals	**215**	**100%**

4.3.1.5 The degree of acceptability of sexual debut by the youths and their reasons

Table 4.4 shows the reasons the respondents highlighted for their opinions on the acceptability of sexual debut. The respondents n=210 (82%) thought sexual debut was not acceptable act due to the following reasons: Unwanted pregnancies: 88(42%), Sexually transmitted diseases: 52(25%), early marriages: 36(17%) and school drop outs: 34(16%).

The proportion of respondents 30(12%) thought sexual debut was somehow acceptable act due to the following reasons: source of financial benefits: 11(38%), gives pleasure: 9(31%), Self-identification: 8(25%) while still 2(6%) of the respondents thought that sexual debut was somehow unacceptable due to religious practice.

The proportion of respondents 16(6%) who thought sexual debut was highly acceptable act gave the following reasons: Pleasure 9(53%), source of money: 4 (27%), ego: 2(26%) while still 1(7%) thought it is highly acceptable to maintain relationship.

Table 4. 1 Degree of acceptability of sexual debut by the youths and reasons for their opinion (n =256)

Degree of Acceptability of sexual debut by the youths and reasons for their opinion					
Not Acceptable (n=210)		**Somehow Acceptable (n=30)**		**Highly Acceptable (n=16)**	
Reasons for the opinion		**Reasons for the opinion**		**Reasons for the opinion**	
Unwanted Pregnancies	88(42%)	Money	11(38%)	Pleasure	9(53%)
STDs	52(25%	Pleasure	9(31%)	Money	4(27%)
Early Marriages	36(17%)	Self-Identification	8(25%)	Ego	2(13%)
School Drop Outs	34(16%)	Religion	2(6%)	Maintain Relationship	1(7%)

4.3.1.6 Opinion of the youth on acceptability of sexual debut by the parents.

Table 4.5 shows the youths' opinions on the acceptability of sexual debut by the parents. The respondents, totaling 229 (89.4%) youths, said their parents considered sexual debut not an acceptable practice, and 14 (5%) of the respondents revealed that sexual debut was somehow acceptable to their parents. Ten (3.9%) said that sexual debut was acceptable to their parents, and only one (0.4%) said that sexual debut was a rarely acceptable practice for the parents. About 0.8% of the respondents preferred not to say anything on this subject.

According to the report of focus group discussions, some parents influenced their daughters to drop out of school because education incurred a lot of money and preference was given to boys. Being idol the girls were predisposed to engagement in sexual debut and get married. The perception that dowry was a source of income made some of the parents also to married off their daughters at an early age. The female group also brought up the issue of the girls being assigned to household chores while the boys went to school, thereby leading to sexual debut.

Table 4.5: Opinion of the youth on acceptability of sexual debut by the parents (n=256)

Opinion of youth on acceptability of sexual debut by parents	Frequency	Percentage
No response	2	0.8
Not acceptable	229	89.4
Rarely acceptable	1	0.4
Somehow acceptable	14	5.5
acceptable	10	3.9
Total	256	100.00

4.3.1.7 The community leaders' opinion on sexual debut according to the youths.

Figure 4.3 illustrates the community leaders who were against sexual debut, according to the youth. The youths who said the chief and other community leaders were on the frontlines were 74 (29%), followed by 72 (28%), who said church leaders, and also 72 (28%), who said parents. Lastly, 38 (15%) said teachers were against sexual debut.

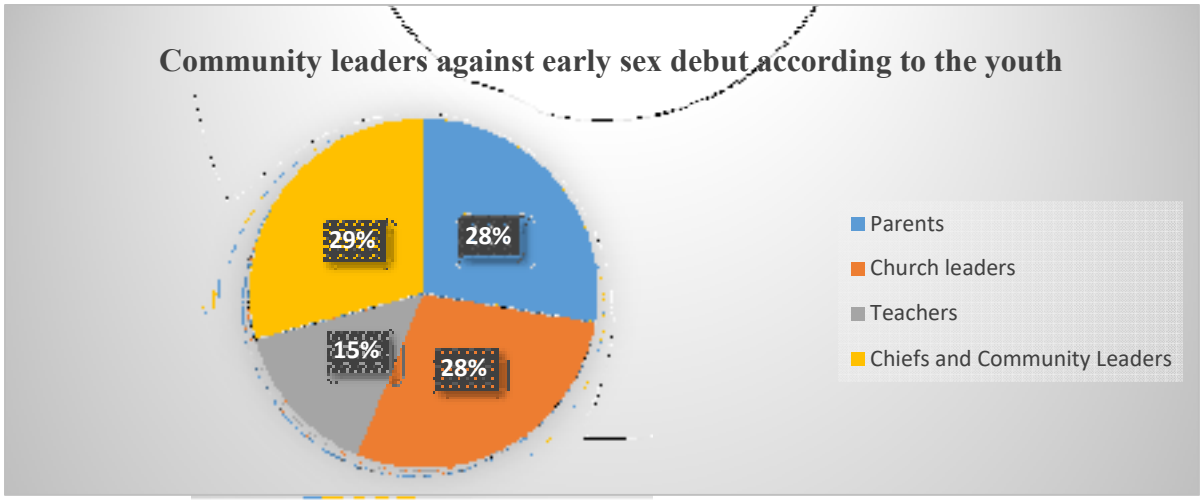

Figure 4.3: Community leaders against sexual debut according to the youth (n=256)

4.3.1.8 The opinion of the youth on cultural practices that contribute to sexual debut

Figure 4.4 highlights the opinion of the youth on cultural practices that contribute to sexual debut. Initiation rites were considered by 128 (50%) of the respondents to be practices that promote sexual debut. The other types of traditional activities noted were night Virgil and discos during funerals, as per 59 (23%), and the aftermath of games and sports, 38 (15%). 28 (11%) of the respondents indicated that during marriage ceremonies, young girls often accompany the traditionally married individual. 3 (1%) of the respondents identified that widow inheritance also promotes sexual debut in society.

The focus group discussions among married youths also highlight the following issues: Peer influence from older brothers and sisters, who sought to demonstrate their maturity, was a significant issue. Social activities such as disco'matanga' and sports after-parties provided avenues for sexual debut among the youths. In certain cultural practices, where 'young girls escorted the one who had been married off to the matrimonial home', sexual debut was a common practice, and the education of girls was not valued as much as that of boys in society.

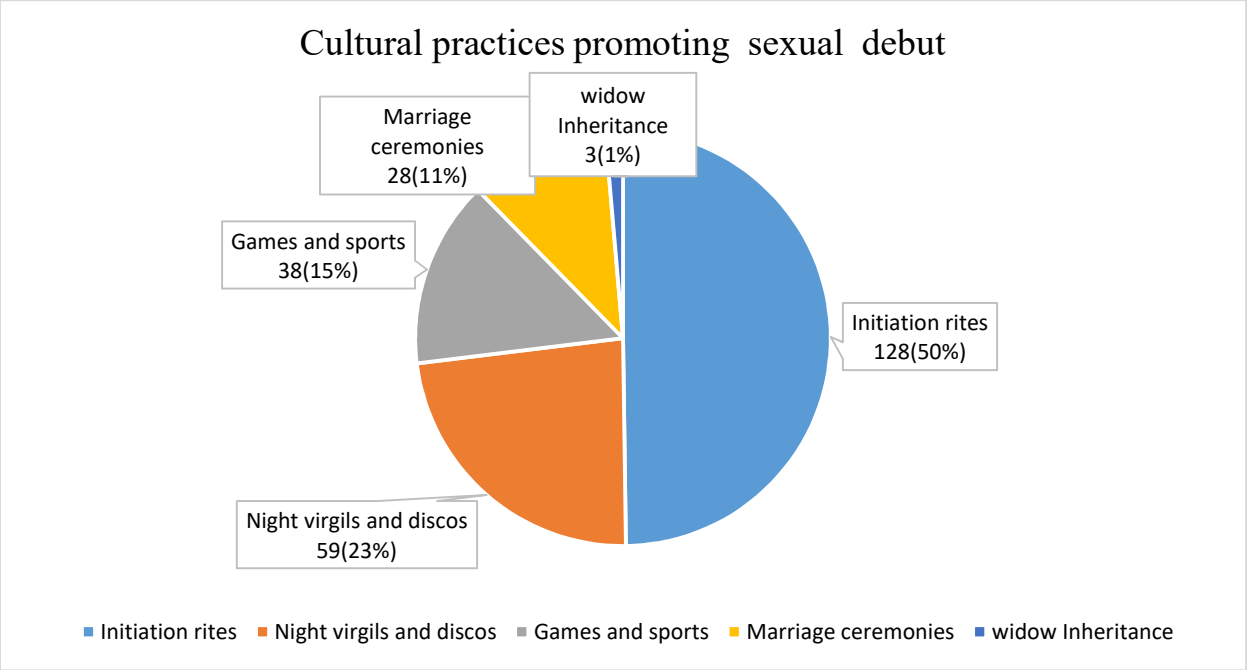

Figure 4.4: Opinion of the youth on Cultural practices promoting sexual debut (n=256)

4.3.2 Socio-economic factors influencing youth involvement in sexual debut

This section outlines the different socioeconomic aspects that influenced the involvement of youth in sexual debut. These included how affordable the school expenses were, the adequacy level of the support given by the parents or guardians, their alternative sources of financial support by the youths, whether or not they had been asked for sex in exchange for money, their knowledge of the term sponsor in the social context, and their approval of the practice of the term sponsor.

4.3.2.1. The affordability of school expenses to the parents according to the youth

Table 4.6 illustrates how the youth of Ndhiwa Sub-County perceived the affordability of school expenses to the parents. Among the 256 respondents, 161 (63%) felt that the school expenses were expensive for the parents, while the remaining 95 (37%) felt the expenses were affordable for the parents.

Table: 4.6: Affordability of school expenses to parents according to the youth (n=256)

Affordability	Frequency	Percentage
Affordable	79	31
Very affordable	16	6
Inadequate	1	1
Expensive	116	45
Very expensive	44	17
Total	**256**	**100.0**

4.3.2.2. The adequacy of the support in terms of pocket money given to youth

Figure 4.5 reveals that 176 (69%) of the respondents thought the pocket money provided while in school was insufficient. The remaining proportion of respondents, 80 (31%), believed that the support given was adequate. The focus group discussion also identified poverty as a major factor that makes the youth drop out of school and get married rather than being idle.

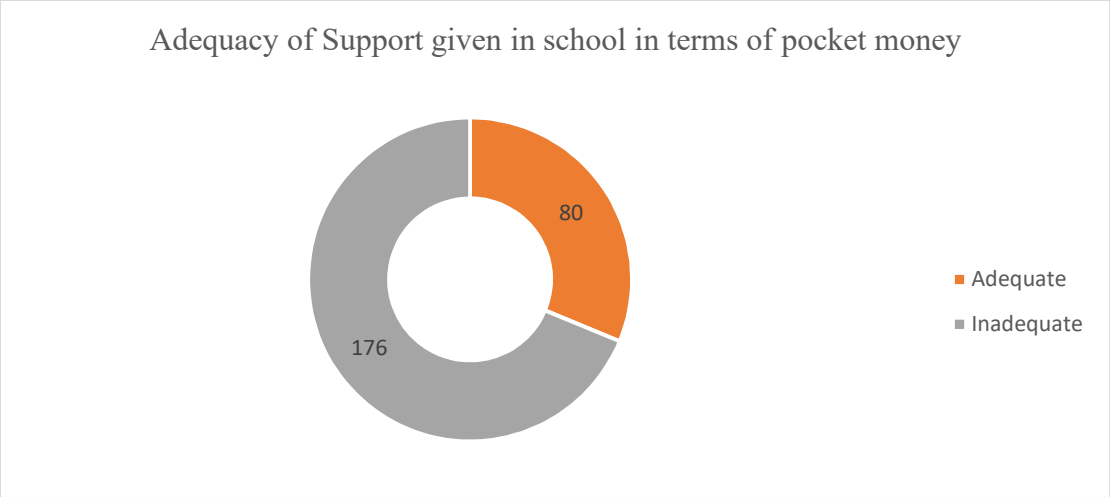

Figure 4.5: Adequacy of the support given in school in terms of pocket money (n=256)

4.3.2.3 Other sources of economic support according to the youth

Table 4.7 shows that other sources of economic support, according to the youths, included: economic activities 97 (38%), donations 71 (28%), sponsorship 67 (26%), gambling 13 (5%), and government support 8 (3%). The focus group discussion also gave the opinion that men lure young ladies into sexual activities in exchange for gifts, which the families accept because of poverty.

Table 4.7. Alternative sources of economic support for the youth (n=256).

Alternative sources of economic support	Frequency	Percentage (%)
Sponsorship	67	26
Government support	8	3
Economic activities	97	38
Gambling	13	5
Donations	71	28
Total	**256**	**100**

4.3.2.4 Issues of sex in exchange for gifts or other services according to gender.

Table 4.8 reveals that 40 (34%) out of 117 male respondents reported having received requests for sex in exchange for materials, whereas 77 (66%) out of 117 male respondents reported never received requests for sex in exchange for material gains like money and other items. Conversely, 74 (53%) out of 139 female respondents reported having received requests for sex in exchange for money or gifts, whereas 65 (47%) out of 139 female respondents never received such requests. Generally, 114 (46%) out of 256 respondents reported having received requests for sex in exchange for gifts, while the remaining 142 (54% of respondents) reported never received such requests. The focus group discussion also identified a lack of basic needs, with some girls in school having sex with older men or even those who were already married in exchange for material gifts and money.

The result was further subjected to a chi-square test of independence analysis, and the findings revealed a significant difference (P value = 0.02, df = 2) between gender and being asked of sex in exchange of money.

Table 4:8: The relationship of gender and having been asked for sex in exchange of money (n=256)

Gender	Whether have been asked for sex in exchange of money			
	Count	**No**	**Yes**	**Total**
Female	Count	65	74	139
	Expected Count	77	62	139
	% within Gender	47. %	53.%	100.%
Male	Count	77	40	117
	Expected Count	65.	52	117.0
	% within Gender	66%	34.%	100.%
Total	**Count**	**142**	**114**	**256**
	Expected Count	**142**	**114**	**256**
	% within Gender	**55.%**	**45%**	**100.%**
	P value= 0.02 df =2			

4.3.2.5 Knowledge about the term sponsorship by the youths

Table 4.9 shows that 243 (95%) of the respondents agreed to have knowledge of the term sponsor, while a small fraction of 13 (5%) stated that they did not have knowledge of the term sponsor.

Table 4.9: Knowledge about sponsorship by the youths (n=256)

Having Knowledge on the term sponsor	**Yes**	**No**	**Totals**
Number of respondents	243	13	256
Percentage	95%	5%	100%

Figure 4.6 further elaborates on the youth's agreement with the sponsorship issue. There were 221 (91%) of the respondents who disagreed with this issue of sponsor, whereas only 22 (9%) of the respondents agreed with it.

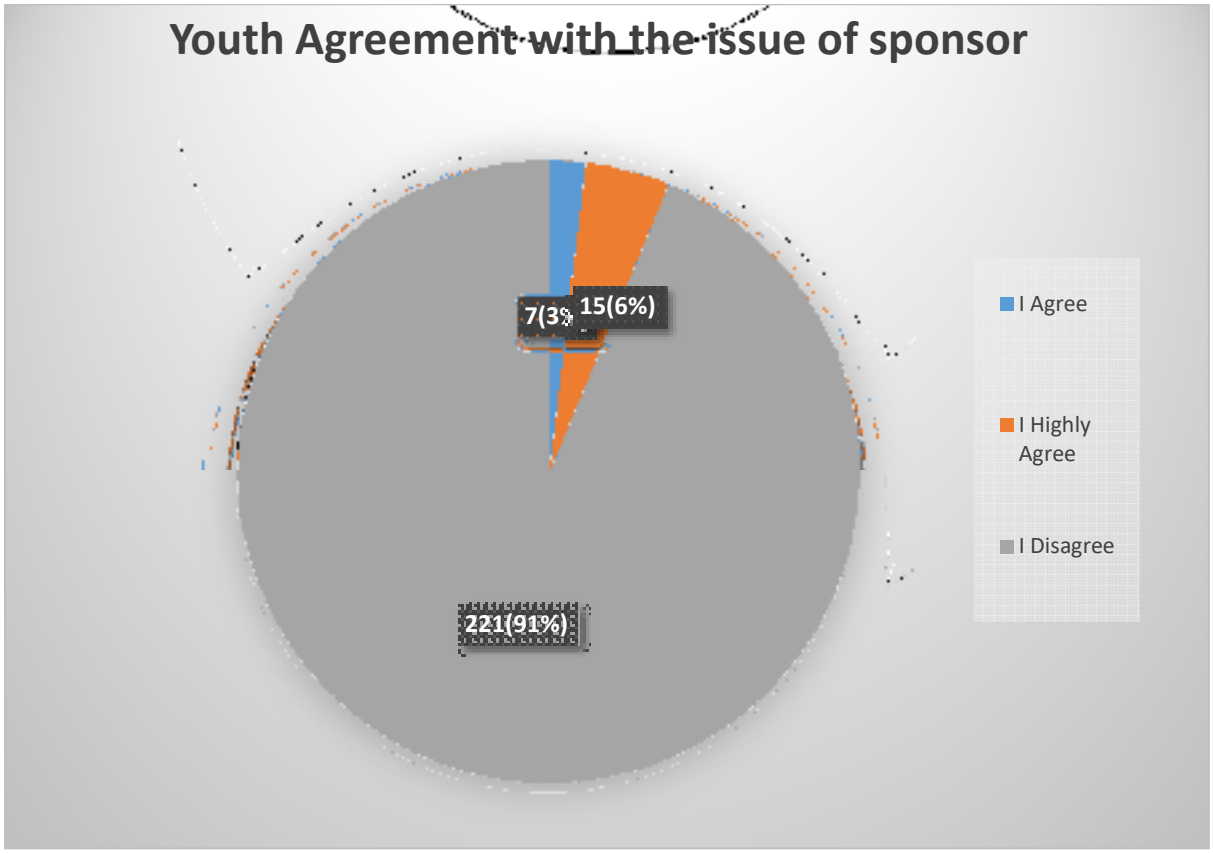

Figure 4.6: Perception of the youth on their agreement with the issue of sponsor (n=243)

4.4 The opinion of the youths aged 15 to 24 years on implementation of mitigation strategies for sexual debut.

The second objective of the study was to determine the opinion of the youth aged 15 to 24 years in Homa Bay County on implementation of mitigation strategies for sexual debut. To address this research objective, the study carefully developed a research questionnaire for youths between 15 and 24 years, identifying the issues aligned as mitigation strategies and their accessibility and utilization for control of sexual debut.

The mitigation strategies for sexual debut were stipulated according to reviewed literature as appropriate information about sexuality issues, social - cultural norms, parental guidance and comprehensive sexual education in learning institutions. Barriers to these strategies enhance the inclination of the youth to sexual debut.

4.4.1 The sources of information about sexual debut among the youth aged 15 to 24 years

Figure 4.7 shows multiple responses in which the youths were asked to choose any two common sources of information. The results show that 196 (77%) of the respondents confirmed that they got information about sexual behavior from peers, 66 (26%) from pornographic media, 42 (16%) from parents, 41 (16%) from school, and lastly, 36 (14% of the respondents) said that they got information from the church.

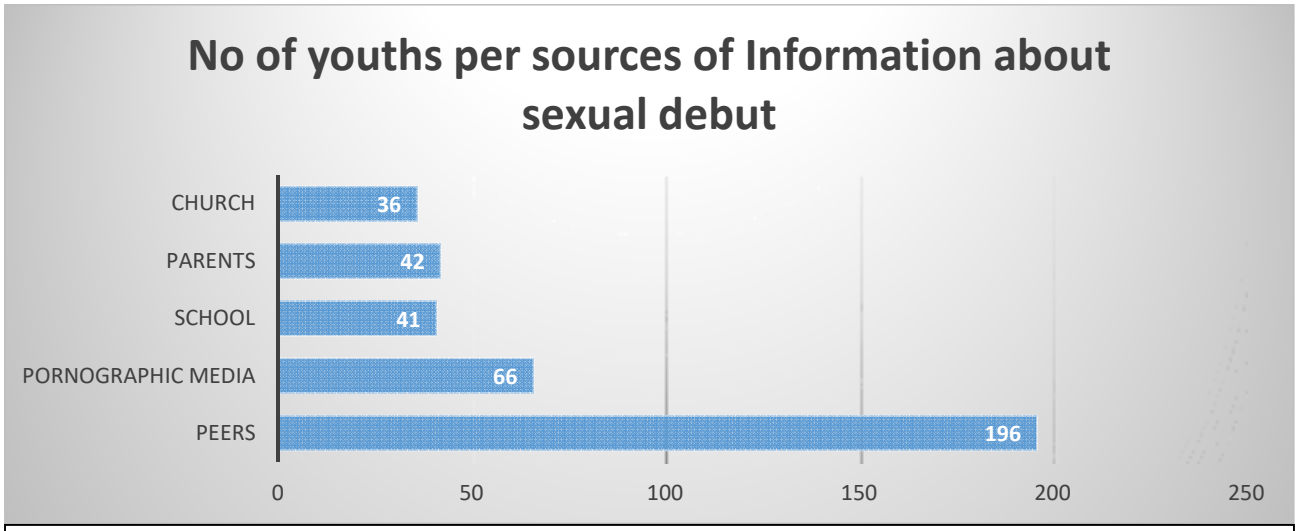

Figure 4.7: Number of youths per Sources of information about sexual debut

4.4.2. The actions that were taken against the youth for engaging in sexual debut.

Figure 4.8 displays the youth's responses to actions taken due to sexual debut. Youth in Ndhiwa Sub County reported sexual debut as highly reprimandable action as confirmed by 145(77%) of

respondents. The respondents reported that reprimands for the victims included caning, removal from normal environments, sending them to relatives, or taking them for police interrogation, among other measures. The respondents totaling to 39 (20%) said that guidance was done in cases where the youth were found engaging in sexual debut. Another 3(2%) respondents said that victims of early sexual activity were taken to health facilities for checkup while 2(1%) said they were forced to be marry.

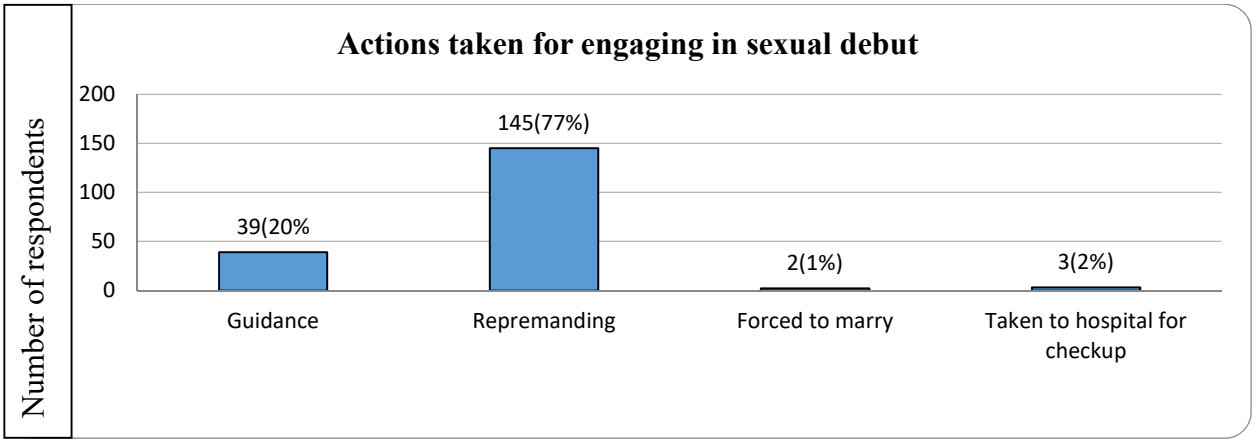

Figure 4.8: Actions taken for engaging in sexual debut (n=187)

4.4.3 Parental discussion of sexual debut issues with their children

Figure 4.9 illustrates the respondents' views on whether parents discuss sexual debuts with their children. The majority of the respondents, 241 (94%), disagreed with the idea that parents do discuss sexual debut with their children. 10 (4%) revealed that parents sometimes discuss sexual debut with their children. Only 5 (2%) of respondents highly agreed that parents discuss sexual debuts with their children.

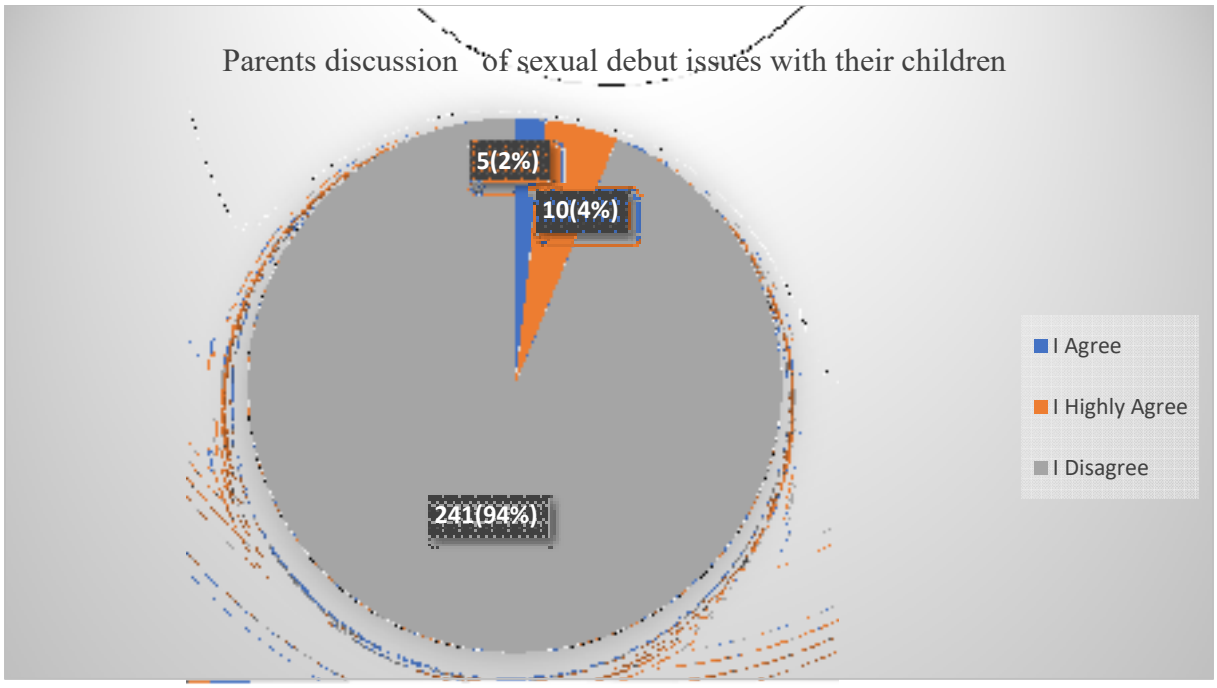

Figure 4.9: Perception of the youth on whether parents discuss sexual debut with their children (n=256)

4.4.4 The opinion of the youth on sexual debut

Figure 4.10 shows that 57 (49%) out of 117 male respondents agreed that sex was an ordinary activity for sex liberation, and 23 (20%) further strongly agreed with the statement. 21 (18%) out of 117 male respondents disagreed with this statement, and lastly, 16 male respondents strongly disagreed with it. The female respondents had the following views: 42 (30%) out of 139 female respondents agreed that early sexual debut activity was an ordinary activity for sex liberation, and 15 (11%) further strongly agreed with this statement. While 66 (47%) out of 139 female respondents disagreed with this statement, 16 (12%) strongly disagreed with the statement that youth consider sexual debut as an ordinary activity for sex liberation. Overall, 137 (53.5%) agreed with this statement, and 119 (46.5%) disagreed with it.

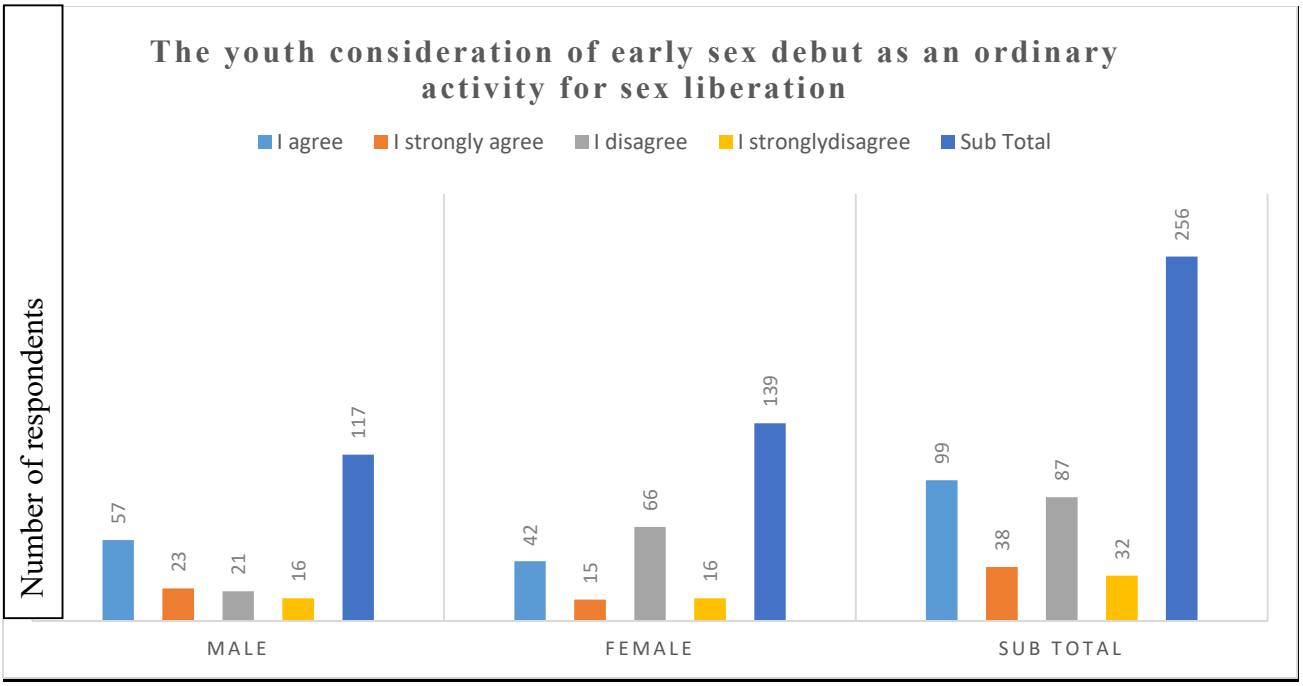

Figure 4.10: The youth consideration of sexual debut as an ordinary activity for sex liberation (n=256).

4.4.6 Sexual education in schools

Reports indicate that schools have implemented sexual education to some extent to mitigate the effects of youth involvement in sexual debut. The school administrations occasionally organized forums to educate students and pupils on issues related to sexual debut.

Figure 4.11 shows that the majority of the respondents (220, or 85.9%) agreed to having had sexual education sessions in school, while 36 (14.1%) said they had not had sex education sessions in their respective schools. The focus group discussion also recommended that having sexual education included in the school curriculum was very important. We could teach the youths about the consequences of sexual debut, such as early pregnancy and sexually transmitted infections. The male youths expressed a need for instruction on condom use.

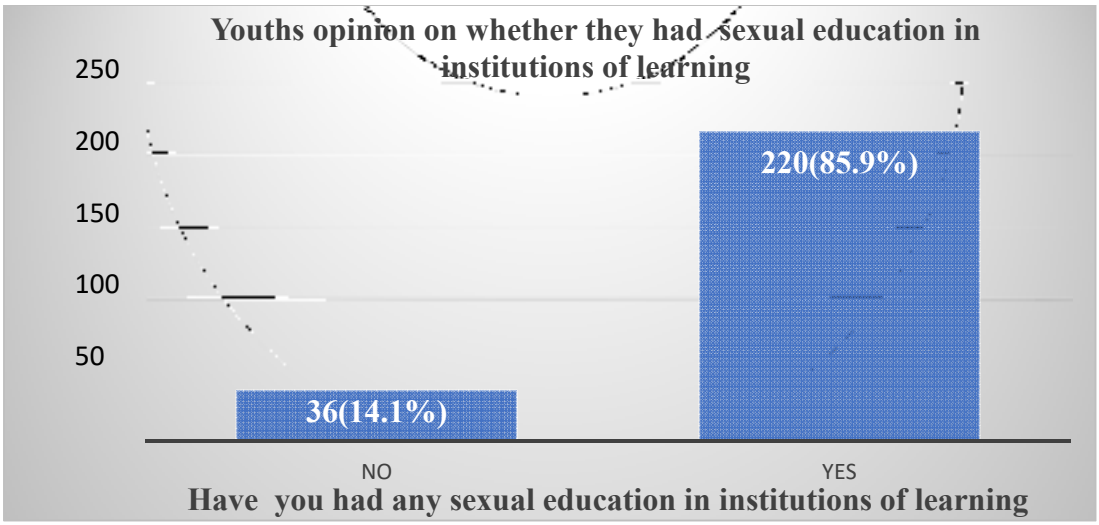

Figure 4:11: Opinion of the youth on whether they had sexual education in institutional of learning (n=256)

4.4.7 Issues taught in school during sexual education sessions

The respondents who had sexual education in school identified the topics discussed during these sessions, as shown in Table 4.10. Most schools identified the following as their main discussion topics during sexual education sessions: 142 (65%) of the respondents identified abstinence from sex, 44 (20%) avoided negative peer influence, 14 (6%) acknowledged the effects of premarital sex, 8 (4%) avoided pornographic media and 12 (5%) avoided risky places.

Table 4.10: Sexual Education issues taught in School (n=220)

Sexual education issues taught in school					**Totals**
Effects of premarital sex	Abstinence	Avoidance of peer influence	Avoiding Risky Places	Avoid Pornographic media	
14(6%)	142(65%)	44(20%)	12(5%)	8(4%)	220 (100)

4.4.8 The opinion of the youth on ways they would use to avoid sexual debut.

The youths were asked an open-ended question about how they could avoid sexual debut if they so desired. This was to determine their ability to control sexual debut. Table 4.10 grouped their responses into the four most common responses.

In various ways, the respondents agreed to the question of their ability to avoid sexual debut based on their wishes. 131 (51% of respondents) said they could do this through abstinence, 91 (36%) said through avoiding negative peer influence), 25 (10%) through seeking parental guidance, and 8 (3%) by avoiding risky places.

The focus group discussion also raised issues such as youth involvement in extracurricular activities in schools and church activities, female security, and basic needs for ladies to avoid sex for gifts. Families of affected girls should provide support to prevent them from dropping out of school.

Table 4.11. How the youth could avoid sexual debut if they wish (n=255)

How the youth could avoid sexual debut if they wish	**Number of respondents**	**Percentage**
Avoiding risky places	8	3%
Seeking parental guidance	25	10%
Avoid negative peer influence	91	36%
Abstinence	131	51%
Totals	**255**	**100%**

4.4.9 Teachers and church leaders free discussion of sexual debut issues with the youth

Figure 4.12 displays the recorded response regarding the possibility of teachers and church leaders engaging in free discussions about sexual debut with the youth. Based on gender, 101 (86%) of the male respondents agree with the fact that teachers and church leaders should freely

discuss issues about sexual debut with youths, whereas 16 (14% of male respondents) disagree with the issue. Similarly, 130 (93%) of the female respondents agree with the fact that teachers and church leaders should freely discuss issues about sexual debut with youths, whereas 9 (7%) of the female respondents disagree with the issue. Overall, 231 (90%) of the youth agree with the idea that teachers and church leaders should freely discuss sexual debut issues.

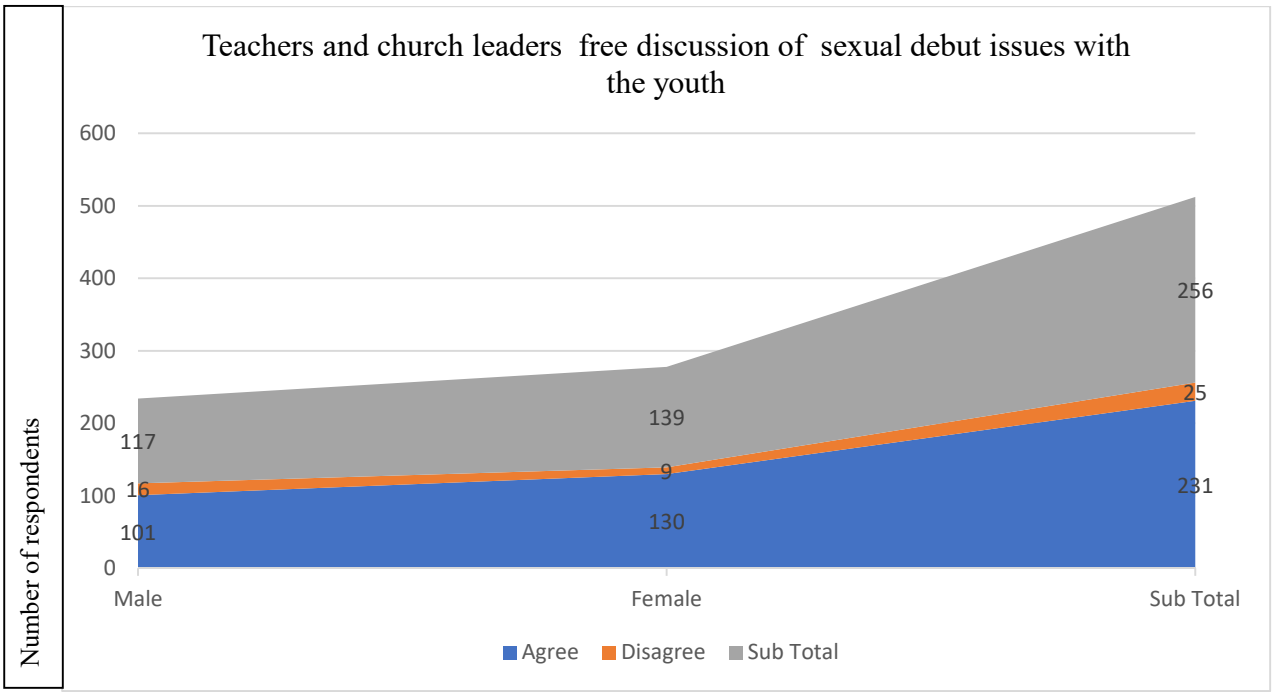

Figure 4:12: Teachers and church leaders free discussion of sexual debut issues with youths (n=256)

4.5 The perceived health effects of sexual debut among youth aged 15 to 24 years in Homa Bay County, Kenya.

The third objective of the study investigated perceived health effects of sexual debut among the youths aged 15 to 24 years in Homa Bay County. The section highlights the perception of the youth on effects of engaging in sexual debut and possible ways of dealing with the issues.

4.5.1 Perception of the youth on the effects of engaging in sexual debut

Figure 4.13 depicts the youth's perception of the effects of engaging in sexual debut. Out of the total respondents, 79 (31%) identified sexual debut as a cause of school dropout, 67 (26%) said

it led to abortion, 64 (25%) said that sexual debut led to early and forced marriages, and still a small percentage of 46 (18%) said that it caused family rejection.

The focus group discussions with the males and females also concluded that there is a dropout rate at school. The men gave the reason that *"when you become a father, you do not go to school with your children."* The focus group discussion also gave information that the girls who became pregnant out of sexual debut were forced into early marriage to old men in a polygamy set up to avoid the risk of delivering in the parents' home. If the girl happen to marry a single man and delivers a baby boy, the child would be socially discriminated by the family of the husband of the mother. Therefore, such children would rely on their grandmothers or maternal uncles for support.

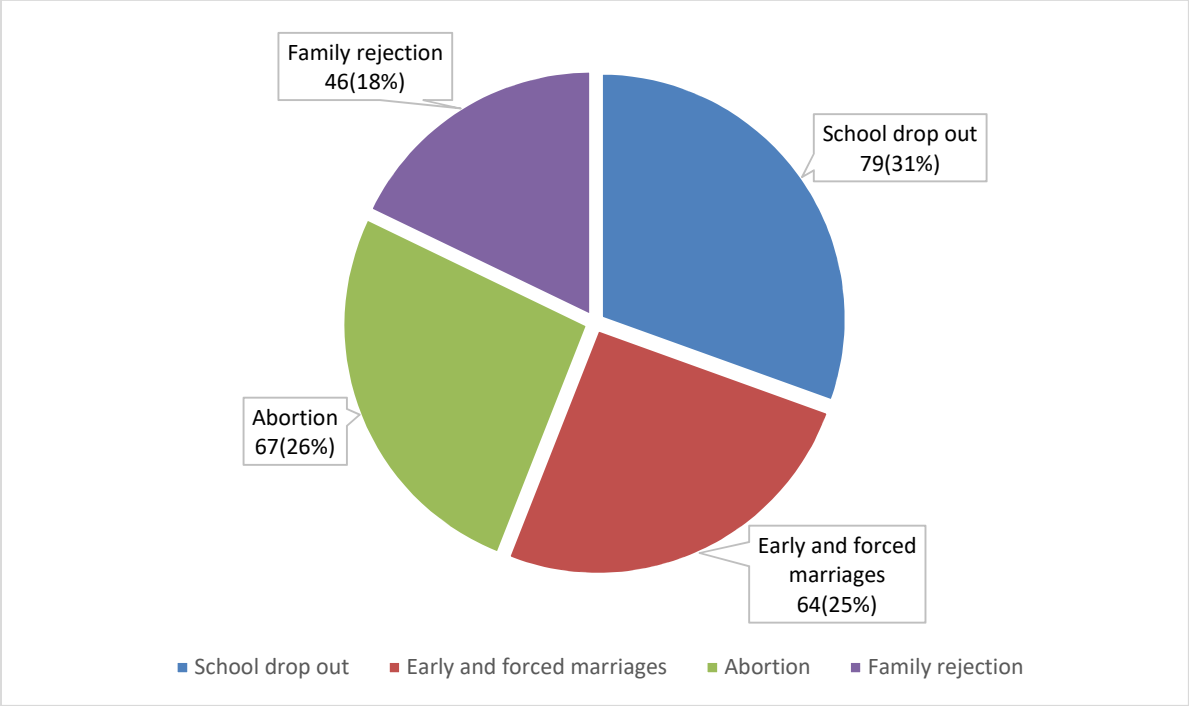

Figure 4.13: Perception of the youth about the effects of engaging in sexual debut

4.5.2 The reproductive health issues associated with sexual debut

Figure 4.14 shows multiple responses in which the respondents were to identify three main reproductive health issues associated with sexual debut. The results were grouped the based on

the five most frequently raised reproductive health issues. The respondents, totaling 184 (72%), identified criminal abortion as one of the reproductive health issues associated with engaging in sexual debut. 143 (56%) and 136 (53%) respondents identified teenage pregnancies and delivery complications in young women, respectively. 89 (35% of respondents) identified youth involvement in sexual debut as leading to sexually transmitted infections and HIV/AIDS, while a small section of the respondents, 29 (11%), associated sexual debut among the youth with problems in family planning.

The focus group discussion by married men and women also came up with similar reproductive health consequences, such as teenage pregnancy, school dropout, and pregnancy complications when the girls cannot give birth naturally, the risk of contracting HIV/AIDS and STIs, and the resultant forced early marriage of teenage girls to old men.

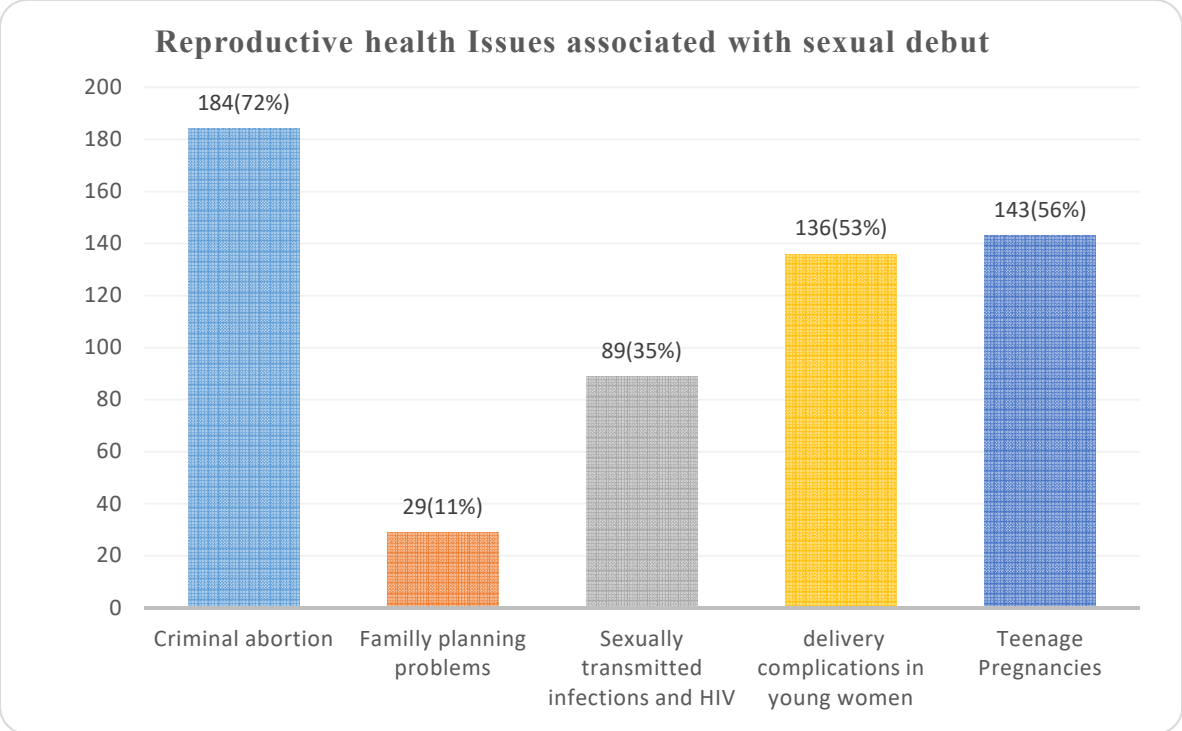

Figure 4.74: Reproductive health issues associated with sexual debut (n=256)

4.5.3 Actions the youth could take to deal with consequences of sexual debut

The youth of Ndhiwa Sub County identified actions they could take to deal with the consequences of premarital sex, as shown in Figure 4.15. There were equal numbers of respondents, 107 (41.8%), who preferred abstinence and avoiding negative peer influence. Twenty (7.8%) respondents suggested using self-control, while 12 (4.7%) suggested reporting the issues to the authorities. 10 (3.9%) of the respondents, however, think that using contraceptives to deal with the consequences of premarital sex, like teenage pregnancy, is worth considering. From the focus group discussions, the men *said the introduction of contraceptives, the use of condoms, creating awareness among the youth on sexual practices, engaging in income-generating activities, and engaging them in social activities like sports can help the youth avoid the consequences of premarital sex. The ladies also stated that providing psychological counseling to affected youths, encouraging affected girls to return to school, and raising community awareness about the dangers of sexual debuts through health education can aid in mitigating the effects of premarital sex.*

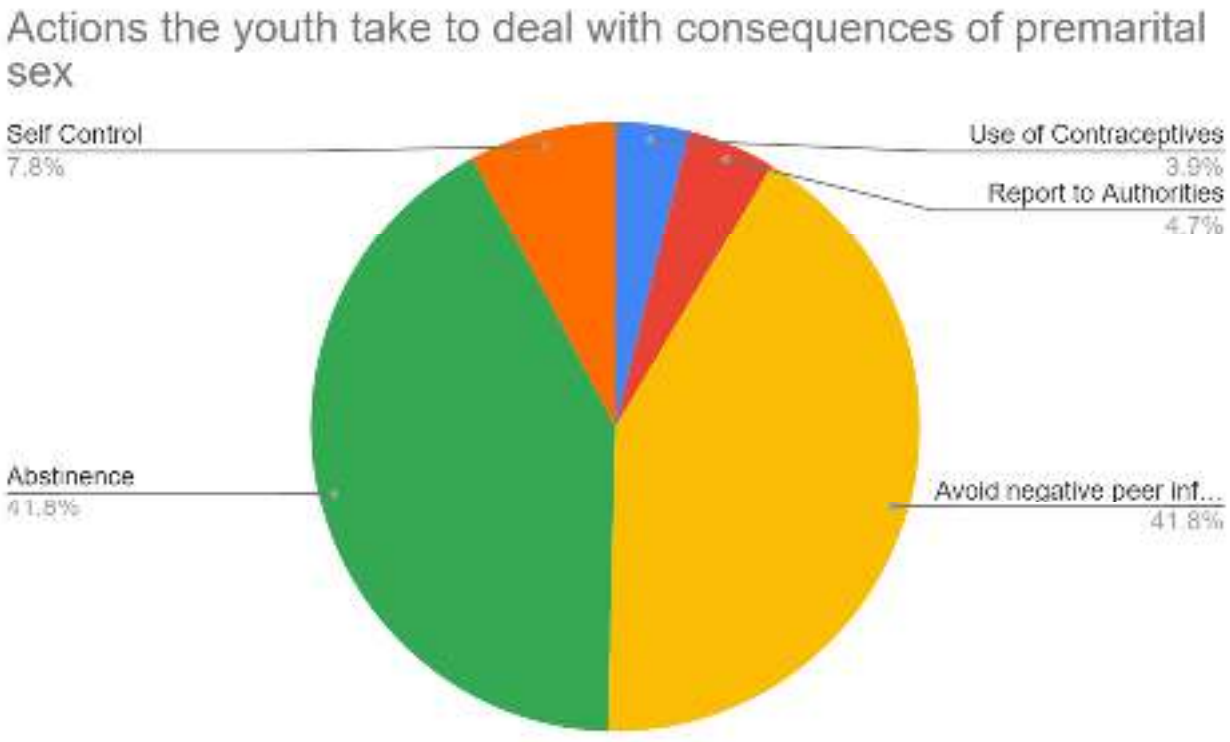

Figure 4:15: Actions taken by the youths to deal with consequences of sexual debut

CHAPTER FIVE: DISCUSSIONS

5.1 Introduction

This chapter discusses the research results in accordance with the study's objectives. We explore the significant emerging issues that will be crucial for the community in addressing the problem of sexual debut. We have discussed the findings in the context of the existing literature.

5.2 Demographic characteristics of the respondents

The age distributions of the respondents reflected the characteristics of both the youths targeted in the study and those who could still be in learning institutions. These characteristics also confirmed the projected census dimensions at the time of study. The respondents' educational level indicated the implementation of the government's 100% transition policy. The majority of respondents attended mixed-day and mixed-boarding schools, which confirms the characteristics of most rural learning environments.

5.3 Socio-cultural and socio-economic factors influencing sexual debut among youths between 15-24 years.

The perceptions of the youth on sexual debut showed that the youths were aware of the issues leading them to sexual debut and had knowledge that society did not approve of it. Most youths in Ndhiwa Sub County believed that having a boyfriend or girlfriend would trigger sexual debut. We subjected the youth's response on whether they had a girlfriend or boyfriend to chi square analysis (P value >0.05). Therefore, the two variables are independent of each other. The majority of the respondents who said they are in social relationships may have meant other relationships that they would not want to directly talk about, like sexual relationships, which are culturally not acceptable. The respondents indicated that they were involved in peer relationships, which implied a level of peer influence among the youth. Shrestha (2019) noted that peer pressure drives early sex debuts. Male and female respondents' findings on the acceptability of early sex debuts showed a uniform view, regardless of gender. This is in concurrence with Arabi-Mianrood *et al.* (2019), whose study showed that sexual debut was still rampant among the youth in Sub-Saharan Africa.

The general majority of male youths agreed with their perception that sexual debut is an ordinary activity for sex liberation. However, this statement was relatively applicable in the case of the

female youths of Ndhiwa sub-county, where the majority disagreed with it. This response confirms the society's perception of the consequences of sexual debut. Females tend to bear the burden of pregnancy and school dropouts, thus disagreeing with the statement. The liberal attitude stems from the fact that men are not as affected as women. This finding concurs with Gazendam *et al.'s* (2020), who concluded that persistent gender stereotypes appear to underlie differences in individual and contextual factors associated with adolescents' sexual behavior. The majority of respondents agreed that sexual debut is not acceptable. Sexual debut was not an acceptable act in society due to the majority of the resultant unwanted pregnancies. This is in concurrence with the research findings by Fatene (2018).

The majority of respondents confirmed that youths learn about sexual behavior from peers and pornographic media. This supports the findings by Muhammad et al. (2021), who found that boys who had frequent media exposure were significantly more likely to report an early sexual debut than those who had no media exposure. Further, the likelihood of an early sexual debut was significantly higher among boys and girls who had exposure to pornography compared to their counterparts. Also, it confirms the findings of a study among Nyamira County's in-school teens that the majority of pupils were fed by their parents, signaling a pluralist setting in which peer pressure, cultural norms, and popular culture on social and mainstream media all played a role in early sexual debuts (Akinyi *et al.,* 2022). The majority of the respondents disagreed with the statement that parents do discuss sexual debut with their children. This is confirmed by the finding that poor communication with parents on sexual and reproductive health issues, attending romantic videos and films, and alcohol consumption were independent predictors of early sexual intercourse among female university students (Olaleye, 2021).

5.3.1 Sociocultural factors influencing youth involvement in sexual debut

According to the majority of respondents, the youths identified four major factors that they considered to cause sexual debut, with peer pressure leading. This agreed with Mohammed (2019), whose study result showed that peer pressure drives youth to earlier sexual experimentation just for pleasure. Shreatha (2019) found that environmental factors predict premarital sex, which aligns with the causes of premarital behavior.

Other types of sociocultural activities influencing sexual debut include matanga discos, the aftermath of social gatherings like sports, and widow inheritance by young unmarried men, as was documented in the focus group discussion by the men. Poton et al. (2020) reported that traditional values in sexual debut have lost their meaning, revealing that despite institutional guidelines, sexual debut remains rampant among the youth.

Culturally, religion influences social norms like those that govern sexual relationships and marriage. The study results showed that sexual debut was not acceptable by the parents, the church, or the community leaders. This finding was in line with Omanga *et al.* (2023), study where female youths cited several reasons for delaying sexual contact to include fear of pregnancy, the burden of caring for a baby, and religious doctrines. In a study by Shrestha (2019), the religion of the adolescents further influences their attitudes, perceptions, and behaviors towards sexual behaviors.

Culturally, society expects all leaders to mentor youth towards acceptable social standards. The study's findings revealed that parents, church leaders, and chiefs shared the responsibility of advocating against sexual debut. The teachers, being with the youths of school age, also put in effort, but to a greater extent, only a few of the youths consider them to be against sexual debut. The finding was in line with Joyce *et al.* (2022), which suggested that health care providers, CHVs, teachers, parents, and community leaders should build capacity on adolescence, adolescents' sexuality needs, and the disadvantages of female genital mutilation (FGM), including early marriage. Community leaders' disapproval of sexual debut has led the youths to conceal their sexuality issues through peer pressure and pornography, as evidenced by the information they receive. The youth reported that the community punishes sexual debut, mirroring the Old Testament's Ten Commandments and the Quran's chapter 24, which both prescribe punishment. Social standards determined that the actions taken against the youth engaging in sexual debut were punitive. We needed to abolish the discrimination against male children born out of wedlock as a social norm, as it amounted to child neglect.

5.3.2 Socio-economic factors influencing the youth involvement in sexual debuts

Some of the respondents believed that making an early sexual debut was an acceptable act due to the potential financial benefits. This aligns with the findings of Akinyi et al.'s (2022) research report, which concluded that people perceive individuals with money as possessing power over others' autonomy, and that their economic environment influences their sexual decisions. The findings suggest that the youth's perception of their parents' high school expenses may lead them to pursue sex as a form of gift-giving. However, the reasons for engagement in sexual debut poverty were reported as making the youth drop out of school, but this was not a direct reason, according to the youth. The idleness after dropping out was due to a preference for sexual debut and early marriage.

The issue of inadequacy of pocket money while in school was noted to be an influence on engagement in manual work, and some of the youth engaged in sexual activities, as evidenced by issues of donations and sponsorship. Due to poverty, some families accepted gifts from a "sponsor," defying societal norms.

Wamonyi et al. (2019) conducted a study in Nigeria on the issue of sex for favor, revealing that wealthy individuals were enticing young adolescents in secondary schools for favors in exchange for sex. This research finding confirms that more female respondents have actually been asked for sex in exchange for a gift, such as money, than male respondents, though the practice is relatively common among the youth of Ndhiwa Sub-County. Although the economic gain in sexual debut is not prominent among the youth in Ndhiwa Sub County, the findings were contrary to those of Son *et al.* (2020) in Korea, which found no notable correlation between socioeconomic characteristics and the age at which women first engaged in sexual activity. The Chi-square analysis of gender and the practice of asking for sex in exchange for a gift reveals a significant difference ($P = 0.002$) between the expected and observed counts of the two variables, indicating that they are not independent. The results of this study demonstrate the existence and practice of the "sponsor" issue in society. A study at the University of Maiduguri found that the most significant positive factor associated with sexual debut was economic support in exchange for sex (Pradanie, Armini, & Untari, 2022). The youths strongly disagree with the practice of sponsoring activities in relation to sexual debut. This may also be due to the set-up of the study

area, because the issue is more common in big towns and higher educational institutions than in rural settings.

5.4 Implementation of mitigation strategies for sexual debut.

The youth of Ndhiwa Sub County identified actions they can take to deal with the consequences of sexual debut. There were almost equal numbers of people who preferred abstinence and avoiding negative peer influence. Some of the respondents, however, think that it is worth considering using contraceptives to deal with the consequences of premarital sex. Abstinence and avoiding negative peer influence are in the domain of perceived behavioral control in the theory of planned behavior, which can be emphasized as life skills and living values to control sexual debut. The idea can be invented, as illustrated in the conceptual framework.

5.4.1 The majority of the respondents agreed to having had sexual education sessions in school. This is in line with reproductive health policy to integrate sex education into learning institutions, though some of the schools may not have implemented it. The study aligns with the findings of Akwara and Idele (2020), who noted that the lack of comprehensive sexual education, insufficient access to contraceptives, and the stigma associated with sexual health issues can prevent young people from seeking the necessary support and information to make informed decisions about their sexual health. The youths also identified the topics discussed during the sex education to include abstinence from sex, avoidance of negative peer influence, avoidance of pornographic media, avoidance of risky places, and sexually transmitted infections (6%) among others. This aligns with what the youths of Ndhiwa Sub County identified as ways to prevent sexual debut and its consequences. Namugerwa's (2022) study recommends reinforcing sex education, emphasizing the importance of medical accuracy in this area.

The respondents agreed that they could avoid sexual debut if they so desired, using strategies such as abstinence, avoiding negative peer influence, seeking parental guidance, and avoiding risky places. The youths have reaffirmed their desire to refrain from sexual debut, a goal they can accomplish through psychosocial support and behavior change communication. This supports the recommendation in a study by Kimeli et al. (2022) for the need to offer and strengthen psychosocial support to adolescents to enable them to cope with their status and educate the

caregivers on the importance of adolescents living with HIV/AIDS having a consistent caregiver for continuity.

In general, the youths agreed that teachers and church leaders should freely discuss sexual debut issues. The youth have overwhelmingly recommended that teachers and church leaders should openly discuss sexual debut issues. This recommendation will improve the youth's access to appropriate information, as they currently receive a significant amount of information from peers and social media, including pornographic content. Geoffroy et al. (2019) confirmed the study's findings, demonstrating that most adolescents obtain sexual and reproductive health information from the media, which may contain inappropriate sexual content. They recommended the need for an accurate and comprehensive SRH education approach for VYAs at an opportune age before the majority engages in sexual behavior.

Most young people concur that examining societal norms is crucial in the effort to decrease early sexual debuts in society. Youth can implement social norms related to sexual behavior change through socialization and acculturation.

5.5 Effects of youth engagement in sexual debut

The youths acknowledged that their sexual debut has significant social and reproductive health implications. This is in concurrence with a previous study by Yoosefi *et al. (2023),* which identified a higher risk of unintended pregnancies, sexually transmitted infections (STIs), including HIV/AIDS, and emotional and psychological challenges. Additionally, early initiation of sexual activity can disrupt educational attainment, hinder economic opportunities, and perpetuate cycles of poverty and inequality as social and public health consequences of sexual debut. The issue at hand is that the youths are 100% aware of the consequences of sexual debut yet still engage in it. The findings from the focus group discussion on the effects of sexual debut were similar to those of the interview. The majority of the female youths did not accept the social norm of forced marriage as a consequence of sexual debut, and they were pleading for support to return to school.

CHAPTER SIX: CONCLUSIONS, RECOMMENDATIONS AND FURTHER RESEARCH

6.1 Conclusions

1. The sociocultural and socioeconomic factors influencing sexual debut evolve around individual attitude and societal issues. The youths accepted that they participated in sexual debut which is not approved according to society norms. Their main sources of information on sexuality issues were their peers and social media. These sources are unregulated and can give improper information. The community reported a very low prevalence of "sponsorship," or sex for gifts or favors, primarily among female respondents. The majority of the youths did not associate their sexual debut with poverty and expressed disagreement with the practice of sex for favors or money.

2. The youths were aware of the mitigation strategies in place, such as the implementation of sexual education in schools across most of Ndhiwa Sub County. The key issues taught in sexual education were: abstinence, avoidance of peer influence, and consequences of sexual debut. The youths believed that providing psychosocial support on the two key issues could help them avoid sexual debut. The youths also said they require free discussion with teachers, parents and church leaders to get social support for behavior change.

3. The youths were aware of the effects of sexual debut, which were mainly social and health-oriented. School dropout, early and forced marriages, and family rejection were dominating the social scene, while teenage pregnancy, abortion, and sexually transmitted infections are major health effects. The youth's opinions on actions to be taken to avoid consequences were primarily abstinence and avoidance of negative peer influence. However, youths still engage in sexual debut, according to the reported trends in Ndhiwa Sub County.

6.2 Recommendations

The youths have expressed themselves as far as sexual debut is concerned. Their perception of sociocultural and socio economic contributing factors effects, and mitigation strategies of sexual debut has come up. Youths generally possess knowledge about sexual debut, understand its

causes and effects, and are aware of potential solutions. Based on the study's findings, the following recommendations are proposed:

Develop and implement age-appropriate, evidence-based sexual education programs in schools and these programs should provide accurate information about contraception, safe sex practices, and the consequences of early sex; emphasize the importance of delaying sexual debut; and provide practical strategies for mitigating early sex, such as communication skills and refusal techniques.

Promote parental involvement in discussions about sexual health and its associated health effects by providing parents with resources and support to facilitate open and informed conversations with their children. Conduct workshops or support groups for parents to address their concerns, provide guidance, and equip them with the necessary skills to communicate effectively with their children.

Promote access to healthcare services by improving access to youth-friendly healthcare services that address the specific health needs of young people and ensuring these services provide confidential and non-judgmental spaces for youth to seek information, counseling, and testing for STIs and Strengthen partnerships between healthcare providers, schools, and community organizations to facilitate access to healthcare services.

6.3 Further research

Evaluation research of sexual education in institutions of learning needs to be done to assess its impact since it is not effecting the expected behavior change among the youth.

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APPENDICES

Appendix I: Questionnaire for the Study

This questionnaire is developed to help in obtaining data for the study based on Perception of the youth on sexual debut and related effects in Ndhiwa Sub County. The information given is confidential thus it is anonymous. . Do not indicate your name on this paper. You can fill yourself or you can be assisted by the authorized personnel as would be applicable.

Section A: Socio-Demographic Characteristics of Respondents

Instructions: please tick what is appropriate for you in the space provided.

1. Indicate your age bracket in years

Between 15– 18 [ ]

Between 19 – 21 [ ]

Between 22 – 24 [ ]

2. What is your gender?

Male [ ]

Female [ ]

3. State your educational status

Primary [ ] secondary [ ] tertiary college [ ] university [ ] Not in school [ ]

4. Indicate the type of school you went to for primary and secondary?

Girls boarding [ ] Girls day [ ] Mixed boarding [ ] Mixed day [ ] Boys day [ ] Boys boarding[ ]

5. If not in school are you working: Yes [ ] No [ ]

6. What is your current occupation or job you are engaged in?

Farming [ ] business [ ] driving [ ] employed [ ] others specify_____

7. What is your economic background?

Very stable [ ] Stable [ ] Less stable [ ] Very poor [ ]

Section B: Perception of the youth on sexual debuts

Please answer the following questions according to your view as genuinely as possible, your responses are confidential.

8. Do you have a boyfriend or a girlfriend Yes [ ] No [ ]

9. If yes what type of relationship are you engaged in? Social [ ] sexual [ ] peer [ ]

10. To what degree is sexual debuts acceptable to you?

Not acceptable [ ] somehow acceptable [ ] highly acceptable [ ]

11. State two reasons for your answer in the question 10 above

i) _____

ii) _____

12. Is sexual debut acceptable to the parents of the youths? Yes [ ] No [ ] somehow [ ]

13. Do the parents discuss issues of sexual debutwith their children?

Yes [ ] No [ ] sometimes [ ] rarely [ ]

14. Where do the youths get information about sexual behavior?

Tick any two that you think are the major source

Church [ ] Peers [ ] Pornographic media [ ] Parents [ ] School [ ]

15 The youth consider sexual debuts as ordinary activity for sex liberation

I agree [ ] I strongly agree [ ] I disagree [ ] I strongly disagree [ ]

Section C: Sociocultural and socioeconomic factors influencing youth involvement in Sexual debut

Please answer all the questions according to your knowledge and understanding (all the information given is anonymous and confidential)

16. What is your religion: Catholic [ ] SDA [ ] Muslim [ ] Protestant group of churches [ ] others specify_____

17. Are there persons in the community that are against sexual debuts (tick all that apply)

Parents [ ] Church leaders [ ] Chiefs and Community leaders [ ] Teachers [ ]

18. According to your thinking what are the main three things that makes the youth to engage in pre-marital sex (tick the three that apply)

Peer pressure [ ] Just pleasure [ ] Being forced by a friend [ ] Rape [ ] Religion [ ] cultural practice [ ] Media pornography [ ] Sex for favour: e.g. Marks in college,[ ]

19. When found to be engaged in sexual debut is there any action taken? Yes [ ] No [ ]

20. If yes then state the action

_____

21. State two cultural practice that you think promote sexual debut

_____

_____

22. How affordable were the school expenses to your parents/guardians

Very affordable [ ] Affordable [ ] Very expensive [ ] Expensive [ ]

23 How was the support given to you while in school in terms of pocket money?

Inadequate [ ] Adequate [ ]

24 Have you ever been asked for sex in exchange of money? Yes [ ] No [ ]

25. Where else would youth get your economic support apart from the parents or guardians? (List below)

26 Have you heard about the word “sponsor” among the youth in social media where people engage in sex in exchange of gifts like money Yes [ ] No [ ]

27 If yes, do you agree with the practice? : I Agree [ ] I highly agree [ ] I Disagree [ ]

Section E; Effects of Sexual debut among the Youth and how they are dealt with.

28. Is there any effects arising from engagement in sexual debutYes [ ] No [ ]

29. If yes which ones apply according to the listed below? (Tick all that you think apply)

Early marriage [ ] School dropout [ ] Family rejection [ ] Forced marriages [ ] Abortion [ ]

30. Sexual debuts affect the health of the youth

I agree [ ] I strongly agree [ ] I disagree [ ] I strongly disagree [ ]

31. How affordable were the school expenses to your parents/guardians

Very affordable [ ] Affordable [ ] Very expensive [ ] Expensive [ ]

32. The reproductive health consequences associated with premarital sex: (tick those that apply)

Teenage pregnancy [ ] Criminal abortions [ ] Family planning methods problems [ ] delivery complications in young women [ ] e) sexually transmitted infections and HIV [ ]

33 State any other issues in your own opinion that can occur as a result of engagement in premarital sex

34. Are you aware of any action the youth can take to deal with consequences of premarital sex?

Yes [ ] No [ ]

35. If yes then state three action the youth can take to deal with the consequences of sexual debut

_____

_____

Section F: Mitigation Strategies for Sexual debut among the Youth

36. Have you had any sexual education in school or any organization a) Yes [ ] No [ ]

37. If yes then name any two issues you were taught about

_____

_____

38. The youths can avoid sexual debuts if they wish: Yes [ ] No [ ]

39. If yes then state how _____

40. Teachers and church leaders freely discuss premarital sexual issues with the pupils or students: I agree [ ] I strongly agree [ ] I disagree [ ] I strongly disagree [ ]

41. The society norms can influence the behavior change in the youth: Yes [ ] No [ ]

Appendix II: Focus Group Discussions Questions

1. What influences the youth to engage in sexual debut in relation to

    a. Sociocultural factors

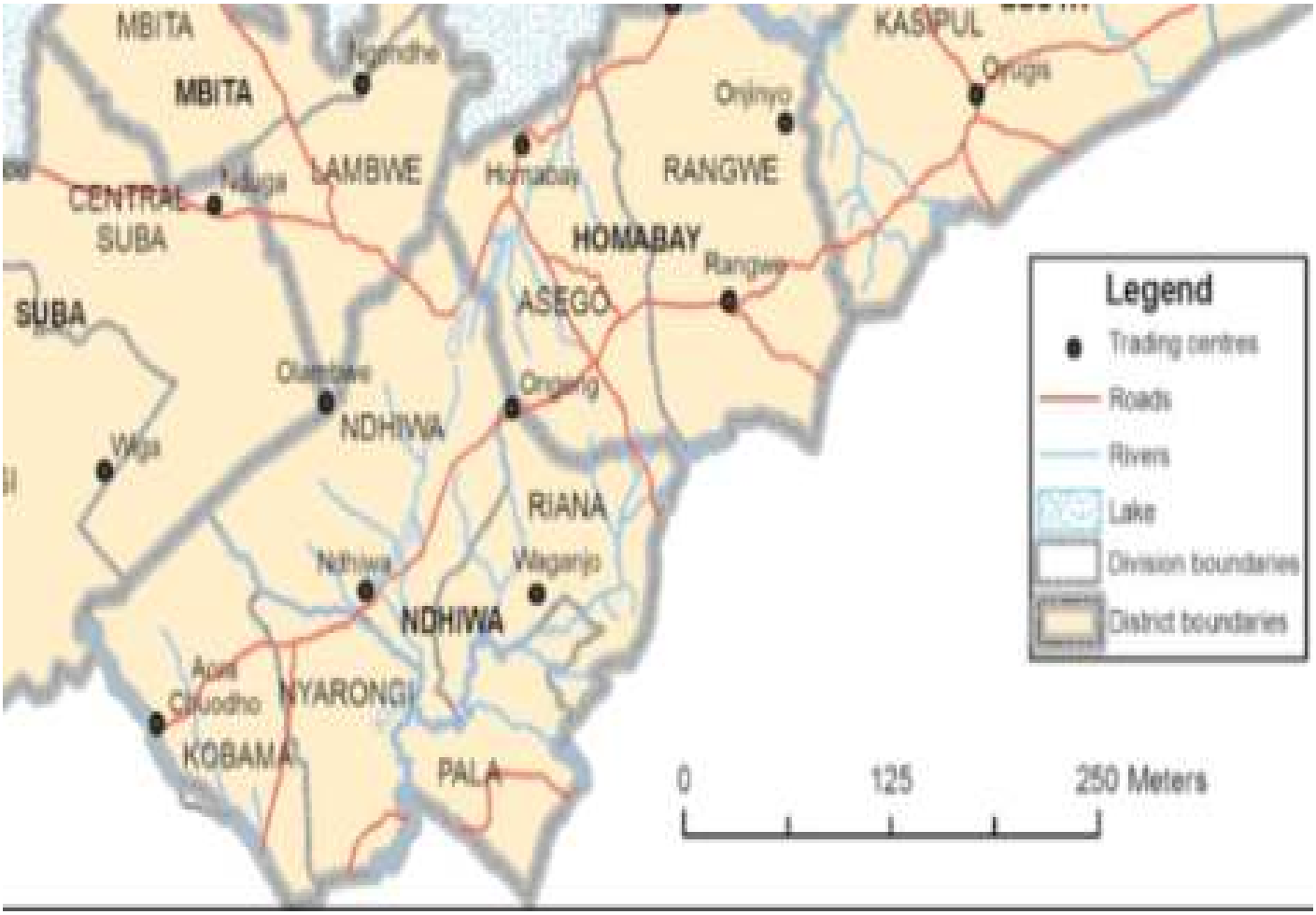
    b. Socioeconomic factors

2. What are the effects of sexual debut to the youth?

3. What is being done to deal with effects of premarital sex?

4. How can sexual debut be prevented or controlled?

Appendix III: Map of part of Homa Bay County showing Ndhiwa sub-county and the study site divisions



Appendix IV: Authority letter from JOOUST Board of Post Graduate Studies

JARAMOGI OGINGA ODINGA UNIVERSITY OF SCIENCE & TECHNOLOGY

BOARD OF POSTGRADUATE STUDIES

Office of the Director

Tel. 057-2501804
Email: bps@jooust.ac.ke

P.O. BOX 210 - 40601
BONDO

Our Ref: H152/4202/2017

Date: 20th April 2021

TO WHOM IT MAY CONCERN

RE: OPIYO GETRUDE ANYANGO – H152/4202/2017

The above person is a bonafide postgraduate student of Jaramogi Oginga Odinga University of Science and Technology in the School of Health Sciences pursuing Master of Public Health. She has been authorized by the University to undertake research on the topic: ***"Perception of the Youth Aged 15 to 24 Years on Premarital Sexual Behavior, Mitigation strategies and Associated Health Effects in Homa Bay County".***

Any assistance accorded her shall be appreciated.

Thank you.

JARAMOGI OGINGA ODINGA
DIRECTOR BOARD OF
POST GRADUATE STUDIES
DATE .....
P. O. BOX 210 - 40601, BONDO,
UNIVERSITY OF SCIENCE & TECHNOLOGY

Prof. Dennis Ochuodho
DIRECTOR, BOARD OF POSTGRADUATE STUDIES

Appendix V: JOOUST Ethical Review Committee Approval

JARAMOGI OGINGA ODINGA
UNIVERSITY OF SCIENCE AND TECHNOLOGY

DIVISION OF RESEARCH, INNOVATION AND OUTREACH
JOOUST-ETHICS REVIEW OFFICE

BONDO

RE: APPROVAL TO CONDUCT RESEARCH TITLED "PERCEPTION OF THE YOUTH AGED 15 TO 24 YEARS ON PREMARITAL SEXUAL BEHAVIOUR, MITIGATION STRATEGIES AND ASSOCIATED HEALTH EFFECTS IN HOMABAY COUNTY"

Appendix VI: NACOSTI Research License

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 426304

Date of Issue: 10/March/2022

RESEARCH LICENSE

This is to Certify that Ms.. Getrude Anyango Opiyo of Jaramogi Oginga Odinga University of Science and Technology, has been licensed to conduct research in Homabay on the topic: Perception of the Youth aged 15 to 24 years on Premarital Sexual behavior, Mitigation Strategies and Associated Health effects in Homa Bay County. for the period ending : 10/March/2023.

License No: NACOSTI/P/22/16045

426304

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

Appendix VII : Permission from Homa Bay County Health Department

DEPARTMENT OF HEALTH SERVICES

Telegrams: "MOH" Homa Bay
Telephone: 21039
When replying please quote
homabaychc@gmail.com

MINISTRY OF HEALTH
HOMA BAY COUNTY
P.O. BOX 52
HOMA-BAY.

Ref: MOH/HB/CTY/RA /VOL.III/06

21st March, 2022

Getrude Anyango Opiyo
H152/4202/2017
JOOUST

Dear Ms.Opiyo

RE: AUTHORITY TO CONDUCT RESEARCH

Your request to collect data on your research title " **Perception of the youth aged 18 to 24 years on Premarital sexual behavior, mitigation strategies and associated Health effects in Homa Bay County** " has been granted with effect from 21st March,2022 to 10th March,2023.

You will be required to adhere to the community norms and regulations, and you are expected to communicate your findings to the Directors' Office at the end of the research period.

Wish you all the best in your research.

DEPARTMENT OF HEALTH SERVICES
COUNTY DIRECTOR OF HEALTH
22 MAR 2022
P.O. BOX 52 - 4300, HOMA BAY - KENYA

Dr. Gordon Okomo
County Director of Health Services
HOMA BAY COUNTY

Appendix VIII: Focus group discussion results:

Focus groups issues of discussion	Married male Youths responses (n=13)	Married Female Youths responses (n=13)
1. What influences the youth to engagement in sexual debut in relation to sociocultural and socioeconomic factors.	• Peer influence from older brothers and sisters where they want to prove that they are grown up. • Social activities like disco 'matanga' and sports aftermath provide avenues for sexual debuts among the youths • Poverty makes them to drop out of school thus they get married rather than being idle. • The men lure young ladies into sexual activities in exchange for gifts which the family will accept because of poverty. • Some of the parents also influence the daughters to drop out of school because education take a lot of money thus they engage in sexual debut and get married.	• The education of girls is not valued as compared to education of boys. • Lack of basic needs where some girls in school have sex with older men or even those that are already married in exchange of material gifts and money. • There are girls who are given away as house helps in favour of the boys to go to school thus are predisposed to premarital sex. • Sometimes the girls engage in sexual debutin cultural practice where young girls escorting the one who has been married off to the matrimonial home. • The girls are married off at an early age because dowry is considered as a source of income.

2. What are the effects of sexual debut to the youth?	• School dropout with a reason that when you become a father you do not go to school with your children. • Risk of contracting HIV/AIDS and STIs • Early marriage	• School drop outs. • Unwanted pregnancies and infections like HIV/AIDS. • Pregnancy complications when the girls cannot give birth naturally.
3. What is being done to deal with effects of sexual debut?	• Introduction of contraceptives and use of condoms. • Creating awareness among the youth on sexual practices. • Engage in income generating activities. • Engage them in social activities like sports.	• Psychological Counseling of the youths who have been affected. • Some parents support the affected girls to go back to school. • Creating awareness in the community about the dangers of sexual debuts through health education.
4.How to prevent or control sexual debut	• Educate on the use of protective items like condom. • Involve the youth in extra curriculum activities in schools and church activities. • Implement strict rules on sexual debutin the community. • Sex education to be part of the school curriculum.	• Engage the youths to avoid idleness and provide security. • Provision of basic needs to the girls e.g. sanitary pads. • Educate the girls on risk factors of early pregnancy. • Education the Family to give support to those who have been affected.