



**AN EVALUATION OF KENYA NATIONAL PrEP
COMMUNICATION CAMPAIGN 'JIPENDE JIPrEP' ON THE
USE OF PRE-EXPOSURE PROPHYLAXIS (PrEP) AMONG
YOUNG WOMEN IN EMBAKASI, NAIROBI – KENYA**

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Fulfilment of the Requirements for the Degree of Master of Arts in
Communication Studies**

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DECLARATION

I, Florence Anam, hereby declare that this research project is my original work and has not been presented for award of degree in any other University

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DEDICATION

I dedicate this research project to my parents, Mr. George Riako Anam and Mrs. Anne Caroline Anam, for wishing this achievement for me; and to my children Vincent and Hope. For you, I got inspired even more to do this.

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ABSTRACT

This study sought to evaluate the Kenya national Human Immunodeficiency virus prevention communication campaign on the use of Pre-exposure prophylaxis as an prevention from human immunodeficiency virus intervention by young women in Nairobi. The general objective of the study was to evaluate the impact of the Kenya National prevention public awareness campaign on the usage of pre-exposure prophylaxis among young women aged 18-24 years in Embakasi, Nairobi. The specific objectives were to: assess the awareness levels of pre-exposure prophylaxis among young women aged 18-24; investigate the usage patterns of pre-exposure prophylaxis among young women aged 18-24; and examine the role of public awareness campaign in promoting uptake of pre-exposure prophylaxis by young women aged 18-24. The study used the Theory of Planned Behaviour and the Health Belief Model as the underpinning theoretical constructs. Both qualitative and quantitative research designs were used. The study population was women aged 18-24 years. The study employed simple random sampling technique to select 50 respondents to fill out close-ended questionnaires. Focus Group Discussions were conducted with 27 young women aged 18-24 years selected using purposive sampling technique. Surveys, in-depth key informant interviews, and Focus Group Discussions were the main data collection methods. Quantitative data was analysed using descriptive statistics and presented in form of tables, charts and graphs. Thematic data analysis method was used to analyse the ensuing qualitative data which were presented in descriptive narratives. The study found that majority of young women in Nairobi were aware of pre-exposure prophylaxis. However, they were not using it to prevent infection from human immunodeficiency virus which shows a knowledge behaviour disparity. The study also found that structural and communication barriers exist that negatively affect access and utilisation of pre-exposure prophylaxis among young women. This study recommends reframing of pre-exposure prophylaxis messages towards presenting it more as a lifestyle choice and less as a biomedical tool. The study also recommends that young women aged 18 – 24 be involved in designing public awareness campaigns on pre-exposure prophylaxis for women.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Treatment
DREAMS	Determined Empowered AIDS free Mentored and Safe Women
FGD	Focus Group Discussion
FSW	Female Sex Workers
GBV	Gender Based Violence
GFATM	Global Fund to fight TB AIDS and Malaria
HBM	Health Belief Model
HER	HIV Emergency Response
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic Health Survey
MDG	Millennium Development Goals
MOH	Ministry of Health (Kenya)
MSM	Men who have sex with men
NACC	National AIDS Control Council
NACOSTI	National Council of Science and Technology
NASCOP	National AIDS and STI Prevention Program

SDG	Sustainable Development Goals
SRHR	Sexual Reproductive Health and Rights
SPSS	Statistical Package for Social Science
STI	Sexually Transmitted Infection
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Overview

This chapter outlines the background of the study, the problem statement, objectives, the research questions, justification of the study, scope and limitations of the study and operational definitions.

1.2 Background of the Study

Human Immunodeficiency virus (HIV) affects women and young girls disproportionately. Various drivers contribute to this trend like unequal economic and socio-cultural influences in the society. According UNAIDS data, 790,000 or 59% of the 1.8 million people who were reported to have new HIV infection in 2017 were women.

Young women and adolescent girls are characterised with trends of increasing national and global new HIV infection data. It is estimated that there are 5000 daily new HIV infections, where 33% are likely to be recorded among young people (both male and female) who are between 15 and 24 years; and 19% recorded among young women who are 15 and 24 years old. Similarly, almost 610,000 young people aged 15 to 24 were newly infected with HIV in 2017. There were 44% more women between 15 years and 24 years who became newly infected with HIV compared to men in the same age (UNAIDS, 2018).

Studies also show that special groups of women are disproportionately affected by HIV and AIDS. Globally, females who practice sex work are approximately 14 times more likely to be infected with HIV than fellow women of reproductive age. HIV prevalence among women who are injecting drugs was 13% compared to 9% among their male counterparts (UNAIDS, 2016).

Gender inequalities; and discrimination harmful; practices stemming from culture and traditional practices; sexual violence against women; unfavourable and inequitable laws; and systemic gaps continue to fuel unequal power relations. All these make young

girls and women vulnerable to HIV acquisition; and impede their access to Sexual and Reproductive Health (SRH) services including HIV prevention services (Dellar, 2015). These drivers continue to exacerbate the disproportionate numbers of new infections in women and adolescents (UNAIDS, 2011).

This situation is not very different in Kenya where 40% of all new HIV infections (52,800 people) in 2017 were recorded in people who were 15 years to 24 years old (NACC, 2018). This population also constituted 51% of the 71,034 adults who became HIV positive in 2016 in the country. Adolescent girls and young women aged 15 to 24 years accounted for 33% of all the new infections recorded in 2016, an increase from the 29% recorded in 2015 (MOH, 2016). The main mode of transmission of the HIV virus among young women is through sexual intercourse signalling that young women and adolescent girls are sexually active (MOH, 2016).

Unfavourable environmental factors that affect the socioeconomic and health status of young women and adolescent girls persist increasing their vulnerability to HIV acquisition. For instance, in 2017, one in seven adolescents aged 15 to 19 in the world were married or in a union (UNICEF, 2017), The Kenya Demographic Health Survey (KDHS) data indicates that 11% of women aged 15 to 19 are married compared to 1% males in the same age group. 15% of women reported having experienced their sexual encounter by the age of 15; 50% by age 18; and 71% by age 20 (MOH, 2014).

Young Women who are married or experience their sexual encounter in their adolescent years are more likely to identify their first sexual experience as forced, more vulnerable to experiences of Gender Based Violence (GBV) or Intimate Partner Violence (IPV), remain highly vulnerable to HIV acquisition as well as maternal health problems that come from early and or mistimed pregnancy (Girls not Brides, 2015). HIV prevalence is estimated to be up to 28 times higher in people who inject drugs and 12 times higher amongst sex workers in Kenya.

Kenya has the fourth largest HIV epidemic globally with 43% of the national population reported to be under the age of 15. Currently, HIV is documented as the leading cause of death among adolescents and young people in the country (NACC,

2014). The achievement of interventions to reduce the spread of HIV among young people in Kenya has an impact on future of Kenya's HIV epidemic response and progress. This will in turn boost the National efforts to realise the targets of the Kenya HIV prevention revolution roadmap and the vision 2030.

Prevention programmes should leverage the declines in HIV prevalence among the general population that has occurred over the last decade to make similar if not more gains. The recent trend in global and national data of increasing new HIV infection among young girls and young women in the last few years coupled with progress in research has set pace for expanding the role of HIV treatment as a tool for HIV prevention. This provides opportunities to reduce the number of new infections and ultimately end HIV acquisition not only among women but also their children during pregnancy, at birth and during breastfeeding (Siringi, 2010; MOH, 2015).

The engagement of young people and particularly young women in the country's development agenda is prioritised by national health policy leadership and decision makers. In order to achieve the targets posed within the Kenya Vision 2030 and contribute to the global goals also known as the Sustainable Development Goals (SDGs), the country will need to move with urgency to meet the HIV prevention needs of adolescent and young people particularly girls and young women. Making innovative HIV prevention options that integrate biomedical, structural and behavioural interventions will be critical in epidemic control among young people not only in Kenya but globally (NACC, 2015).

1.2.1 Pre- Exposure Prophylaxis (PrEP)

Global progress in science and research evidenced the success of HIV treatment in reducing HIV infections, illnesses, and deaths from AIDS. Pointing to the critical role of HIV prevention as a strategy to end AIDS, this recent scientific progress has resulted in new HIV prevention products that have provided the much-needed hope in various opportunities to control and stop the HIV epidemic (Koechlin, 2016).

One of the new HIV prevention interventions currently in use by various populations is Pre-Exposure Prophylaxis (PrEP). PrEP is the use of an antiretroviral medication to prevent the acquisition of HIV by a HIV negative persons. Currently, PrEP is taken orally, using an antiretroviral (ART) drug available for treatment of HIV infection. The ARV approved for PrEP use is tenofovir plus emtricitabine, also known as TDF-FTC, or by the brand name Truvada. The efficacy of oral PrEP has been shown in four Randomised control trials to be high when the drug is used as directed. Data shows reduced HIV acquisition by up to 92 % in people at risk of HIV infections when PrEP is used as directed (WHO, 2017).

In 2015, World Health Organisation (WHO) launched guidelines recommending PrEP to people at substantial risk of HIV infection as an additional prevention intervention. Their usage is part of a comprehensive prevention package that includes HIV testing, counselling, male and female condoms, lubricants, ARV treatment for partners living with HIV, voluntary medical male circumcision (VMMC), and harm reduction interventions for people who use drugs (WHO, 2015).

Following these developments, Kenya provided guidelines for implementation and use of PrEP in the updated HIV consolidated guidelines for preventing and treating HIV launched in 2016. These guidelines also recommended the use of the Truvada for use of PrEP (MOH, 2016).

The reviewed Kenya National treatment guidelines paved way for program implementers and health workers to make PrEP available to those who are deemed at risk of HIV acquisition. National HIV programmes such as the DREAMS initiative, Prevention Options for Women Evaluation Research (POWER), Prevention Options for Women and Adolescent girls (Priya), Monitoring Pre-Exposure Prophylaxis in Young Adult women (MPYA), Liverpool VCT (LVCT) and other partners whose goal is to prevent reduce HIV in young women have since used PrEP as one of the interventions for program recipients (ATHENA Initiative, 2017).

The PrEP campaigns in Kenya are spearheaded by NASCOP through the campaign banner 'Jipende JiPrEP'. The 'Jipende JiPrEP' campaign, which started in May 2017 at the launch of PrEP guidelines in Kenya, is ongoing. The campaign aims to enhance demand creation and usage of PrEP. It is the main intervention for creating awareness and educating the public on the benefits of PrEP for preventing new HIV infections. The campaign targets the whole population however just like PrEP intervention, this campaign focusses on three populations deemed at risk of HIV acquisition and to whom PrEP use is encouraged. These are female sex workers (FSW), Men who have sex with men (MSM) including male sex workers, and Adolescents and young women (NASCOP, 2017).

Although the efficacy of PrEP is known, various stakeholders continue to grapple with behavioural and structural drivers that impede its access and use. Evidence points to the challenges of adherence that affect how people in Kenya effectively use medications. This behaviour could risk the effectiveness of PrEP for HIV prevention which is largely determined by correct and consistent use as directed by health professionals (Baggely, 2016).

What remains critical is the need for PrEP awareness campaigns to address the needs of young girls and women for example gaps in using other HIV prevention interventions. PrEP campaigns need to make sure that women know about PrEP, because it may be easier for them to take tablets than to get a man to use a condom (Manguro, 2017).

1.3 Statement of the Problem

Globally, AIDS was the primary cause of death among women who aged between 15 and 49 years in 2017 (UNAIDS, 2017). Even as new HIV infections continue to decline among the general population, young women who are 15 to 24 years, and teenagers aged 10 to 19 years, continue to account for disproportionate numbers of new HIV infections globally (UNAIDS, 2018). It is estimated that in Eastern and Southern Africa, young women who were between 15 and 24 years acquire HIV approximately five to seven years earlier than males of the same age (Dellar, 2015).

Against the backdrop of these new HIV infections and AIDS mortality among adolescents and young women, there is progress in scientific research and policy environment that has resulted in development and availability of new and more efficacious biomedical HIV prevention products like PrEP which have been made available for adolescents and young women aged 18 to 24 years as a priority target population (Ying, 2015).

Kenya, through MOH, provides PrEP to those deemed at risk of HIV infections. However, the Ministry identifies adolescents and young women aged 18-24 years as a priority target alongside sex workers, men who have sex with men, and people in serodiscordant relationships. The PrEP awareness campaign launched in 2017 dubbed 'Jipende JiPrEP' aimed at increasing awareness of PrEP and promoting demand creation for the use of PrEP for HIV prevention.

In spite of these efforts, the available data shows that the PrEP uptake among women is limited, raising concerns among global stakeholders in health (Challene, 2017). Concerns also exist on the slow pace in which the Kenyan population, particularly young women and girls, use PrEP for HIV prevention. In November 2017, media reports, acting on MOH data, reported that the low numbers of people on PrEP who were recorded at 9000 signalling a slow pace towards the 500,000-people enrolled on PrEP by 2020 target set by the Ministry of Health during the launch of the National framework for the implementation of PrEP in Kenya (Gathura, 2017).

Reports from early monitoring of programmes delivering oral PrEP to adolescents and young women show a slow pace and low levels of uptake of PrEP in this population compared to uptake by serodiscordant couples and female sex workers (Dunbar, 2018). Programmes such as those implemented by Liverpool VCT (LVCT) based in Nairobi (Kenya), report that adherence of PrEP among adolescent girls and young women remains poor. Whereas the general uptake of PrEP by this population remained low, for sites supported by the PEPFAR Dreams initiative; Uptake was less among younger women, married women and those living with partners. Various factors were attributed to this including discouragement from sexual partners, peers and guardians;

misconceptions and myths about PrEP use, poor risk perceptions and conflicting priorities (LVCT, 2018).

This study sought to evaluate the impact of the national PrEP communication campaign on use of Pre-Exposure prophylaxis (PrEP) as an HIV prevention intervention by adolescents and young women aged 18-24 years in Embakasi East, Nairobi (Kenya).

1.4 Research Objectives

The general objective of this study was to evaluate the Kenya National communication campaign ‘JIPENDE JIPrEP’ on the usage of PrEP by young women aged 18-24 years in Embakasi, Nairobi.

1.4.1 Specific Objectives

- i. To assess the awareness levels of PrEP among young women aged 18-24 in Embakasi, Nairobi.
- ii. To establish the usage patterns of PrEP among young women aged 18-24 in Embakasi, Nairobi.
- iii. To examine the role of public awareness campaigns in promoting the uptake of PrEP among young women aged 18-24 in Kenya.

1.5 Research Questions

- i. What is the awareness levels of PrEP among young women aged 18-24 in Embakasi, Nairobi
- ii. What are the usage patterns of PrEP among young women aged 18-24 in Embakasi, Nairobi?
- iii. What is the role of public awareness campaign in promoting uptake of PrEP by young women aged 18-24 in Kenya?

1.6 Justification of the Study

This study was necessitated by the fact that HIV and AIDS continue to be the primary cause of death among women in Africa, and particularly among young women who are between 15 and 24 years of age. Despite progress in science and availability of modern HIV prevention interventions like PrEP, new infections among young women this age

continues to be on the rise both in Kenya and globally. Yet, very little effort is directed at improving targeted communication around PrEP, with particular regard to creating awareness that would not only support uptake but ensure effective usage and retention in order to benefit from its efficacious prevention capabilities.

1.7 Significance of the Study

The findings of this study would be useful to stakeholders in health including Ministry of Health and civil society organisations working with young women and girls to understand specific messages on PrEP support effective usage by women and girls. It will provide clarity on the information gaps that exist, as well as aid in the development of messages responsive to their needs.

The findings of the study may be useful in developing training and workshop modules that can be used to engage service providers, and even the media, by the Ministry of Health through the NASCOP in order to improve communication and service delivery within PrEP implementation.

Young women and girls stand to benefit from identifying clear recommendations that can be used for community-led advocacy and engagement with national policy makers and program implementers thereby resulting in better service delivery practices that would impact on their use of HIV prevention interventions.

More broadly, this study and its ripple effects has the capacity to impact on the national and global achievement of Sustainable Development Goal three, *Good Health and Well-being*, and Goal five, *Gender Equality*. At national level, the study could provide invaluable data to enhance the Government of Kenya's Big Four Agenda, which has universal access to healthcare as a core pillar.

The study findings may be resourceful to other researchers interested in the area under study. This is vital since the findings could provoke follow up studies in the same direction.

1.8 Scope and Limitations

This study sought to evaluate the impact of the National PrEP awareness campaigns ‘Jipende JiPrEP’ on the use of PrEP among young women in Embakasi, Nairobi (Kenya). The study population was young women aged 18 to 24 years. Geographically, the study was conducted in Nairobi County and the sample drawn from Embakasi East constituency. This was a descriptive design study employing mixed methods approach. Both quantitative and qualitative data were collected through administering questionnaires and qualitative. Data was also collected through Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs). The study employed both simple random and purposive sampling methods in selection of respondents and FGD participants respectively which presents some potential bias.

1.9 Operational Definitions

Adolescents	The term adolescents shall refer to UN’s definition to reflect persons both male and female aged 10- 19 years’ old.
Young women	Refers to women aged 18 to 24 years.
Adolescent girls	Refers to girls and young women aged 18-24years.
PrEP	Pre-exposure Prophylaxis (PrEP) is a form of HIV prevention in which a HIV negative person at high risk of HIV infection takes daily antiretroviral medication to prevent HIV infection. Shall refer to Oral PrEP in this study.
HIV Prevalence	Refers to the percentage of people tested and found to be HIV positive within a given population.
HIV incidence	The estimated number of persons newly infected with HIV during a specified time period.
HIV incident rate	Rate of estimated number of persons newly infected with HIV during a specified time period over the number of persons at risk for HIV infection

Risk Perception	The subjective judgement that people make about the characteristics and severity of a risk
Key Populations	Shall refer to the UNAIDS category of Key populations for HIV; are people who inject drugs, men who have sex with men, transgender persons and sex workers.
Cisgender	Those whose personal identity and gender corresponds with the sex assigned at birth.
Transgender	Those whose sense of personal identity and gender doesn't correspond to the sex assigned at birth.
Gender transition	The process of changing one's gender presentation and/or sex characteristics to accord with one's internal sense of gender identity
HIV prevention interventions	Are commodities and services that are can be used to prevent one from HIV infection. These shall include but not limited to condom use, HIV testing, voluntary male circumcision, PrEP, Post exposure Prophylaxis (PEP), Counselling

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

Literature review provides a sound conceptual, theoretical and practical understanding of the research topic. Particularly the chapter discusses existing evidence and studies on the HIV situation, the HIV prevention roadmap, the role of public health awareness campaign in health promotion. Studies that research the relationship between awareness campaigns and health behaviour particularly among young people will also be discussed to examine the centrality of awareness campaign on usage of PrEP.

2.2 HIV Situation among Young People

2.2.1 Global and Regional Situation

The world is witnessing a stagnation of HIV new infections among the adult population in the recent years with data on new infections among adults recorded at 1.9 million in 2015 and 1.8 million in 2018. Young girls and women who are 15–24 years old are particularly at high risk of getting infected with HIV (UNAIDS, 2018).

UNAIDS reports that of the 610,000 young people aged 15 to 24 newly infected with HIV in 2016, adolescents aged 15 to 19 accounted for 260,000 new infections. Additionally, 44% more girls aged 15 to 24 years were infected with HIV compared to men in the same age. Gender customs that are considered harmful, disparities in access to basic social development resources, education and sexual compounded by suboptimal reproductive health services, economic disparities, lack of access to food as and violence continues to make young women and girls vulnerable to getting HIV HIV (UNAIDS, 2017).

The rates of new HIV infections are not falling fast enough for the realisation of the Fast-Track milestones of less than 500,000 HIV infections by 2020. The complacency in terms of response being witnessed by key players including donors and bilateral funding agencies indicates a course for concern with many urging for strengthened efforts to reduce new infections and prevent an imminent rollback on the gains made so far (UNAIDS, 2018)

Global and regional data also show a divergence in new infections among adolescents and young women and their male peers in the same age from 10 years. Although equal numbers of boy and girl children born of HIV positive mothers remain HIV free by age 10, when they get to their teenage period, the disparities on the impact of HIV becomes clear. For example, in eastern and southern Africa one in three young women and girls has HIV compared to male peers in the same age group. In order not to lose the gains made in keeping children free from HIV, as well as close the tap on new infections among children to achieve an AIDS free generation, efforts have to be intensified to prevent HIV in adolescent girls and young women who are still very young into their reproductive journey (Karim, 2017).

Young women who identify as key population continue to be disproportionately affected by HIV. Their immediate HIV risk primarily associated with sexual behaviour stem from their sexual identities and practice. For instance, for transgender women, the risk is advanced through anal sexual relations, while for sex workers, the risk is elevated from exposure to clients whose HIV status remain unknown, and who, for financial gain, agree to not use a condom (Inguane, 2015).

Evidence shows that knowledge levels of risk remains low among young women from key populations. Additionally, majority of these women have no power to mitigate those risks because of multiple and intersectoral barriers. Criminalisation and contradiction with the laws of the land, HIV stigma compounded by stigma related to their sexual identities and choices, have resulted in denial of essential health information and services. It has also resulted in denial of agency and autonomy to make decision which in turn affect their access and utilisation of HIV prevention interventions like PrEP (McClure, 2015).

Prompted by the global data on high levels of HIV acquisition among girls and young women, stakeholders in health – globally and at national levels – strengthened HIV prevention approaches targeting this population. Kenya is signatory to the UN political declaration on ending AIDS which targets to reduce annual infection of HIV in this population to fewer than one hundred thousand by 2020 (UNGA, 2016). To achieve

these targets, adolescent girls and young women need to access and utilize innovative and new HIV prevention interventions like PrEP.

2.2.2 HIV Situation in Kenya

Kenya bears the fourth largest epidemic globally. Approximately, 51% of all new infections in 2015 were recorded among adolescents and young people who are 15 to 24 years old. In 2015, this population also accounted for 29% of the reported number of HIV infections in the country (MOH, 2016). According to national annual data, there are approximately 1.6 million people living with HIV in Kenya. 53,000 people became newly infected with HIV in 2017, of this, 27,000 were young women 15-24 years (MOH, 2018).

The current trend in HIV incidences among young people particularly adolescent girls and young women continues to present a significant challenge to the control of HIV epidemic resulting in the country identifying adolescents and young people as a priority population for the HIV response (NACC, 2014). Notwithstanding milestones have been realised in research on the role of antiretroviral treatment in ending deaths due to AIDS and improving the health of people living with HIV while protecting one from being infected with HIV. Poor uptake, adherence and retention to prevention intervention persists among this population. This is partly due to the fact that adolescent girls and young women often do not have the final say on matters related to their own healthcare (Eakle, 2018).

Legal barriers that restrict young people from gaining access to health services for example getting information and services to protect themselves from HIV or for young women preventing pregnancy continues to be expose young girls to risk of pregnancy and HIV. In 2013 it was reported that 70% unmarried sexually active girls aged 15 to 19 years not having their contraceptives needs met (IPPF, 2013).

Unfavourable and age-restricting punitive laws that criminalize HIV transmission and those related to key populations, negative gender stereotypes and harmful norms and traditions have continued to make young women shy away from accessing sexual health services including those that protect them from HIV infections (Ziraba, 2018).

Gender inequality continues to expose adolescent girls and young women to the risk of HIV acquisition while the impact of HIV exposes young women to gender inequality. Young women are most likely to be victims of intimate partner violence, gender-based violence, lack capacity to negotiate monogamy, condom use or Voluntary Medical Male Circumcision (VMMC) with their sexual partners (Beguy, Mumah, & Gottschalk, 2014).

Although evidence shows a direct relationship between knowledge of sexual and reproductive health and HIV risk, many young people have inadequate information on HIV and sexual education, therefore, lack the capacity to make informed decisions about their HIV prevention choices (UNAIDS, 2017). This is compounded by limited capacity among adolescent girls and young women to effectively engage policy makers and stakeholders in health in advocacy efforts. These efforts are usually aimed at identifying their health needs and enabling them to demand their health rights. Prioritizing young women and adolescent girls in the HIV prevention efforts will put the country on the right path to honour health commitments (Mugo, 2016).

2.3 HIV Prevention Revolution

The HIV prevention landscape has in the recent years witnessed a revolution given the scientific progress which has provided new knowledge and tools to prevent HIV. This includes PrEP; and knowledge of the use of newer optimized ART by people living with HIV. These measures have reduced the risk of HIV transmission.

Backed by this progress in science, Kenya developed and launched the HIV Prevention revolution roadmap that provided targets and milestones that would guide the country towards the goal of zero new HIV infections and an end to AIDS by 2030. The roadmap emphasizes the delivery of combination prevention packages integrating biomedical, behavioural and structural interventions, and sustainable investment in HIV prevention research (NACC 2014).

Whereas the evidence on the strength of treatment for preventing new HIV infections are becoming more established, it is important to understand that drivers of HIV are structural; social and cultural. Policy makers and stakeholders in health will need to

strengthen a variety of measures needed to respond to the needs of various populations particularly the needs of adolescent girls and young women who continue to be affected by HIV burden (Nana, 2016)

2.4 PrEP Knowledge and Awareness

Public awareness messaging that seek to increase knowledge of PrEP plays an integral part in people's ability to make informed choices vis a vis their health. This is why understanding the knowledge and practices as well as values and preferences that may affect how young women make decisions about using PrEP including when they would use it, when and why they would stop its use is important. Additionally, determining the knowledge gap and its influence on usage of PrEP as a HIV prevention tool will provide much-needed guidance for improving PrEP implementation programmes and policy and structural landscape needed to support its optimal use and achieve desired results.

Pre-exposure prophylaxis or PrEP is the use of an antiretroviral medication to prevent a HIV negative individual from acquiring HIV. Currently PrEP is taken orally, using an antiretroviral drug available for treatment of HIV infection (tenofovir plus emtricitabine). The efficacy of oral PrEP has been shown in four Randomised control trials and is high when the drug is used as directed (WHO, 2015).

Although it is documented that PrEP provides an opportunity for empowering adolescents to take control of their sexual health, gaps exist in already existing sexual and reproductive health interventions including those that ensure that young women and girls are able to make informed choices about contraceptive methods. These exiting gaps create concerns about whether initiation to PrEP particularly for adolescent girls and young women will be free from coercion or force (UNICEF, 2015).

Since the beginning of the implementation, the uptake of PrEP has been slow, particularly among young women compared to men with studies showing women have adherence challenges and often stop PrEP usage once they start (Namey, 2016). Data from the TAP study in South Africa found that whereas there is an impressive uptake

of PrEP among female sex workers, retention was recorded as low over time (Earkle, 2017).

Adherence challenges have also been noted among young people with HIV and taking ARV's. This signals the possibility that other factors, specific to this population, may affect their behaviour towards uptake and treatment of oral-based HIV prevention and treatment options (ATHENA Initiative, 2017).

Implementers also argue that for successful PrEP implementation, programmes must be integrated within sexual and reproductive health programmes so that young women are exposed to a range of products within the same space. This has proven very effective for ensuring consistency in the uptake and retention of PrEP services by this group (Eakle, 2018).

Information access is essential in increasing knowledge and awareness, influencing perception and behaviour. Yet, barriers to information access still exist which damage the ability of adolescents and young women to make well-informed decisions in regards to their sexual and reproductive health. This includes how to protect themselves from acquiring HIV. According to Kenya Health Demographic Survey (KDHS), women are less likely to access mass media compared to men with only 11% of women recorded to have weekly exposure to media compared to 35% men (MOH, 2014).

Public awareness campaigns have been conducted at global and national levels with an expectation that this would translate in increased demand and use of PrEP particularly by adolescent girls and young women. However, empirical evidence shows an inverse relationship between public awareness campaigns on PrEP and usage by adolescent girls (Namey, 2017).

People on PrEP have, from time to time, alluded to the importance of targeted messaging and peer-led interventions as motivating factors to seek and adhere to PrEP. This has prompted the need for innovative strategies that increase the knowledge of and access to PrEP by young girls and women globally and in Kenya (Goparaju, 2017).

It is important to consider other influences including environmental and personal that may have a direct impact on how young people use PrEP. Risk perception, stigma associated with HIV, fear of frequent testing while on PrEP, health care worker attitude, harsh and non-supportive parents and guardians are some of the reasons that young women and adolescent girls may affect their usage of PrEP (Ngure, 2016).

Aside from evidence of social, cultural, and systemic barriers that affect the use of PrEP among women and girls, very little is known of the existing messages targeting women and girls particularly those that address their reproductive health concerns. These include messages on use of PrEP during pregnancy and when breastfeeding and including what effects PrEP has on their lives across their sexual and reproductive cycle (ATHENA Initiative, 2017).

Messaging is a critical ingredient in motivating demand creation, usage and retention to PrEP. Messages that acknowledge the diversity of women and their non-homogenous exposure to risk throughout their lives have shown impact on acceptability of PrEP (Mugo, 2016).

2.5 PrEP Campaign in Kenya: ‘Jipende JiPrEP’ in Perspective

The National PrEP campaign in Kenya is spearheaded by NASCOP through the campaign banner ‘Jipende JiPrEP’. This campaign was started in May 2017 with the aim of enhancing demand creation and usage of PrEP. Anchored within the national framework for the implementation of PrEP, the campaign has the following key objectives within the PrEP national communication strategy: to increase knowledge of PrEP services, the product and provide information on where it can be accessed; to create a positive perception and improve the attitude towards PrEP amongst all stakeholder groups; and to increase demand for PrEP amongst the target audience (NASCOP, 2016)

The ‘Jipende JiPrEP’ campaign has been useful for communications, advocacy and community engagement action for educating the public on the benefits of PrEP as a tool for preventing new HIV infections. The campaign targeted three populations deemed at risk of HIV acquisition and to whom PrEP use is encouraged. These are

female sex workers (FSW), Men who have sex with men (MSM) including male sex workers and Adolescents and young women (Jhpiego, 2018).

The campaign is documented to have reached over 70% of the Kenyan population through mainstream media including the newspaper, radio, and television. On social media, the ‘Jipende JiPrEP’ campaign has 6,417 likes on their Facebook page and over 1,450 followers on Twitter. YouTube videos have 281,571 views from 60% males and 40% females. The data and information shared underscores the critical role of PrEP public campaigns in demand creation and usage of PrEP by young women in Kenya (NAS COP, 2018; Jhpiego, 2018).

2.6 Emerging Gaps

From the literature reviewed, it is evident that adolescent girls and young people continue to be at high proportions of risk for HIV acquisition. This risk makes them vulnerable to a myriad of other social development problems. Similarly, social development issues continue to make them vulnerable to HIV acquisition.

Whereas information access is important for increasing knowledge and awareness on PrEP; influence the perception to HIV risk by adolescent girls and young women, which is instrumental for driving their behaviour in regards to usage of PrEP, knowledge on PrEP remains limited in adolescent girls and young women according to a review done in Kenya and Uganda as part of the DREAMS Innovative challenge programme. Misinformation, myths, misconception and concerns about what effects prolonged use of PrEP will have on reproductive health of adolescents and young girls remains the key reasons why uptake and retention to PrEP is low (ATHENA Initiative, 2017).

Stigma also remains a significant barrier to use of PrEP among targeted populations in Kenya. Since the roll out of PrEP in the country in 2017, the uptake has been slow particularly among girls and young women according to the Jhpiego who are implementing the national four year PrEP ‘Jilinde’ project (Were, 2019).

PrEP has mostly been marketed and sold as a HIV prevention intervention that targets key population groups. This has had an impact on the young women's perception of risk and their need to use PrEP as a HIV prevention method as well as the perceptions of community about PrEP which has hampered support for its use by young women. In order to be able to normalize PrEP as a HIV prevention intervention, communities need to be sensitized in order for them to accept the concept (Eakle, 2018; Raifman, 2019).

Even though media campaigns have a considerable impact in public agenda setting, evidence shows that the media cannot be solely responsible for influencing behaviour change. There are many other environmental factors that affect one's perceptions of risk and their choices and behaviour (Seymour, 2017). Public awareness initiatives need to deliberately address individual, community, structural, and systemic barriers that affect the uptake and use of PrEP (Raifman, 2019).

2.7 Theoretical Framework

This study was guided by the theories of Planned Behaviour (TPB) and the Health Belief Model (HBM).

2.7.1 Theory of Planned Behaviour (TPB)

The Theory of Planned Behaviour (TPB) is an expansion of the Theory of Reasoned Action (TRA) which was proposed by Ajzen and Fischbein. The theory argues that individuals make logical, reasoned decisions to engage in specific behaviours by evaluating the information available to them (Ajzen, 2010).

The Theory of Reasoned Action places importance on the role of attitude, intentions (beliefs about a behaviour) and subjective norms (beliefs about others' attitudes toward a behaviour). The concept of perceived behavioural control, defined as an individual's perception of the ease or difficulty of performing the particular behaviour expands this model to TPB.

An individual's behaviour is determined by their intention to engage in the behaviour which is influenced by the value the individual places on that behaviour, the ease with which the behaviour can be performed, the views of others on the behaviour and the perception that the behaviour is within their control (Ajzen, 2010).

The model is more applicable when the chance of success and actual control over performance of a behaviour are suboptimal. It is suited in predicting behaviour and retrospective analysis of behaviour, and has been widely used in relation to health. For example, a study to understand the patients' management of Arthritis using the TPB model, looked at the influence on attitudes, partner and social support, self-efficacy and intention. The findings showed moderate success in explaining behaviour of patients managing arthritis (Strating, 2006).

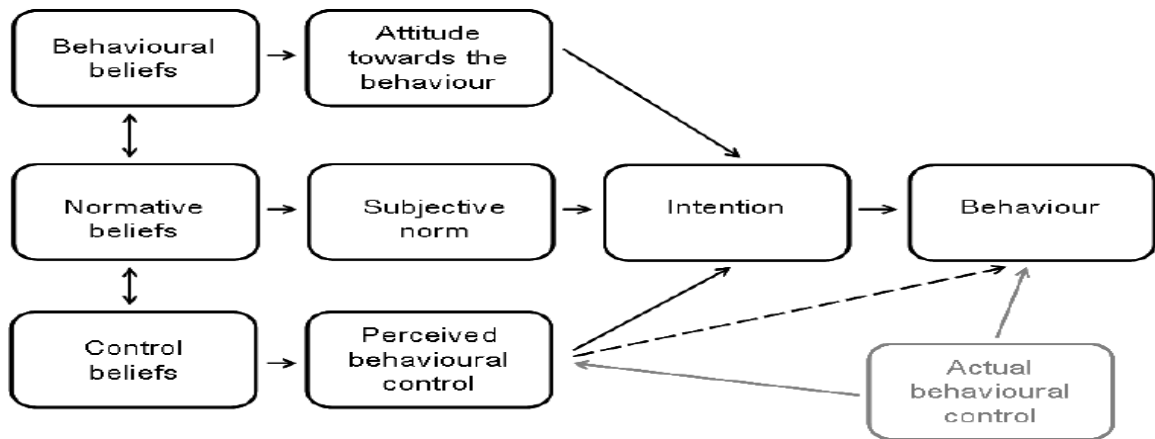
The more favourable a person's attitude is towards behaviour and subjective norms, and the greater the perceived behavioural control, the stronger that person's intention will be to perform the behaviour in question. However, people will be expected to carry out their intentions whenever the opportunity arises (Mamiaga, 2009).

In application, adolescent girls or young women with positive attitudes about using PrEP to protect themselves from HIV will use PrEP. This can only happen if they perceive that they are supported by peers and or loved ones to use PrEP and strongly believe in their capacity to use PrEP for HIV prevention.

Behaviour control is similar to self-efficacy depending on how difficult one perceives the engagement in the behaviour. Ideally, how strong an attempt the individual makes to engage in the behaviour and how much control that individual has over the behaviour (behavioural control) are influential in whether he or she engages in the behaviour. This model emphasises the need for knowledge and awareness in reinforcing an individual's attitude and intentions to perform desirable behaviour. Additionally, the theory emphasises the additional role of social support towards enabling behaviour adoption by individuals (Hammond, 2010).

According to Fischbein & Ajzen, human action is guided by three major considerations: Behavioural Beliefs (beliefs about the likely consequences), Normative Beliefs (beliefs about the normative expectations of others), Control Beliefs (beliefs about the presence of factors that may facilitate or impede performance of the behaviour)

Figure 2.1: Theory of Planned Behaviour



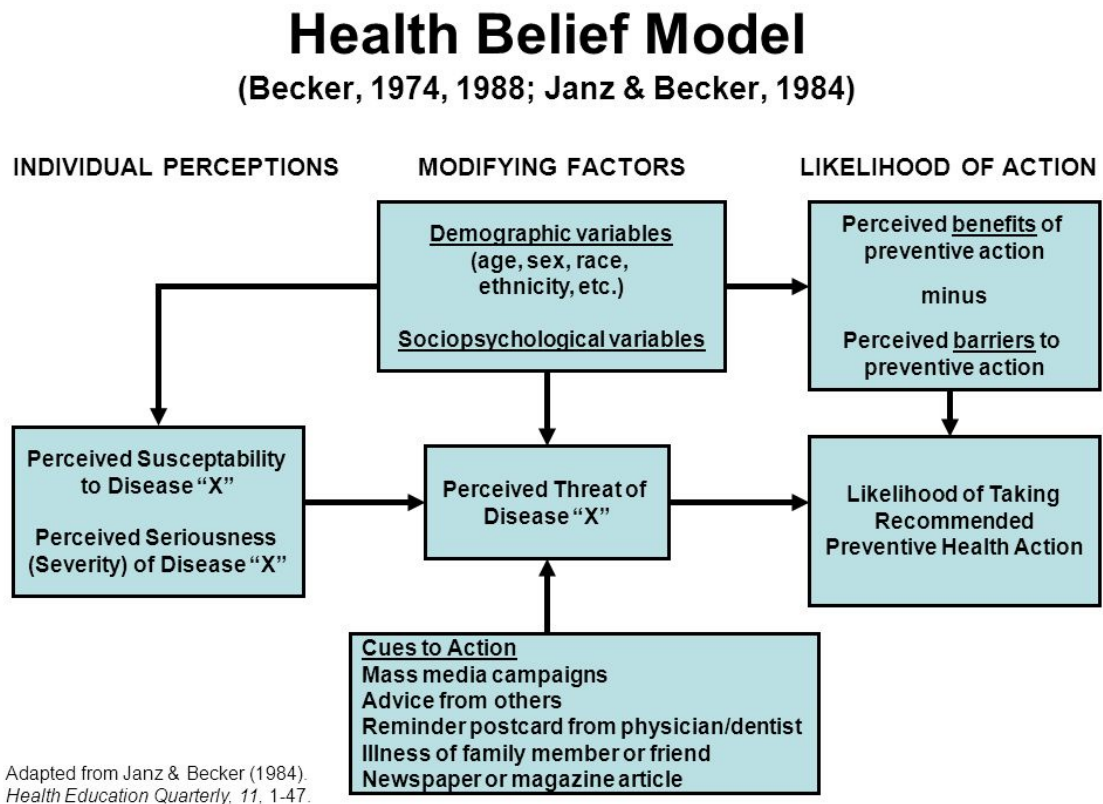
Source: Ajzen (2010)

2.6.2 The Health Belief Model (HBM)

The Health Belief Model is one of the most widely used models that looks at how beliefs impact behaviour. It is useful for understanding health behaviours in order to guide health promotion and disease prevention programmes. HBM explains and predict individual changes in health behaviours (Becker, 1975).

Developed by Becker in 1974, the HBM posits that a person’s health behaviour is predicated on the following elements: perceived susceptibility, perceived severity, perceived barriers, and perceived benefits (Corcoran, 2007) as illustrated in figure 2.2

Figure 2.2: Health Belief Model



This theory is relevant in determining the behaviour of adolescent girls and young women and their uptake and use of PrEP as it indicates one's behaviour is dependent on their risk/benefit analysis or their analysis of the cost and benefit of adopting a certain behaviour (Naidoo & Wills, 2005).

The following factors affect one's ability to adopt a health prevention behaviour according to the HBM: *perceived susceptibility* which means that people will only change their behaviour if they believe themselves to be at risk; *perceived severity* which means that the ability of one to adopt a behaviour lies within their assessment of how severe the consequences of not changing their current behaviour is; *perceived barriers* which is the assessment by a person of how hard adoption of the behaviour will be and *perceived benefits* meaning people are more likely to adopt a behaviour if they see there is something in it for them to adopt that behaviour (Becker, 1975).

HBM recognises that an individual may want to change a behaviour or adopt a certain disease prevention behaviour does not mean they will automatically adopt that behaviour creating a need for additional factors that could nudge one into changing their behaviour. These include *self-efficacy* and *cues to action* (Corcoran, 2007).

Cues to action are external factors or events that prompt an individual to make health behaviour change, and could range from media health promotion messages or listening to someone's experience about having adopted a particular behaviour, or even having close relatives and or friends affected or die from a particular disease. For example, an individual may adopt an HIV prevention behaviour if he or she loses a relative or friend to AIDS-related complications (Becker, 1975). The concept of *self-efficacy* was added to the HBM in 1988 and looks at an individual's belief in his or her ability to adopt particular behaviour or make behaviour change (Montanaro, 2014; Conner & Norman, 2005).

In praxis, the theory argues that for a young woman to adopt use of PrEP for HIV prevention is dependent on whether they think of themselves at risk of acquiring HIV, their anticipation of how severe the consequence it is for them to get HIV, the benefits of using PrEP for HIV prevention, and also, instead of the other HIV prevention tools they have been using for example condoms and their anticipated barriers to using PrEP. Self-efficacy which is the belief of the young woman in her ability to use PrEP as well as other external factors like health promotion/education influence the adoption of PrEP by young women-

Albert Bandura, in his self-efficacy theory, argues that all humans have the ability and capacity to exercise control over the nature of their life. This, in essence, is their agency to make choices that they deem good for them. In making these choices, however, one is influenced by levels of information given, as well as how the environment they exist in will be supportive of their agency and choice (Bandura, 2001). This is supported by a study comparing HBM and TPB theory based condoms intervention that found that constructs that explain behaviour are not the same as those that produce behaviour (Montanaro, 2014).

Health promotion is important for shaping behaviour of adolescent girls and young women on the use of PrEP for HIV prevention. Policy makers and programme implementers must maximise impact through engaging adolescent girls and young women in participatory approaches for developing and implementing health promotion messaging that is responsive to their realities and needs (Barnes, 2009).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Overview

This section describes the methods that will be used in conducting the study. It describes the research design, study area, study population, sample size and sampling procedure, research instruments, data analysis and ethical consideration.

3.2 Research Design

This study used a descriptive design that employed mixed methods approach. Descriptive research design provides an accurate account of characteristics of a particular individual, situation, or group. This design leads to discovering new meaning, describing a particular phenomenon and how people respond or adapt the behaviour (Dulock, 1993). In this study, the focus was on evaluating the impact of the ‘Jipende JiPrEP’ campaign on the use of PrEP among young women in Kenya.

3.3 Research Approach

This mixed methods study reinforces the transformative paradigm which focusses on the experiences of marginalized communities, rooted in the recognition of injustice and inequality, includes analysis of power differentials and utilizes research as a tool for addressing disparities (Jackson, 2018).

The transformative paradigm provides a framework for addressing inequality and injustice in society using culturally competent, mixed methods strategies. Recognizing that realities are constructed and shaped by social, political, cultural, economic, racial or ethnic values points to the role of power and privilege in a research context. Transformative paradigm argues for the strength of combining qualitative and quantitative methodological and believes in mixed studies qualitative dimensions is necessary for gathering community perspectives while a quantitative dimension provides the opportunity to demonstrate outcomes that have credibility for study participants and scholars (Mertens, 2007).

This is relevant and fits in the study which sought to determine the disparities that exist in adolescents and young women access to PrEP as a HIV prevention intervention and provide recommendations for mitigating the gaps or challenges identified. Transformative mixed methodologies provide a mechanism for addressing the complexities of research in culturally complex settings that premise action for social change.

3.4 Research Method

The study utilized both qualitative and quantitative research methods. These two methods were found to complement one another, allowing both the frequency and the possible explanations for findings to be explored.

3.5 Study Population

This study was carried out in Nairobi County where 41% of the population is aged below 15 years and 21% of the population constitute young people who are 15 to 24 years old. According to national HIV estimates is has a high disease burden and incidence (NACC, 2018). Nairobi is signatory to the UNAIDS led Global fast track cities since 2014. The fast track cities: ending the AIDS epidemic campaign is an initiative by signatories to strengthen their HIV/AIDS response towards achieving UNAIDS targets to end AIDS (Nairobi City Council, 2015).

Specifically, the study focused on Embakasi East Sub-County and the target population was young women aged 18-24 years. Embakasi East Sub-County has a total population 159,897 and sex ratio of 1.0; The population of adolescents aged 10-18 is 49,092 while that of adolescents and young people aged 15-34 years is 81,154 (Kenya National Bureau of Statistics, 2009). Embakasi East constituency from where the sample was drawn, has five County Assembly wards namely Upper Savanna, Lower Savanna, Embakasi South, Utawala, and Mihango.

The choice of this geographical area was informed by the fact that Embakasi East Constituency is densely populated and the young women from the area representing different socio demographic background. Mihango, in Embakasi East, is also an informal settlement and home to many young people who are at risk of HIV acquisition

due to various social economic drivers including poverty, unemployment, congested living conditions, crime, low literacy, high school dropout rates among others. It is also one of the areas in which the US funded DREAMS initiative that targets young women at risk of HIV acquisition is being implemented. The programme targets young girls with a large number of young women accessing HIV prevention information and commodities like PrEP (National Council for Population and Development, 2017).

3.6 Sample Size and Sampling Procedures

A sample is a sub-set of the population drawn through a definite procedure. Some studies focus on a large population which cannot all be studied. Therefore, it is important to have a portion of the population. The sample should contain the elements and the characteristics of the population being studied (Banerjee & Chaudhury, 2010).

For purposes of quantitative data collection, this study utilized probability sampling technique, and in particular, the simple random sampling method. This technique enabled selection of samples that possess the characteristics and the qualities that are viable for this research work (Creswell, 2014).

The researcher, working closely with an institution implementing social and health programmes targeting adolescents and young women based in Embakasi East, confirmed at the time of the study that there were 250 young women aged 18-24 years listed as beneficiaries. The names on the master list were coded using unique numbers. The numbers were written down in small pieces of paper that were then rolled up and put in a tin. The researcher then randomly picked the rolled papers putting aside every fifth paper. These were then collected and the unique numbers listed to correspond to the names on the master list. A total of 50 respondents were selected for purposes of collecting quantitative data.

For purposes of qualitative data collection, the study employed purposive sampling technique. A sample size that was deemed representative of diverse young women so as to obtain feedback that will lead to the attainment of saturation was obtained. According to Glaser and Strauss (1967), the attainment of saturation occurs when

adding more participants to the study does not result in additional perspectives or information (Glaser and Strauss, 1967).

Ultimately, the estimation of the number of participants in a study required to reach saturation will depend on the scope of the study, the qualitative method used, number of interviews and quality of data which should guarantee representation. (Sage, 2000).

This was particularly important to consider for this study because of the potential engagement young women who self- identify as at highest risk of HIV acquisition maybe due to their sexual identity, lifestyle choices or other perceived drivers that are likely to expose them to among other things stigma, violence and harsh judgement from the public. Morse advises that 30 to 60 participants are adequate to obtain the richness of data required for qualitative analysis (Morse, 1994).

In this study, a sample of 27 young women aged 18-24 years was drawn through purposive sampling and interviewed through Focus Group Discussions. Eight Key Informant Interviews (KII) were also conducted with Key leadership in the Ministry of Health, PrEP program implementers and leadership of community peer-based organisation.

3.7 Data Collection Methods

Data collection procedures have an important role in the outcome of the research (Mugenda, 2003). In this study, a Survey, Focus Group Discussions, and Key Informant Interviews were used as the main data collection methods.

The data collection tools were pre-tested with participants drawn from a youth group targeting young women who were attending the health information day at the site on that day. A total of six young women which is approximately 20% of the study population were interviewed using the questionnaire (Appendix 3) and focus group discussion guide (Appendix 1). Additionally, the youth group leader was interviewed using the key informant interview guide (Appendix 2).

The questionnaires were closed ended and sought to gather information on the extent to which `Jipende JiPrEP` campaign messages influence use of PrEP among young women aged 18-24 years. The questionnaires were administered to 50 young women from the study site within seven days. Some of study respondents were users of PrEP and others not using PrEP. The population of the study was young women who may have challenges truthfully answering certain intimate questions in relation to sexual behaviour and perception of risk. To this end, the questionnaires were instrumental in gathering this data in an easy and discrete way. The use of questionnaire as one of the data collection method is significant since it gives valid results (Kothari, 2004).

Focus Group Discussions and Key Informant Interviews were the main data collection methods for qualitative data.

Focus Group Discussion data was collected using focus group interview guides (Appendix 1). Three FGDs targeting 30 study participants were conducted. Three FGDs were conducted with a total of 27 participants as illustrated in Table 3.1 below.

Table 3.1: Target Population

FGD	No. of Participants	Adolescents	
		18-19	20-24
001	7	2	5
002	11	3	8
003	9	4	7

Plans were made with the programme staff in the study site to identify and support in the purposive selection of the young women who participated in the FGDs.

A total of eight Key Informant Interviews were conducted using an interview guide (see Appendix 2). Participants for the key informant interviews were individuals and those in key leadership positions within the Ministry of Health, PrEP programme implementers, and leadership of community peer-based organisation including networks of young people living with HIV and youth groups as illustrated in Table 3.2 below.

Table 3.2: Sample Size

KII	No. Participants	Profile of participants
MOH officials	2	Including National and county
Program Managers	1	Implementing HIV prevention projects in NGO
Peer Educators	2	
Youth group leaders	2	
Head organisation of Women Living with HIV	1	
Total	8	

The KII interview guide was designed to capture information on demographics, socio-economic status, awareness levels on HIV prevention, testing and treatment, uptake of PrEP as a HIV prevention intervention, barriers to accessing HIV prevention interventions and perception of risk by young women.

Qualitative data from Focus Group Discussions (FGDs) were voice recorded and later transcribed. In addition, field notes in respect of all the interviews were prepared. Using the voice recorded data and field notes, a data summary sheet was created and classified in themes based on the research questions and reported in narrative form.

3.5 Data Analysis and Presentation

The study employed the descriptive analysis methods. This type of analysis is used in both quantitative and qualitative techniques applied in any research. Quantitative data from the questionnaire were coded into the computer for the computation of descriptive statistics. The Statistical Package for Social Sciences (SPSS Statistics 22.0) was used to generate descriptive statistics. The results were presented in form of tables, charts, and bar graphs.

Qualitative data generated from the open-ended questions in Focus Group Discussions and Key Informant Interviews were analysed using the discourse analysis method which focussed on understanding naturally occurring language use and what influences their occurrence in the responses from the study participants (Hult, 2015). The discourse analysis method was chosen because it heavily relies on analysing speech as data in a complementary way. Findings from the data analysed were arranged into themes and information presented in prose form connected to the objectives of the study, literature review findings and discussions.

3.6 Ethical Considerations

Ethical considerations are very critical, especially in social and health related research. The nature of this PrEP study required an approach with great sensitivity, since it explored the most intimate sphere of someone's private, sexual and emotional life.

The participants were informed about the aim of the study and probable benefits, assured that participation in the research would not culminate in any harm, denial of services or access to resources in the organisations where they work or are affiliated. Consent forms were then signed by the participants before the start of every interview. Due to the sensitive nature of the data and information collected for this study, the presentation of data findings sought to anonymised study sites and any information that would put at risk the location and identity of the study respondents and participants.

During the study, a certificate of field work (appendix 4) was obtained from the university in order to seek permission from National AIDS Control Council and NGO in Embakasi East sub county to conduct the study. After data collection, the results were presented before the School of Journalism panel where the panel advised the researcher on key points to be changed. Afterwards, the certificate of corrections (appendix 5) and a certificate of originality was obtained. (appendix 6)

CHAPTER FOUR

DATA ANALYSIS PRESENTATION AND INTERPRETATION

4.1 Overview

This chapter consists of the data presentation and interpretation of the findings of the study. The data presented was based on the research questions of the study. The data was collected through the use of questionnaires, focus group discussion and key informants interview guides where the two were designed in line with the objectives of this study.

4.2 Response Rate

A total of 50 questionnaires were filled demonstrating 100% response rate. For the Qualitative data collection, the study anticipated to conduct three Focussed Group Discussions (FGD) with 30 participants and conduct 10 interviews with key informants. However, the study response for FGD was 27 participants within three FGD sessions and eight KII interviewed. The overall response rate was above the recommended threshold of 75% and provided sufficient empirical data for analysis (Baruch, 2008).

4.3 Demographic Presentation

The demographic characteristics captured from the respondents include gender, age, marital status, employment status, education level, and religion. The inclusion of demographic characteristics provides the researcher with the understanding of how particular characteristics influenced the understanding of the campaign by participants and their actions thereof. In this study, 50 questionnaires were distributed to the respondents and out of this, 50 were completed and returned.

4.3.1 Gender

Gender attributes and identity presentation was useful for this study to be able to understand how the campaign was understood by young women across their diverse gender identities. 96% of the responded identified as cisgender women while 4% identified as transwomen as shown in Table 4.1.

Table 4.1: Gender

Gender	Frequency	Percent
Cisgender	48	96.00
Transgender	2	4.00
Other	0	0
Total	50	100.0

Cisgender women are those whose personal and gender identities correspond with their birth sex, while transgender women are those who were assigned male sex at birth but whose sense of personal identity is female as demonstrated by the experience of the 20-year-old focus group discussion participant.

When I was born, I was a boy, my parents gave me a boy's name and treated me like a boy. I always felt something was missing, I did not understand what was going on then I saw a program on TV and finally had a name to who I was, I have always identified as a transwoman ever since and recently started to transition.

Understanding gender identities and how they relate to access to, understanding, and utilisation of the PrEP campaign messaging is important for ensuring targeted messaging that is responsive to the needs of diverse groups of young women.

4.3.2 Age

This study targeted young women aged 18-24 years. In order to better understand the perspectives of the younger women and the older women the study sought to analyse the age of the study respondents and participants. 87.76% of the study respondents were aged 20-24 years while 12.24% were aged 18-19 years.

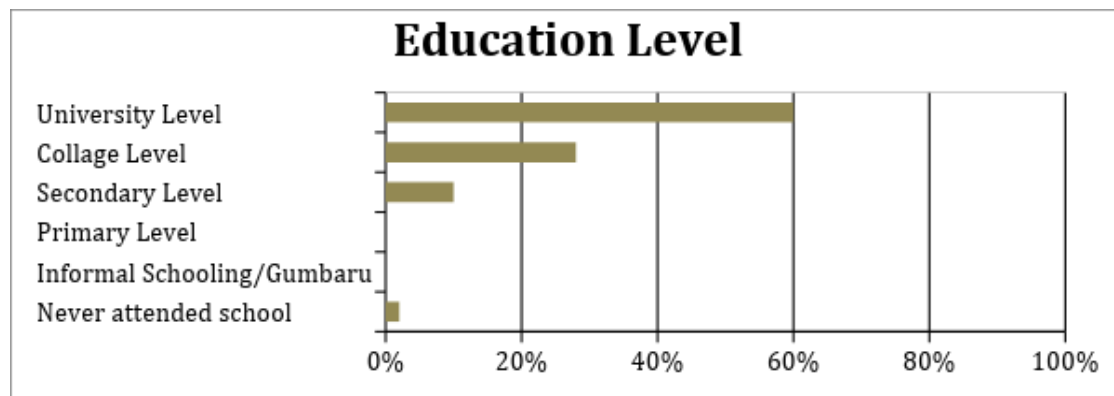
Table 4.2: Age

Age	Frequency	Percent
18 – 19	7	12.24
20 – 24	43	87.76
Total	50	100.0

4.3.3 Education

Figure 4.1 shows that majority of the study respondents in this study have post-secondary school level education. 30 respondents (approximately 60%) of the respondents attained university level education, 14 respondents (28%) attained collage education, 5 respondents (10%) secondary level education and only 1 respondent (2%) never attended school. Understanding the level of education provides an understanding of the role of education in understanding and utilisation of PrEP campaign messages for behaviour change towards HIV prevention.

Figure 4.1: Education Level



The evidence of the role of education in the prevention of HIV infections among young people and improve health outcomes of those who are HIV positive is well established and acknowledged. Educated mothers living with HIV are more likely to seek testing during pregnancy and seek understand that HIV can be transmitted by breastfeeding. These women are also more likely to understand the role of ART in preventing vertical transmission and likely to remain adherent to ARV treatment during pregnancy and breastfeeding. A study in Malawi showed that only 27% of women with no education were aware of this, compared with 60% of women with secondary education or higher (Makvana, 2016).

The Global Education Monitoring Report 2019 highlights the role of education on knowledge of HIV among young people in East and Southern Africa and underscores that schooling reduces the risk of HIV (Lyon, 2016). Young people who stay in school longer are not only more likely to be aware of HIV and AIDS, but also more likely to

take prevention measures like use of condoms, getting tested, and discussing HIV/AIDS with their partners. While the importance of education may be clear, gaps still remain in communicating updated responsive knowledge about HIV and AIDS to adolescents and young people (UNESCO, 2019).

4.3.4 Marital Status

The Kenya modes of transmission study conducted in 2009 provided evidence that shifted the country’s policy and programmes that have continued to shift perceptions and narratives around risk of HIV acquisition within stable and cohabiting relationships. The study found that 12% of all new HIV infections was among people who do sex work and their clients; and 44% of infections occurred between married/cohabiting/ stable relationships. Health promotion programmes which were previously targeting those believed to be single and most at risk were then targeted at couples; policy shifts took place to target key population including sex workers and their clients, men who have sex with men and gay men (MOH, 2009). Understanding the respondents’ marital and relationship status is useful for appreciating how these relationships affect risk perceptions and the choices made towards decisions to prevent HIV acquisition by young women even after exposure to PrEP promotion campaigns.

Table 4.3: Marital Status

Marital Status	Frequency	Percent
Married	5	10.00
Cohabiting/Come we stay	6	12.00
In a steady relationship	7	14.00
Divorced	0	0.00
Single	30	60.00
Separated	2	4.00
Total	50	100.00

The marital status of the target group was captured as presented in Table 4.3. The Majority of the respondents (60%) were single; 14% in steady relationships; 12% in cohabiting relationships; 10% married; and 4% as separated. Knowledge of respondents' marital status is important in understanding their (marital status or relationship status) influence of on the uptake and utilisation of health promotion campaigns on HIV prevention.

Reports from monitoring of PrEP service delivery among adolescents and young women shows that among the most prevalent factors that influence uptake and retention to PrEP by this population is discouragement from sexual partners, peers and guardians (LVCT, 2018).

The study also found that the marital status indicated did not align to perceived sexual behaviour for young women. From the Focus Group Discussions, participants who identified as single did indicate that they were not in relationships, but dated casually however, did not believe those moments to be relationships. The conflict between young women's understanding of what it constitutes being in a relationship and the general perceptions and resulting messaging was identified as a challenge towards accessing PrEP by young women in the FGD.

Q: What are some of the challenges that adolescents and young women face in the uptake and use of PrEP?

P1: It is not clear for us who needs to use this PrEP (YES! from other participants), some of us have a relationship that starts in the morning and by midnight it's over, how will PrEP help protect me? (Laughter).

P2: I was told that I need to use it for like 7 days before I can be protected. How is that even possible *na hawa maboy wa siku hizi wa kukupea pressure from day one na ukikataa ana kughost?* (with these men of today who pressure you to have sex on day one and if you say no they disappear)

P3: I think *gava inafaa kuwa up to date na vile mayouth hurelate, si kama kitambo, then watuambie* how to use this PrEP *vile tutarelate*. (I think the government needs to be up to date with how young people relate nowadays then tell us how to use this PrEP in our reality)

P4: If I meet a guy on tinder, we go out for the night, I may not even know his name, how is that a relationship? When the night is done we both move on”.

Haberer et al (2019) in their paper ‘PrEP as a lifestyle and investment for adolescents and young women in Sub Saharan Africa’ reinforce the reality that current standard PrEP service delivery models will not meet the needs of this population (Haberer et al, 2019). Health promotional campaigns play a huge role in shaping public perception. It is, therefore, important that PrEP awareness campaigns targeting young women take into account the realities of their agency and decisions in regards to sex and sexuality which dynamically evolves and adapting to technology and global influences.

This point was further reinforced by a PrEP program manager at an NGO that responds to health and social development issues for young women:

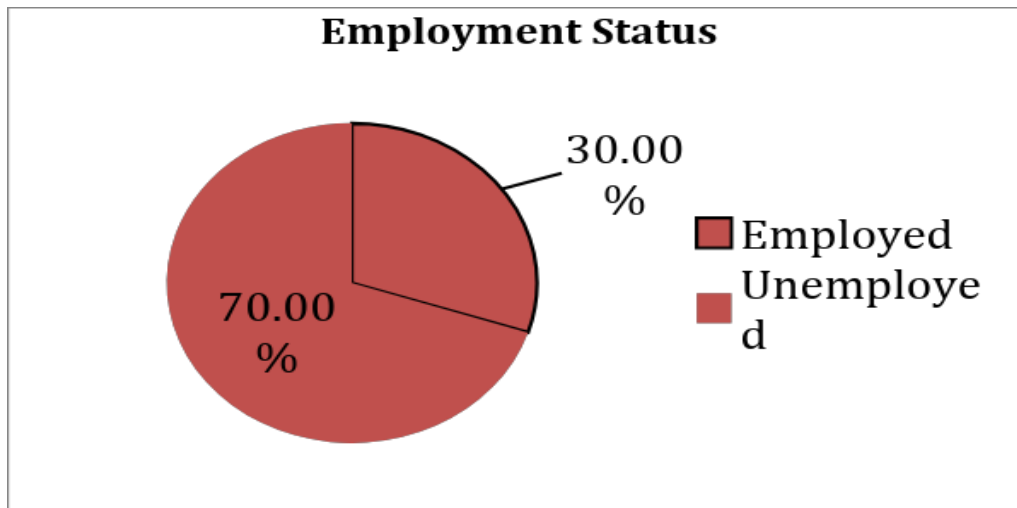
We cannot talk to these young people with our perceived ideas of how dating is and should work, this generation has a lot of casual sexual engagements and for our messages to be effective we must find ways to understand young people, their choices and how we can protect them within those choices.

One way of doing this is understanding the various characteristics that are common among adolescents which have a bearing on their health behaviour including their neurocognitive development, their lack of experience with sustained medical use and their socially connected lifestyles (Haberer et al, 2019).

4.3.5 Employment Status

Empirical evidence on the role of financial or economic independence in promoting autonomy and agency in women’s decision making about their health has been recognized the world over (UNAIDS, 2018). Understanding the employment status of the study participants is important in gauging how their knowledge behaviour gap on HIV prevention and particularly on the use of PrEP is influenced by their financial dependence on someone else including spouses, sexual partners, parents or guardians (Moumita, 2018). Majority (35) of the study respondents representing 70% of the study respondents were unemployed while 30% were employed as demonstrated in Figure 4.2.

Figure 4.2: Employment Status



With many of the respondents residing in the areas characterised by high levels of poverty compounded by experiences of inadequate access to social and health information and commodities; the impact of lack of income on the decisions by young women to adopt and implement HIV prevention strategies was evident in discussions during the FGD and Key Informant Interviews where participants indicated young women were more dependent on parents, guardians and sexual partners for money for upkeep, going to the hospital and purchase of HIV prevention interventions like condoms or even PrEP as demonstrated in the FGD question and responses below:

Q: Do young women your age need to have someone's permission to access PrEP? Whose permission do you need? Does this impact the access to HIV prevention options and adherence by young women?

P1: Not really, but to go to the hospital you need money, to buy things like CD's (condoms) you need money and this is where the problem starts. *Juu mimi siezi uliza mum pesa ya sijui CD ama PEP, hiyo siku hatutalala hiyo nyumba* (more laughter) (I can't ask my mum for money for condoms or PEP because that day we won't sleep in that house)

P2: I depend on my sponsor mostly because he doesn't want to use a condom so I demand that he gets me P2 or gives me money to prevent pregnancy, I use what he gives me to also access PEP from a friend who knows a friend. (Laughter), I do not want to go get this from the hospital.

Denialism on adolescents and young people's sexuality by parents and guardians who young women depend on for financial support to access HIV prevention services continues to have varied impact on the ability of young women aged 19-24 to access information and services that builds their capacity to prevent STI, HIV and mistimed pregnancies (Chiweshe, 2017).

Young people depend on their parents and guardians for financial support and the generational differences, prejudices and understanding of sex, sexuality and gender identity realities; most of the young women find challenges in seeking financial support from their parents and guardians.

This reality is summed up by a 20-year-old peer educator from one of the universities in Nairobi:

Most of us are in school and depend on our parents or guardians, so how will you tell them you need money to buy condoms, or get PEP or even contraceptives when they believe we are not supposed to have sex? Don't even talk to us about sex or HIV?

For some, particularly sex workers, the decision to use PrEP is made to protect themselves in their quest for financial independence as intimated by the experience of a 19-year-old sex worker network member in Nairobi:

I use PrEP because as a sex worker I do not want to miss an opportunity to make more money because the client doesn't want to use a condom.

Understanding employment status and its influence on young women's access to information and services to prevent HIV acquisition is key in designing health promotion campaigns that respond to their needs and realities.

4.4 Awareness and Knowledge about PrEP

4.4.1 PrEP Awareness

This research sought to understand the extent to which young women are aware about PrEP particularly as a HIV prevention intervention. Majority of the respondents, 83% had heard of and were aware of PrEP while 12% had not heard of and were unaware of PrEP.

When asked if they believed PrEP can protect young women from acquiring HIV, 91% responded in the affirmative while only 9% were pessimistic.

Whereas the result of this study show an incredibly high level of knowledge and awareness of PrEP among young women, the reality or the global trend is that knowledge of PrEP particularly among women in heterosexual relationships or who are cis gender remains very low. Many of the young women sometimes confused PrEP with PEP not understanding that one is Pre-Exposure prophylaxis and the one Post exposure. Disparities exist to varying degrees among different populations and identities (ATHENA Initiative, 2017; Mugo, 2017; Haberer et al, 2019).

The disparity in the awareness of PrEP among young women was corroborated by participants during focus group discussions:

Q: Do you know what PrEP is? (Prob knowledge and understanding of PrEP)

P1: No I do not know; I have never heard of PrEP.

P2: When I came to the centre and shared with the case worker that I sometimes do sex work she told me about PrEP and asked if I wanted to use it to prevent HIV, I immediately agreed because most times I do not know the status of my clients and I have been worried I can get sick.

P3: Isn't it PEP? The one that one is supposed to use once they have had risky sex? One must take it within 24 hours.

It is also imperative to note that the study respondents who responded in the affirmative were mostly aged 21-24 years and had been exposed to health talks as part of activities within the NGO that provided health and social interventions for young women in Embakasi. This was not the same experience with the respondents aged 18-19 years

old. Younger women, however, may not have awareness of PrEP because they are not yet exposed to the information in school as the curriculum is prohibitive of sex education while the information on HIV taught in schools remains outdated and out of touch with the realities and needs of young women.

This line of thought was also strengthened by the key informant program manager at one of the national NGO's:

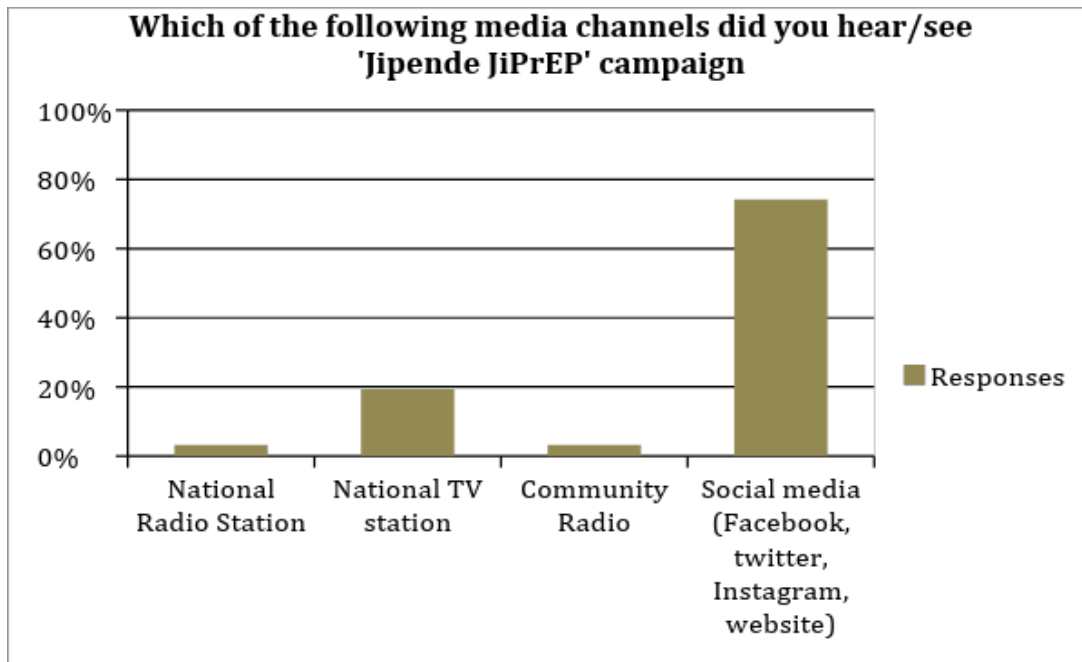
Sometimes it becomes difficult to discuss HIV prevention strategies especially with school going young women because we are restricted on what we have to say. Messages that are promoted at school are those of abstinence only with the messages in the curriculum sometimes eliciting fear and even stigma particularly for young people born with HIV. It is hard to navigate these very many layers of restriction to reach the young people with messages so we opt to have out of school programmes, however these rely a lot on the parents or guardians allowing their children to come to our health talk and education events.

Kenya, with the support of UNICEF, is in the process of finalising a teacher's guide for HIV prevention in school. Discussions with key stakeholders engaged in the process of writing this guide reveal that PrEP is not mentioned even once in this guide. Condoms and PEP are also not discussed in this guide which seems to focus more on guiding children, adolescents, and young people from engaging in risky behaviour.

4.4.2 Awareness of PrEP National Communication Campaign

The study sought to understand if respondents had seen or were aware of the PrEP national communication campaign. Respondents were asked to indicate if they had heard of the National PrEP communication campaign 'Jipende, JiPrEP' to which 60% of the respondents indicated that they heard and seen 'Jipende JiPrEP' campaign, while 40% of the 50 respondents interviewed, indicated that they never heard of the campaign. The respondents who had heard or seen the campaign were asked where they saw or heard of the PrEP 'Jipende JiPrEP' campaign. 75% of the respondents indicated social media as the media channel from which they heard or saw the 'Jipende JiPrEP' campaign; 19% indicated national television, 4% National Radio and 3% from Community radio as shown in figure 4.3.

Figure 4.3: Awareness of PrEP National Communication Campaign



The ‘Jipende JiPrEP campaign communication strategy was developed and is currently being implemented in order to introduce PrEP to the Kenyan market, increase awareness and knowledge about it; increase its demand amongst MSM, FSWs, and AGYW; and create a positive perception of PrEP in the community. Reports on the reach and mode of access for information on PrEP nationally align with the information from study respondents and participants about where they heard about PrEP. According to the national PrEP implementation programme, the campaign has reached 11,922,21 people through broadcast and media advertising. It has also reached 351,123 people through social media under the hashtag #jipendejiPrEP (Jhpiego, 2018).

Empirical evidence from a study on Africa millennials and technology in 2017 found that majority of young people prefer to use of social media through their smartphones to access information therefore making this media platform the best medium for reaching the young people. Additionally, young people tend to use dual media technologies to access information at the same time. For example, 57% of the respondents in the study revealed they liked to watch news as they browse the internet on their smartphones (Geopoll, 2017).

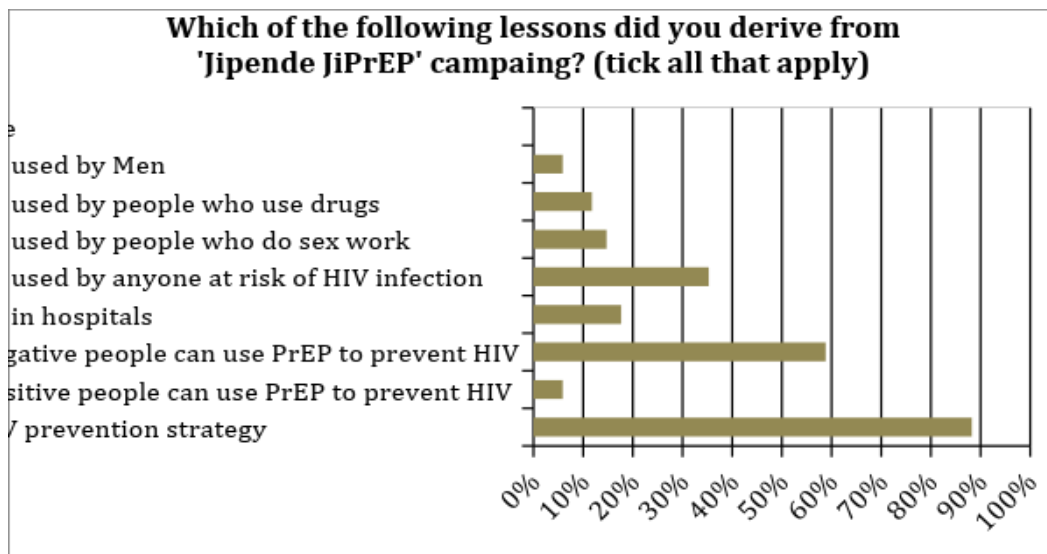
The question of whether social media is accessible to majority of young women in Kenya is critical to understanding the impact of harnessing social media messaging on PrEP to reach as many young women across the country and particularly in areas with high HIV burden. A study in 2017 revealed that 86% of Kenyans on Twitter and Facebook social media platforms were from Nairobi, the remaining 14% were distributed across the country (Bloggers Association of Kenya, 2018)

Effective implementation of the national PrEP communication strategy will require a robust mix of both social media and mainstream media to reach those who have no access to internet or smartphones particularly in areas out of Nairobi.

4.4.3 Lessons from the Campaign

To further understand the key messages derived by young women from the PrEP national campaign ‘Jipende jiPrEP’, the researcher asked respondents to list the messages they identified most from listening and seeing the campaign and the results are illustrated in figure 4.4.

Figure 4.4: Lessons from the Campaign



From the findings, 88% of the respondents derived the lesson that PrEP is a HIV prevention strategy from the ‘Jipende JiPrEP’ campaign; 59% learned that only HIV negative people can use PrEP to prevent HIV. From the campaigns, the most

understood information was those that educate on the role of PrEP to prevent HIV which seem to be clear among the study respondents and participants.

Communicating facts about PrEP efficacy remains high priority as willingness to use PrEP is linked to people's perceived efficacy of PrEP. Many people want to know that PrEP will work before they use it. (Underhill, 2016).

The Health Belief Model magnifies the role of exposure to external influences such as health information by young women on their acceptability on use of PrEP. Messaging plays a big role in making young women understand how PrEP works and how it works and its benefits (Conner & Norman, 2005).

The study finds a lot of inconsistencies and mixed messaging around young women's knowledge about access and usability including who can use PrEP; where it can be accessed; the dosage; and alternative prevention methods. From the survey, 18% of the respondents indicated learning that PrEP is only available in hospitals, 35% learned that PrEP is used by anyone at risk of HIV infection while 15% and 12% of the respondents learned that PrEP can only be used by sex workers and people who use drugs.

Choice of language and framing of messages on PrEP must take into consideration how messages are understood and interpreted as this will have a bearing on how adolescent girls and young women will use PrEP (Underhill, 2016). For young women, messaging on PrEP is not meant for them as the messages focus on addressing women who identify as sex workers or women who are in sero-discordant unions (LVCT, 2018).

Views from participants in FGDs exhibited confusion on how PrEP was used with many indicating they were confused by what they hear from the media.

Q: Do you think PrEP awareness campaigns in Kenya reach young women aged 18-24?

P1: Sometimes but then I seem to think they mean those who are sex workers or maybe married to HIV positive men as that is what I hear mostly.

P2: No because no one really explains the time and work needed to take the medication, I didn't know I need to take 7 days of use before I can even say I am safe from HIV.

P3: Sometimes I am confused because I always see that PrEP is for gay men and women who practice sex work; even if you go to their facebook and titter pages you will see that they have pictures of gay men. I have never bothered to learn anything else from the campaign because I do not do sex work.

P4: Its hard of you do not have a phone to get such information because it's hard to find it from mainstream media since your parents are always there watching TV with you. Even when in school it's hard to find this information.

Understanding young women's interpretation of public campaign on PrEP is important in providing clarity on how these messages have an effect on young women's perception of risk and subsequent uptake and use of health intervention being promoted (Lubinga, 2016).

Confusion also stemmed from the many messages about HIV that do not seem aligned with reaching target population information needs. For example, at the same time the PrEP national campaign was going on, the National ART campaign 'Anza Sasa' was ongoing to encourage all those who tested HIV positive to initiate ART immediately citing one of the benefits for doing so as the HIV positive person achieving suppressed viral load and greatly reducing their chances of infecting a HIV negative partner with HIV.

These messages were running at the same time in the same media channels and elicited confusion as shared by a 24-year-old director of a youth organisation in Nairobi interviewed:

I saw another advert asking people to take ARV's because it will protect them and also ensure they do not infect someone, since the person with

HIV is already on medicine and will not be able to infect me, I do not see why I should also take PrEP because if my partner is positive and taking their treatment and is fine then I am also fine.

The levels of misinformation or misinterpretation seem to be high among young women as underscored by Focused Group Discussions where participants generally shared their value for responsive messaging in order to effectively get sold on using PrEP:

Q: In your opinion is the PrEP national campaign useful in creating awareness and promote use of PrEP by young women?

P1: Yes I think it's useful because we get to know what is and look for more information online however needs to be consistent on messaging so as not to cause confusion.

P2: The campaign though good must also be able to answer the many questions that young women and girls have before we can for sure make a decision to use it.

P3: *Hizi campaign pia ni mingi (Laughter) hata mtu anakuwa confused.*
(These campaigns are too many sometimes one can get confused.)

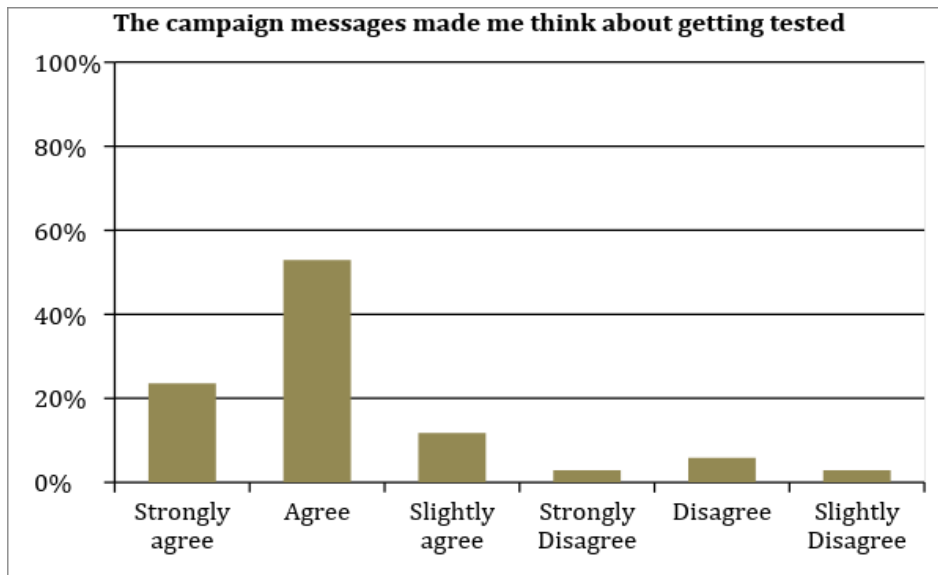
A Ministry of Health official in the national HIV prevention department also weighed in to the discussions indicating the need to have messaging that is geared towards empowering young women to make informed decisions:

I believe the campaign needs to respond to the questions and needs of young women because currently it's not. The young women are told PrEP is for people at risk of HIV infection but no one breaks it down for them to understand exactly what those risks are; Many of the young people do not consider themselves at risk and therefore will not come forward to use PrEP and where for one reason or another we have reached them during our outreach activities most of them do not remain adherent to PrEP and drop out.

On being asked if the campaign messages provided them any new knowledge about PrEP, 41% of the respondents *strongly agreed*, 38 % *agreed* and 12% *slightly agreed*.

Respondents also indicated that the messages had an impact on how they were approaching the HIV and AIDS subject (see Figure 4.5).

Figure 4.5: PrEP Campaign Messages and Influence on HIV Testing



Questionnaire respondents were asked whether they agreed with the statement watching the PrEP campaign messages made them think about getting tested for HIV. From the findings, 24% of the respondents strongly agree, 53% agree and 12% slightly agree that the campaign made them think about getting tested. During the FGD, participants intimated that knowledge on ways of protecting themselves from HIV infection motivated them to test and know their HIV status so they can decide to take the treatment or not.

The foundation of the study on Health Belief Model is demonstrated by the findings and the role of messaging on PrEP in influencing young people to test for HIV (Dunbar, 2018). Knowledge of HIV prevention, knowledge about where to get HIV testing and discussions about HIV prevention and perceived risk have been identified as predictors for uptake of HIV testing among young people (Babalola, 2007; Peltzer, 2013).

Exposure to HIV prevention messages, particularly about PrEP, builds confidence on adolescents and young women's ability to use PrEP and contributes to changing community perceptions and behaviour around uptake and use of PrEP. This reinforces the role of self-efficacy in influencing behaviour as discussed in the health belief model

and also the important role of subjective norms in adoption of behaviour as theorised within the theory of Planned Behaviour (Becker, 1975; Corcoran, 2007).

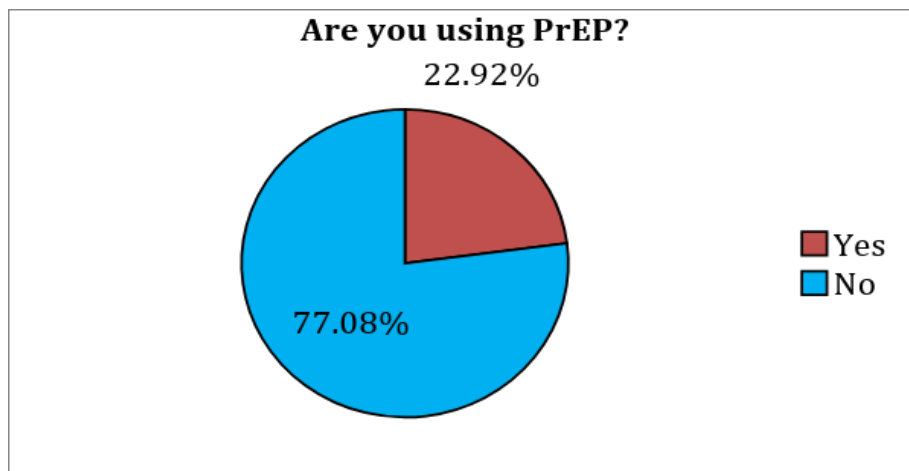
4.5 Usage Patterns of PrEP among Young Women

One of the objectives of this study was to understand the usage patterns of PrEP among young women aged 18-24 years. The respondents were asked a series of questions to provide an understanding of how many of them were on PrEP, the duration for which they had been using PrEP for HIV prevention, how adherent they were to PrEP and what if any were the barriers for effective uptake and utilisation of PrEP by this target population and their peers.

4.5.1 PrEP Use

Only 23% of the respondents in this study admitted to having used (still using) PrEP with 77% indicating that they are not using PrEP for HIV prevention as shown in figure 4.6. Of the respondents on PrEP majority which is 40% have been taking PrEP for over six months, 27% for two months, 13% for one month and 20% for one week.

Figure 4.6: PrEP Use



The study also sought to understand where most of young women accessed PrEP from and found that the three places where young women accessed PrEP were public health facility 57%; NGOs 19% and Private hospitals 14%. As much as majority of the respondents in this study are aware of PrEP and its benefits, especially on protecting young women from getting HIV infected, very few of them are translating that

knowledge into practice and actually using PrEP as a mode of protecting themselves from HIV acquisition. This knowledge-behaviour gap requires an in-depth analysis of the behavioural and structural barriers that continue to affect access to PrEP by young women.

The Theory of Reasoned Action draws a link between attitude and the environment (subjective norms) as the influences of behaviour that one learns and reinforces (Ajzen & Fishbein, 1980). The practicality of this is that if young women do not observe any positive outcome from using PrEP, and maybe in observing the environments reaction to using PrEP find that to be unfavourable and uncondusive for example full of judgement, stigma and violence then as much as they may have the knowledge and information about PrEP, they will not come forward to use it (ATHENA Initiative, 2017).

The additional factor building up from the Theory of Reasoned Action into the Theory of Planned Behaviour looks beyond the relationship between behavioural intention and actual behaviour and argues that for behaviour to actually occur then one perceived behavioural control has to be in existence. Perceived behavioural control is achieved through self-efficacy and controllability. Self-efficacy refers to an individual's belief in their own ability to thrive in performing the behaviour while controllability refers to one's belief that they personally have control of outside factors and are confident in their ability to successfully perform the behaviour (Ajzen, 1985).

This is the belief by an individual that they have the capacity to adopt the new behaviour meaning that people are more likely to adopt a new behaviour if they believe they will be successful in doing it; similarly, adolescents and young women are more likely to uptake and use PrEP when they believe they will be successful at using PrEP (Pulerwitz, 2018; Dunbar, 2018).

This argument is reinforced by the experiences of young women participants in the FGDs as illustrated below:

Q: What kinds of concerns do young women have about PrEP and its use for HIV prevention?

P1: I wonder what people will think about me getting PrEP, like I am sex minded (*eeeh*, chorus agreement)

P2: *Ijulikane kuwa like nimeamua mapema kuwa naenda kuhave sex, nitaexplain aje mzae akinipata?* (It will become public knowledge that I have decided to plan to have sex, how will I explain this to my parents if they find me with PrEP?)

P3: I wonder if this will not affect me later when say I want to have a child? No one keeps to answer this question as they keep telling me I am too young to think about children.

P4: *Watu wenye najua wanameza hii dawa wanasema ni kumeza kila siku muda mrefu.. si ni kama kumeza ARV's! (laughter) Basi, si ningoje tu nipate hiyo Ukimwi then nimeze dawa?* (More laughter)
(My friends who I know are taking PrEP told me it's taking medication everyday like taking ARV's. why don't I just wait then to get HIV then I be on treatment for life?)

Evidently, concerns around effects of the drugs and duration of drug uptake, as well as its efficacy also exist among young women and these concerns have a bearing on their use of PrEP (ATHENA Initiative, 2017).

The findings also reinforce the argument that awareness of PrEP does not necessarily translate to knowledge of PrEP (Eshienkwene, 2018). The young women in this study are aware of PrEP. However, they are not using PrEP for HIV prevention, in part, because of lacking in-depth knowledge to address the various myths and misconceptions that they have about PrEP use (LVCT, 2018).

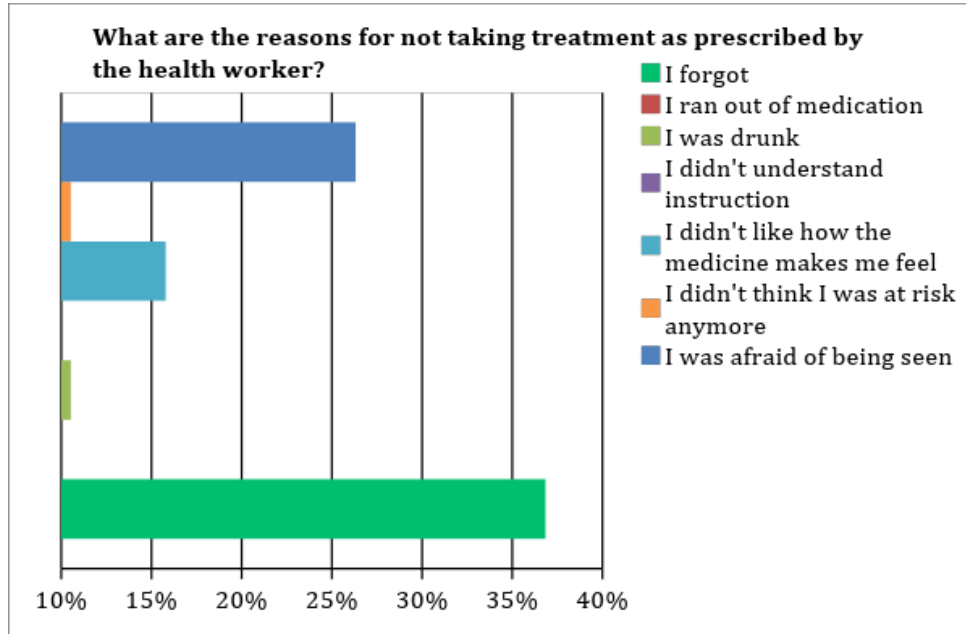
4.5.2 Adherence to PrEP

The efficacy of PrEP is assured when a HIV negative person remains adherent to taking their medication as prescribed by health worker. One is required to take PrEP every day and is documented to reach maximum protection for receptive anal sex after seven days of continuous use, while for receptive vaginal sex, maximum protection can be achieved after at least 20 days. It is still unclear the number of days it takes to reach maximum protection for insertive vaginal and anal sex (Challene, 2017; CDC, 2017).

The respondents on PrEP were asked if they had skipped their treatment. 60% of the respondents responded in the affirmative, while 30% did not skip their treatment.

Figure 4.7 below shows the reasons why young women skip their PrEP treatment.

Figure 4.7: Reasons for not Taking Treatment as Prescribed by the Health Worker



37% admitted to skipping their medication because they forgot, while 26% indicated they were afraid of being seen; 16% indicated they did not like how the medications made them feel; 11% did not believe they were still at risk and 10% skipped their treatment because they were drunk.

These findings are in concord with those found in LVCT report. The study shows 86% of the young women in the study who were eligible were initiated on PrEP. Only 26% were retained in the first month, 17% in the second month and only 10% retained at six months. Reasons for poor adherence included poor health worker attitudes, PrEP myths and misconceptions, side effects and reduced self-perception of HIV risk (LVCT, 2018).

Information from Focus Group Discussions indicate that even though it was clear for women that PrEP was useful for preventing HIV acquisition, the information on the efficacy of the preventative therapy being linked to adhering to the treatment to achieve

maximum protection is still very minimal or lacking in some participants. Also clear in these discussions is the influence of the environment on to how women made decisions around taking their PrEP medications as advised by the doctor.

Q: What are some of the challenges that adolescents and young women may face in the uptake and use of PrEP? (probe for adherence, stigma and access issues)

P1: I don't think I want anyone to know that I am taking PrEP even though I take it because my husband is HIV positive and we are trying to have a baby, I don't think many people will understand especially my family, they will make noise as to why I chose to get married to a man who is positive or think I am having many partners, who needs that drama?

P2: I was told to take the treatment every day at 7pm, sometimes I am still out of the house at that time so I forget and I remember late so I do not take it.

P3: I did not think I was at risk anymore because my boyfriend and I decided we will be exclusive. I do not know his HIV status however but I trust him (laughter)

P4: When I am going home to visit my parents I do not take the medication with me, someone maybe my sisters will find it then there will be drama. I don't want to explain why I am on PrEP

Adolescents and young women are socially connected in all aspects of their lives and their decision making influenced to a large extent by what their peers, parents or guardians and sexual partners think (Haberer, 2019). Because PrEP has been promoted as the HIV prevention commodity for people considered to be at high risk of HIV, young women shy away from taking it in public because they believe people will condemn the choices around their sexuality (Earkle, 2017).

This is in line with the Theory of Planned Behaviour (TPB) – one of the theories used in this study. TPB posits that people make logical reasoned decisions to engage in a specific behaviour by evaluating the information available to them. The emphasis by this theory is that an individual's decision to adopt a behaviour is influenced by their attitude or beliefs about their behaviour; perceived behavioural control or their ability to undertake that behaviour successfully and subjective norms or what other people's

views are about that behaviour. Similarly, many young people will come forward and use PrEP and remain adherent to its use in an environment which empowers them to believe they can use PrEP and remains very consistent in supporting PrEP use among young women doing away with stigma and other structural barriers that continue to limit their belief in their ability to effectively use PrEP to prevent HIV acquisition (Conner & Norman, 2005).

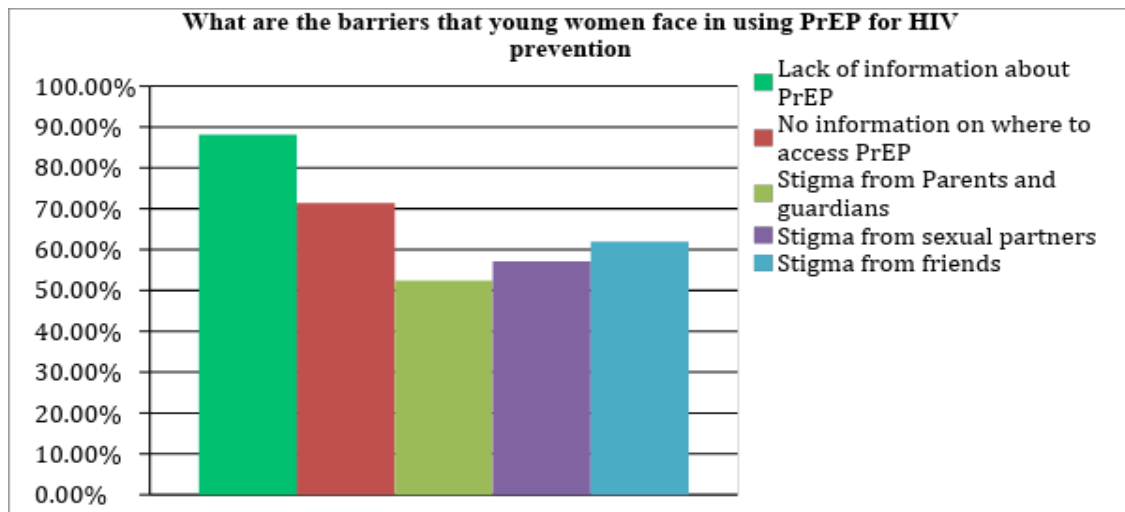
A Director of an organisation that supports Women living with HIV interviewed as a key informant for this study contributed to this discussions and shares that;

It is difficult for a young girl who lives in an environment that believes that PrEP is for a certain group of people who we have been categorised as ‘bad’ or ‘in conflict with the law’ to be safe to use PrEP freely. They fear backlash from their parents, their community and their peers; they fear that people will automatically assume they are also engaging in sex work.

4.5.3 Barriers to Using PrEP

In understanding the PrEP usage patterns of young women, the study sought to establish barriers that impeded access and use of PrEP by young women. Their responses are illustrated on figure 4.8.

Figure 4.8: Barriers that Young Women Face in using PrEP for HIV Prevention



From the responses, 88% indicate lack of information about PrEP as a barrier; 77% of the respondents indicate gaps in information of where to access PrEP as a barrier; stigma from parents and guardians 52%; stigma from sexual partners at 57%; and stigma from friends at 62%. According to a paper presented at the 10th international AIDS conference from the Kenya ‘Jilinde’ project implemented by JHpiego titled *Manifestations of stigma in the context of a national oral pre-exposure prophylaxis (PrEP) scale-up program in Kenya*, stigma has been documented as a significant barrier to people coming forward to uptake and continue to use PrEP and often manifests in the following three types; Product stigma related to use of PrEP, identity stigma related mostly to the sexual identity and classification of ‘risk’ population and behavioural stigma (Were, 2019).

These findings align well with experiences shared by the FGD participants and corroborated by the key stakeholders interviewed for this study as shown by responses from a youth leader and MOH official below;

Q: What are some of the barriers that women may face in accessing, using and retaining to PrEP for HIV prevention:

P1: If you look around, the use of PrEP by women in heterosexual relationships away from sex work is very minimal and leaves women with a lot of information needs that are rarely addressed.

P2: Women are not socialized to have any form of agency around their sex and sexuality in Africa, you can see this in how PrEP is being used by women. Young women are not getting the support they need to use PrEP, the information is minimal and the environment too hostile and unfavourable.

The role of public awareness campaign in promoting the uptake of PrEP among young women must be that which seeks to inform and educate the communities that interact very closely with young women in order for them to create an enabling environment for use of PrEP. The listing of Stigma from sexual partners, parents, guardians and friends Is a clear signal that even though the respondents may be aware of PrEP and its benefits, the lack of this knowledge by the parents, guardians, friends and sexual partners will continue to affect how young women use PrEP.

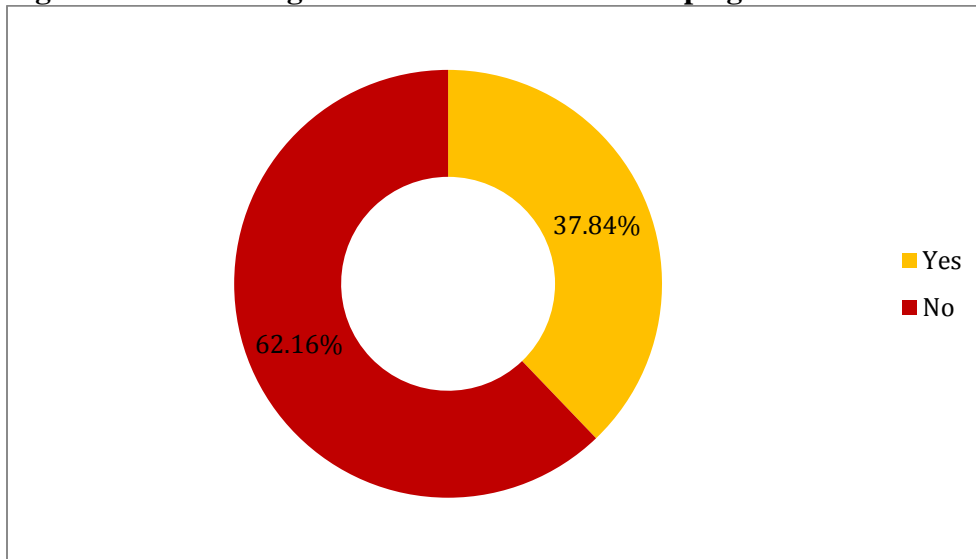
PrEP service delivery assessment show the intricate role that lack of support from the environment that adolescents and young women exist in plays in their use and retention to PrEP. Many young women, even after initiating on PrEP, drop off because of lack of support from partners, peers and community. Fear of disclosure and HIV stigma also demotivates young women from continued PrEP use (LVCT, 2018; Raifman, 2019).

The National communication campaign on PrEP ‘Jipende, JiPrEP’ has mostly used social media to reach young women and other targeted populations thereby reaching a small percentage of the general population. Even though PrEP as a national program targets specific populations because of their increased vulnerability to HIV infections, knowledge and awareness on PrEP for general public plays a big role in ensuring young women get the support they need to use and retain to PrEP (Dunbar, 2018), (Haberer, 2019)

4.6 The Role of Public Awareness Campaign

The study sought to understand young women’s considerations on the role of public awareness campaigns in influencing their uptake and use of PrEP. The respondents were asked if they thought public awareness campaigns are important for influencing young women use of PrEP to which 97% responded in the affirmative. Further, the respondents were also asked if they knew of any other PrEP campaigns other than the national campaign ‘Jipende JiPrEP’ to which 62% indicated they were not aware of any other PrEP campaign while 38% were aware of other PrEP messages as indicated in Figure 4.9.

Figure 4.9: Knowledge of other PrEP Public Campaigns



Evidence the world over points to the ability of public awareness campaigns to produce positive change in health related behaviour across a large population. Although exposure to messages from public campaigns are largely passive and campaigns have to compete with factors like social norms, behavioural factors and persistent product marketing, the success of public health campaigns have been linked to existence of policies that support behaviour change, concurrent availability of commodities and services as well as consistent community programmes that ensure an enabling environment for behaviour adoption and change (Wakefield, 2010; Barnes, 2009; Pulerwitz, 2018).

Effective messaging must take into consideration the intricate characteristics of adolescents which have a bearing to their interpretation of messages on PrEP. Typical adolescents are not cognitively mature enough to understand risk and look at long term benefits to their health choices; are mostly healthy and have not been exposed to long term use of medication for their health and are highly affected by the socio-ecological influences to their lives (Haberer et al., 2019).

PrEP messaging has laid emphasis on biomedical benefits and achievements making these seem unrealistic for young women and adolescent girls. Focus on monitoring and communicating progress in reduction in HIV new infections is not relatable to their viewpoints and immediate issues. The framing of PrEP messages need to communicate benefits that fit within things that adolescents and young women find desirable. Their attitude on the benefits of PrEP plays a big role in their uptake and retention to its use for HIV prevention (LVCT, 2018).

Both the Health Belief Model and Theory of Planned Behaviour underscore the importance of perceived benefits of PrEP in an individual's intention to use PrEP. Adolescents and young women must identify benefits of PrEP that relate to their social-ecological constructs such as the current messages about PrEP being about preventing HIV can be innovatively improved to show the health benefits of using PrEP to be HIV free, live healthy life, finish education, get a job and live their ideal dream life. This will go a long way in encouraging young women to use PrEP as the benefits are more relatable (Montanaro, 2014; Haberer et al., 2019).

The respondents were also asked to list the other PrEP campaigns they were aware of. They listed the following campaigns: The 'be self-sure' campaign which is the National campaign on HIV self-testing kit; The 'Jijue, Jipange' campaign that is led by the National AIDS control Council (NACC) and is a HIV anti-stigma and testing promotion among adolescents and young people in Kenya and lastly the "Condoms always in Fashion' campaign which is a condom use for HIV prevention campaign by AIDS Healthcare foundation.

These responses underscore the fact that the occurrence of many campaigns at the same time lead to confusion and cross messaging by young people which affects their uptake and use of PrEP as a HIV prevention tool.

Timothy Gill, in his paper, *Public Health Messages: Why Are They Ineffective and What Can Be Done?* Argues that current public health campaigns haven't implemented lessons learned from previous campaigns about the intensity, scope and duration needed to achieve changes in behaviour with many campaigns being short term (Gill,

2012). Consistent messaging about new health products is important not only for building knowledge capacity but also for ensuring sustained behaviour that promotes use of the product (Montanaro, 2014)

Respondents were asked if they have participated in any form of public awareness campaign on HIV prevention; 62% of respondents have not been engaged and 38% have been engaged in development or implementation of public awareness campaigns.

Very little information exists on the participation of adolescent girls and young women participation in the designing of health promotion messaging on PrEP. This has affected the nature of demand creation messaging on PrEP that does not resonate with young women and affects their use of PrEP (LVCT, 2018). This situation is similar to findings from a study carried out to identify if young adults appreciate health promotion messages on diet and exercise. The study found that young adults did not find current health promotion messages useful for them nor was in supporting them overcome perceived barriers to making desired health decisions (Berry, 2018).

The limitation on engagement of adolescents and young women in framing messages that they can relate to is evident from the findings above. Respondents however believe that young women play a vital role in the design and implementation of messaging that will be understood by their peers. They also indicate that this participation in message development, design and implementation of campaigns provide an empowering benefit to young women who are engaged, promotes ownership and ensures sustainability of projects as demonstrated in the FGD below:

Q: In your opinion Is engaging young women during the development and implementation of the campaign good for making the campaign useful?

P1: Yes, we are able to help the government and program people design messages that young women can understand, relate to and connect with.

P2: True also it empowers us as individuals when you say something and they are able to listen and adopt your suggestion, i feel motivated to

even engage with young people and tell them to look out for these campaigns or adverts as I was part of the team and I feel like the success of the campaign is mine too.

P3: Yes, we are able to use our lived experiences to shape how the campaign is designed, planned for and implemented. It therefore responds to our current realities.

Participation of adolescent girls and young women in the design and implementation of health promotional messages and campaigns targeting them and their peers is a right and should be of high priority. A strong health communication campaign that recognises diversity reduced information inequality and ensures health program messaging reach the intended audience for the intended impact (Estrada et al, 2018).

Health promotion programme aim to disseminate knowledge and awareness of health related in order to have a positive health outcome among targeted populations or general populations. Understanding of the message by the target audience is very important in achieving health promotion goals particularly in settings where social and cultural beliefs have a bearing on people's behaviour on HIV prevention (Muturi, 2005).

The assumption, therefore, is that when adolescents and young women uptake and use PrEP as advised by their health providers then the national public campaign would be deemed successful. This however isn't the case as the study finds that even though the young women are aware of PrEP, the messages aren't motivating them enough to use it for HIV prevention (LVCT, 2018; Mugo et.al, 2018).

Successful health promotion campaigns are those that focus on increasing understanding of the communicated messages and understanding of the audience through building a sustained relationship with the audience or stakeholders through dialogues and two-way symmetrical communication that enable contributes toward the maintenance of the newly adopted behaviours and practices (Muturi, 2005). In order to have responsive health promotion campaigns whose impact is viewed from a community development lens, it is imperative that adolescents and young women participate and are engaged in the development, planning and implementation of PrEP health campaigns targeting them (Pulerwitz, 2018).

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Overview

The purpose of this chapter is to provide a summary of the key findings as well as give a comprehensive conclusion, recommendations and areas for future study.

5.2 Summary of Findings

This study primarily set out to evaluate the national PrEP communication campaign ‘Jipende JiPrEP’ on the use of PrEP as a HIV prevention intervention.

The first objective was to assess the awareness levels of PrEP among young people in order to determine if this had a bearing to how young people used PrEP. The study found that there was a high level of awareness of PrEP among the study respondents and participants. Approximately 88% of the respondents in the survey were aware of PrEP. This was possible because most of the respondents had been exposed to health awareness talks on PrEP over a period.

The study found that the high levels of awareness of PrEP among the respondents does not reflect the reality across the country where many people remain unaware about PrEP and have not seen the national PrEP campaign ‘Jipende, JiPrEP’. This is because the campaign has mostly utilized social media, therefore limiting access to those who do not have smart phones or the internet.

In order to reach more people, the campaign may need to utilize mainstream media and other forms of community participatory approaches to disseminate information on PrEP to adolescents, young women, and their communities.

The high levels of awareness do not necessarily translate to knowledge and then to action around using PrEP by adolescent girls and young women. Literature review showed the importance of understanding characteristics of adolescent girls and young women and how these may affect their use of PrEP as a way to design messages that are relatable to them.

The second objective of the study was to understand the usage patterns of PrEP among young women aged 18-24 years in Embakasi, Nairobi (Kenya). The study found that majority of young women do not use PrEP as a HIV prevention intervention. From this study, only 22.92% of the respondents were using PrEP compared to 77.08% of the respondents who reported they were not using PrEP for HIV prevention. Further in depth analysis showed these findings were similar to program evaluation reports from national PrEP demonstration studies targeting young women in Kenya where 86% of eligible young women were initiated on PrEP and only 10% were retained on PrEP six months after initiation.

Lack of support from peers, sexual partners and guardians, changes in risk perceptions, stigma, myths and misconceptions were listed as the reasons that led to young women shying away from use of PrEP or stopping use of PrEP once initiated.

These findings show a serious gap in the framing and content of the messages within the 'Jipende JiPrEP' national campaign as it is not achieving its objective of promoting demand creation for PrEP among targeted populations including adolescents and young women.

Where as many women were aware about PrEP, majority of the respondents and experiences from focus group discussions point to young women not using PrEP because they have a lot of questions and fears particularly around drug adverse effects from long term use, lack understanding of how long they have to take the treatment before they are deemed protected from getting HIV, the effects of the drugs on their reproductive ambitions and plans among others. The 'Jipende JiPrEP' messages on social media do not answer to these knowledge needs of young women who then conclude that PrEP is not for them.

In determining adherence to PrEP as per health worker instructions to achieve ultimate efficacy the study found that majority of the respondents who were on PrEP had skipped their medication due to fear of being seen by parents, sexual partners or peers, forgetting to have the medication when they are not at home, because of side effects of the medication and because they were drinking alcohol. This lack of adherence puts the

efficacious capacity of PrEP at risk thereby continuing to put the young women at risk of HIV acquisition.

The study also unearthed key barriers to use of PrEP by young women that points to the lack of awareness, information and knowledge about PrEP and its benefits for HIV prevention among the general population. This has a bearing on how people support or make the environment uncondusive for PrEP use by young women. Lack of awareness on PrEP and lack of knowledge of where to get PrEP were listed as key barriers to young women accessing and using PrEP. Stigma from parents, guardians, friends and sexual partners also play a big role in how young women use PrEP.

Adolescent and young women poses low cognitive maturity, their focus on issues that matter to them are mostly short term and more concentrated on glamour. Adolescents are mostly healthy and do not have reason to be in health facilities neither do they have experience being on long or sustained use of medication. Additionally, the lives of adolescents and young women are centred on social-ecological influences, meaning their decisions are dependent on what they perceive as acceptable by the people around them including peers, sexual partners and parents or guardians.

Understanding these characteristics provide an opportunity to inform how the framing of health promotion messages on PrEP for this population must be considered in order to achieve the goal of getting more girls and young women using PrEP to prevent HIV infections.

The third and final objective was to examine the role of public awareness campaign in promoting uptake of PrEP among young women in Kenya.

The study found that majority of the adolescent girls and young women who participated in the study have also not participated in the development of PrEP health promotion campaign design and implementation which could explain the reason current messages are not responding to their needs.

From the theories underpinning this study - Health Belief Model and Theory of Planned Behaviour – an individual’s understanding of the benefits of adopting a new behaviour plays a critical role in their decision-making process (whether to adopt and sustain that behaviour). Additionally, from the Theory of Planned Behaviour, the role of subjective norms which is the influence of how other people perceive a certain behaviour has a bearing on how young women will decide to use or not use PrEP.

Information and knowledge on PrEP currently emphasises on the biomedical benefits of PrEP. For example, reports always mention the percentage of risk reduction as a benefit of using PrEP; strategies and programmes on PrEP have always focused on labels that gives more attention to risk, and populations already stigmatised by society like sex workers or men who have sex with men. This has over time has elicited a negative perception among the general public whose result is an unfavourable environment for young women to use PrEP.

Framing of PrEP messages need to shift towards presenting PrEP more as a lifestyle choice and less as a biomedical tool. This would give value to its use that will motivate young women and the people around them to use it.

The campaign could also benefit from using influential people and celebrities as ambassadors of PrEP. These should be people that Adolescents and young women look up to. The ‘Jijue Jipange’ campaign by NACC that targeted young people with Anti stigma and promotion of HIV testing used celebrities to popularise their message and can be replicated for PrEP campaigns.

5.3 Conclusion

The study sought to evaluate the national public campaign on PrEP ‘Jipende JiPrEP’ on the use of PrEP by adolescents aged 18-24 years and found that the campaign did not have a major impact on use of PrEP as a HIV prevention intervention by adolescents and young women.

From the study data, 83% of respondents were aware of PrEP and 90% were aware of its benefits as an HIV prevention tool for young women. However only 22% of the respondents admitted to be using PrEP for HIV prevention.

There is evidently a huge knowledge-behaviour gap on the use of PrEP by young women in Kenya. Various reasons exist for this including; stigma, structural, social, cultural and economic factors which continue to curtail the autonomy and agency of young women making it impossible for them to use PrEP. Whereas there is a robust social media public awareness campaign that seems to align with where young people particularly women get their information from, that information doesn't translate into adoption of PrEP use as a behaviour for protecting one from HIV by young people. The messages need to be packaged in a language that addresses all the needs of young women. In order to achieve this focus, it is important to take into account intricate characteristics of young women and adolescents.

Adolescents and young women require broader communication and structural interventions to address their questions, fears and barriers to use of PrEP including fears about how the drug works and its effects on their reproductive cycle, interactions with contraceptives, stigma and lack of support from peer, sexual partners and guardians as well as policy barriers that prevent adolescents from accessing PrEP without consent from parents.

The fact that information on PrEP is not well articulated by the general population leads to a lot of misinformation and generalised perceptions about its use and the people who chose to use PrEP making young women shy away from its use. A repackaging of the PrEP public campaign is needed to reduce the stigma and prejudices that exist about PrEP use in order to address the huge knowledge-behaviour gap that currently exists.

5.4 Recommendations

This study proposes four key recommendations influenced by the realities of the barriers which continue to widen the disparity between knowledge and behaviour for PrEP use among young women. The recommendations are aligned with the study objectives to improve the uptake and use of PrEP by young women in Kenya.

5.4.1 Repackage PrEP Communication Message

This study recommends a repackaging of the PrEP messaging to shift away from framing use of PrEP as a biomedical HIV prevention tool to framing messages that promote PrEP as a lifestyle choice to a healthy living. This will be more relatable to young women as well as lead to changes in perceptions by general public on the benefits of PrEP creating a conducive environment for its use.

The national Public awareness campaigns on PrEP as many other campaigns and messages have packaged and marketed PrEP as a male product with very little to no information that is targeted for women. In Kenya as much as the target population for use of PrEP includes gay men, sex workers, injecting drug users and adolescent and young women, from the communication shared so far, general public perception is that PrEP is a HIV prevention product for gay men and people who do sex work. The Jipende Jilinde JiPrEP facebook page illustrates this reality; the profile picture is the ‘rainbow flag’ that promotes respect for sexual rights alongside two men. The general perception and public understanding therefore is that PrEP is not for women leave alone young women. PrEP messaging need to be inclusive to change public perception and elicit the much needed support for young women to uptake and use PrEP to reduce avertible new HIV infections and be on course to realizing the goal of zero new infections by 2030.

5.4.2 Address Barriers to Use of PrEP

All stakeholders in the HIV response must commit to addressing the barriers that affect the use of PrEP by young women. This requires expanding PrEP communication strategy implementation to reach more people who may not need to use PrEP but whose support is needed to enable young women to access PrEP including parents, guardians, teachers, religious leaders, community leaders, and peers.

Targeted messaging on how PrEP works and the importance of adherence must be included by health workers or social workers that are in constant interactions with young women for them to understand and efficiently use PrEP.

The NACC coordinates the HIV response multi-sectoral approach and needs to investigate further and document national-level data on the barriers to uptake and use of PrEP in Kenya and particularly by young women. This documentation will provide a premise for investing in programming that eradicates barriers to information, addresses stigma and violence and builds the capacity of young women to speaking up against barriers, societal power dynamics and unfavourable environments that pose a threat to use of PrEP to protect themselves against HIV.

5.4.3 Involve Young Women in Communication Strategy Development and Implementation

This study recommends that MOH through NASCOP engage young women in the conceptualization, development, and dissemination of PrEP public awareness campaigns. This will not only aid in the development of messages that respond to their needs and realities but also will be better utilized as the young women develop ownership of the messages and its outcome. This engagement needs to be deliberate and not tokenistic, must empower the young women to be able to fully participate at all levels including during monitoring and decision making of data from periodic feedback mechanisms.

5.5 Recommendations for Further Research

This study recommends that further scientific inquiries be conducted to evaluate the impact of PrEP campaigns at the national level. Further scientific inquiries are needed to determine the barriers PrEP use by adolescent girls and young women.

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APPENDICES

Appendix 1: Focus Group Discussion (FGD) GUIDE;

THE IMPACT OF ‘JIPENDE JIPrEP’ CAMPAIGN ON THE USE OF PRE-EXPOSURE PROPHYLAXIS (PREP) AMONG YOUNG WOMEN IN KENYA.

INTRODUCTION:

My name is [interviewer name] representing We are collecting information seeking to evaluate the impact of public awareness campaigns on Pre-Exposure Prophylaxis (PrEP) use by young women in Kenya.

This is a project undertaken in partial fulfilment of requirements for the degree of Master of ARTS in Communications Studies. The study also be useful for informing the programmers and policy makers implementing PrEP among young women to design programmes that respond to the needs of young women. All of the information that you provide will be kept confidential and only accessible to the team conducting the research.

Your names will not be linked to the information you give however for purposes of recording all your responses we shall use coded identification. We will be recording your responses to enable us capture all the aspects of the FDG’s discussion and will endeavour to maintain confidentiality for all our responses.

Please note that your participation in the survey is voluntary but we will however appreciate your responses and contributions. We will take about **one hour and 30 minutes** in this FDG and refreshments will be provided. You are free to stop responding to the questions at any point and will not be penalized for your decision to do so. We will also be seeking your contacts in order to follow up with further questions and information should there be need. We will keep your contact information confidential and will ensure it is not linked to the information you give us. If you are willing to participate in the study please sign below;

Participant/Respondent Code..... Sign.....

INTRODUCTION; - Pre-exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of getting it to prevent HIV infection by taking a pill every day. The pill (brand name Truvada) contains two medicines (tenofovir and emtricitabine) that are also used in combination with other medicines to treat HIV.

Knowledge and awareness

1. Do you know what PrEP is? Probe knowledge and understanding of PrEP with particular interest in:
 - a. What PrEP is;
 - b. Why is PrEP is needed for HIV Prevention
 - c. What is the evidence that PrEP works;
 - d. What is the current guidelines;
2. Who should use PrEP? Probe knowledge and understanding of PrEP use with particular interest in;
 - a) Can PrEP ensure HIV prevention to all adolescent girls and young women;
 - b) What about people who are only at risk of acquiring HIV infection during certain periods;
 - c) How is PrEP taken? Is it a pill, syrup, injection?

Perceived barriers to access and use:

3. What are the barriers to PrEP access, use and adherence? Probe knowledge and perception of barriers for PrEP use with particular interest in;
 - a) How easy or difficult is it for young people to access PrEP?

- b) Where is PrEP accessed?
 - c) Is it easy or hard for young women to use and adhere to PrEP?
Why?
 - d) What are some of the reasons why young women shy away from using PrEP?
2. Should adolescent girls and young women access PrEP for HIV prevention? If yes, why and if no, why not/

Role of Public Awareness Campaigns for promoting use of PrEP

3. Have you heard of any PrEP awareness campaign?
- a. Which ones have you heard of? Probe for knowledge of the Kenya National PrEP campaign ‘JIPENDE JIPrEP’
 - b. Do you think awareness on PrEP reaches young women aged 18-24?
 - c. Do you think having Awareness campaigns is helpful for promoting PrEP use? How?

Understanding usage patterns of HIV prevention interventions (PrEP) by young women

- 4. How does PrEP affect adolescent girls and young women and their sexual health?
- 5. What are some of the challenges that adolescents and young women may face in the uptake and use of PrEP? (Probe for Adherence, stigma, access gaps)
- 6. What kinds of concerns do young women have about PrEP and its use for HIV prevention?
- 7. What forms of support should adolescent girls and young women be given or provided so as to access PrEP? Where and from whom?

8. For those on PrEP what are your views about the services provided by the healthcare professionals when accessing PrEP?
9. Do young women your age need to have someone's permission to access PrEP? Whose permission do you need? Probe for influence of parents, relatives, partner? Please describe and explain this more.
10. Does this impact the access to HIV prevention options and adherence by young people?
11. Do you think education will influence how adolescents and young people access and use HIV prevention options like PrEP?

CLOSING

- 1. Just before we finish, do you have any questions for me?**
- 2. Is there anything you had wanted to say but didn't have the chance to say?**

I would like to thank you all VERY MUCH for telling me about your experiences and opinions today. Your openness and your honesty about these things will help me better understand the impact of awareness campaigns on use of PrEP by young women. The recommendations from the final report will be useful to policy makers and PrEP program implementers to provide support and services that will ensure young women use PrEP to prevent HIV acquisition.

THE END

Appendix 2: Key Informant Interview (KII) Guide

THE IMPACT OF ‘JIPENDE JIPrEP’ CAMPAIGN ON THE USE OF PRE-EXPOSURE PROPHYLAXIS (PREP) AMONG YOUNG WOMEN IN KENYA.

INTRODUCTION:

My name is [interviewer name] representing We are collecting information seeking to evaluate the impact of public awareness campaigns on Pre-Exposure Prophylaxis (PrEP) use by young women in Kenya.

This is a project undertaken in partial fulfilment of requirements for the degree of Master of ARTS in Communications Studies. The study also be useful for informing the programmers and policy makers implementing PrEP among young women to design programmes that respond to the needs of young women. All of the information that you provide will be kept confidential and only accessible to the team conducting the research.

Your names will not be linked to the information you give however for purposes of recording all your responses we shall use coded identification. We will be recording your responses to enable us capture all the aspects of the interview and will endeavour to maintain confidentiality for all our responses.

Please note that your participation in Interview is voluntary but we will however appreciate your responses and contributions. You are free to stop responding to the questions at any point and will not be penalized for your decision to do so.

This interview will last 45 minutes. Do you have any questions or concerns before we begin?

We will also be seeking your contacts in order to follow up with further questions and information should there be need. We will keep your contact information confidential and will ensure it is not linked to the information you give us.

If you are willing to participate in the study, please sign below;

Participant/Respondent Code..... Sign.....

About the Interview Participant

1. Tell me about yourself and how long you've been with the organisation.
2. Do you work closely with young women aged 18-24 years?
3. What services do you provide?
4. Have you worked in any other area of the organisation?

Knowledge of PrEP by young women

1. In your opinion are young women knowledgeable about PrEP?
2. In your opinion where do young women access information and knowledge on usage of PrEP?
 - a. What is their most preferred source?
 - b. Why do they prefer this source of information?
3. Are you aware of the National awareness campaign on PrEP?
 - a. Tell me a little bit about what you know
 - b. In your opinion is the campaign useful in creating awareness and promote PrEP use by young women?
 - c. Are you involved in the campaign (including design, implementation and monitoring? If yes what is your role?

PrEP Usage and retention

1. In your opinion are young women aged 18 – 24 years using PrEP for HIV prevention? Explain your answer.
2. Where do young women access PrEP from?
3. What kinds of concerns do young women have about PrEP and its use for HIV prevention?
4. What are some of the support needs for young women to use and retain to PrEP for HIV prevention?
5. What are some of the barriers that they may face in accessing, using and retaining to PrEP for HIV prevention?

Role of public awareness campaigns

1. In your opinion are public awareness campaigns useful for influencing uptake and retention to PrEP?
2. What are the campaigns that have worked so far to influence young women to use PrEP?
3. What is so unique about the campaigns identified above?
4. In your opinion who should run these public awareness campaigns?
5. What are the media that are most appreciated by young women to get information on PrEP?

CLOSING:

Thank you very much for your time. Your knowledge and insights will be very helpful to us. **Just before we finish, do you have any questions for me? Is there anything you had wanted to say but didn't have the chance to say?**

I would like to thank you all VERY MUCH for telling me about your experiences and opinions today. Your openness and your honesty about these things will help me better understand the impact of awareness campaigns on use of PrEP by young women. The recommendations from the final report will be useful to policy makers and PrEP program implementers to provide support and services that will ensure young women use PrEP to prevent HIV acquisition.

THE END

Appendix 3: Questionnaire

THE IMPACT OF ‘JIPENDE JIPrEP’ CAMPAIGN ON THE USE OF PRE-EXPOSURE PROPHYLAXIS (PREP) AMONG YOUNG WOMEN IN KENYA.

INTRODUCTION:

My name is [interviewer name] representing We are collecting information seeking to evaluate the impact of public awareness campaigns on Pre-Exposure Prophylaxis (PrEP) use by young women in Kenya.

This is a project undertaken in partial fulfilment of requirements for the degree of Master of ARTS in Communications Studies. The study also be useful for informing the programmers and policy makers implementing PrEP among young women to design programmes that respond to the needs of young women. All of the information that you provide will be kept confidential and only accessible to the team conducting the research.

Your names will not be linked to the information you give however for purposes of recording all your responses we shall use coded identification. We will be recording your responses to enable us capture all the aspects of the interview and will endeavour to maintain confidentiality for all our responses.

Please note that your participation in Interview is voluntary but we will however appreciate your responses and contributions. You are free to stop responding to the questions at any point and will not be penalized for your decision to do so.

This interview will last 45 minutes. Do you have any questions or concerns before we begin?

We will also be seeking your contacts in order to follow up with further questions and information should there be need. We will keep your contact information confidential and will ensure it is not linked to the information you give us.

If you are willing to participate in the study, please sign below;

Participant/Respondent Code..... Sign.....

Instructions

First, I am going to ask you questions about yourself and the questions about the campaign will follow. Please feel free to tick/circle where applicable.

SECTION A: Social –Demographic Characteristics

1. Sexual identity

Cisgender [] Transgender [] Other (indicate).....

2. Age

18-19 [] 20-24 []

3. Marital Status

- a) Married []
- b) Cohabiting/come we stay []
- c) In a steady relationship []
- d) Divorced []
- e) Single []
- f) Separated []

4. Education level

- a) Never attended school []
- b) Informal Schooling/Gumbaru []
- c) Primary level []
- d) Secondary level []
- e) College level []
- f) University level []

5. Religion

- a) Christian []
- b) Protestant []
- c) Catholic []
- d) Muslim []

Others (Specify).....

6. Employment Status

- Employed [] Unemployed []

SECTION B: Usage PrEP

7. Are you using PrEP?

- Yes [] No []

If yes, for how long have you been on PrEP?

- a) One week []
- b) One month []
- c) Two months []
- d) over 6 months []

8. Where do you access PrEP?

- a) From health facility []
- b) From community Organisation []
- c) From NGO []
- d) From Private hospital []

9. Have you ever skipped your treatment?

Yes [] No []

10. If yes Indicate how many times in a month have you missed your treatment

1-7 days [] 10- 15 days []

One Month [] Prefer not to answer []

11. What are the reasons for not taking treatment as prescribed by the health worker?

a) I forgot []

b) I was drunk []

c) I didn't like how the medicine makes me feel []

d) I didn't think I was at risk anymore []

e) I was afraid of being seen []

f) I ran out of medication []

g) I didn't understand instruction []

SECTION C: Awareness of PrEP

12. Are you aware about PrEP

Yes [] No []

13. Do you think PrEP can protect young women from acquiring HIV?

Yes [] No []

14. Are you aware of the Jipende JiPrEP campaign

Yes [] No []

15. Which of the following media channels did you hear/see `Jipende JiPrEP` campaign

- a) National Radio Station []
- b) National TV station []
- c) Community Radio []
- d) Social media (Facebook, twitter, Instagram, website) []

16. Which of the following lessons did you derive from `Jipende JiPrEP` campaign?
(tick all that apply)

- a) PrEP is a HIV prevention strategy []
- b) Only HIV positive people can use PrEP to prevent HIV []
- c) Only HIV negative people can use PrEP to prevent HIV []
- d) PrEP is only in hospitals []
- e) PrEP is only used by anyone at risk of HIV infection []
- f) PrEP is only used by people who do sex work []
- g) PrEP is only used by people who use drugs []
- h) PrEP is only used by Men []

17. To what extent do you agree with the following statements about the campaign?

- a. The campaign messages provided me with new knowledge about PrEP testing strongly agree

Agree

Slightly agree

Strongly Disagree [] Why.....

Disagree [] Why.....

Slightly Disagree [] Why.....

b. The campaign messages made me think about getting tested

- Strongly agree [] Why
- Agree [] Why.....
- Slightly agree [] Why.....
- Strongly Disagree [] Why.....
- Disagree [] Why.....
- Slightly Disagree [] Why.....

c. The campaign messages made me think about the risk of HIV

- Strongly agree [] Why
- Agree [] Why.....
- Slightly agree [] Why.....
- Strongly Disagree [] Why.....
- Disagree [] Why.....
- Slightly Disagree [] Why.....

18. To what extent do you agree with the following statements about the campaign?

a. The campaign provided me with new knowledge about HIV stigma reduction

- Strongly agree [] Why
- Agree [] Why.....
- Slightly agree [] Why.....

Strongly Disagree [] Why.....

Disagree [] Why.....

Slightly Disagree [] Why.....

b. The campaign propelled me to think about changing my attitude towards those living with HIV

Strongly agree [] Why

Agree [] Why.....

Slightly agree [] Why.....

Strongly Disagree [] Why.....

Disagree [] Why.....

Slightly Disagree [] Why.....

c. The campaign made me think that one can still live even if tested positive for HIV

Strongly agree [] Why

Agree [] Why.....

Slightly agree [] Why.....

Strongly Disagree [] Why.....

Disagree [] Why.....

Slightly Disagree [] Why.....

SECTION D: Barriers to usage of PrEP by young women 18-24

19. What are the barriers that young women face in using PrEP for HIV prevention

- a) Lack of information about PrEP []
- b) No information on where to access PrEP []
- c) Stigma from Parents and guardians []
- d) Stigma from sexual partners []
- e) Stigma from friends []

20. Who are the people who can support young women to use PrEP

- a) Parents and guardians []
- b) Health care workers []
- c) Peers []
- d) Media []
- e) Religious leaders []
- f) Teachers []
- g) Sexual partners []
- h) NGO's []

21. If you are given PrEP would you use it?

Yes [] No []

b) Explain reason your answer

.....
.....
.....

SECTION E: The Role of the Public awareness campaign

22. Do you think Public awareness campaigns are important for influencing how young women use PrEP?

Yes [] No []

23. Do you think Public awareness campaigns are important for influencing how young women use PrEP?

Yes [] No []

24. Do you know about any other Public awareness campaign on PrEP or HIV prevention?

Yes [] No []

b) Please list three

.....
.....
.....

25. Have you been involved in any form of public awareness campaign on HIV prevention?

Yes [] No []

26. Your opinion is engaging young women during the development and implementation of the campaign good for making the campaign useful? Explain your

answer.....
.....
.....

THE END

Appendix 4: Certificate of Field Work



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REF: CERTIFICATE OF FIELDWORK

This is to certify that all corrections proposed at the Board of Examiners meeting held on 13/05/2019 in respect of M.A/PhD. Project/Thesis Proposal defence have been effected to my/our satisfaction and the project can be allowed to proceed for fieldwork.

Reg. No: K50/86828/2016

Name: Florence Adhiambo Rako Aram

Title: The Impact of 'Sipende JiPreP' Campaign on
the use of Pre-Exposure Prophylaxis (PEP) among young women in Kenya

Prof Ndeh Ndete
SUPERVISOR

[Signature]
SIGNATURE

16.5.2019
DATE

Dr Samuel Sirinj
ASSOCIATE DIRECTOR

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SIGNATURE

16/5/2019
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Prof Ndeh Ndete
DIRECTOR

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Appendix 5: Certificate of Correction



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REF: CERTIFICATE OF CORRECTIONS

This is to certify that all corrections proposed at the Board of Examiners meeting held on 23/08/2019 in respect of M.A/Ph.D. Project/Thesis Proposal defence have been effected to my/our satisfaction and the project/thesis can be allowed to proceed for binding.

Reg. No: K50/86828/2016

Name: Florence Adhiambo Riako Anam

Title: An Evaluation of the Kenya National PrEP Communication

Campaign 'Super PrEP' on the use of PrEP among young women in
Embakasi, East Nairobi, Kenya

Prof. Naethi Naethi
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Appendix 6: Certificate of Originality

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