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KENYAN YOUTH: THEIR SEXUAL KNOWLEDGE AND PRACTICE

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Any views expressed in this paper are those of the author. They should not be interpreted as reflecting the views of the Institute for Development Studies or the University of Nairobi.

Youth, Reproduction and Population:

INTRODUCTION:

Over 50% of the total population in Kenya today is under 20 years old. The projections are that this ratio will continue for a number of decades unless our reproductive behaviour and practices change, and until society accepts that a fast growing population might be detrimental to its own development and welfare. To try to counter this a family planning service has been started in the country. Both the information given and the services provided by the family planning organisation are meant for those who are married.

So far the number of women accepting contraceptives is small. It is suspected that the number effectively using contraceptives is even smaller and that more needs to be done if a significant number of women and men are to become effective users.[1] Due to the limited scope of this paper, we shall not argue here that just to provide contraceptives to the population or to limit the availability of contraceptives to those married is insufficient to bring about lowered birth rates. As argued elsewhere,[2] family planning by itself cannot bring about any significant drop in the population growth rate. There is still the enormous problem of educating the entire population in what is available for those who want to space or limit the number of children they have. At the moment, one of the major problems in diffusing family planning information is that the media and the messages are limited mainly to those who can read or write in either Swahili or English. The other problem is that the target population is the group which has either entered the procreative age or has already reached desired family size.

The type of information that is being disseminated can be referred to as "reaction to crisis" and as such can only be expected to raise doubts in the minds of some who do not think that Kenya is headed for a population crisis. The theory of reaction to crisis is that all

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1. Effectiveness is generally measured in terms of birth-averted per woman or for the population at large. Some people have tended to think the number of women accepting contraceptives is the same as those who are effectively using them.

2. The author has on several occasions argued this point. See for example, "Who Needs Family Planning", "Population Education for our Schools" and "The Pill and the Family". In Strategies for Improving Rural Welfare IDS Occassional Paper No. 4, University of Nairobi, 1971 pp 270-386.

efforts should be directed to the source of crisis and concentrated there until the crisis is over. Subsequently, all our efforts to "solve" our "population crisis" are directed towards fecund women and no effort is being made to educate those who will be entering the reproductive category in the next few years.

The purpose of this paper is to present statistics on the current level of knowledge among the youth of Kenya. We also discuss their attitudes to such life aspects as children desired, job preferences and knowledge about family planning methods.

The Study

The present study, while it was not conducted on a national basis, is representative of the youth between the ages of 13 to 25 years in the country. 92% of the respondents come from 24 of the 41 Kenyan Districts. The other 8% come from Uganda and Tanzania (5% Uganda; 3% Tanzania). It must be pointed out that Central Province, which ethnically is dominantly Kikuyu was overepresented with 192 respondents compared with 126 from the rest of the districts. The data presented should therefore be taken with caution and be considered statistically biased in favour of one region over the others. All the respondents were in some training instituion at the time of interview and all have had a minimum of eight (8) years of education. The actual interviews were conducted in and around Nairobi between January and April 1972. All together 320 young people were interviewed. We believe that taken together the respondents are representative of the youth of the country with the characteristics found in this group.

METHODOLOGY.

The data was collected by means of a questionnaire which had been designed by the Family Planning Association of Kenya Executive Staff for their own purposes. They wanted to administer the questionnaire to groups of students in teachers training colleges, secretarial colleges and secondary schools. It was administered by the Association staff member whenever he gave a lecture in family planning or sex education. The students were asked to fill in the questionnaire before the lecture and no effort was made to prevent "cheating".

It was hoped that a follow-up questionnaire would be administered after the lecture, thus giving a clear picture of the before and after knowledge. However, follow-up questionnaires were not usually administered due to some field problems such as failure of students to turn up or lack of time on the part of the person who was administering the questionnaire.

The findings reported here, therefore, represent only the before lecture knowledge on reproductive biology, contraceptive methods and attitudes towards family planning. The questionnaire does not meet the usual scientific requirement nor does the Association claim that they used any scientific methods in selecting their respondents. Interviews were not scheduled nor were the institutions, whose students answered questionnaire, selected. Interviews were administered in all the institutions which, at various times between January and April, 1972, invited the Association to send a guest speaker. The Association sent its questionnaires in advance and requested that they be completed. The completed questionnaires were collected before the lecture.

Data processing of the completed questionnaire was done at the Institute for Development Studies, University of Nairobi by the author. The present report is therefore the product of an effort of the Family Planning Association of Kenya (FPAK) and the Institute for Development Studies (IDS). The analysis and conclusions reached here should in no way be attributed to either the FPAK or the IDS, The author takes full responsibility for this report.

RESULTS.

Knowledge on Reproduction.

The respondents were asked to name three organs of reproduction in the male. The results are presented in Table 1.

As would be expected, 95% of the males can identify at least two male sex organs as compared to 78% of the females respondents. However, it is interesting to note in Table 2 that a larger percentage of males than females could name at least three female reproductive organs. When responses are compared with education, a different pattern emerges. Those who have up to eight years

TABLE 1

PERCENTAGES OF RESPONSES ON MALE SEX ORGANS

NAME OF ORGAN	% CORRECTLY NAMING ORGANS			
	M	F	RESPONDENTS SEX NOT IDENTIFIED	TOTAL
Penis	95	78	96	83
Testicles	95	78	83	83
Vas Deferens	5	1	4	2
Prostate Gland	7	1	17	4
Other	63	56	52	58
D/K	0	2	0	1
R/A	4	5	0	44
PERCENT	268	221	252	235
BASE	82	215	23	320

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1. Throughout the tables some total percent bases add up to more than 100%. This is because some questions were multiple. All figures appearing against any response are percentage figures and not raw figures. The bases on which the percents are calculated may differ in each Table because not all respondents answered every question. Thus for each Table, the response category is calculated on the basis of those who answered that particular question, and those who indentified themselves as either males, or females. It will be noted that some respondents did not give their sex, age, or years of education.

DK throughout this report refers to "Don't Know". This is different from "R/A" - refused to answer" in that those who did not know the answer actually wrote so in the appropriate space while those who refused to answer left the response space blank. These two categories, DK and R/A, should be interpreted to mean that the respondent had no answer, i.e. did not know. In some tables, we have the category "OTHER", which means that respondents had a wrong response and they too should be considered with the "don't Knows".

The questionnaire used in this study is presented as Appendix 2.

of education could not name Vas Deferens though 5% who claim to have had at least nine (9) years of education could name this organ. From Table 3, we can conclude that as years of education increase, so does the knowledge level about reproduction.

TABLE 2

FEMALE SEX ORGANS

NAME OF ORGAN	% CORRECTLY NAMING ORGAN			
	M	F	RESPONDENTS SEX NOT IDENTIFIED	TOTAL
Ovary	68	64	65	65
Uterus	62	64	70	64
Vagina	83	72	74	75
Fallopian Tubes	11	15	13	14
Other	35	36	26	35
DK	0	0	0	0
R/A	5	5	4	5
PERCENT	264	256	252	258
BASE	82	215	23	320

TABLE 3

YEARS OF EDUCATION COMPARED TO KNOWLEDGE OF MALE SEX ORGAN

NAME OF ORGAN	YEARS OF EDUCATION				
	ED NOT REPORTED	7-8	9	10	11+
Penis	13	13	16	19	15
Testicles	71	29	68	69	77
Vas Deferens	5	0	5	0	14
Other	11	13	11	12	2
PERCENT	100	100	100	100	100
BASE	134	38	64	26	58

While it would be easy to conclude that the knowledge levels of the youth concerning reproductive organs seems to be limited, it should be cautioned that the responses given by our students may not be fully representative of their knowledge on these matters. The questionnaire, it is recalled, was in English which is a second language for the majority of the students. The question therefore may not adequately measure the respondents' knowledge in these matters but rather may measure the respondents' knowledge of the English language. It may well be that the majority of the students could name all the male and female reproductive organs if they answered the questions in their own language. Since the language of instruction in Kenyan schools is English from the earliest years, however, we are still inclined to conclude that the students do not have basic knowledge on reproductive matters and that, especially in the primary schools, reproductive organs are rarely mentioned.

The respondents were asked to complete the sentence, "Spermatozoa are tiny, but very active. They are produced in the _____". Table 4 gives the results. As can be seen the majority of the youth (64%)correctly completed the sentence. The "Wrong answer", "don't know" or "refuse to answer (RA)" response columns should be added together to mean that respondent does not know the answer. (For ease of reading the Tables we shall continue to present the columns with these breakdowns.)

TABLE 4

PERCENTAGE BY SEX CORRECTLY COMPLETING SENTENCES

RESPONSES	MALE	FEMALE	RESPONDENTS SEX NOT GIVEN	TOTALS
Testicles	85	56	56	64
Wrong Answer	9	28	22	22
Don't Know	0	2	0	2
R/A	6	14	22	12
TOTAL PCT	100	100	100	100
BASE	82	215	23	320

As in the case of male/female reproductive organs, the higher the education of the respondents, the greater the chances that they will correctly name the organ or complete the sentence with the appropriate response. Thus in Table 5 we note that those with more years of education were able to complete the sentence correctly.

TABLE 5

PERCENTAGE BY YEARS OF EDUCATION SUCCESSFULLY COMPLETING THE SENTENCE (ITEM 3)

PLACE OF SPERMATOZOA PRODUCTION	YEARS OF EDUCATION					
	ED. N/R+	Up to 8	9	10	11+	Totals
Testicles	63	58	59	61	74	64
Wrong Answer	20	34	20	31	19	22
DK	2	0	2	0	2	2
R/A	15	8	19	8	5	12
PERCENT	100	100	100	100	100	100
BASE	134	38	64	26	58	320

+ . N/R refers to the category of respondents who did not report years of education completed.

In another question, the respondents were asked to complete the following sentence: "one ovum is released from the female _____ approximately every 28 days". Table 6 gives the results.

TABLE 6

% BY SEX CORRECTLY COMPLETING THE SENTENCE

RESPONSE	SEX OF RESPONDENT			
	M	F	N/R	TOTALS
Correct (Ovary)	62	32	48	41
Incorrect	31	47	43	43
DK	0	2	0	1
R/A	7	19	9	15
PERCENT	100	100	100	100
BASE	82	215	23	320

Less than a third of the females attempting the sentence completion could correctly state that the ovum is released from the ovary. In contrast, 62% of the males had the correct response, even though they do not experience menstruation. Lack of knowledge on the part of the female respondents perhaps indicates the well known situation in Kenya where fewer females than males have had access to education. It is possible that figures presented in this and other tables on womens' knowledge about reproduction reflect the women's status in education. In Table 7 we note that as years of education increase so does the knowledge level.

TABLE 7

YEARS OF EDUCATION COMPLETED COMPARED TO CORRECT RESPONSE

RESPONSE	YEARS OF EDUCATION					
	ED. N/R	Up to 8	9	10	11+	Totals
Correct (Ovary)	37	39	36	19	67	41
Incorrect	45	58	36	50	33	43
DK	2	0	0	4	0	1
R/A	16	3	38	27	0	15
PERCENT	100	100	100	100	100	100
BASE	134	33	64	26	58	320

In another question we asked the respondents to state one which day of the menstrual cycle they thought a woman is most fertile and likely to get pregnant (counting the first day of menstruation as Day One). As Table 8 indicates, less than one quarter of both the males and the females could estimate the day, i.e., the 14th day of the cycle. Perhaps the significance of the revelation is that many young people, especially young adults in schools, seem to be having intercourse with greater frequency than has been the case under the traditional society. However, while many indicate that they know a method of birth control, few of them have in fact used any or are willing to use any. (We shall present data below on contraceptive knowledge). The method most often relied upon by the youth is the "safe period". "Safe period", while it is most unreliable, depends on the girl's knowledge of her menstrual cycle in order for it to be considered at least minimally reliable. Our youth do not seem to know when the safe days are.

TABLE 8

KNOWLEDGE OF WHEN WOMAN LIKELY TO BECOME PREGNANT COMPARED TO SEX OF RESPONDENTS. (IN PERCENT)

MOST LIKELY DAY	SEX OF RESPONDENT			
	M	F	N/R	TOTAL
14th Day	22	22	39	23
Other days	64	61	39	61
DK	0	2	0	1
R/A	14	15	22	15
PERCENT	100	100	100	100
BASE	82	215	23	320

When we compare the responses by years of education we note that education and knowledge are related as Table 9 below shows:

TABLE 9

YEARS OF EDUCATION COMPARED TO WHEN IN HER MENSTRUAL CYCLE A WOMAN IS LIKELY TO BECOME PREGNANT

MOST LIKELY DAY	YEARS OF EDUCATION					
	N/R	Up to 8	9	10	11+	Totals
14th Day	19	8	19	19	50	23
Other days	59	89	70	54	38	61
DK	-	0	0	0	3	1
R/A	21	3	11	27	9	15
PERCENT	100	100	100	100	100	100
BASE	134	38	64	26	58	320

In another question, the respondents were asked to complete the following sentence: "The shedding of the lining of the uterus is known as _____." Table 10 and 11 give the results by sex and by education respectively.

TABLE 10

RESPONDENTS' RESPONSES BY SEX COMPARED TO THEIR ANSWERS

SHEDDING OF UTERUS LINING	SEX OF RESPONDENTS			
	M	F	N/R	TOTALS
Menstruation	27	40	30	36
Incorrect Answer	37	17	18	22
DK	1	1	0	1
R/A	35	42	52	41
PERCENT	100	100	100	100
BASE	82	215	23	320

TABLE 11

RESPONDENTS' RESPONSES BY YEAR OF EDUCATION

RESPONSE	YEAR OF EDUCATION					
	N/R	Up to 8	9	10	11+	Totals
Menstruation	33	32	29	15	60	36
Incorrect	23	29	27	12	16	22
DK	2	0	2	4	0	1
N/A	42	39	42	69	24	41
PERCENT	100	100	100	100	100	100
BASE	134	38	64	26	58	320

Responses to other questions on reproduction show the same pattern and thus clearly indicate one or two things. Firstly, had the questionnaire been in the students' language, perhaps a higher percentage of them would have been able to give the correct responses. This, while it is a possibility is doubtful, especially when we bring the cultural element into our discussion. Traditionally, young people learned about matters concerning reproduction, child bearing and related matters during their initiation period or after. The societies then had built-in means for ensuring that such things were taught. Today, however, when formal education has replaced traditional forms of education, it is not possible for young people to receive the same type of education as in the past. Consequently, most young people know little if anything about reproduction except what they read, hear and think, which is generally not correct.

Secondly, these responses might indicate that there is little, if anything, being taught at the schools about reproduction and especially human reproduction. Whatever little is being taught in the schools is usually in the upper secondary schools. Some people would argue that this is the best time to introduce serious discussions about human reproduction since the students are older. Since the vast majority of our youth never get to attend secondary school, however, they would be completely excluded from such discussion.

Because these are the young men and women who are soon to join the ranks of parenthood, it is therefore important that they learn something about how they reproduce and thus be in a position to advise their own children. It is contended here that the parents of these young people are not in a position to advise their children, mainly because of embarrassment but also because they don't know the answers themselves. The institutions which were responsible for this type of education have been eroded. Nevertheless, the need for this knowledge continues to decline. The question to be asked is whether our society shall ignore this basic and essential part of training for its youth or whether it will make adequate arrangements to transmit the basic knowledge to them? This important question will be discussed in the concluding remarks of this paper.

Knowledge on Contraceptive Methods.

There is debate in Kenya, especially among the decision-makers, as to whether population education and/or sex education should be formally taught to our youth, especially unmarried youth both in and out of schools. The voices that advocate this type of education are few in number in comparison to those who feel that matters pertaining to sex and family planning should be left to the parents who, as already indicated above, do not have the knowledge to teach their children.

Neither the advocates nor the opponents of teaching population/sex, however, have any documentation of the attitudes and knowledge of our youth concerning these matters, which would give our policy makers scientifically gathered information.

This study does provide such information. For example, one of the questions on contraceptive methods asked the respondents to write down at least four female contraceptive methods they knew. Table 12 gives the results.

From Table 12 and 13 it is clear that the youth, especially those who are in school, do know of at least one method of contraception. On the question asked about female contraceptive methods, the fact that the respondents mentioned the condom as a method of contraception should be interpreted as knowledge of contraceptive but without

TABLE 12

KNOWLEDGE OF THE FEMALE CONTRACEPTIVE METHODS COMPARED TO SEX OF RESPONDENT

METHOD	SEX OF RESPONDENTS			
	M	F	N/R	TOTALS
Oral Pill	79	55	74	61
Injections (Depo-Provera)	13	18	13	17
IUD	33	33	30	33
Abstinence	6	9	9	8
Condom	26	12	17	16
Jellies, & Creams	10	16	4	14
Diaphragm	9	5	9	6
Rhythm	16	19	9	18
DK	1	7	0	5
N/A	18	27	17	24
Other	33	24	43	28
PERCENT	237	225	226	230
BASE	82	215	23	320

TABLE 13

KNOWLEDGE OF FEMALE CONTRACEPTIVE METHODS COMPARED TO YEARS OF EDUCATION OF RESPONDENTS

METHOD	YEARS OF EDUCATION					
	N/R	Up to 8	9	10	11+	Totals
Pills	67	24	45	54	91	61
Injections	21	5	17	4	19	17
IUD	38	13	22	19	50	33
Abstinence	4	11	13	15	7	8
Condom	13	0	14	8	38	16
Jellies & Cream	16	5	6	54	3	14
Diaphragm	6	0	6	0	12	6
Rhythm	20	8	16	23	17	18
DK	6	0	8	0	3	5
N/A	19	63	36	15	3	24
Other	29	16	17	42	36	28
PERCENT	240	145	200	238	279	230
BASE	134	38	64	26	58	320

the accompanying knowledge of whether it is the woman or the man who uses it.

We have indicated elsewhere[3] that, though the pill is difficult to use, it is the most popular method of contraception among our women. The pill is by far the best known method of contraception, not only by those who use it but also by those who know of any method. Among our respondents, 61% mentioned the pill as a method. The Intra-uterine Device (IUD) is the second best known method with 33% of the respondents mentioning it. It is interesting that the rhythm method, known by 18% of the respondents, is better known by female respondents than the males (19% and 16% respectively). It will be recalled that the rhythm works according to the menstrual cycle although this method is fairly well known by our female respondents, their knowledge does not seem to extend to practical use of it since only 22% of the female respondents knew that a woman was most likely to become pregnant on the 14th day of the menstrual cycle. (See Tables 8 & 9).

Injections (Depo-Provera), while receiving an over-all 17% mention by the respondents, are not widely available in Kenya because their use is restricted to women with five children or more. Thus, even assuming that a good many of the respondents have used a method of contraception, it is not possible that any of them have used the depo-provera. The condom, which is easily available and which one would expect to be well known among the youth, takes fourth place overall, it takes third place among the males but sixth place among the females.

When the knowledge of female contraceptives is compared to the educational level, the same pattern emerges, thus perhaps indicating that years of education do not make much difference in terms of knowledge of contraceptives. Education would seem to make the difference only when one considers the various methods available.[4]

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3. J. Mugo Gachuhi, "Who Needs Family Planning?", IDS Staff Paper No. 115, 1971.

4. This notion also confirms our earlier finding in a different study. See Gachuhi, Loc. cit.

On the question of male contraceptive methods, the respondents were able to think of only three methods (see table 14). The condom takes a commanding lead as male contraceptive method (47% over all). It is mentioned by 60% of the males as compared to 40% of the females. Sterilization, while it is considered a method of birth control, is mentioned by only 5% of both the males and females.[5] It is noteworthy that neither the male nor the female respondents thought of sterilization as a female method of contraception. While sterilization is not widely known or practiced in Kenya, 10% of the male respondents consider it to be a method which the men can use.

Abstinence, the only other method thought of as a male method by both the males and the females, received a 2% mention from both the sexes. This should be compared to the number of males (6%) and females (9%) who thought of abstinence as a method of female contraception.

TABLE 14

KNOWLEDGE OF MALE CONTRACEPTION COMPARED TO SEX

METHOD	SEX OF RESPONDENTS			
	M	F	N/R	TOTALS
Condom	65	40	48	47
Sterilization	10	4	4	5
Abstinence	2	2	0	2
Other+	50	34	39	39
DK	2	7	0	5
N/A	20	40	39	35
PERCENT	149	127	130	133
BASE	82	215	23	320

+ "Other" refers to methods that cannot constitute contraception, e.g. pray to God.

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5. Sterilization among many people in Africa whether young or old, is equated with castration. As such, it would be very difficult to persuade many men to undergo the operation.

TABLE 15

MALE CONTRACEPTIVE KNOWLEDGE COMPARED TO RESPONDENTS' EDUCATION

METHOD	YEARS OF EDUCATION					
	N/R	Up to 8	9	10	11+	Totals
Condom	49	11	45	42	69	47
Sterilization	7	0	2	4	9	5
Abstinence	1	3	2	4	3	2
Other	39	18	44	31	50	39
DK	7	3	5	0	3	5
R/A	29	74	39	31	21	35
PERCENT	132	109	137	112	155	133
BASE	134	38	64	26	58	320

The question in knowledge was followed by one in which the respondents were asked to name a contraceptive method which they considered to be 100% effective. Table 16 shows the response breakdown.

TABLE 16

ONE METHOD THAT IS 100% EFFECTIVE COMPARED TO SEX

100% EFFECTIVE METHOD +	SEX OF RESPONDENT			
	N/R	M	F	TOTALS
Sterilization	0	10	1	3
Abstinence	0	6	2	3
Pills (Oral)	9	21	19	18
Injections	0	4	3	3
Other	17	31	18	21
DK	4	2	4	4
R/A	70	28	53	48
PERCENT	100	102	100	100
BASE	23	82	215	320

+ Sterilization and Abstinence are of course the two methods that are 100% effective. Oral pills and injections are also known to be almost 100% effective.

Taken together, 27% of the respondents know of at least one method that is considered to be 100% effective. By sex, 41% of the males know of at least one method that is 100% effective. This is in comparison to only 25% of the females even though it is the women who use most of the contraceptives currently available. Surprisingly, since it is practiced by a number of young people, nowhere was abortion mentioned by the respondents as a method of contraception. Perhaps it is because abortion is a post-conception method rather than a pre-conception measure. It should nevertheless be considered a method which a very large number of Kenyan youth know about and which a sizeable number of them have used at one time or the other.

When the question on effective contraceptive method is cross-checked with respondents' years of education (Table 17), the oral pill is by far the best known method of contraception that they consider to be 100% effective. This is followed by abstinence, injections and sterilization tying for the second place. The fact that these three methods are not widely used in the country - and thus information on them is not very widely circulated --- might give a clue as to why they are not considered to be 100% effective. Among those who have 11 or more years of education, the pill is the most popularly considered as 100% effective (21%). Sterilization is considered to be effective by 12% of this group while injections and abstinence vie for the third place. The rest of the breakdown is presented in Table 17.

Table 18 shows, 12% of the males were able to name IUD as the female method that is 97% effective while only 10% of the female respondents could do so. As the years of education increase, the young people come to consider the available methods not only in terms of their availability and use but also in terms of the degree of their effectiveness. What these responses perhaps indicate is that, while Kenya young adults know of or have at least heard of the various contraceptive methods, many of them may not know how reliable each method is compared to its effectiveness or side effects.

Finally on knowledge of contraceptives, the respondents were asked which two methods they would consider using when the time

TABLE 17

METHOD THAT IS 100% EFFECTIVE COMPARED TO RESPONDENTS' YEARS OF EDUCATION

METHOD	YEARS OF EDUCATION					
	N/R	Up to 8	9	10	11+	Totals
Sterilization	2	0	2	0	12	3
Abstinence	1	0	8	4	3	3
Pills	28	8	8	8	21	18
Injection	4	0	3	0	3	3
Other	19	8	17	32	29	21
DK	5	3	5	0	2	4
R/A	40	82	58	50	31	48
PERCENT	100	101	101	100	101	100
BASE	134	38	64	26	58	320

TABLE 18

FEMALE CONTRACEPTIVE WHICH IS 97% EFFECTIVE COMPARED TO SEX AND EDUCATION

METHOD	SEX OF RESPONDENTS				YEARS OF EDUCATION					
	N/R	M	F	TOTALS	NR	Upto 8	9	10	11+	TOTALS
IUD	0	12	10	10	12	3	5	12	16	10
Incorrect	41	48	32	37	34	18	34	42	57	36
DK	0	1	5	3	5	2	5	0	0	4
R/A	59	39	53	50	49	79	56	46	27	50
PERCENT	100	100	100	100	100	100	100	100	100	100
BASE	23	82	215	320	134	38	64	26	58	320

came. We found that the male[6] as well as the female respondents said they would use the oral pills. Even when compared to educational attainment all the respondents answering the question indicated they would prefer to use the pill. The second ideal contraceptive method among the male respondents is the condom while the females would choose the IUD as an alternative method of contraception. The following Tables give the respondent's choices of methods they would use when the time came.

TABLE 19

IDEAL CONTRACEPTIVE CHOICE BY SEX OF RESPONDENT

METHOD	SEX OF RESPONDENT			
	M/R	M	F	TOTALS
Oral Pills	26	27	24	25
IUD	0	5	7	6
Condom	4	17	3	7
Injections	0	6	6	6
Abstinence	0	4	3	3
Safe Period	0	1	3	3
Doctor's Advice	0	0	2	1
Jellies & Creams, etc.	0	0	1	1
Sterilization	0	0	0	0
None	0	1	0	0
DK	0	1	1	1
R/A	70	39	49	48
PERCENT	100	100	100	100
BASE	23	82	215	320

6. The fact that the responding males indicated that they would use methods which are only applicable to females might be an indication of one or two things: Firstly, it is probable that the respondents did not understand the question, or secondly, the males, while they indicated a method they would use when the time came, did so perhaps with the idea that they would recommend such methods to their spouses rather than use them personally. The responses, it should be recalled are merely expressing an ideal choice. But the fact that many of them see the need for use of contraceptives may be an indication that in the future, contraceptives may be widely used.

When ideal contraceptive method is cross tabulated against education, the following emerges:

TABLE 20

IDEAL CONTRACEPTIVE CHOICE COMPARED TO RESPONDENTS' EDUCATION

METHOD	YEARS OF EDUCATION					
	N/R	Up to 8	9	10	11+	Totals
Oral Pill	27	8	23	23	35	25
IUD	5	3	2	15	9	6
Condom	6	0	6	8	12	7
Injection	4	10	9	0	3	5
Abstinence	2	5	3	4	2	3
Safe Period	3	3	2	0	5	3
Doctor's Advice	0	5	3	0	0	1
Jellies, Creams, etc.	0	0	0	12	0	1
Sterilization	0	0	0	0	0	0
None	1	0	0	0	0	0
DK	2	0	2	0	0	1
R/A	50	66	50	38	34	48
PERCENT	100	100	100	100	100	100
BASE	134	38	64	26	58	320

In these tables we have presented data on the young people's knowledge of family planning/contraceptive methods available. It is clear that most of the respondents answering specific questions know that contraceptives are available for family planning; they know what they are and they also have limited knowledge of use-effectiveness of some of the available methods. As indicated, ideally the majority of those answering the questions would like to use contraceptives of one kind or the other for family planning. Whether the ideal will hold over their fecund period can at this time be only a matter of conjecture. It would be hoped that these ideals are strong and genuine enough to be cherished overtime. Even so, for those who are concerned about population growth and the general welfare of the Kenyan people to assume this trend is hopeful without extra inputs on their part would be an error. As already implied, the aspects of the inputs

we have in mind will be discussed in the concluding chapter of this paper. Before we can go to that, however, we present data on attitudes towards family planning; e.g. desired number of children, sex of children, career aspiration and desired place of residence, i.e., in town or country.

Youth Attitudes Towards Family Planning, Children, Career Choices, etc.

Perhaps the most important concern for many parents in Kenya today is whether or not their children will pass the primary school examination and go on to secondary school. For those who cannot pass well enough to go to secondary school, their concern as well as that of their parents is whether or not they will be able to find employment, especially in the modern sector. Even for those young people who manage to pass the examination and go on to secondary school, their worry, which is also becoming a major concern for the nation, is whether they will be able to find employment or not upon completion of their secondary school training.

Unemployment and the rapid rise in population are at the moment perhaps Kenya's biggest and most serious problems. Each depends on the other, i.e. unemployment is generally a result of too many people demanding too few jobs. The corollary is that too many people bring about unemployment problems, especially when the population rate is growing faster than the economy which would supply employment. For Kenya, at the moment, population is rising at a faster rate than the economy is able to absorb. Ideally, of course, one would want to have the economy growing faster than the population. In other words, when a nation is trying to accelerate her economic development, she ought to find ways of slowing down her population growth rate to a tolerable level.

For the next two or so decades the nation's population growth rates, whether fast, average or slow, will very much depend on the decisions and actions we make today. The introduction of family planning services as an integral part of our over-all development strategy and concentration on rural development not only to create employment but also to improve the welfare of our rural population are only two of the decisions that Kenya has taken in her fight against underdevelopment.

Success or failure of such actions on the whole depends not only on the government's ability to provide the needed capital and incentives but to a large extent on the attitudes of the people towards a specific innovative idea.

Our contention is that family planning, or better yet, population policy affecting the rate of population growth depends not just on a policy declaration but also on the measures taken to realize such a policy. Thus, for the rate of population growth to be influenced in the future, a decision concerning youth and their role in nation-building will have to be made. What youth thinks about programs such as family planning, indeed whether the youth thinks there needs to be a population policy, the number of children they think they would like to have, their future aspirations, etc., are all important in any planning which is expected to result in positive growth and development in the future.

To date, however, whether in family planning, population education, and/or sex education, we have left the youth out of the program, often without even knowing whether they have an attitude or an opinion towards those matters.[7] Mostly, their opinions are not regarded as important.

In our questionnaire we wanted to know the ideal number of children the respondents want to have when they marry. As Table 21 indicates, the majority (61%) wants to have four or less children. This is significant because in previous studies (Dow, Heisel, Molnos) the ideal number of children desired by a couple has been stated as 6.7. children. It would seem that the youth, especially those in school are beginning to seriously consider the number of children they would like to have in contrast to their parents who generally have left things to fate. These reasons for desiring fewer children are presented in Table 21 below.

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7. Youth is usually left out of family planning service because by many people's definitions family planning services are for the married. For the development of this attitude see J. Mugo Gachuhi "Population - Education for our Schools" IDS Working Paper No. 27 March, 1972.

TABLE 21

IDEAL NUMBER OF CHILDREN DESIRED COMPARED TO SEX OF RESPONDENTS

NUMBER OF CHILDREN	SEX OF RESPONDENTS			
	N/R	M	F	TOTALS
2 - 4	51	68	59	61
5 - 6	9	19	28	24
7 or more	9	7	8	8
As many as possible/ God's will/Fate etc.	9	5	2	3
DK	0	0	1	1
R/A	22	1	2	3
PERCENT	100	100	100	100
BASE	23	82	215	320

Disregarding the "not reported" (i.e. N/R, Sex of respondent not reported), it seems that the males want to have fewer children than the females. If this is indeed true, perhaps the often voiced complaint that African males are anti-family planning could be dealt a serious blow.[8] Perhaps this particular group wants fewer children because

8. The contraceptives provided through family planning are nearly always for women. In most countries, recruitment for family adopters is done among the women and it is not unusual that many contracepting women do so without the knowledge of their husbands. We have no evidence in Kenya to show clearly that the males don't approve of family planning. In fact we believe that the opposite is true. The problem as we see it, is that the deliberate campaign to involve only the women and not the men is based on wrong premise; i.e. it is easier to get the women to want to use contraceptives since they are the childbearers and the sufferers. Males, we believe, are keen to have children but only those they can afford to provide with modern amenities - e.g. schooling, land, etc. This is especially true in the present Kenyan situation where jobs, education, etc. are becoming difficult to obtain. The present trend also seems to be that, whereas the females want to marry at an earlier age, many young people are postponing their marriage and some are going so far as buying a consumer item rather than plunging into marriage.

of the situation in which it finds itself, i.e. fairly well educated, training for professional careers and therefore no longer considering children as the only source of prestige. Table 22 confirms the notion that the more education one has the fewer children are desired.

TABLE 22

NO. OF CHILDREN DESIRED COMPARED TO EDUCATIONAL LEVEL

NO. OF CHILDREN		YEARS OF EDUCATION				
	N/R	Up to 8	9	10	11+	Totals
2 - 4	62	34	75	42	65	61
5 - 6	20	50	14	46	19	24
7 or more	8	13	5	8	7	7
As many as possible/ God's will/Fate etc.	3	0	6	0	4	3
DK	1	3	0	0	2	1
R/A	6	0	0	4	3	3
PERCENT	100	100	100	100	100	100
BASE	134	38	64	26	58	320

Clearly the direction of the desired number of children is toward fewer and fewer children. Sixty-five percent of those with eleven or more years of education want to have up to four children while only those with up to eight years of education want to have more than 4 children. If education is an important variable in the number of children desired, the question arises that, since the majority of our young people do not go much past the primary schools, should special efforts be made to inform them on matters concerning their future welfare as well as that of their children? It seems that, as a person continues with education, his chances improve for learning about his reproduction and the fact that he can control it. To those who do not have this opportunity, some special efforts to provide them with this information would seem to be in order.

In another question, respondents were asked to give the reasons why they desired this number of children. The results, we think, are most significant and perhaps might point out future directions in population campaigns. They are significant in that, in most

KAP (Knowledge, Attitude and Practices) studies, reasons for the desired number of children have been: "for old age security" "god's will", etc. In this study the most important reasons for desire for children, are in order of importance, (1) wealth, (2) education (3) family welfare and (4) health. These are important variables which influence each other and the fact that our youth is recognising them may very well affect the future aspirations and ability to acquire them and could to a significant degree influence the decision on the number of children a couple is willing to have.

Even when desire for children is checked against the educational attainment variable or sex variable the four major reasons are still out-standing.

TABLE 23

REASONS FOR DESIRE TO HAVE THIS NO. OF CHILDREN COMPARED TO RESPONDENT'S SEX

REASONS	SEX OF RESPONDENT			
	M/R	M	F	TOTALS
Wealth	23	32	31	30
Education	17	31	27	27
Family Welfare	0	8	11	9
Health	4	9	8	8
Traditionalism	0	5	5	5
Favorite No/desire	4	5	3	4
Security Insurance	0	1	3	3
Prestige/Fame	4	1	1	1
Underpopulation	0	1	1	1
Overpopulation	0	1	0	0
Even numbers	0	0	1	0
National Security	0	0	1	0
No reason	0	1	1	1
DK/R	48	5	8	10
PERCENT	100	100	100	100
BASE	23	82	215	320

One of the major reasons given as to why Kenya should have a population policy which encourages a small family norm is the almost alarming rate of population increase. While these are valid reasons, any effort to use rapid population growth rate as an argument to persuade the Kenyans to adopt family planning is probably destined to fail. So is the argument advanced by opponents of a population policy that we need more people because the country is underpopulated. Only 1% of the respondents said that they wanted to have more children because they were concerned with the country's underpopulation. In the total percentage mention, no one thought that overpopulation was a problem even though, when considered by sex, 1% of the male respondents gave overpopulation as their major reason for desire to have fewer children.

Our ongoing field work confirms this notion even among the older people. The aspect that the family planning educators should be emphasizing when trying to convince the people of the need for family planning and smaller families, should be education; that is,can a family afford to educate its children. Education of children will depend on parental wealth which the majority of the respondents consider a major reason for their desire to have fewer children. Table 23 is self-explanatory and does not need too much emphasis on our part. We should emphasize, however, that the often voiced statement that Africans are traditional in outlook and especially in matters concerning children is perhaps more of a prejudice than a fact. We strongly suspect that while traditionalism may sometimes be a barrier to adoption of innovation, especially contraceptives, it is not the major reason why our people refuse to use contraceptives. We feel that they don't adopt them <u>because they have not been provided with alternatives</u>: that is, they are not convinced that their problems will be solved by simply using contraceptives. At the same time that pro-family planning campaigns are being waged, there must also be structural changes in other institutions of the society - changes which too often individuals have no power to affect. When people are persuaded to have smaller families, it must at the same time be demonstrated that the

smaller number of children they do have will have better opportunities e.g., that there will be schools and employment for them and that the parents will be provided for in their old age by government sponsored social security if they do not have large families to look after them.

Contraceptives are not an alternative to family welfare, nor indeed to national welfare. They are an integral part of the over-all welfare. Similar campaigns and efforts must therefore be made in other aspects of life.

Education cannot be emphasized enough because it is the one commodity that Kenyans cherish most. Important as it is in Kenyans' minds, its practical utility is questionable as a means for primary school leavers to achieve personal and family welfare. It would therefore do us no good to want to introduce population/sex education in our schools unless we also make an effort to reform our educational curriculum so that the type of learning a pupil gets, no matter how limited, can serve first his needs, then those of his family and, when possible, those of his nation.

Table 24 below shows the respondents' reasons for their desire to have a certain number of children when compared to the years of education they have completed. As we have tried to show throughout this paper, the role of education in population and related matters cannot be minimized. In fact we are convinced that the schools must be involved in population matters if we are concerned about our population growth rates. In short the youth has to be informed and involved from the very start of our efforts if we can expect to bring about any change in the country's fertility rates. It must be recalled that while these statistics would indicate that any efforts in population matters directed to the youth might be well invested and that the schools are a promising place for teaching such matters, the indices we have are only those idealized by youth, e.g. in terms of the number of children they would like to have. One would have to wait for the actual reproductive performance to see how closely it approximates the ideal. The fact that our youthful respondents are in school and that many of them are aware of the changing situations in the country in education and employment might be taken as a good indication of the probable birth pattern in the near future.

TABLE 24

REASONS FOR DESIRE OF X NO. OF CHILDREN COMPARED TO EDUCATIONAL LEVEL OF RESPONDENTS

REASONS	YEARS OF EDUCATION					
	N/R	Up to 8	9	10	11+	TOTALS
Health	31	24	28	31	35	30
Education	31	19	28	27	24	27
Family Welfare	5	18	8	15	12	9
Health	4	26	11	0	5	8
Traditionalism	1	5	11	8	5	5
Favorite No/desire	6	0	0	4	5	4
Security/Insurance	2	0	3	0	7	2
Prestige/Fame	1	0	2	0	2	1
Underpopulation	1	0	0	0	0	1
Overpopulation	1	0	0	0	0	-
Even Numbers	1	0	0	0	0	-
National Security	0	0	0	0	2	-
No Reason	1	0	1	0	0	1
DK/RA	15	8	8	15	3	11
PERCENT	100	100	100	100	100	100
BASE	134	38	64	26	58	320

Table 25 below gives the respondents' first born preferences both by sex and education.

TABLE 25

COMPARISON OF FIRST BORN PREFERENCE BY SEX AND EDUCATION OF RESPONDENTS

FIRST BORN PREFERENCE	SEX OF RESPONDENT				RESPONDENTS EDUCATIONAL LEVEL					
	N/R	M	F	TOTALS	N/R	Up to 8	9	10	11+	TOTALS
Boy	44	77	51	57	56	42	64	54	62	57
Girl	9	6	36	27	23	42	27	46	14	26
Any	17	15	9	11	10	16	5	0	22	11
R/A	30	2	4	5	11	0	4	0	2	6
PERCENT	100	100	100	100	100	100	100	100	100	100
BASE	23	82	213	318	134	38	64	28	58	320

For the majority of the male respondents (77%) as for the majority of the female respondents (51%), the preferred first born child is a boy. Even as education level rises the majority of the respondents would still like to have a boy as the first born child. It is noteworthy that 6 times as many female respondents as males would prefer to have girls as their first born.

Before discussing the implication of this table on small family norm, it would be instructive to present data on another question which attempted to find out the ideal sex ratio of children among our respondents.

In patrilocal societies the desire for sons is so high that it would seem almost impossible to convince a couple who have not borne any sons to limit their family. In fact we suspect that the ideal number of children: i.e. four, that most of the African couples indicate as their desire would depend on the distribution of their children's sexes. Thus a couple might say they desire to have so many children, then stop having any more. This is likely to be so mainly if they get an equal number of boys and girls. Evenness of the sexes is important because it assures that neither partner has named more relatives than the other. This notion is especially true among the Eastern Africa Bantu groups.

Some couples would prefer to have more sons than daughters, perhaps indicating that the idea of inheritance and old age social security is still very much around.

Until the inheritance laws are changed to allow girls to inherit from their parents equally with boys, the problem of desire for boys rather than girls is likely to continue. Furthermore, we suspect that the same preference also contributes to the inequality of women in our society in almost all kinds of occupations, as reflected in the educational attainment of our women as well as in formal employment. The implication of this is obvious in family planning activities. A couple will not want to limit the number of boys and girls. Many would rather have more boys than girls. In fact the game might become one of competition between the husband and the wife to see who can reproduce him or herself more than the other. Table 26 shows clearly that ideally many of the respondents would prefer to have an equal number of boys and girls even though nearly a quarter of the males (24%) would prefer to have more boys than girls. The sizable (31%) over all percentage who say it would not make any difference, would in actual performance, probably also try to balance the sexes of their children.

The respondents were asked in this question to put a mark against any of the four given choices which they thought they would want to apply to them.

TABLE 26

IDEAL SEX RATIO COMPOSITION COMPARED TO SEX OF RESPONDENT AND EDUCATION ATTAINMENT

IDEAL SEX RATIO	SEX OF RESPONDENT				RESPONDENTS' YEARS OF EDUCATION					
	N/R	M	F	TOTALS	NR	UP TO 8	9	10	11+	TOTALS
Equal No. Boys & Girls	27	40	51	47	41	42	49	58	50	46
More girls than boys	6	4	9	8	3	18	9	8	7	7
More boys than girls	30	24	10	14	19	3	11	15	12	14
Makes no difference	35	36	30	31	37	37	31	19	31	33
PERCENT	100	100	100	100	100	100	100	100	100	100
BASE	23	82	215	320	134	38	64	26	58	320

We have no evidence yet concerning the reproductive behaviour of the various groups in different occupational categories. Theoretically it would seem that those with more education and occupying whitecollar and other professional jobs would tend to have fewer children than those with little or no education and having comparatively low occupations. On the assumption that one's occupation influences his fertility behaviour, we asked our respondents what were their occupational aspirations upon completion of their studies. As Table 28 indicates, the career pattern of most of the respondents is already very much determined by the type of training they are pursuing.

More than half (52%) of the respondents said that they would choose to be teachers after completing their studies while another 21% said they would like to be secretaries. Fifteen percent chose nursing and there were no other substantially large groups. Career choices or the nature of one's occupation generally determine where one will be living. Thus in Table 28 we asked the respondents where they would like their work to be, in cities and towns or in the country side. Forty percent of these responding to this question said they would prefer to work and live in the cities and towns while 55% said they would want their work place to be in the country side.

Assuming that Table 28 truly indicates the future trend, in terms of young people's migration, it would seem that the policy makers do not have much to worry about, at least as far as the influx of "educated" young people is concerned. However, we are doubtful as to whether the 78% of the males and the 47% of the females who indicated desire to work in the countryside did so purely from their genuine love for country life, or because the nature of their occupations leaves them without much control over where they would be posted by their employers. The latter would be the realistic appraisal of the situation as the majority of the male respondents are training to be teachers while only 38% of the female respondents are training for similar occupation. Another 28% of the female respondents as compared to 1% of the males are training to be office secretaries. The chances of a primary school teacher being given his teaching assignment in the urban areas are limited as compared to the majority of those training to be secretaries whose chances of urban employment are almost 100%. Thus 51% of the females indicated that their desired place of work is in towns and cities while only 17% of the males chose to live in such places.

TABLE 27

OCCUPATIONAL ASPIRATIONS OF RESPONDENTS BY SEX AND YEARS OF EDUCATION OF RESPONDENTS

OCCUPATION CHOICE	SEX OF RESPONDENTS				YEARS OF EDUCATION					
	N/R	M	F	TOTALS	N/R	Up to 8	9	10	11+	TOTALS
Teacher	48	87	38	52	62	15	48	27	67	51
Secretary	18	1	28	21	26	13	14	34	13	20
Nurse/Midwife	4	0	23	15	0	55	26	31	5	15
Farmer	4	1	0	1	1	0	0	0	2	1
Politician	0	1	0	1	0	3	2	0	0	1
Senior Civil Servant	0	1	1	1	0	3	2	4	0	1
Cateress	0	0	1	1	0	3	2	0	0	1
Matron	0	0	1	1	0	3	1	0	0	1
Professor	0	1	1	-	1	0	0	0	0	-
Doctor	0	1	1	-	1	0	0	0	2	1
Air Hostess	0	0	1	-	1	0	0	4	2	1
Hotel Manager	0	0	0	0	0	0	0	0	2	-
DK	0	4	0	1	1	0	0	0	2	1
R/A	0	4	0	1	9	5	5	0	5	6
PERCENT	100	100	100	100	100	100	100	100	100	100
BASE	23	82	215	320	134	38	64	26	58	320

TABLE 28

DESIRED PLACE OF WORK BY SEX AND EDUCATION

PLACE OF WORK	SEX OF RESPONDENTS				YEARS OF EDUCATION					
	N/R	M	F	TOTALS	N/R	Up to 8	9	10	11+	TOTALS
City/Town	17	17	51	40	32	45	37	73	41	39
Country Side	44	78	47	55	57	52	61	27	57	55
Any	4	1	0	0	1	3	0	0	0	1
Don't Care	0	0	0	-	0	0	0	0	0	-
R/A	35	4	2	5	10	0	2	0	2	5
PERCENT	100	100	100	100	100	100	100	100	100	100
BASE	23	82	215	320	134	38	64	26	58	320

The fact that most of the students who are enrolled in primary teachers' colleges are not generally the academically bright and that the teaching profession often is not their first career choice might give an indication as to why they would tend to choose rural life over life in the city. To start with, one's chances of getting to a training institution of any kind, and especially on public funds, increases as years of formal education increase. Thus slightly more than half (54%) of the males responding to the question had a maximum of nine years of education which is no longer enough to help them acquire white-collar-city-centred employment. However, their education can and often does, get them into the teaching profession and the secretarial profession, both of which are nevertheless prestigious to-day.

Table 29 presents data based on a question which asked the respondents where they would like to have a home for their families, e.g., "a home in the town where I work"; " a home in the country side where I work", or "two homes: one in town, and a shamba in the country side".

Desired place of residence closely reflects career choices. Thus, 67% of the male respondents and 37% of female respondents would like to have a home in the country where they work. Only 2% of the males and 11% of the females would like to have a home in a town. This perhaps reflects the respondent's knowledge of the difficulties encountered in towns, especially in acquisition of property such as homes. However, given the choices, 27% of the males and 48% of the females would like to have two homes, one in the countryside and one in town. The high proportion of females who fall within this category perhaps indicates the relative ease with which women, especially those with education, can and do find employment in urban areas in comparison to males with equal education. It also perhaps indicates the females' desire for the future, e.g. to marry someone who is better educated than they are and working in urban areas, thereby raising their own status. Their expressed desire to live in towns as reflected by their career choices confirms this. It should be noted that high female migration into East African urban centres is a fairly recent phenomenon.

TABLE 29

DESIRED PLACE OF RESIDENCE COMPARED TO SEX AND EDUCATION OF RESPONDENTS

RESIDENTIAL PLACE	SEX OF RESPONDENTS				YEARS OF EDUCATION					
	N/R	M	F	TOTALS	N/R	Up to 8	9	10	11+	TOTALS
In town	4	2	11	8	8	18	6	0	7	8
Country Side where I work	39	67	37	45	51	37	50	19	43	45
Two homes: Town and Country side (Shamba)	22	27	48	41	27	45	42	81	48	40
Any	0	1	0	-	1	0	0	0	0	-
DK	0	0	1	-	1	0	0	0	0	-
R/A	35	3	3	6	12	0	2	0	2	6
PERCENT	100	100	100	100	100	100	100	100	100	100
BASE	23	82	215	319	134	38	64	26	58	320

The men, however, seem to be more realistic about the unemployment situtation in towns and seem to know that their status will not be raised by their wives since they do not expect to be marrying girls with more education than they have. The strong desire to have a home in the country does not just reflect the young peoples' career choices. Perhaps much more fundamentally, it reflects the African desire to own land. Land, especially among the agricultural groups, is one of the most sought after commodities, for even a man who has a lot of liquid wealth, still wants land somewhere. The strong desire for homes in the countryside perhaps might also reflect the fact that only recently have our towns and cities begun to have permanent dwellers. The rural ties are so strong for most people that it is as yet difficult to isolate "urban man" from "rural man".

CONCLUSION:

Our purpose has been to present data on current levels of knowledge among selected youth of Kenya concerning reproduction, their knowledge about contraceptives for family planning, their attitudes towards use of contraceptives, their desired number of children and their job choices as well as preference for place of residence.

We have noted that the knowledge level concerning reproduction is very limited among our school-going youth and that many of them know about contraceptives even though they may not have used any. Evidence presented also indicates that four is the ideal number of children for the majority of the respondents, especially if the ratio of the sexes is even.

What all this evidence points to is that our schools do not seem to be making any serious effort to educate our youth in such vital aspects of life as reproduction. Preparation for living, by equipping our youth with the vital knowledge that they will need for their lives, is probably one of the most important roles of the schools. The high proportion of youth (over 50%) in Kenya that is under the age of 20 years indicates that within a short time, this group will be called to make vital decisions affecting every one in the country. For them to be able to play their roles effectively they must be able first of all to make personal decisions such as the number of children they want to have.

The high population growth rate and the increasing difficulty in finding formal employment are sufficient reasons to want to inform the youth on matters concerning population. We believe that the schools have this vital responsibility to the individual, the family and Kenyan society at large. Ways of incorporating population/sex education matters in the school syllabus have to be found. If indeed the people of Kenya are concerned about the high rate of population growth and the effects this has on the general economic welfare of both the individual and the society, the sooner action is taken to teach the youth about population and the role of youth population dynamics, the better it will be.

Population/sex education is a vital and legitimate activity of the school and society. By itself, of course, it cannot produce lasting results as far as the relationship of the sexes is concerned. It should be part of the integrated training for living.[9] We believe the youth of the country wants to know about reproduction, about family planning methods and about population issues in development. Young people have posed a challenge to the adult society, which ought to be accepted and answered in a non-emotional atmosphere. What factual information we give to the youth now may go a long way in helping them make rational decisions concerning their future and that of the nation

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9. See J. Mugo Gachuhi "Population Education for our schools". IDS, University of Nairobi. op. cit.

APPENDIX

Perhaps the best way to learn about the knowledge and attitudes of youth concerning specific issues is to listen to their questions. The Family Planning Association of Kenya, after giving a lecture, invites questions from the audience and tries to answer them as well as possible. These are often written out by the members of the audience mostly because some young people find it too embarrassing to ask the question orally. Their need to have the factual information is apparent, however, in the type of questions they ask. Also some adults raise questions especially during agricultural shows where the Association has a stand and display of various contraceptives. It is apparent that the adult questions are not much different from those asked by their children.

The fact that adults seem to know as little, if not less, than their children raises a very important educational policy issue. Too often a number of influential people take a moral stand that sex or family life education is the responsibility of the parents. If the parents are as ignorant of the facts as their children, how then can they be expected to pass on useful information to them. If they cannot, doesn't the educational system then have the responsibility of ensuring that it supplies the information which the society, as represented by the parents is unable to? As a society we have a vital responsibility to our youth. To withhold information on reproduction and population would be a disservice for the future well being of the individual and the nation.

This appendix is divided into six sections. The first 4 sections present the questions[1] raised by the youth in school - broken down by area of inquiry: (a) reproductive questions (b) contraceptive questions (c) general family planning attitude questions and (d) questions on sex education. The fifth section presents questions raised by university students and professional youth and welfare officers in the country. The last section (f) is on questions which parents raise. It should be recalled that these questions are gathered from all parts of the country. To this extent, they shed some light on the type of information the people want to receive. No effort is made to edit the questions.

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1. The author and the Family Planning Association independently keep files on questions such as those reported here.

Appendix

Questions generally raised by Kenyan Youth

(A) REPRODUCTION:

1. Can a woman become pregnant in the day when she is expecting her monthly period?
2. If a woman's monthly period starts on the 28th and she delivers on the 2nd, she expects to have her normal monthly cycle at the same dates, can this be possible?
3. I hear that some women do not get children because their husband's sperms have got round heads and in other cases two heads, is this true?
4. Sometimes doctors say that a certain woman has got infected tubes, how does this come?
5. It is understood that the first sperm to reach the ovum is the one that fertilizes the ovum and yet in some cases a woman has had intercourse and yet she doesn't become pregnant?
6. What happens when a woman gets twins and only one sperm did the actual fertilization?
7. There are women who gets twins every time, does it mean that she produces two eggs at a time?
8. A woman has got two tubes, does it mean that each tube has got different placentas?
9. Is it true that when a woman becomes pregnant the uterus is closed that there is nothing coming from there?
10. What is the best interval of spacing children?
11. I understand that the testes are like a machine, how long does it take them to make the spermatozoa matured so that they can be used for reproduction?
12. What is the difference between blood group and blood and does either of them affect reproduction?
13. Some girls fear playing sex as they say they do not have a safe period, is it true that they don't have a safe period?
14. Which is the safest period for a woman?
15. Does climate affect the monthly cycle of a woman?
16. When is a woman most likely to get pregnant?
17. What are the techniques of determining the sex of the child to be born?

18. What is wrong with a man who can never make a woman pregnant?
19. Why do some women suffer during pregnancy? and during menstruation?
20. When a woman's monthly period comes after 3 weeks does it mean that there is something wrong with her uterus? Is she likely to become pregnant?
21. How far should a sperm be inserted in the uterus to guarantee conception?
22. What is wrong with a couple which cannot have a child but when separated either one may have a child?
23. Where is the egg fertilized?
24. If one tube is blocked, it it possible for the woman to get a child?
25. What is the composition of identical twins and the ordinary twins? How do they come about?
26. I have heard many cases that when a child is being formed, it makes the mother undergo a complete blood transfusion. What is the explanation behind this? Is this what happens when every child is born to the same mother?
27. I understand that in some cases a child is born with the head facing upwards instead of downwards or the cord surrounds the baby two or three times, what causes this?

(B) CONTRACEPTIVES:

1. The pills, in my opinion, are not very effective especially when they are given to illiterate women because sometimes they forget to take them. What do you think should be done to such women?
2. All women are not the same. Some have their period for only two days, others for five days and others for even ten days. Are all these women going to count from one to fourteen so that they can know their fertile period?
3. It sometimes happens that after a woman has been using pills for a long time and she stops because she wants to have a child, she gets a deformed child. Does it mean that the pills affect a woman's ovaries?

4. When a woman has been taking pills and then stops she desires to have a child, she stays for a very long time before getting pregnant and it is said that the man's sperms do not have life, does it mean that the pills affect the man?

5. When a woman is seriously sick and she is advised not to take pills, does it mean that the pills affect the disease she is suffering from?

6. When a woman has had a loop inserted does it ever come out on its own?

7. Some women get skin diseases when they have a loop inserted and when they go to see a doctor they say they were told that the disease is caused by the loop. Is this true?

8. When a woman becomes pregnant while wearing a coil, it is understood that she brings forth a child with the coil in his hand, how does this happen?

9. Women become scared when they are advised by the doctors that the injections is only for those with children because if you do not have you might risk, how can we avoid this?

10. Which clinics in the country are having the injections because I have not heard of it in any clinic that I have attended?

11. If a woman is very sexy, I understand that the injection affects her sex desire, is this true?

12. Some men complain that they feel the coil in the woman when playing sex, is this the doctor's fault or whose is it?

13. Does sterilization mean that a person will never be productive again?

14. Some men complain that when a woman uses the foaming tablets, the vagina becomes too slippery and they do not enjoy sex. Is this true?

15. Is it true that women with sterilized husbands do not get satisfied after having sexual intercourse?

16. I have been given to understand that sometimes a woman needs to be operated to have a coil taken out of her uterus. What is the cause of this?

17. Is there any need of taking the pills when the husband is away?

18. Suppose one wants to play sex, can she take just one pill for that one time?

19. Which is the best method of family planning available?

20. What causes the bleeding that occurs when one fails to take pills continuously?
21. What would happen if one continues taking pills when she is pregnant?
22. Why does the coil hurt some women?
23. Suppose one forgets to take the pills for 4 or 5 days and then takes all those pills at the same time, would it help? or what would happen?
24. If you finish a packet of pills, stay for more than seven days before starting the other packet, what would happen if you play sex at this time?
25. Is there a permanent method of contraception whereby a woman is assured of never getting a child?
26. Is it advisable for the unmarrieds to practice family planning especially by the injection method?
27. How effective is the withdrawal method?
28. Why do coils cause lower abdominal pains and severe pain during monthly period and mostly on the left side?
29. Is it true that continuous use of the contraceptives makes somebody barren? If so why and how?
30. What is the maximum period for taking the pills?
31. We have been told that if we take these pills for more than 10 years we may spoil the pregnancy/missing any of the limbs. Is this correct?
32. Do pills make women to be pregnant in the fallopian tubes instead of in the uterus?
33. Is it true that women taking pills may get more than one child?
34. Doesn't the loop block the entrance to the uterus?
35. Is it true that if you don't use the pills properly and you happen to become pregnant, you can produce a child without one eye, or one hand or something of the sort?
36. Do the pills agree with all the women or are there some women who are not suitable for the pills?
37. I suppose that the injection method is new, supposing it had been there for ten years and the woman has been using it all that time, is there a possibility that the woman will never at all produce any ovum in her life?

38. How are creams and jellies used?
39. Are all these methods for women or they can be used by men too?
40. Is it safe to use these creams and jellies alone?

(C) VALUE & GENERAL FAMILY PLANNING AND POPULATION QUESTIONS:

1. I understand that the injection is given even to the young single girls, do you get permission from the girls, parents or don't you think you are doing harm to these girls?
2. If a woman is very sexy, I understand that injections affect her desire. Is it true?
3. Some women complain that they loose the sex desire after using contraceptives. Do such women get their monthly periods?
4. It is true that people are moving from rural areas to the urban areas. Is there anything that the Government is doing to stop this because our urban areas are going to be flooded with people?
5. Could the Government do something to have irrigation schemes round the Republic of Kenya so that these rural people can stop moving to urban centres?
6. What is our current growth rate and how does it affect the size of our families?
7. Why should your organization think it wise to advice school girls to practice family planning?
8. How can we communicate with other people in order to win their support and accept family planning?
9. Does it really help when a Chief or a District Commissioner approaches people in the field of family planning and yet they are not trained in this field?
10. Is there anything that the Government is doing to increase qualified staff in the rural areas to motivate people in family planning?
11. Most women, especially in the rural areas, are very shy and they are not free to bring forward their complaints about family planning methods that they use. What should be done to such women to make them feel free with the practice of family planning?

12. At what age can your clinic give contraceptives to school girls with the consent of the parents or even without?
13. What's wrong with the woman who tries all the contraceptive methods available and every one of these methods do not suit her?
14. The advice you give to girls is not suitable for them, you advise them as if they were married, is there any other way of advising these single girls?
15. Mothers or generally parents in most cases do not support the advice you give the single girls. Can't you change your policy and instead of going around advising girls about contraception methods, go around advising the parents so that they can talk to their daughters?
16. Why is it that the Asian population is growing at a higher rate than others?
17. Which are the most effective methods of contraception available to guarantee a success in family planning?
18. Which is the disease that a woman gets from the pills?
19. Why don't the men take pills?
20. Is there a need of taking pills while the husband is away?

(D) SEX EDUCATION:

1. What are the signs of Gonorrhoea in man and in woman?
2. Gonorrhoea is said to block the fallopian tubes. Does it block for the man too?
3. I understand that if a woman goes around with different men she cannot become pregnant. Is this true?
4. What is wrong with the men who have no desire for women?
5. Is there any harm to the girl who stays a virgin throughout her life?
6. Do men enjoy sex as women do?
7. Who is the best teacher for sex education?
8. Why shouldn't school girls be allowed to use contraceptives?
9. When a couple want to get a child and do intercourse every day without any success, does it mean that the man will lose the need for sexual intercourse?

10. In some cases a husband might be working away from his home and when he comes back home he might find his wife in her menstruation period. I understand that if the man plays sex with his wife at this time, he might get a disease like gonorrhoea, is this true?
11. Why is it that when we are playing sex and we feel like passing urine, sperms come out instead of urine?
12. A man may have 3 goes of ejaculation when he plays sex but his penis is still erect. Does it mean that he is very strong?
13. How many methods of playing sex are there and which is the most satisfactory?
14. When a man bathes in a basin and masturbation happens to take place, can these sperms fertilize a woman bathing in the same water?
15. Is it a sin to do abortion?
16. Is it harmful for a man to withdraw before he feels satisfied?

(E) QUESTIONS BY UNIVERSITY STUDENTS AND PROFESSIONAL YOUTH AND WELFARE OFFICERS.

Welfare Officers: How true are the following allegations against family planning:

1. That contraceptive users get too much tuned to sex, i.e. wanting to play sex vey much and very often:
2. That they complain of pain in the productive organs
3. That they loose enjoyment in sex.
4. That the pills do not necessarily stop pregnancies. Some women get pregnant even when using contraceptives.
5. That contraceptives make women sterile, i.e. they cannot have children when they want to.
6. That contraceptives have a medical immunity which stops reaction of other drugs in the body and in consequence recovery from other diseases is difficult.

University Students:

7. There is a very high rate of promiscuity today because society norms and values have changed, the single mother is despised and the extended family collapsing. How can we instil morality in our people?

8. In the Bible we read that Jesus was born of a virgin mother. Is this possible from a medical point of view?
9. In my view, the Roman Catholic Church stands for a dogma of the ideal society which is non-existent. Why cannot the Church be realistic and support abortion?
10. Why does the church not support the teaching of sex education, family planning and abortion?
11. The Roman Catholic Church beliveves in God and hence does not support abortion. Should atheists support abortion?
12. Can you give us statistics related to the psychological effects of abortion and unwanted pregnancies?
13. Is it not a belief of some people that one of the chief roles of woman in society is as an instrument of pleasure?
14. Since contraceptives are not 100% effective and if single girls abort they become unacceptable for marriage, what are we to do?
15. What action is the Family Planning Association taking to have legalized abortion in the country?

(F) QUESTIONS PARENTS ASK CONCERNING REPRODUCTION, CONTRACEPTION, FAMILY PLANNING, POPULATION, ETC.

We have raised the questions as to how much the parents know in matters that are of importance to the growth and development of youth, especially in matters relating to reproduction, family planning, sex education, national development, etc. In this appendix we present some of the questions raised by parents concerning these matters. As is quite clear, adults ask the same questions as their children. Their kick of knowledge perhaps underscores the need to have schools take on responsibility in teaching these matters. The obvious duplication of the questions asked by the youth is to underscore our point that parents seem to have less knowledge in these matters than their children.

1. Can pills be harmful when taken for a long time?
2. There are some women who miss their menstruation sometimes for unknown reasons. Is it advisable for them to use pills?
3. For those who do not know how to read, how do they know when to start on a new packet of pills?
4. Is it true that in some cases the loop can penetrate into the walls of the uterus?

5. Why is it that if a woman becomes pregnant when she has a loop inserted in her, she miscarries?
6. Why is there a string hanging out into the vagina after one has loop inserted?
7. Does the injection Depo-Provera delay the pregnancy?
8. Is it advisable for a single woman to be sterilised?
9. Is a couple with two children eligible for sterilization ?
10. Are there many men coming forward for sterilization?
11. What are the qualifications for one to apply for sterilization?
12. Which of the contraceptive methods is best for a person suffering from a liver disease?
13. Why do most women have backaches and headaches during menstruation?
14. Why does it seem to take very long for some women to get pregnant?
15. What is the cause of miscarriage?
16. Why is it that some women become very fat while on the pill?
17. How much do you charge for the injections?
18. Is there any injection that can be used for more than three months?
19. Do all these methods apply to women only or are there some that can be used by men?
20. Which method of family planning is best?
21. How is the coil used?
22. Does it mean that the coil kills the ovaries?
23. What are you trying to do by advising people to do family planning?
24. Since you started this organization, are there many people who have accepted to do family planning?
25. Is there any method that would be effective for life?
26. Is it a must that one takes the pill every day?
27. Is the wire you are calling a coil, the thing that I hear people calling a lock?
28. Is there any special diet for women with coils inserted into the uterus?
29. Does one have to swallow the coil through the mouth?
30. Some people say that a woman with a coil inserted grows thin and miserable, is this true?