FACTORS INFLUENCING YOUTH PARTICIPATION IN APHIAplus KaMili HIV PREVENTION INITIATIVES IN DALLAS SLUMS, EMBU - WEST DISTRICT

BERNARD EDIEDU OGWANG

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DECLARATION

This research project is my original work and has not been presented for an academic award in any other institution of higher learning.

Signature…… Date……..…

BERNARD EDIEDU OGWANG **REG No: C50/60356/2010**

This research report has been submitted for examination with my approval as the University Supervisor.

Supervisor's Signature…….Date……

PROF. EDWARD K. MBURUGU

DEDICATION

This research project is dedicated to my wife, Alicerose Ndia, without whose love, support and patience it would have not been possible, and to my daughter, Elaine Amira who had to endure my absence for long periods as I wrote the research paper.

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I would like to sincerely thank the almighty God for granting me wisdom, strength and good health during the entire research project period.

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Special acknowledgements go to all the youths, community leaders and community health workers who participated in this research project. Without you this project would not have been completed.

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ABSTRACT

The importance of meaningful participation as a strategy in prevention of new HIV infections among youths has been a consistent message in all HIV related commitments to date. While efforts have been made to promote young people's participation in targeted HIV related activities, fewer programs have tried to promote youth participation as part of a more encompassing strategy. Not much is known about the factors influencing youth participation in HIV prevention initiatives. The research objectives of this study were to; identify the approaches adopted by APHIAplus KaMili project to encourage participation of youths in Dallas slums; to assess the extent to which youths participated in the project; to establish the socio-economic determinants of youth participation in the project and to establish challenges facing youth participation in the project. APHIAplus KaMili project works with the government and community based organizations in Eastern and Central provinces to increase the use of quality health services, products and information through provision of comprehensive information and quality integrated service packages.

The research study covered four villages; Matakari, Kathigari, Mbona and Dallas Mjini villages within Dallas slums in Embu west District. Stratified random sampling was used to divide the respondents aged 15-24 years into equal proportions and to separate youths who had participated from those who had not participated in HIV prevention initiatives. The researcher anticipated interviewing a total of 104 youths aged 15 – 24 years. The researcher selected two community leaders and community health workers as key informant interviewees from all the four villages through purposive sampling. The researcher used questionnaires, key informant interviews and focus group discussions. Descriptive statistics were used to show distributions, relationships between variables under study, proportions in terms of texts, percentages, charts and tables. Qualitative data was analyzed manually and emerging themes presented in narrative form.

The study found that the approaches adopted by APHIAplus KaMili project include; encouraging youths' participation through engagement and participation in HIV prevention initiatives; supporting the youths through peer learning and instilling a sense of community and local bonding with others; encouraging the youths to express their views and opinions freely without discrimination and providing the youths with skillful training for their HIV prevention. However a significant proportion of youths were not participating in these initiatives and efforts should be made by the project to ensure that they participate in the HIV prevention initiatives. The study also established that nature of residence; employment status and source of income were critical socio-economic determinants of youth participation in APHIAplus KaMili HIV prevention initiatives.

The project needs to ensure involvement of youths in design, planning, monitoring and evaluation of HIV prevention initiatives. Developing a reward system which entails recognition of the most active youths in the project, expanding opportunities for jobs and internships for youths by the project and ensuring that as many youth groups as possible are linked to micro financing institutions will also ensure meaningful participation of youths in HIV prevention initiatives in Dallas slums, Embu west District.

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ABBREVIATIONS & ACRONYMS

AIDS	–	Acquired Immune Deficiency Syndrome
APHIAplus	–	AIDS Population and Health Integrated Assistance project
BCC	–	Behavior Change Communication
CHW	_	Community Health Worker
FHI	–	Family Health International
HIV	_	Human Immunodeficiency Virus
ICAP	_	International Centre for AIDs Prevention care and treatment
ICPD	–	International Conference on Population and Development
KaMili	–	Coined from Swahili words '*Katikati*' and '*Mashariki*' meaning Central and Eastern
KNHD	–	Kenya National Human Development
LVCT	–	Liverpool VCT Care and Treatment
PATH	–	Program for Appropriate Health in Technology
PMTCT	–	Prevention of Mother To Child Transmission
SPSS	–	Statistical Package for Social Scientists
UN	_	United Nations
UNFPA	–	United Nations Populations Fund
UNGASS	–	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	–	United Nations Children's Fund
USAID	–	United States Agency for International Development

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Background statement

Youth is a highly evocative term that changes depending on its context. The concept has been extensively critiqued in social sciences (Lesko, N 2001, and Durham 2000). In international development programs and policy, one framework of defining youth is by age, and there are numerous age - based categories. These categories include youth, young person, adolescent (early, middle and late stage) and many of them overlap. The UN defines adolescents as 10 -19 and young people as 10-24. They also define youth as 15 – 24, this being the time for maturing and for developing skills and knowledge in readiness for integration into the economic, social and political spheres of life. The focus of this research is on youths aged 15 -24 years.

Meaningful participation has been perceived as in many ways as practiced in the development sector. Siderenko (2006) postulates that participation can take different forms; direct, representational, political and information based. The US national commission on resources for youth defines youth participation as involving youths in responsible, challenging actions that meets genuine needs with opportunity for planning and/or decision making affecting others in an activity whose impact or consequences extends to others – outside or beyond the youth participants themselves. For purposes of this research, meaningful participation implies youth involvement in making decisions related to project conceptualization, design, budgeting, management, implementation, monitoring and evaluation of APHIAplus KaMili youth projects in Dallas slums.

Most of the world is young. The rest of us have all been young. But it is easy to forget that we are young in a particular social setting. McKinnon (2001) contends that in the developed world, education systems and other institutions may treat youths as a rehearsal for ‘real’ life. In the developing world, adult responsibilities can only come too soon, leaving hardly a space for childhood. But despite the contrast, something usually lacking in both scenarios is control over one’s life; a chance to really contribute to the decision making that affects us.

This escapes our attention because we are more likely to think of youths as part of a lifecycle, than youths as a social grouping (Foster. J, Naidoo. K, 2001). The advice we give to them, even to our selves, is too often; 'wait until you grow up'.

Literature reviews and other sources of information point to the importance of participation. With respect to HIV and other health issues, social participation is vitally important to health (Dario and Aglobitse 2004; Health development agency 2004). This is no less true of work with young people than with other groups. Youth participation in the identification of needs in program design and development should lead to greater acceptability and appropriateness (Landsown 2001, Kirby et al, 2003; Senderowitz et al; 2003). It should also result in programming that is inclusive rather than stigmatizing. Through meaningful participation, young people become a potential resource in addressing the global HIV pandemic (Bellamy 2002; Bond 2004; FHI 2005).

One of the clearest rationales for participation and involvement of young people in HIV prevention initiatives derives from the United Nations convention on the rights of the child (CRC). This assigns to children and young people the right to freely express their views and opinions, and have them considered in relation to many walks of life. This includes the manner in which they are treated by adults and society more generally, as well as the services that are provided, and to which they have access. Taking seriously the words of this convention should be the cornerstone of any coherent future public health response, HIV and AIDs prevention responses included.

Peter Piot the executive director UNAIDs, reaffirms the critical role of youth participation in HIV prevention initiatives when he says; "*According special priority to young people will change the future course of the epidemic. Changing behaviors and expectations early results in a lifetime of benefit both in HIV prevention and in overcoming HIV-related stigma, the challenge is to promote effective programs that engage young people in all aspects of the response to HIV/AIDS. . . . In every country where HIV transmission has been reduced, it has been among young people that the most spectacular reductions have occurred. "*

While efforts have been made to promote young people's participation in targeted HIV related activities, fewer programs have tried to promote young people's participation as part

of a more encompassing strategy (Morrow 1999). Research suggests that young people typically feel excluded from the wider societal decision making and perceive many efforts to increase their involvement in program planning as tokenistic (Lansdown, 2001, Bellamy 2002; Mathews 2003). The challenge therefore lies in developing frameworks and participation opportunities that respect young people's interest and needs and which are perceived as valuable by the young people concerned.

Youth participation can be a tool for enabling youth empowerment, through which communities take responsibility for diagnosing and working to solve their own health and development problems (Morgan, 2001). Wallerstain (2006) postulates that the most effective empowerment strategies are those that build on and reinforce authentic participation ensuring autonomy in decision making, sense of community and local bonding, and psychological empowerment of the community members themselves, who include the youths.

The importance of preventing HIV infections and meaningful participation among young people has been a consistent message in all HIV/AIDS related commitments to date, particularly ICPD+5, the millennium development goals, the declaration of commitment made at the 2001, United Nations general assembly special session on HIV/AIDS (UNGASS), and the general assembly political declaration on HIV/AIDS in 2006. HIV prevention among young people is also one of the 'Essential programmatic actions for HIV prevention' in the UNAIDS policy position paper intensifying HIV prevention. This is only possible when youth are meaningfully involved in the HIV prevention programs.

When young people are provided with necessary means and skills training, they can be important advocates for their specific sexual and reproductive health needs. Given the possibility to speak up, they can introduce more youth sensitive perspectives to policy-making processes. UNFPA's commitment to youth participation is reflected in a wide range of initiatives from peer education to advocacy work. These initiatives build on and utilize the skills, knowledge and enthusiasm of young people.

Young people are increasingly participating in important events that help shape the global response to HIV/AIDS, such as the UN general assembly special session on HIV/AIDS and the International AIDS conference. Though there are concerted efforts to ensure meaningful

participation of young people in HIV prevention responses, little is known about factors which influence youth participation hence sustained participation of youths has been consistently reported as a challenge in HIV prevention programming.

According to the Kenya youth policy (2009), youths constitute about 75% of the country's population, forming the largest source of human resource. However, they have remained on the periphery of the country's affairs and their status has not been accorded due recognition. They have been excluded from designing, planning and implementing programs and policies that affect them. Many of the youth who are productive and energetic remain unemployed, continue to suffer from poor health and lack sufficient support. Some of them have special needs that require attention. This situation has continued to be perpetuated by lack of young people's participation in the design, planning and implementing of programs aimed at addressing their plight a situation occasioned in part by lack understanding of factors influencing youth participation in HIV prevention initiatives hence the need to conduct this research.

The National youth policy (2009) recognizes that the youths are a key resource that can be tapped for the benefit of the whole country. It endeavors to address issues affecting young people by providing broad-based strategies that can be used to give the youth meaningful opportunities to reach their maximum potential. It provides a broad framework within which all stakeholders, including the civil society, private and public sectors, can contribute to youth development. However, the document does not provide insights into the drivers of youth participation in HIV prevention programs.

The cornerstone of youth response to HIV prevention is empowerment through capacity building. Young people are supported using a peer learning approach, enabling them to develop critical life skills that promote abstinence, fidelity among young married couples, and correct and consistent use of condoms. At the same time, service providers and volunteer peer counselors are trained to meet the needs of young people. These strategies have however not translated into understanding factors that influence youth participation.

In Kenya several HIV intervention programs have been initiated such as: HIV testing and counseling, prevention with positives' (PwP), voluntary medical male circumcision (VMMC)

for HIV prevention; community-based HIV/AIDS prevention, care and support project (COPHIA), prevention of mother-to-child transmission (PMTCT) and behavior change communication (BCC). Recent research shows that the most effective form of HIV prevention among young people is combination prevention which relies on evidence informed, strategic and simultaneous use of complimentary behavioral, biomedical and structural prevention strategies (UNAIDS 2010).

1.1.1 APHIAplus KaMili

APHIAplus (AIDS, Population and Health Integrated Assistance) KaMili is a cooperative agreement running from January 2011 to December 2015. The project is funded by United States Agency for International Development (USAID) and is a partnership comprising; JHPIEGO, the National Organization of Peer Educators, African Medical and Research Foundation (AMREF), Liverpool VCT Care & Treatment, Land O' Lakes, Kenya Red Cross, PATH, Christian Health Association of Kenya (CHAK), and ICAP.

APHIAplus KaMili works with the government and the community based organizations to increase use of quality health services, products and information, by increasing the availability of comprehensive information and quality integrated service packages, high-impact interventions at community and facility levels. Youth participation in HIV prevention responses within the project areas is one of the strategies that the project utilizes and is as a result working with young people both in and out of school in HIV prevention programs.

1.2 Problem statement

Young people remain at the center of the HIV/AIDS epidemic in terms of rates of infection, vulnerability, impact, and potential for change. They have grown up in a world changed by HIV and AIDS and though many have participated in, and have comprehensive and correct knowledge about how to prevent HIV prevention (KDHS 2009), not much is known about factors which influence their participation in HIV prevention responses.

Rajani (1999) notes, youths' energy, if well utilized, puts them in good stead of solving socio-economic ills. Youths face the economic and social impact of HIV/AIDS at family, community and national levels. They must therefore be at the center of prevention actions.

Thus all national HIV/AIDS strategies need to focus on young people. Young people need information, opportunities to develop skills to avoid risks, to negotiate safer sex, access to condoms and youth-friendly services.

Youth participation can be a tool for enabling youth empowerment, through which communities take responsibility for diagnosing and working to solve their own health and development problems (Morgan, 2001). Organizations such as World Health Organization emphasize the importance of youth involvement in the design, implementation, and evaluation of programs intended to address their needs. In addition, a growing body of research shows that youth participation in reproductive health and HIV/AIDS programs helps young people to develop confidence, change attitudes, and establishes more meaningful relationships with adults.

Adults should be aware of the advantages of working with the youths. The creation of a supportive environment will certainly encourage more genuine youth participation in HIV prevention responses. Youth will be more receptive to working with supportive adults, when they recognize the pivotal role they can play in the society. Therefore it is important that youth work hand in hand with adults." capitalizing on this force of change calls for young people to work in partnership with adults who encourage their participation and are receptive to their ideas" (UNAIDS 1999)

Even though many non-profit and youth serving organizations such as APHIAplus KaMili have come to embrace the notion that youth voices should be part of organizational decision making (Zeldin Et al. 2000), most observers agree that corresponding research on youth participation- its prerequisites, organizational features, current scope and impacts – remain in the early stages. In part this reflects a lack of consensus on conceptual frameworks and definitions, especially the ones that take into account the influence of local contexts (Spring 2001). Broad and meaningful participation seems to require a larger policy context in which the voices of the youth are listened to and taken seriously, and we still have much to learn about the multiple ways in which context influences local efforts.

Despite the importance of youth participation in the context of HIV prevention initiatives, very few programs have been designed which involve youth participation in solving

HIV/AIDS related issues. Besides, no study has been done on the determinants of youth participation in HIV prevention responses in Embu west district. This study sought to fill-in the knowledge gap by establishing factors influencing youth participation in the APHIAplus KaMili HIV prevention initiatives in Dallas slums, Embu west District.

1.3 Research questions

The study sought to answer the following research questions;

i. What are the approaches adopted by APHIAplus KaMili project to encourage participation of the youths?

ii. To what extent do youths participate in the APHIAplus KaMili project?

iii. What are the socio-economic determinants of youth participation in APHIAplus KaMili project?

iv. What are the challenges facing youth participation in APHIAplus KaMili in Dallas slums?

1.4 Study objectives

This section describes the broad objective and the specific objectives of the research study. These objectives were developed to respond to the research questions of this study.

1.4.1 Broad objective

To assess the factors influencing youth participation in APHIAplus KaMili HIV prevention initiatives in Dallas slums, Embu west District.

1.4.2 Specific objectives

From the research questions above, the study sought to answer the following specific objectives;

i. Describe approaches adopted by APHIAplus KaMili project to encourage participation of the youths in Dallas slums, Embu District.

ii. Ascertain the extent of youth participation in the APHIAplus KaMili Project in Dallas slums, Embu District.

iii. Identify the socio-economic determinants of youth participation in APHIAplus KaMili project in Dallas slums, Embu District.

iv. Establish challenges facing youth participation in APHIAplus KaMili in Dallas slums, Embu District.

1.5 Justification of the study

This study is justified in the sense that it adds to the body of knowledge on youth participation in HIV prevention initiatives. This knowledge is useful in making program decisions by various stakeholders as reflected below;

1.5.1 APHIAplus KaMili

This study is important to the Management of APHIAplus KaMili granted it facilitates better understanding of factors influencing youth participation in the APHIAplus KaMili project. This is because the results of this study describe the factors influencing youth participation in the programs designed for HIV prevention and the value of such youth participation to the project.

1.5.2 Government

This study is important to the Government through the ministries of Health, Children and Gender as it helps in designing policies that helps in HIV/AIDs prevention and response programs for young people. The research project also provides insights on factors influencing youth participation in HIV prevention programming and can be used as an advocacy tool for youth participation in HIV prevention programs.

1.6 Scope of the study

The study focused on identifying factors influencing youth participation in APHIAplus KaMili HIV prevention initiatives. The study focused on the different approaches adopted by

USAID's APHIAplus KaMili project to attract and encourage participation of the youth, their level of participation, the effect of their participation on the program's success and challenges affecting their participation in APHIAplus KaMili Project.

The study was confined to four villages in Dallas slums, this being one of the areas that APHIAplus KaMili project covers. The study utilized descriptive survey research design approach on a target population of youths within the location. From the target population of 1,007 youths aged 15 -24 years where the research was carried out, 104 youths representing 10.3 percent were selected through probability sampling to participate in the research. The researcher also identified 2 community leaders and 2 community health workers from each of the four villages to participate as key informants.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This section provides insights into literature review on young people and HIV and AIDS conducted by other scholars. The researcher limited himself to literature which informed and was related to the proposed area of study. This section also reviews two theories upon which this study was anchored.

2.1 Rising population of youth infected with HIV/AIDS

HIV/AIDS is a prominent health issue for young people. Recent studies suggest over half of those now being infected with HIV/AIDS are aged between 15 and 24 (UNICEF 2004, UNAIDS 2006). Involvement of young people is seen as a precondition for successful HIV/AIDS management and this has become a central pillar of international AIDS policy (UNGASS 2001, UNICEF 2002, UNAIDS 2006). Closely linked is the widespread recognition that for youth struggles against HIV/AIDS to be successful, they need to go hand in hand with youth social development (Wallerstain 1992, Campbell, et al 2005)

Adolescents tend to underestimate, downplay or deny their risks of HIV infection. Case studies by the World Health Organization (WHO) indicate that only between one fifth and one third consider themselves at risk (UNAIDS 2003). Many young people do not recognize that their partner's behavior also puts them at risk. Others may perceive HIV as something that occurs only among sex workers, drug users or men who share intimate relations. Feelings of invincibility, combined with the lack of awareness of the consequences of risky behavior, may make them less likely to take precautions to protect their health and lives.

HIV-infected adolescents represent a unique, yet diverse, population requiring specialized medical and psychosocial HIV care. Perinatally and behaviorally infected adolescents often have differing therapeutic needs, but may share common difficulties, including medication, no adherence, high-risk sexual behavior, psychosocial stressors, and concomitant psychiatric disorders (UNAIDS 2003).

Addressing these needs within a culturally sensitive framework and in the context of a population-specific approach to treatment is paramount to optimizing care. Harm reduction for this group to maximize their health and limit HIV transmission to others is also critical with respect to the rising incidence of newly diagnosed HIV-positive adolescents. Implementing a formal, multidisciplinary program that involves individual youths and their families for improved transition to adult HIV care will afford such adolescents a better chance for a healthy adulthood.

Despite the existence of effective preventive strategies, the number of youths infected with HIV continues to mount, with the sharpest increases being recorded among women, especially the young. Though as at the beginning of the epidemic prevalence was higher among men, since 1985 the percentage of women among adults aged 15 to 49 living with HIV has risen from 35 per cent globally to almost 50 per cent.

In addition to being more physiologically vulnerable to HIV infection, women in many societies are now at higher risk of being infected because of other factors, including gender discrimination, poverty, sexual exploitation, and the inability to negotiate for condom use with partners (UNAIDS 2003). Where heterosexual sex is the dominant mode of transmission, the impact on women, especially the young, remains disproportionately high. In global terms, women aged 15 to 24 years are 1.6 times more likely to be living with HIV than young men in the same age group.

Several social factors are driving these trends. Exploitative intergenerational and transactional sex increases the vulnerability of women. Young African women tend to have considerably older male partners than themselves, partners who are more likely than young men to be infected with HIV. The age difference between partners reflects power differences and makes it more difficult for young women to negotiate condom use. Across Southern Africa, as in other regions, the spatial mobility of men and rural to urban migration are contributing factors to the spread of the disease. Numerous studies have documented that, when couples are separated, men are more likely to engage in sex with casual partners (UNAIDS 2003).

In South Africa most of the young people acquire HIV and AIDS through risky sexual behavior specifically through unprotected sex and sex with multiple partners and others through vertical transmission (mother to child transmission or through breast feeding) (Rohleder, Swartz, & Kalichman 2009). This is not any different to the Kenyan situation (KAIS 2007, KDHS 2009)

According to Clauss-Ehlers (2010) youth are especially susceptible to acquiring HIV because of the development issues they encounter such as peer pressure, poor judgment and ignorance of the epidemic or lack of access to condoms.

2.2 Approaches to youth participation in HIV prevention

Mayer and Pize (2009) argue that young people form a diverse group of people with varying needs within the transitional period between childhood and adulthood, HIV risk based on geographical boundaries and individual factors impact the approaches taken towards youth participation.

An argument is put forth by Karim and Karim (2010) that one of the ways of involving the youth in HIV prevention programs is through interventions such as peer education; which refers to the use of trained individuals for a particular target group to educate their peers. Some programmes have even gone further to involve the youth in the design of the intervention programmes themselves (Karim & Karim, 2010).

Youth need to be made aware of their sexual and reproductive rights, they require teaching on how to assert themselves. They should be informed that those who stigmatize and discriminate their peers based on HIV status, go against the human rights laws (Karim & Karim, 2010)

One of the models that has been adopted according to UNICEF (2009) is the HIV Alert school model which is used as a strategy for HIV prevention; the teachers and students get to discuss HIV and AIDS as part of their regular meetings and this has been seen to yield a lot of good participation results.

There has been establishment of HIV prevention education programs which have played a key role in global fight against HIV and AIDS. Youth of the same age group are brought together in a forum and taught on prevention measures and in the end the forums encourage participation (Gamble and Wei, 2010). From a global perspective young people between the ages 15-24 years account for an estimated 50% of their own lives to participation in online meeting spaces where they get to talk about HIV/AIDS and even go as far as coming up with initiatives of preventing it says Hoechsmann and Poyntz (2011) the youth really play a strong role in tackling the obstacles of the pandemic.

2.3 Factors determining youth participation in HIV prevention initiatives

Youths need to be accorded some level of trust in terms of faithfulness and their capabilities if they are to participate meaningfully; their role in addressing key social issues should be recognized and even their input taken into consideration (Catholic Relief Services, 2011). According to the UN (2011) certain approaches such as the youth empowerment programme seen as an investment for today and the future which involves meaningful participation in decision making for themselves and society in matters pertaining to HIV and AIDS prevention have been adopted.

United Nations (2011) postulates that for participation to be effective, young people need a voice in the global governance system. It is critical that they feel a sense of purpose and respect characterized by new approaches to communication and dialogue which brings about opening up by the young people on how the HIV prevention agenda can be moved forward.

The availability of effective life skills curricula in schools and communities is imperative in HIV prevention since it involves the participation of the youth says Houlihan and Green (2011) adding on that unless a climate is developed where youth can talk freely about sex and their sexuality then it is highly unlikely that good strategies will be developed to prevent HIV.

Young people need to be provided with adequate healthcare services and it should be made accessible to all of them and not just the ones who can afford it; the idea of health services should be a social duty of every government so that all the young people can gain access to

them, this in the long run will determine their participation in AIDS prevention programmes. (United Nations, 2010)

2.4 Challenges facing youth participation in HIV prevention

The current generation of young people has the most daunting challenges than any other generation has ever faced due to the wider social, economic and environmental implications (Weakland & Hollingshead 2009). According to Youniss and Levine (2009) youth development programs that are in place should look beyond the needs of individual youths and they should address broader social issues.

The IMF (2010) came up with the conclusion that the youths are minimally involved in gainful employment and economic involvement and this poses a threat to their participation in HIV prevention programs since they feel marginalized and left out. Having a job provides a person not only with a source of income but a basis of dignity and self-respect for effective participation (Evans & Shen 2010).

Uko (2009) is of the argument that when youths do not get access to education and skills training this may act as a barrier to participation in HIV prevention programmes; education will help them develop their intellects while skills training will help in the enhancement of practical skills. Education is important in understanding the information and skills learnt about HIV and AIDS (Mwiturubani & Gebre 2009).

It is imperative for youths to take a leading role in protecting the environment and promoting sustainable livelihood but the irony is that it is indeed a leading challenge to them (Weakland & Hollingshead 2009). When young people are not engaged in such important global issues facing the Earth, their engagement and participation in HIV prevention response is quite minimal since it falls on the same plane with global issues facing the world today (United Nations Human Settlements Program 2010).

Pfund and Fowler-Kerry (2010) argue that youth are almost always marginalized when it comes to policy making but the flip side of it, is that their involvement is compelling in combating HIV and AIDS. Youth should be involved in engaging a wider range of development priorities which include HIV prevention programs (World Bank 2009)

2.5 Theoretical framework

The study was anchored on two theories. These are social exchange theory associated with George C Homans (1961) and Peter Blau (1964) and social network theory associated with J.L. Moreno (1934) and John Barnes (1954).

2.5.1 Social exchange theory

Social exchange theory evolved from psychology, sociology and economics to explain human behavior based on self-interest and choices made to accomplish personal goals. According to the proponents of social exchange theory, Homans (1961, 1964), Blau (1964, 1967) and Emerson (1962, 1972a, 1972b), the basic premise of the theory is that people make choices to maximize rewards and minimize costs. Social behavior is viewed in terms of the pursuit of rewards, the avoidance of punishment and other forms of costs.

2.5.1.1 Assumptions of social exchange theory

Exchange theory is based on the premise that human behavior or social interaction is an exchange of activity, tangible and intangible (Homans 1961, p. 12-3), particularly of rewards and costs (Homans 1961, p. 317-8). Rewards can be tangible (money) or intangible (attention, status, affection) so long as they are seen as having value or bringing satisfaction. Costs occur as either physical or emotional advantages or missed opportunities to gain rewards. The theory treats the exchange of benefits, notably giving others something more valuable to them than is costly to the giver, and vice versa (Homans 1961, pp. 61-63), as the underlying basis or open secret of human behavior (Homans, 1961, p. 317) and so a phenomenon permeating all social life (Coleman 1990, p. 37).

A key concept of social exchange theory is the idea of reciprocal exchange. Reciprocal exchange refers to the expectation that when people receive rewards, they respond by doing good things for others (Homan 1974). Furthermore, reciprocal exchange involves the idea that interactions between people should remain stable. Cultural norms and laws provide parameters that guide reciprocal exchanges. In general, cultural norms and laws are upheld when large numbers of people see them as beneficial. However in some circumstances

people may violate norms and laws when they believe the costs are too great and the rewards too small (Thibaut & Kelley, 1959).

Social exchange theory is one of the most useful perspectives for understanding participation of young people in HIV prevention responses. Participation in HIV prevention provides many potential benefits as indicated elsewhere in this research project. Participation of youth in HIV prevention initiatives provides young people with opportunities to express and demonstrate their beliefs; learn new things such as how to prevent themselves from HIV infection; fend off feelings such as guilt, shame and isolation arising from being either infected or affected by HIV and AIDS; and enhance their self-confidence and sense of efficacy in meaningful participation in HIV prevention initiatives.

Volunteer commitment which for purposes of this study is critical in defining meaningful participation of youth in HIV prevention initiatives in Embu west is directly connected to the concept of reciprocal exchanges. Young people become committed to volunteering with and for an organization when their self-interests merge with the interests and needs of the organization (Kanter 1972; Sherr 2003b). Sometimes youths are oblivious of the potential benefits of their participation in HIV prevention initiatives. However when they are mobilized and sensitized, they become cognizant of the potential benefits which in turn motivates them to participate in HIV prevention responses. Social exchange theory therefore becomes critical in providing a framework upon which the research proposal is developed. These benefits or rewards in the context of exchange theory, that arise from youth participation in HIV prevention initiatives provide satisfaction hence sustaining motivation for participation in HIV prevention responses.

Social exchange theory also contends that the potential for new relationships – real or perceived – that offer comparable forms of support decreases an individual's dependency and boosts bargaining power (sprecher 1998; Van de Rijt & Macy 2006). In sub Saharan Africa, many adolescents and young adults are involved in concurrent sexual relationships (Xu, Luke and Zulu 2010), which are also believed to fuel the spread of HIV/AIDS (Lurie and Rosenthal, 2010). These sexual behaviors are no different from youths living in Dallas slums in Embu west.

2.5.1.2 Final thoughts on social exchange theory

Though social exchange theory has its strengths as articulated in the literature review, the researcher is also not lost to some of the criticisms of sociological approaches that are anchored on social exchange paradigms. According to Miller, social exchange reduces human interaction to a purely rational process that arises from an economic theory. The theory favors openness but there are times when openness isn't the best option in a relationship. This becomes even important as one addresses the dynamics of youth participation in HIV prevention initiatives. Social exchange theory is also not detestable at least according to some critics who believe that its central concepts – costs and rewards – are not clearly defined. Sabatelli and Shehan (1993) say that it is impossible to make an operational distinction between what people value, and what they perceive as rewarding and how they behave. Rewards, values and actions appear to be defined in terms of each other.

All said and done the researcher believes in this theoretical approach despite its perceived inherent weaknesses. The researcher also agrees with Colman's response to some of these criticisms when he says that goal directed activity is a large part of socialization today, as we are taught to live purposefully in a rationally organized world. One cannot afford to motivate young people to participate in activities that are lacking in focus, purpose and clearly defined goals.

2.5.2 Social network theory

Social network theory also referred to as network analysis has its roots in several theoretical perspectives. Some have traced it to psychiatrist J. L. Moreno (1934), who developed an approach known as sociometry in which interpersonal relationships were presented pictorially. Others have traced the approach to the work of British anthropologists John Barnes (1954), Elizabeth Bott (1957), J. Clyde Mitchell (1969) and others. (Berkowitz 1982) have even viewed network analysis as an outgrowth of the French structuralism of Claude Levi – Strauss (1969)

In 1954 a sociologist A. J. Barnes first used the term ‘social network’ in describing the ways people interacted with each other in the real world. The term described the patterns of how people interacted with each other. He and other social scientists explored those patterns and attempted mapping out how people interacted. Over time, the term he first coined changed into way of thinking. His idea grew into a whole new way of looking at the world. What he once described mapping of social patterns is now a new paradigm. This new paradigm or way of looking at how people socialize gained notoriety as people attempted to understand and describe what people were doing on the internet.

The power of social network theory stems from its difference from traditional sociological studies, which assume that it is the attributes of individual actors. Social network theory produces an alternate view, where the attributes of individuals are less important than their relationships and ties with other actors within the network. This approach has turned out to be useful for explaining many real-world phenomena, but leaves less room for individual agency, the ability for individuals to influence their success; so much of it rests within the structure of their network.

The social network theory in the context of the study looks at social behavior and participation, not as an individual phenomenon but through relationships, and appreciates that HIV risk behaviour, unlike many other health behaviours, directly involves 2 or more people (Morris, 1997). For youths in Embu west to effectively participate in HIV prevention initiatives, they have to develop meaningful relationships with their peers and adult stakeholders. With respect to sexual relationships, social networks focus on both the impact of selective mixing (ie how different youths choose who they mix with), and the variations in partnership patterns (length of partnership and overlap). Although the intricacies of relations and communication within the couple (for youths who are already in a relationship), the smallest unit of the social network, is critical to the understanding of HIV transmission in this model, the scope and character of one’s broader social network, those who serve as reference people, and who sanction behaviour, are key to comprehending individual risk behaviour (Auerbach, 1994).

In other words, social norms are best understood at the level of social networks. Participation of youths in Dallas slums in HIV prevention initiatives therefore becomes meaningful and significant when they adopt peer led approaches. Besides engaging those who serve as reference people including stakeholders such as parents, adults and community own resource persons are likely to significantly enhance their support for meaningful involvement of young people in HIV prevention initiatives.

One application of the sexual network theory for HIV prevention among youths in Dallas slums is the concept of 'bridge populations' that form a link between high and low prevalence groups (Morris, 1997). A significant proportion of new infections are arising not only in those who engage in casual heterosexual sex, either with sex workers or others. There is an equally high (or possibly even higher) rate of incidence in the "partners of young people who have casual heterosexual sex" and other steady partners. Sex workers and their partners remain a key population at risk of HIV infection, because of the frequency of concurrent partners and lack of consistent condom use. The clients of sex workers form a bridge population with the general population. More worrying are the even greater number of women, especially young women, who engage in "transactional sex" and at times in so called "part-time" sex work (MoTS 2009). KDHS (2003) noted that 16% of girls 15–19 report receiving money, gifts or favors for sex in the past 12 months. Sex work is quite prevalent in Dallas slums and these statistics are likely to be similar given the high rates of unemployment and poverty among youths living in the slums.

This therefore does beg the question of "who is infecting who?" an important question that requires response when designing programs that ensure youth participation in Dallas slums. The incidence amongst the steady partners of young people who have multiple partners demonstrates that those who are engaging in casual heterosexual sex are putting all of their partners – casual, regular, occasional, steady, long term etc. - at risk. Social network theory provides the proposed study a theoretical framework for investigation of;

• The composition of important social networks that influence youth participation in HIV prevention initiatives in Dallas slums

• The attitudes of the social networks towards safer sex among young people in Dallas slums

• Whether the social network provides the necessary support to change behavior and foster youth participation in HIV initiatives in Dallas slums

• Whether particular youths within the social network are at particularly high risk and may put many others at risk. This would help in ensuring that youth participation is inclusive and involves all subpopulations.

2.5.2.1 Final thoughts on social network theory

Although few network-based interventions have been tried, the concept has proven complementary to individual-based theories for the design of youth HIV prevention programs by focusing on the partnership as well as the larger social group. Analysis of network mixing provides the means to see efficiency of transmission and effective points of intervention. Knowledge of these intervention points is imperative in ensuring meaningful participation of youths in Dallas slums. Though we are all responsible for our actions, we don't make decisions in a vacuum. Youths like other animals, are part of complex social and environmental networks, meaning that our actions inherently influence the actions and reactions of those around us. Social connectedness influences youth participation in HIV prevention initiatives and the networks in which we are a part can spread positive and negative behaviors.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This section describes the procedures which the researcher followed while conducting the study. The section describes the area of the study, research design, study population, sampling procedures, data collection techniques, data analysis and presentation.

3.1 Area of the study

Dallas slum is situated in Embu west District of Embu/Mbeere County. The slum consists of 6 villages and has a population of more than 18,000 residents (UN HABITAT report 2009). The settlement has most of the characteristics of urban informal settlements where residents live in squalid conditions where settlement is highly congested. Dallas slums are an informal community with significant socio economic and environmental challenges, including 1) a lack of proper sanitation; 2) perennial flooding 3) high unemployment; 4) Urban Poverty and 5) HIV/AIDS. Despite these challenges, the community has a strong and united community structure, based on its unique history, with an underlying willingness to work as a group to achieve mutual benefits (Umande Trust 2007).

The research study covered Matakari, Kathigari, Mbona and Dallas Mjini villages within Dallas slums in Embu west district, Eastern province. These villages were selected as study sites through purposive sampling since APHIAplus KaMili has been implementing an urban health project which seeks to promote youth participation in HIV prevention responses as part of the urban Health strategy. This project is mainly supported by the Ministry of public health and sanitation, Ministry of youth and sports, youth serving organizations, the local community and its leaders.

3.2 Research design

The study adopted a descriptive survey design which according to Churchill (1991) is appropriate where the study seeks to describe the characteristics of certain groups, estimate the proportion of people who have certain characteristics, and make predictions. This was

based on the constructivist epistemology which holds that reality is what respondents generally perceive it to be. The descriptive survey design was the most appropriate for this study which provides insights into factors influencing youth participation in HIV prevention responses in Dallas slums, Embu west District. In survey research design, a survey is used to obtain a description of a particular perception about a situation, phenomena or variable and their views are taken to represent those of the entire population. Questionnaires and interviews were used extensively to collect data and are seen as efficient ways of gathering data representing large populations (Irura, S, et al 2009).

Descriptive survey research designs were used in preliminary and exploratory studies to allow researchers to gather information, summarize, present and interpret data for the purpose of clarification (Orodho 2003). According to Mugenda and Mugenda (2003) the purpose of descriptive research is to determine and report the way things are and it helps in establishing the current status of the population under study. The design was chosen for this study due to its ability to ensure minimization of bias and maximization of reliability of evidence collected. Furthermore, descriptive survey design raises concern for the economical completion of the research study. The method is rigid and focuses on the objectives of the study (Gay, 1992).

3.2.1 Study population

Dallas comprises of six villages with an estimated population of 1,007 youths aged between 15 – 24 years living in the 4 villages where the research was carried out (APHIAplus KaMili baseline report 2011). The study selected its respondents from four villages namely; Matakari, Kathigari, Mbona and Dallas Mjini. The respondents included youths aged 15-24 years, community health workers and community leaders.

3.2.2 Sampling procedure

The researcher used both probability and non-probability methods during the study. Stratified random sampling which entailed subdividing youths aged 15-24 years into males and females to ensure equal proportions in the sample of study was applied. Stratified random sampling was also used to separate youths who had participated in HIV prevention programs for the

last 2 years preceding the study from those who have not participated in HIV prevention responses in the same period. Mugenda & Mugenda (2003) postulate that Stratified random sampling generally has more statistical precision than simple random sampling. Once the groups had been subdivided into homogenous sub populations, the researcher then identified 26 study participants from each of the four villages in the area of study, through simple random sampling. The researcher anticipated interviewing a total of 104 youths aged 15 – 24 years. This represented 10.3 percent of the study population in the four villages of Dallas slums. The sample size was sufficient enough to ensure representativeness of the population under study. Ten percent of the accessible population is sufficient for studies whose research design is descriptive in nature (Kasomo, D. 2006).

The researcher selected two community leaders and community health workers as key informant interviewees from each of the four villages through purposive sampling. This method ensured that the researcher selected respondents with the required information regarding youth participation in HIV prevention responses.

3.2.3 Data collection techniques

The researcher used the following data collection methods during the study process;

***Use of questionnaires*;** given the relatively large sample of youths participating in the research, this research instrument was ideal in data collection. The researcher used this instrument since it ensured that confidentiality was upheld, saved time and that there was no interviewer bias. Questionnaires have several advantages such as time saving, and allows for information to be collected from a large sample and in diverse regions.

Key Informant Interviews; The researcher used face to face interviews to collect a wide range of information on factors influencing youth participation in HIV prevention responses in Dallas. The Key informant interviews were administered to community leaders and community health workers selected through purposive sampling for their knowledge and understanding of Youth participation in HIV prevention responses in the 4 villages of Dallas slums. Key informant interviews sought qualitative information that could be narrated and cross checked with quantitative data, a method called “triangulation”.

Focus Group Discussions (FGDs); the researcher used focus group discussions during the study as a way of drawing upon respondents attitudes beliefs, experiences and reactions in ways which was not be feasible using the methods mentioned above. The researcher established 2 focus groups of 12 youths which were homogenous in nature. Focus groups have a high apparent validity since the idea is easy to understand the results are believable, are low cost and helps in getting quick results.

3.2.4 Data analysis and presentation

After administering the questionnaires, the researcher used codes and had data converted into numerical codes for statistical analysis. A Statistical Package for Social Sciences (SPSS) version 17.0 was used for data analysis. Descriptive statistics was computed for all the variables to ensure quality of data. The results from the sample were then generalized to the study population of the 4 villages in Dallas slums.

Cross tabulation was run on SPSS to establish correlations between the different variables. The researcher then organized the results around the four objectives of the study. The researcher used descriptive statistics to show distributions, relationships between variables under study, proportions in terms of texts, percentages, charts and tables.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 Introduction

This chapter presents and interprets analyzed data generated from the study on factors influencing youth participation in HIV prevention initiatives. Data is organized around the study objectives and is presented in two parts; data presentation, analysis and interpretation. The researcher had targeted 104 study participants out of which 81 returned their filled in questionnaires forming 77.9 percent response rate.

4.1 Data presentation

This section presents data which was collected and analysed from the questionnaires, key informant interviews and focus group discussions. Data is presented in the form of texts, tables, pie charts, graphs, frequencies and percentages.

4.1.1 Distribution of respondents by village

Table 4.1 indicates that 33.3 percent of the respondents came from Matakari village, 30.9 percent of the respondents were from Dallas Mjini Village, 19.8 percent of the respondents indicated Kathigari village whereas 16 percent of the respondents said they were from Mbona village. All the targeted villages were significantly represented in the study. The findings can therefore be generalized across the four villages that were targeted.

Table 4.1: Village of the respondents

Village	Frequency	Percentage
Matakari village	27	33.3
Kathigari village	16	19.8
Mbona village	13	16.0
Dallas Mjini village	25	30.9
Total	**81**	**100.0**

4.1.2 Gender and Education

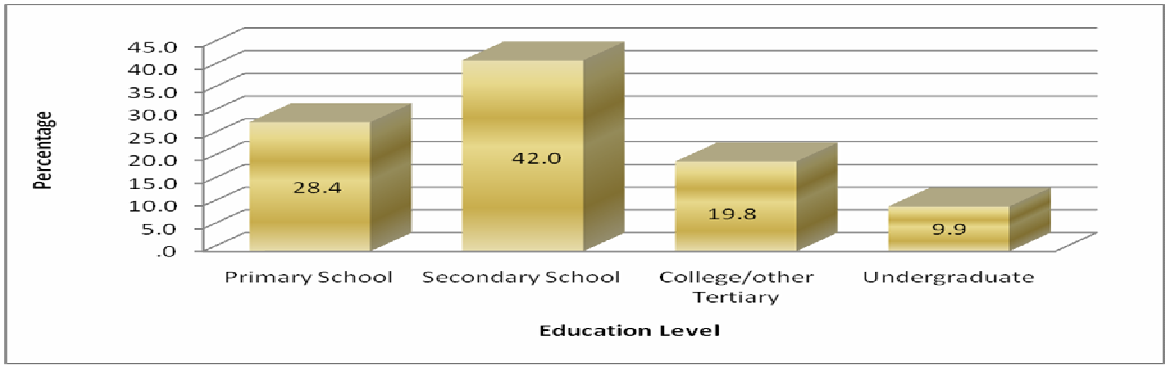
Table 4.2 below indicates that 58 percent of the study participants were females compared to males at 42 percent. This shows that gender differences were taken into consideration in an attempt to ensure that the study wasn't biased towards one particular gender.

Table 4.2 Distribution of the respondents by gender

Gender	Frequency	Percentage
Male	34	42.0
Female	47	58.0
Total	**81**	**100.0**

Majority of the respondents (42 percent) indicated they had attained secondary school education, 28.4 percent of the respondents indicated that they had obtained primary school education, 19.8 percent of the respondents had obtained college and other tertiary level of education whereas 9.9 percent of the respondents had attained undergraduate as their highest level of education. This is an indication that most of the youths who participated in the research had attained secondary level of education and below.

Figure 4.1: Level of education

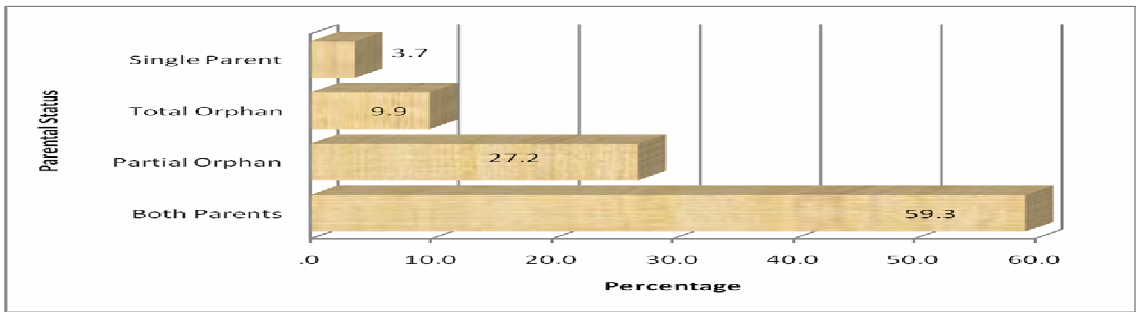


4.1.3 Respondents parental status

The study sought to determine the parents status of the respondents. From the findings as reflected in figure 4.2, 59.3 percent of the participants indicated that they had both parents, 27.2 percent of the respondents reported that they were partially orphaned, 9.9 percent of the

respondents indicated that they were total orphans whereas 3.7 percent of the respondents indicated they were from single parents.

Figure 4.2: Parental status of the respondents



4.1.4 Respondents' sibling according to number and gender

Table 4.3 above shows that 40.5 percent of the girls had one sibling, 19.2 percent of the girls had two siblings, 27.6 percent of the respondents indicated they did not have a sibling, 6.3 percent of the respondents indicated three, 2.2 percent of the respondents indicated five. Among the boys, the study found that 23.5 percent of the respondents reported one sibling, 26.5 percent of the respondents indicated none, 17.6 percent of the respondents mentioned two, 11.8 percent of the respondents had three, and 8.8 percent of the respondents indicated five whereas 11.8 percent of the respondents had four siblings.

Table 4.3: Respondents siblings by number and gender

Number of siblings	Girls		Boys	
	Frequency	Percentage	Frequency	Percentage
None	13	27.6	9	26.5
One	19	40.5	8	23.5
Two	9	19.2	6	17.6
Three	3	6.3	4	11.8
Four	2	4.2	4	11.8
Five	1	2.2	3	8.8
Total	**47**	**100.0**	**34**	**100.0**

4.1.5 Distribution of respondents according to age and marital status

The study found that 64 percent of the respondents who participated in the study were aged between 17 to 20 years , 27 percent of the respondents indicated that they were aged between 21 and 24 years while 9 percent of the respondents were 14 to 16 years.

Figure 4.3: Distribution of respondents by age

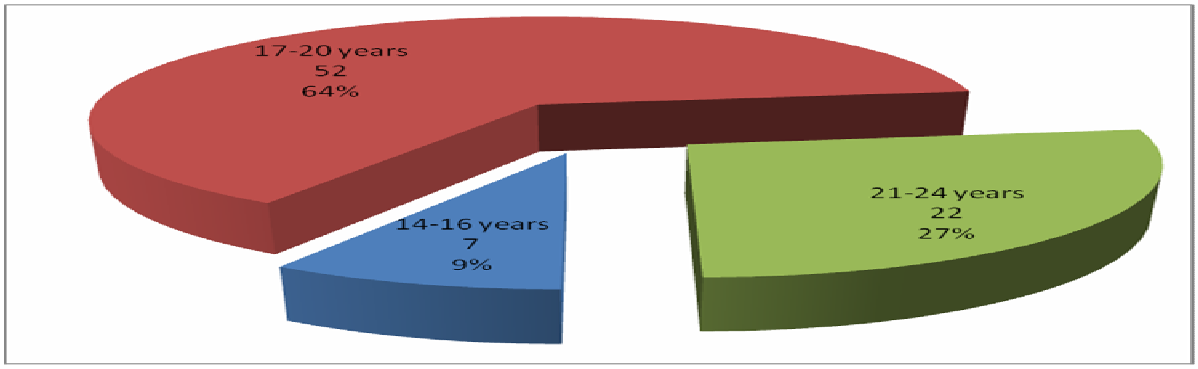
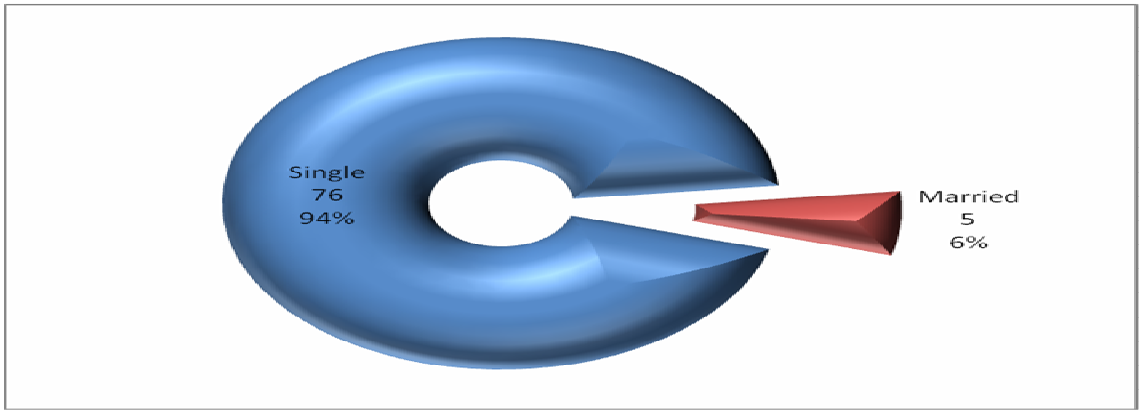


Figure 4.4 shows that majority of the respondents who participated in the study (94 percent) indicated they were single while 6 percent of the respondents indicated they were married at the time of the study.

Figure 4.4: Distribution of respondents according to marital status

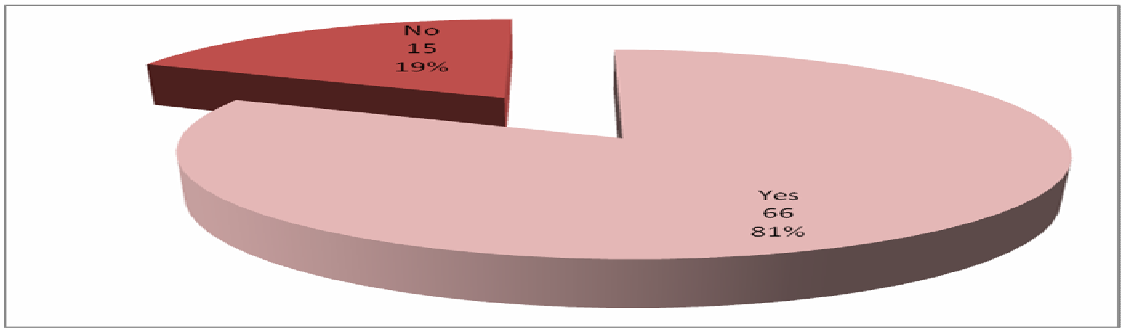


This could be attributed to the fact that young people who are single are likely to find time to partcipate the the projects compared to the married youths whose extra responsibilities means that they have to find means of fending for their families.

4.1.6 Proportion of respondents according to knowledge of HIV status

Figure 4.5 shows that 81 percent of the respondents knew about their HIV status compared to 19 percent of the respondents who indicated they didn't know about their HIV status. This shows that majority of the study participants had taken a HIV test at the time of the study.

Figure 4.5: Respondents knowledge of HIV Status



The study further revealed that the reasons for having gone for a HIV test. The reasons included; In order to plan for the future, had sex with multiple partners, frequently fell ill, to change behavior, because I/my wife was pregnant, to know about my health, to know HIV status, to clear doubts and for curiosity reasons.

"I had had unprotected sex with over ten sexual partners whose HIV status I did not know, I wanted therefore to be sure of my HIV status since I wanted to get married" Male FGD participant.

The reasons given by the respondents who had not gone for a HIV test included; not having exposed themselves to HIV infection, Fear of being discriminated against in the event they turned HIV positive, lack of easily accessible youth friendly services and feeling of invincibility.

"Stigma and discrimination is still high in Dallas. Some young people fear being stigmatized. I once met a youth who told me that he can't be infected with HIV hence no need for the test. Others feel that HIV tests are only for people who are promiscuous" CHW from Matakari

4.2 Data analysis and interpretation

This section presents data analysis and interpretation. Data is organized around the study objectives described in chapter one of the research study.

4.2.1 APHIAplus KaMili program and participation of respondents

The study sought to find out whether the study participants had ever heard about the APHIAplus KaMili project. Table 4.4 shows that 90.1 percent of the respondents indicated that they had heard about the Project, while 9.9 percent of the respondents said that they had not heard about the program. Majority of the youth including those who had not participated had heard about the APHIAplus KaMili project.

Table 4.4: Proportion of respondents who had ever heard of the APHIAplus Project

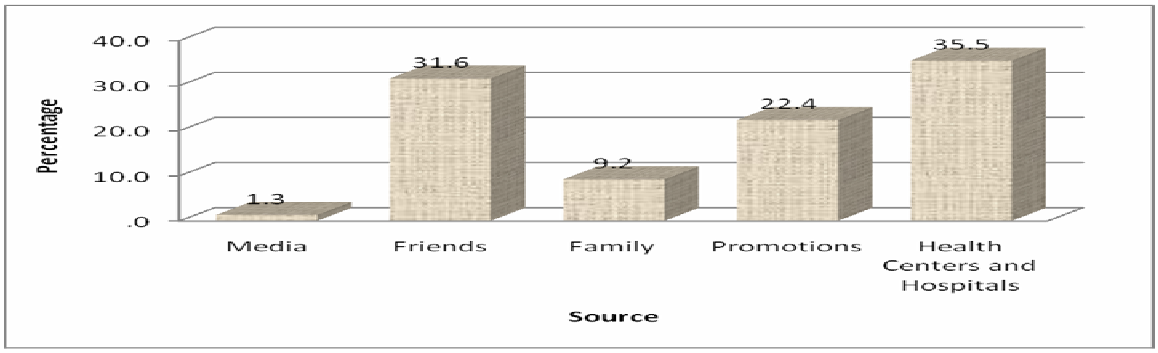
Ever heard of APHIAplus project	Frequency	Percentage
Yes	73	90.1
No	8	9.9
Total	**81**	**100.0**

The study revealed that the approaches adopted by APHIAplus KaMili in attracting the youth to the project were; organization of seminars, discussion groups, education forums, sports activities, community mobilization and sensitization for HIV and AIDS. The study also revealed from the interviewees that the approaches adopted by APHIAplus KaMili were effective in addressing the objectives of the group. The interviewees indicated that the channels adopted in marketing APHIAplus KaMili project were through media campaigns, friends, group invitation and meetings. The study further revealed that interviewees were actively involved in promoting the Project within the village.

"*I have seen APHIAplus KaMili organizing for youth friendly activities such as sports, seminars and engaging them as peer educators. They come to chief's barazas and talk about their project; they also stick posters encouraging youth participation in different villages in Dallas. This way youth are attracted to their projects. They should however be more aggressive in marketing their youth initiatives through door to door campaigns*." Community leader from Matakari

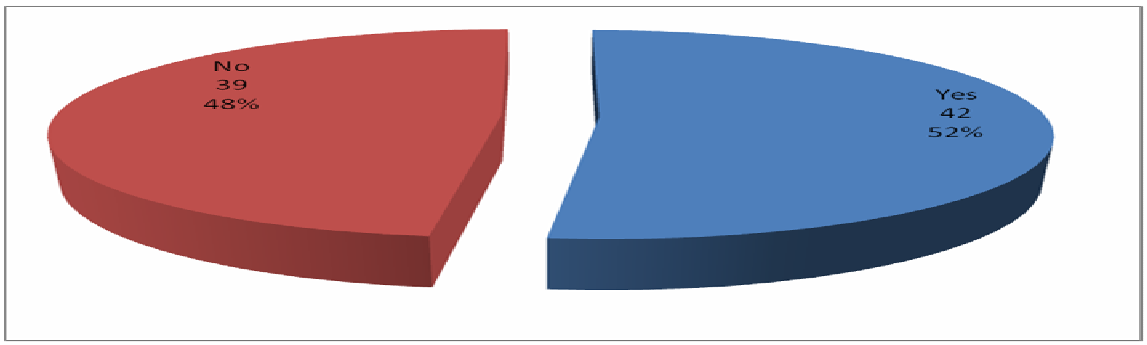
The study also sought to know how the respondents came to know about the program. Figure 4.6 shows that that 35.5 percent of the respondents knew APHIAplus program through health centers and hospitals, 31.6 percent of the respondents indicated that they knew through friends, 22.4 percent of the respondents indicated through promotions, 9.2 percent through families while 1.3 percent of the respondents indicated they knew APHIAplus KaMili through the media.

Figure 4.6: Knowledge of the APHIAplus KaMili project



The study found that 52 percent of the respondents indicated they had benefited compared 48 percent of the respondent who indicated they had not benefit from the program as reflected in figure 4.7, this is an indication that APHIAplus KaMili was popular among the youths especially those who were already participating in the project.

Figure 4.7: Proportion benefiting from the programs offered by APHIAplus KaMili



The respondents indicated that they had benefited from APHIAplus KaMili through, Counseling, participation in projects, education through seminars and sensitization on HIV

leading to Knowledge of HIV status, being equipped with life skills, being offered short term contracts to work for the project, support for education by being offered a scholarship.

4.2.2 Encouragement of active participation

Table 4.5 shows that 71.6 percent of the respondents felt that programs offered by APHIAplus KaMili encouraged their active participation whereas 28.4 percent of the respondents indicated programs offered by APHIAplus KaMili did not encourage their active participation.

Table 4.5: Extent to which APHIAplus KaMili encourages active participation

APHIAplus encourages participation	Frequency	Percentage
Yes	58	71.6
No	23	28.4
Total	**81**	**100.0**

The study further revealed that projects offered by APHIAplus KaMili encourage their active participation through facilitation for their lunches and transport during youth events, mobilization of young people to start/join youth groups which are then linked to micro-financing institutions, training of young people in leadership skills who are then utilized as peer counselors by the project, facilitation for behavior change support groups for young people when they undergo a HIV test, offering youths job opportunities whenever such opportunities arise, engaging youths in carrying out outreaches, providing facilitators to mentor and guide youth leaders and peer educators, organizing youth friendly activities such as sports days, drama festivals and using young people living with HIV and AIDS in mobilization and sensitization of young people to access HIV prevention services.

"APHIAplus provides lunches and transport; they asked us to register our group and then linked us to K-Rep bank who gave us a loan. We bought 24 rabbits and several chickens which we are rearing as our income generating activity." Female FGD participant

A five-point Likert scale was used to collect and analyze data whereby 1 point was allocated to 'strongly disagree'; 2 points to 'disagree'; 3 points to neutral; 4 points to agree; and, 5

points to ‘strongly agree’. Table 4.6 shows that majority of the respondents (mean 4.20) felt that programs have encouraged their participation in HIV prevention initiatives while 4.11 of the respondents indicated that support through peer learning had really encouraged their participation towards HIV prevention. 4.07 felt that participation approaches adopted towards HIV prevention had encouraged their sense of community and local bonding with others while a mean of 4.06 of the study respondents indicated that the program had provided them with skillful training for their sexual and reproductive health needs and programs allowed them to express their views and opinions freely without discrimination.

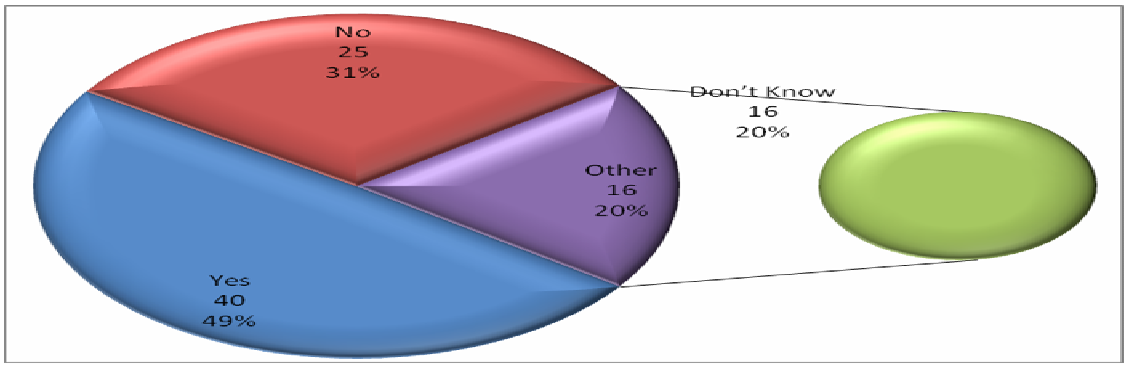
Table 4.6: Extent to which respondents agree whether approaches adopted by APHIAplus KaMili encourage youth participation

Types of encouragement	Degree of agreement						
	Strongly Disagre	Disagre	Neutral	Agree	Strongly Agree	**Mean**	**STDEV**
Programs allows me to express my views and opinions freely without discrimination	4	5	9	27	36	**4.06**	**1.115**
Programs have encouraged my engagement and participation in HIV prevention initiative	2	6	12	15	46	**4.20**	**1.093**
Participation approaches adopted toward HIV prevention have encouraged a sense of community and local bonding with others	5	5	9	22	40	**4.07**	**1.184**
Program has provided me with skillful training for my sexual and reproductive health needs	8	5	6	17	45	**4.06**	**1.327**
Support through peer learning has really encouraged my participation towards HIV prevention	10	1	5	19	46	**4.11**	**1.333**
Involved in the design, implementation and evaluation of the programs offered.	23	22	16	10	10	**2.53**	**1.343**

In each case, respondents disagreed that they were involved in the design, implementation and evaluation of the programs offered as shown by mean 2.53.This indicates that the APHIAplus KaMili uses a number of approaches to encourage youths to participate in the project.

The researcher wanted to establish whether the approaches adopted by APHIAplus KaMili had been effective. Figure 4.8 indicates that 49 percent of the study participants felt that they had been effective while 31 percent of the respondents indicated that the program was not effective. 20 percent of the respondents said they didn't know. This shows that APHIAplus KaMili project has been effective at least to some extent.

Figure 4.8: Effectiveness of approaches adopted by APHIAplus KaMili



The study further revealed that the study participants felt that approaches were effective in the sense that they had succeeded in creating awareness and providing information on HIV/AIDS, had led to increase in number of youths who know their HIV status, had enabled reduction of idleness among youths in Dallas slums since they were always engaged in various activities within the project, had trained and empowered them on Adolescent Sexual and Reproductive Health and that the project had created job opportunities for some youths. Respondents who felt that the approaches were not effective, indicated that project practiced favoritism and nepotism. Some study participants owed this to the fact that they had never heard of the project, while others indicated that the project was not being implemented in all the villages in Dallas slums.

The study sought to know from the respondents what tips would help APHIAplus KaMili project in order to improve their participation in HIV prevention responses. Majority of the respondents felt that involving them in program design, planning, implementation, monitoring and evaluation of youth HIV prevention initiatives would create ownership leading to improved participation, conducting community mobilization and sensitization on the benefits of youth participation, mounting an aggressive door to door campaign

encouraging youths to participate in HIV prevention initiatives**,** encouraging youths to know their status and thereafter leading the fight against stigma and discrimination, Supporting more schools in implementing the school health program, developing more innovative and exciting youth friendly programs, facilitation of their meals and lunches after participating in HIV prevention initiatives, creating employment opportunities and developing a reward system for youths who mobilize their peers to participate in the project.

The interviewees felt that the level of youths involvement within the APHIAplus KaMili HIV prevention initiatives was high though this has not been scaled up to all the villages in Dallas slums.

"This is a good project though I wish it could be scaled up to the 2 villages where in Dallas where APHIAplus is not working currently. My friends from those villages keep on asking me when the project will be implemented there." Female FGD participant from Kathigari

The study further established from the community leaders and community health workers perspective that the youths' socio-economic status influences their involvement in the APHIAplus KaMili Program to a very great extent. The study revealed that youth involvement in the projects helped in stemming out social vices and new HIV infections. The challenges facing participation in APHIAplus KaMili's HIV prevention initiative were lack of funds, family issues, lack of appropriate time and lack of youth commitment to the project. The study revealed that what APHIAplus KaMili needs to do is to improve youth participation in their HIV prevention initiatives through increased seminars, frequent meetings, increased discussions amongst youth and organizing of sporting events.

4.2.3 Extent of youth participation in APHIAplus KaMili program

Table 4.7 shows that 51.9 percent of the respondents indicated they had participated compared to 48.1 percent who indicated that they had not participated in APHIAplus KaMili activities. This is an indication of many youths not participating in the project and it is therefore imperative that that the project diversifies their approaches and provide incentives that will encourage youths to participate in the youth projects designed for youths in Dallas slums in Embu.

Table 4.7: Participation in any of the APHIAplus KaMili projects.

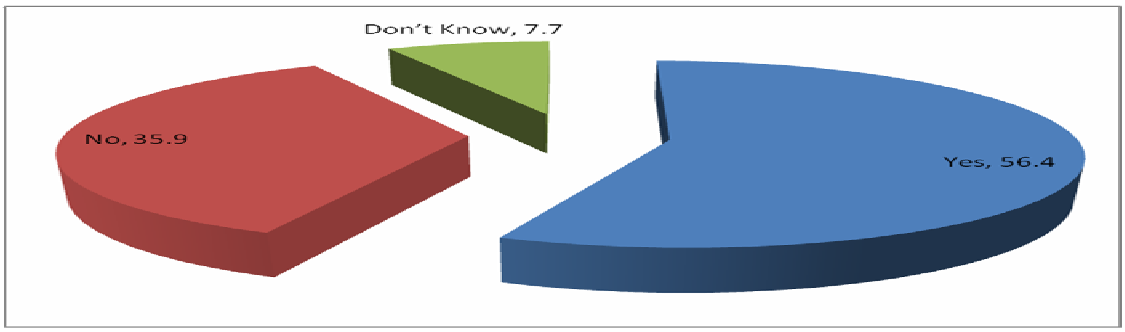
Ever participated	Frequency	Percentage
Yes	42	51.9
No	39	48.1
Total	**79**	**100.0**

The study revealed that youths were involved in the program through the school Health program, sports events and drama festivals organized for youth out of school, through training, mentorship and capacity building, during health days such as world TB day, world AIDS day, by being invited to participate in seminars, as peer educators, by being engaged during community mobilizations and sensitizations.

"Every year, APHIAplus KaMili organizes what is called the male involvement football tournament where youth teams compete for trophies. This is usually my favorite since I'm a footballer. During these football tournaments, they pass on HIV, sexual and reproductive health messages to young people." Male FGD participant from Mbona village

Figure 4.9 shows that 56.4 percent of the respondents felt that APHIAplus KaMili programs provided solutions for meaningful participation in HIV prevention and Treatment compared to 35.9 percent of the respondents who indicated that the project had not offered meaningful solutions. 7.7 percent of the respondents indicated they didn't know whether they had offered solution to APHIAplus KaMili project.

Figure 4.9: APHIAplus KaMili project providing solutions



The respondents reported that these solutions had been provided for through peer education programs which had empowered majority in making informed decisions, by ensuring access

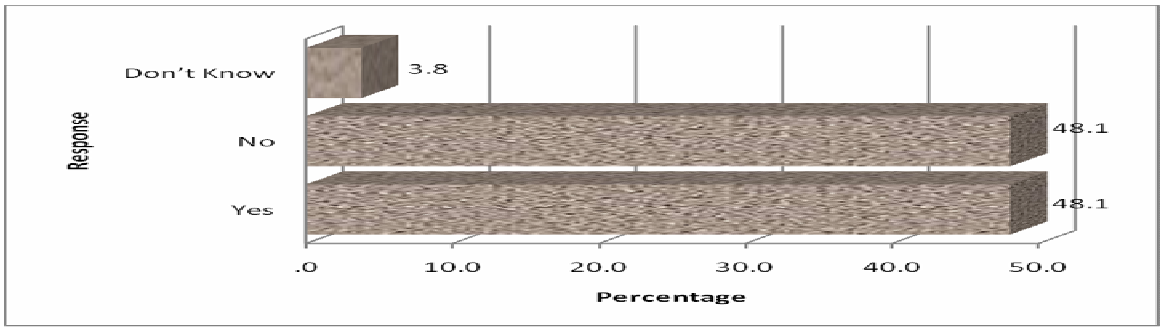
to HIV testing, care and treatment services for young people, through participation in sports events, drama festivals and world health days, through engagement in mobilization and sensitization for HIV prevention activities and in behavior change support groups.

"*The project has empowered young people through trainings. Through sports youths have been kept busy hence using their time constructively and not in crime."* CHW

The study established that 48.1 percent of the respondents indicated that they had been empowered through participation in HIV prevention initiatives while a similar proportion of respondents 48.1 percent, reported not to have been empowered through participation. 3.8 percent of the respondents indicated that they didn't know granted the fact that they were not participating in project activities at the time of the study.

"I used to get sick quite often though I kept on going for treatment. One day a nurse at the dispensary supported by APHIAplus advised me to take a HIV Test which I did. I was diagnosed with HIV and she immediately enrolled me on HIV care and treatment. I'm now one of the peer educators and honored to sensitize my peers on HIV issues." Male FGD participant from Dallas Mjini

Figure 4.10: Extent of empowerment from participation in APHIAplus KaMili programs



The respondents reported that they had been empowered through training on peer education, by being linked to micro financing institutions, through the behavior change support groups and through access to sexual and reproductive health services such as Family planning services, condoms, ARVs and STI treatment services.

The respondents were required to state to what extent various factors affected their participation in HIV prevention initiatives. The study utilized the 5-point Likert scale to collect and analyze the data collected from the participants.

Table 4.8: Factors affecting participation in HIV prevention initiatives

Factor affecting participation	**Degree of agreement**						
	Very Low Extent	Low Extent	Neutral	High Extent	Very High Extent	**Mean**	**STDEV**
Social participation (being allowed to contribute openly about anything to do with my sexuality)	21	11	14	19	16	**2.98**	**1.482**
De Stigmatization (the programs do not encourage discrimination and bad treatment to those who are infected and affected by HIV)	6	16	1	16	42	**3.89**	**1.405**
Inclusion (youths allowed to make decisions and policies on matter pertaining to HIV prevention program)	17	0	18	30	16	**3.35**	**1.371**
Respect (being given an audience and consideration by adults on matters pertaining to HIV prevention)	15	10	15	21	20	**3.26**	**1.430**
Interest (the programs are aimed at needs which are valuable to me)	12	7	11	25	26	**3.57**	**1.396**
Participation (it is voluntary, active and well informed)	8	5	14	23	31	**3.79**	**1.283**

Table 4.8 shows that most of the respondents indicated de stigmatization (mean score of 3.89) as affecting participation in order of importance. This was followed by voluntary participation with a mean of 3.79, then interest with a mean of 3.57. The respondents rated inclusion (mean score 3.35), respect (mean 3.26) and social participation (mean score 2.98) as neutral.

On whether the respondents had reached their full potential in participation, the study found that 70.4 percent of the respondents felt they had not reached full potential in participation, 18.5 percent of the respondents indicated they were not sure while 11.1 percent of the respondents indicated that they had achieved full potential in participation, this shows that majority of the youths felt that they had not fully exploited their potential while participating

in the programs. APHIAplus KaMili project needs to identify ways in which they can help the youths reach their full potential. This could be through soliciting for ideas from the youth themselves.

Table 4.9: Proportion of respondents reaching full potential in participation

Whether reaching full potential	Frequency	Percentage
Yes	9	11.1
No	57	70.4
Not Sure	15	18.5
Total	**81**	**100.0**

The study established that youths thought that their participation in programs could be maximized through involvement in designing, planning, implementation, budgeting, monitoring and evaluation of youth programs, engagement of youths within the project areas as interns whenever such opportunities arise, employment, planning for more youth seminars and inviting those who are not participating to attend, establishing/decentralization of APHIAplus KaMili field offices within the project areas, increasing funding for youth activities and developing a reward/ recognition mechanisms for the most active youth volunteers in the project, greater and meaningful involvement of young persons living with HIV/AIDS in HIV prevention initiatives targeting young people and increasing access to youth friendly services.

4.2.4 Socio-economic factors affecting participation

From the findings on the respondents employment status, 80.2 percent of the respondents indicated they were unemployed, 9.9 percent of the respondents indicated they were self-employed, 3.7 percent of the respondents indicated that they were doing casual work, those who indicated their employment status as employed were 2.5 percent which is similar to the proportion of respondents who indicated that they were students. 1.2 percent of the respondents indicated others. This is an indication the majority of the youths were unemployed. The study further revealed that those who indicated other, were either contractual employees whose contracts had temporarily expired or were students.

Figure 4.11: Employment status

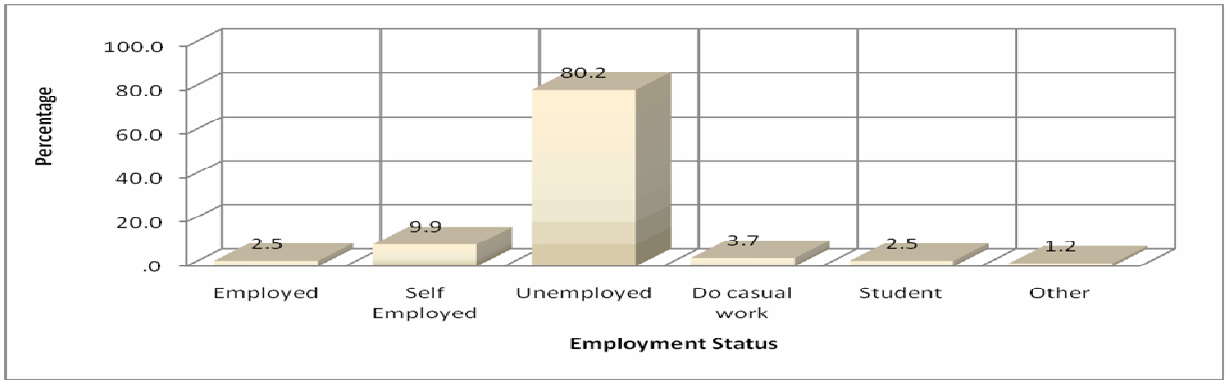
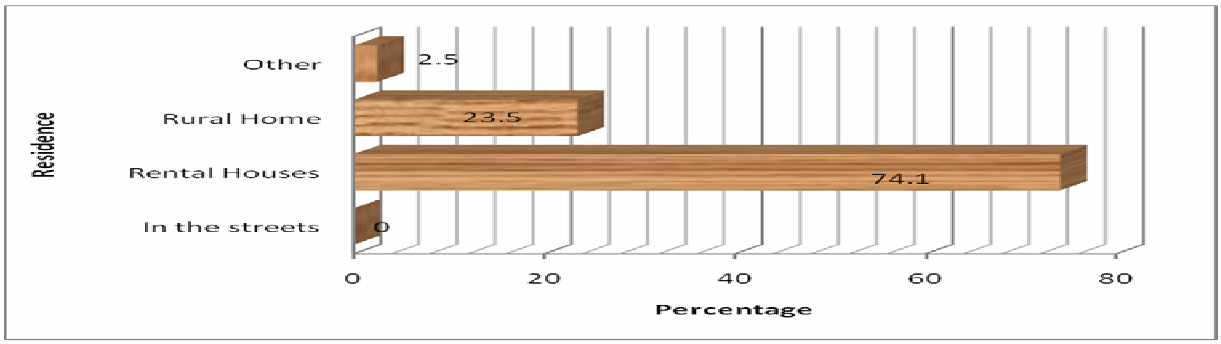


Figure 4.12 shows that 74.1 percent of the respondents were living in rental houses, 23.5 percent of the respondents indicated their rural home while 2.5 percent indicated other as were they lived. The findings illustrate that the majority of the youths participating in the APHIAplus KaMili project were living in rental houses depicting their low economic status.

Figure 4.12: Nature of residence



Nearly 35 percent of the respondents indicated that they had been affected by the HIV pandemic while 65.4 percent reported that they had not been affected by the HIV pandemic. *"I went for a HIV test and I was HIV negative. This has not stopped me from participating"*. Female FGD participant from Dallas Mjini

Discussions from the focus group discussions however indicated a higher proportion of young people who indicated that they had been affected by the epidemic. Being affected by the HIV pandemic is not the sole motivating factor for the youths to engage in APHIAplus KaMili project as majority had not been affected.

Table 4.10: Respondents affected by the HIV

Whether affected by HIV	Frequency	Percentage
Yes	28	34.6
No	53	65.4
Total	**81**	**100.0**

The study established that youth have been affected by HIV through loss of their relatives friends and significant others through death, by taking responsibility of orphans left by those infected by HIV, by rendering some of their close relatives jobless hence increasing unemployment and therefore poverty levels and by dropping out of school to take care of their ailing relatives.

The study revealed that majority of the respondents (mean 2.48) disagreed that lack employment which would empower them to participate more fully was a socioeconomic factor which affected participation in HIV prevention initiatives.

Table 4.11: Socio-Economic factors affecting participation in the Project and whether it is agreed to they affect

Factors affecting participation	Degree of agreement						
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	**Mean**	**STDEV**
Peer pressure at times pushes me to engage in sexual behavior that is risky to my health thus am guilty to participate in prevention fully.	40	16	12	9	4	**2.02**	**1.237**
Poor decision making and judgment has made me be vulnerable to HIV so I don't trust myself to participate in prevention	56	19	3	2	1	**1.43**	**0.785**
I do not have enough information about HIV; how it spreads and how to prevent it thus my participation is low	57	19	2	3	0	**1.40**	**0.715**
My contribution to the prevention measures are not taken seriously by adults	33	14	10	18	6	**2.38**	**1.393**
I lack employment which would empower me to participate more fully	27	21	14	5	14	**2.48**	**1.441**

A significant proportion of respondents (mean 2.38) disagreed with the statement that, their contribution to the prevention measures are not taken seriously by adults, as well as the statement that, peer pressure at times pushes me to engage in sexual behavior that is risky to my health thus I'm guilty to participate in prevention fully as shown by mean of 2.02 which they also disagreed to.

The study further found that respondents strongly disagreed that poor decision making and judgment had made them vulnerable to HIV such that they did not trust themselves to participate in prevention as shown by mean 1.43 and that they do not have enough information about HIV; how it spreads and how to prevent it thus their participation was low as shown by mean of 1.40.

The study also sought to know the challenges that the respondents faced in participating in APHIAplus KaMili's HIV prevention initiatives. Majority of the respondents indicated that lack of participation in designing, planning for and implementation of youth programs, alcoholism, poverty, unemployment, sexual coercion and exploitation, crime and other risky behaviors as major challenges impeding youth participation. lack of proper HIV education, corruption leading to poor leadership, stigma and discrimination, lack of sufficient funds to scale up HIV prevention initiatives, illiteracy, lack of confidence to talk about certain things, bad influence and ignorance, lack of youth friendly services also rated high while, lack of skills, uncooperative population in the community, lack of time to participate in HIV prevention initiatives, lack of unity among participating groups, travelling costs, limited opportunities for participation, lack of confidence, peer pressure, religion especially opposed to condom use and homosexuality, certificates and fear of stigma and discrimination were also reported as challenges that youth face while participating in APHIAplus KaMili's HIV prevention initiatives.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the findings, conclusions and recommendations of the study whose aim was to assess the factors influencing youth participation in the APHIAplus KaMili HIV prevention initiatives in Dallas slums, Embu west District. The summary of the findings, conclusions and recommendations are organized around the study objectives.

5.2 Summary of findings

The findings of this study show very high awareness levels by the youth from Dallas slums on the existence of the APHIAplus KaMili project. The study found that 90.1 percent of the respondents indicated that they had heard about it, an indication that most of the youth had heard about the APHIAplus KaMili (AIDS, Population and Health Integrated Assistance) project. This was true for all the respondents regardless of whether or not they were participating at the time of the study. Majority of the respondents indicated to have known about the project from a Health Centre supported by the project (35.5 percent) and from friends (31.6 percent). The rest reported to have known about the project through promotions, family and the media.

Majority of the youths (52 percent) had benefited from APHIAplus KaMili project. The focus group discussions established that majority of the youths who had benefited were those who were already participating in the HIV prevention initiatives. The youth who had benefited from the project indicated to have benefited through counseling, knowledge of their HIV status, training and mentorship on life skills, peer education, by being offered short term jobs, by being involved in health days and sporting events and through scholarships offered by the project. Those who were not participating at the time of the study indicated not to have benefited from the project.

The project encourages active participation of youths in programs offered by APHIAplus KaMili. Active participation is encouraged through incentives such as lunch allowances, transport reimbursements during youth events, mobilizing youths to form youth groups and

linking them to micro financing institutions, training and mentoring of young people to mentor other youths on prevention of HIV & AIDS, support for behavior change support groups for young people after undergoing HIV tests, offering job opportunities whenever they arise, regular organization of youth friendly activities such as sports days, drama festivals, involving young people when conducting HIV prevention outreaches, and through involvement of young people living with HIV in their HIV prevention initiatives for young people.

APHIAplus KaMili encourages youth participation in HIV prevention initiatives and support through peer learning. Participation approaches adopted towards HIV prevention has encouraged their sense of community and local bonding with others. The program has provided them with skillful training for their sexual and reproductive health needs and allowed them to express their views and opinions freely without discrimination. However participation in the design, monitoring and evaluation of the youth projects offered is lacking.

Majority of the respondents (49 percent) indicated that the approaches adopted by the project were effective. The approaches adopted by APHIAplus KaMili were effective in the sense that they had succeeded in creating awareness and providing information on HIV/AIDs, had led to increase in number of youths who know their HIV status, had enabled reduction of idleness among youths in Dallas slums since they were always engaged in various activities within the project, had trained and empowered them on adolescent sexual and reproductive health and the project had created job opportunities for some youths. However (31 percent) felt that the approaches were not effective. The focus group discussion established that part of the reason the respondents thought they were not effective was that they had not reached all the youth living in Dallas slums. It is important that the project therefore looks at approaches that are likely to reach all the youths in the project area.

Involving young people in program design, planning, implementation, monitoring and evaluation of youth HIV prevention initiatives creates ownership leading to improved participation, conducting community mobilization and sensitization on the benefits of youth participation, mounting an aggressive door to door campaign encouraging youths to participate in HIV prevention initiatives**,** Supporting more schools in implementing the

school health program, developing more innovative and exciting youth friendly programs, creating employment opportunities and developing a reward system for youths who mobilize their peers to participate in the project are important approaches in improving youth participation in HIV prevention initiatives in Dallas slums.

The project was providing solutions to meaningful participation in HIV prevention initiatives among youths. The project was providing these solutions through peer education programs, through participation in sports events, drama festivals and world health days, by being involved in mobilization and sensitization for HIV prevention activities and through support for behavior change support groups. The respondents reported that they had been empowered through training on peer education, by being linked to micro financing institutions, through behavior change support groups and through access to sexual and reproductive health services such as Family planning services, condoms, ARVs and STI treatment services. The study established that de stigmatization, voluntary and active participation, and interest were the most important factors affecting participation In HIV prevention initiatives among youths in Dallas slums. Inclusion, respect and social participation were rated as neutral.

The project has not ensured that youths reached their full potential in participating in APHIAplus KaMili HIV prevention initiatives. This clearly shows that though efforts had been put in place by the project, the expectations for meaningful participation was greater and that the project needed to do more to ensure that the youths reach their full potential. This potential for participation in HIV prevention initiatives could be achieved through involvement in designing, planning, implementation, budgeting, monitoring and evaluation of youth HIV prevention initiatives, engagement of youths within the project areas as interns whenever such opportunities arise, establishing/decentralization of APHIAplus KaMili field offices within the project areas, increasing funding for youth activities and developing a reward/ recognition mechanisms for the most active youth volunteers in the project, greater and meaningful involvement of young persons living with HIV/AIDS in HIV prevention initiatives targeting young people and increasing access to youth friendly services.

Majority of the youths were unemployed and this was a key factor in affecting their participation in HIV prevention initiatives. Being unemployed meant that they could not concentrate on volunteering for the project while for others this provided time to participate in such activities. Being employed also meant that some could not get time to participate in the APHIAplus KaMili program while for others this meant that they could only afford little time for the project. Those who were self-employed indicated that this afforded them an opportunity to create time to participate in the project. A significant number of youths were either living in rental houses or in their rural homes. The nature of residence affected participation in HIV prevention initiatives granted that most of the youths spent most of the time in their work stations while those who were living with their parents in rental houses could only participate in the project depending on how much time their parents could afford them.

The study established that a higher proportion of youths reported that had not been affected by the HIV pandemic. This was not however consistent with their responses during the focus group discussions an indication that they might have interpreted being affected to mean being infected with HIV. Youths indicated that they had been affected by HIV pandemic by losing their relatives friends and significant others through death, taking responsibility of orphans left by those infected by HIV, rendering some of their close relatives jobless hence increasing unemployment and therefore poverty levels and dropping out of school to take care of their ailing relatives.

Majority of the respondents disagreed that lack of employment which would empower them to participate more fully was a socioeconomic factor which affected participation in HIV prevention initiatives and that, their contribution to the prevention measures are not taken seriously by adults, that peer pressure at times pushes them to engage in sexual behavior that is risky to my health thus am guilty to participate in prevention fully as shown by mean of 2.02 which they also disagreed to. The study further found that respondents strongly disagreed that poor decision making and judgment had made them be vulnerable to HIV such that they did not trust themselves to participate in prevention as shown by mean 1.43 and that they do not have enough information about HIV, how it spreads and how to prevent it thus their participation was low as shown by a mean of 1.40.

Youths in Dallas slums face numerous challenges in participating in APHIAplus KaMili's HIV prevention initiatives. These challenges include; lack of participation in designing, planning for and implementation of youth programs, alcoholism, poverty, unemployment, sexual coercion and exploitation, crime and other risky behaviors. Lack of sufficient funds to scale up HIV prevention initiatives, illiteracy, negative peer pressure, lack of youth friendly services also rated high while, lack of time to participate in HIV prevention initiatives, travelling costs, limited opportunities for participation, lack of confidence, religion especially opposed to condom use and homosexuality, and fear of stigma and discrimination were also reported as challenges that youth face while participating in APHIAplus KaMili's HIV prevention initiatives.

5.3 Conclusions

Based on the findings described in this research project, the study concludes that APHIAplus KaMili project encourages youths' participation by encouraging the youths' engagement and participation in HIV prevention initiatives; supporting the youths through peer learning and instilling a sense of community and local bonding with others; encouraging the youths to express their views and opinions freely without discrimination and providing the youths with skillful training for their sexual and reproductive health needs.

The extent of youths' participation is enhanced by the program discouraging discrimination and bad treatment to those who are infected and affected by HIV (de stigmatization), making participation voluntary, active and well informed and the program aiming at needs which are valuable to the youths. However youth participation could be enhanced by involving young people in program design, planning, monitoring and evaluation of youth HIV prevention initiatives as this creates ownership and therefore improved participation.

The study concludes that various socio-economic factors affect youths' participation in APHIAplus KaMili HIV prevention initiatives targeting young people. These include youths' self-distrust with regards to poor decision making and judgment making them vulnerable to HIV and lack of enough information about HIV, how it spreads and how to prevent it, Peer pressure pushing the youths to engage in sexual behavior that is risky to their health, making them have guilty conscience to engage in the project. Others included prevention measures

not being taken seriously by adults and lack of employment somewhat deters the youths from participating in HIV prevention initiatives.

5.4 Recommendations

In line with the findings and conclusion of the study, the researcher would make the following recommendations as a precursor to improving the performance of APHIAplus KaMili project;

The project needs to ensure greater involvement of youths in design, planning, monitoring and evaluation of youth projects on HIV prevention. This will ensure ownership of the HIV prevention initiatives by young people leading greater participation. Further diversification of the projects approaches encouraging participation of the youths will ensure that as many youths as possible will be engaged in HIV prevention initiatives tailored to their individual needs.

Planning for HIV prevention initiatives for young people needs to consider the community calendar to ensure that such initiatives are heightened during times when youths are available and can participate. Youth friendly Activities such as sports, drama festivals and talent shows for youth in school and those out of school should be planned especially during school holidays over the weekends and in the evenings when young people who are engaged elsewhere can participate.

Mounting an aggressive door to door campaign to encourage youths to participate in HIV prevention interventions will ensure increased participation. Community mobilization and sensitization for young people focusing on the benefits of participation will also lead to increased motivation for participation by youths in HIV prevention initiatives.

The project needs to decentralize its field offices and to establish more youth friendly hubs complete with educational materials, recreational activities, HIV care and treatment services in Dallas slums where young people easily access project staff, HIV information, care and treatment services. Community health workers and peer educators can then be allowed to coordinate their peer education activities for those hubs. This will enhance ownership of the

project HIV prevention activities targeting youths by the young people living in Dallas slums.

Developing a reward system which entails recognition of the most active youths in the project, expanding opportunities for jobs and internships for young people by the project and ensuring that as many youth groups as possible are linked to micro financing institutions or are involved in table banking projects will ensure wealth creation for the youths and therefore increased motivation for participation granted the added incentives. Adults in Dallas slums require sensitizations and mentorship on the need to recognize youth's contribution to the HIV prevention measures as a way of encouraging their participation in the project.

5.5 Area of further research

The study suggests that similar studies be done in other non-slum areas that APHIAplus KaMili is implementing HIV prevention initiatives targeting young people. This will ensure greater understanding of the factors influencing youths' participation in HIV prevention initiatives in the project areas.

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APPENDICES

Appendix I: Questionnaire for youth

This questionnaire seeks information on the factors determining youth participation in HIV prevention responses. All the information you give will be treated with confidentially and used for academic purposes only and nothing else what so ever. Kindly complete each of the sections in the questionnaire as instructed. Do not indicate your name as the information given is confidential.

SECTION A: DEMOGRAPHIC INFORMATION

Kindly answer and tick where appropriate

1. What is your gender?

   Male [ ] Female [ ]

2. Kindly indicate which age bracket you fall in.

   14-16 years [ ] 17-20 years [ ] 21-24 years [ ]

3. Marital status?

   Single [ ] Married [ ] other [ ] specify…….

4. From which village in Dallas slums do you come from?

   Matakari village [ ] Kathigari village [ ]

   Mbona village [ ] Dallas Mjini village [ ]

5. What is your highest level of education?

   None [ ] Primary School [ ]

   Secondary School [ ] College/other Tertiary[ ]

   Undergraduate [ ] Postgraduate [ ] other [ ] specify……...

6. What is the status of your parents?

   Both parents are alive [ ] I have only one parent alive [ ]

   I am orphaned [ ] I'm a child of a single parent [ ]

7. Indicate your siblings:

   a) Number of brothers [ ] b) Number of sisters [ ]

8. Do you know your HIV status?

   Yes [ ] No [ ]

9. If Yes in question 7, kindly state the reasons why you went for a HIV testing

   ……
   ……
   ……

10. If No, in question 7, kindly state the reasons why you have not gone for HIV testing

    ……
    ……
    ……

SECTION B: APPROACHES ADOPTED

Kindly answer and tick where appropriate

1. Have you ever heard of the APHIAplus KaMili (AIDS, Population and Health Integrated Assistance) program?

   Yes [ ] No [ ]

2. If yes, in question 1 how did you get to know about the APHIAplus KaMili program?

   Media [ ] Friends [ ] Family [ ]

   Their Promotions [ ] Health Centers and Hospitals [ ]

   Other [ ]
   specify……

3. Have you benefited from the programs offered by APHIAplus KaMili?

   Yes [ ] No [ ]

4. If yes in question 3, please explain briefly how you have benefited from the programs APHIAplus KaMili has offered.

   ……
   ……
   ……
   ……

5. Do the programs offered by APHIAplus KaMili encourage your active participation in them?

   Yes [ ] No [ ]

6. Explain briefly your answer to question 5.

   ……

   ……

   ……

7. Please state the extent to which you agree or disagree with the following statements on approaches adopted by APHIAplus KaMili to encourage your participation in HIV prevention response. **(1 is Strongly Disagree, 2 is Disagree, 3 is Neutral, 4 is Agree and 5 is Strongly Agree)**

	1	**2**	**3**	**4**	**5**
The programs allows me to express my views and opinions freely without discrimination					
The programs have encouraged my engagement and participation in HIV prevention initiative.					
The participation approaches adopted toward HIV prevention have encouraged a sense of community and local bonding with others					
The program has provided me with skillful training for my sexual and reproductive health needs.					
The support through peer learning has really encouraged my participation towards HIV prevention					
I am involved in the design, implementation and evaluation of the programs offered.					

8. Do you think the approaches adopted by APHIAplus KaMili have been effective?

   Yes [ ] No [ ] Don't Know [ ]

9. Explain your answer in question 8 on the previous page

   ……

   ……

   ……

10. What tips can you give to APHIAplus KaMili to improve your participation in HIV prevention initiative?

    ……
    ……
    ……

SECTION C: EXTENT OF YOUTH PARTICIPATION

Kindly answer and tick where appropriate

1. Have you ever participated in any of the APHIAplus KaMili programs?

   Yes [ ] No [ ]

2. If yes in question one above how were you involved?

   ……
   ……
   ……

3. Have the APHIAplus KaMili programs provided solutions to give you meaningful opportunities for participation in HIV prevention and treatment?

   Yes [ ] No [ ] Don't Know [ ]

4. Explain your answer in question 3 above

   ……
   ……
   ……

5. Have you found any empowerment from your participation in programs offered by APHIAplus KaMili aimed at HIV prevention initiative?

   Yes [ ] No [ ] Don't Know [ ]

6. If Yes, explain how

   ……
   ……
   ……
   ……

7. To what extent have the following factors affected your participation in HIV prevention initiative? **(1 is Very Low Extent, 2 is Low Extent, 3 is Neutral, 4 is High Extent and 5 is Very High Extent)**

	1	**2**	**3**	**4**	**5**
Social participation(being allowed to contribute openly about anything to do with my sexuality)					
De Stigmatization(the programs do not encourage discrimination and bad treatment to those who are infected and affected by HIV)					
Inclusion (youths allowed to make decisions and policies on matter pertaining to HIV prevention program)					
Respect(being given an audience and consideration by adults on matters pertaining to HIV prevention)					
Interest(the programs are aimed at needs which are valuable to me)					
Participation (it is voluntary, active and well informed)					

8. Do you think you have reached your full potential in participation?

   Yes [ ] No [ ] Not Sure [ ] Don't Know [ ]

9. What do you think should be done for your participation to be maximized?

   ……
   ……
   ……
   ……

SECTION D: SOCIO-ECONOMIC FACTORS AFFECTING PARTICIPATION

1. What is your employment status?

   Employed [ ] Self Employed [ ] Unemployed [ ]

   Do casual work [ ] other [ ]
specify…….....

2. Where do you live?

   In the streets [ ] Rental Houses [ ] Rural Home [ ]

   Other [ ]……

3. Have you been affected in any way by the HIV pandemic?

   Yes [ ] No [ ]

4. Explain your answer above

   ……
   ……
   ……
   ……

5. Please state the extent to which you agree or disagree with the following statements on the socio-economic factors affecting your participation in HIV prevention initiatives. **(1 is Strongly Disagree, 2 is Disagree, 3 is Neutral, 4 is Agree and 5 is Strongly Agree)**

	1	**2**	**3**	**4**	**5**
Peer pressure at times pushes me to engage in sexual behavior that is risky to my health thus am guilty to participate in prevention fully.					
Poor decision making and judgment has made me be vulnerable to HIV so I don't trust myself to participate in prevention					
I do not have enough information about HIV; how it spreads and how to prevent it thus my participation is low					
My contribution to the prevention measures are not taken seriously by adults					
I lack employment which would empower me to participate more fully					

6. State some of the challenges facing your participation in APHIAplus KaMili's HIV prevention initiatives?

   ……
   ……
   ……
   ……
   ……

THANK YOU FOR YOUR PARTICIPATION

Appendix II: Interview for Community Leaders and Community Health Workers

Section A: General Information

1. Name of interviewee (optional) ……..
2. What are some of the approaches adopted by APHIAplus KaMili in attracting the youth to the program?
3. Do you think the approaches adopted by APHIAplus KaMili have been effective?
4. What are some of the channels that were adopted in marketing APHIAplus KaMili program?
5. Are you actively involved in promoting the Program within the village?
6. Currently what is the youths' level of involvement/uptake of the program?
7. How does the youths' socio-economic status influence their involvement in the APHIAplus KaMili Program?
8. How has the youth involvement in the programs helped stem social vices and HIV prevalence?
9. Kindly state some of the challenges facing your participation in APHIAplus KaMili's HIV prevention initiative.
10. What do you recommend APHIAplus KaMili needs to do to improve youth participation in their HIV prevention initiative?

THANK YOU FOR PARTICIPATION

Appendix III: Focus Group Discussion

Topic: Factors influencing youth participation in HIV prevention initiatives

Discussion points

- Approaches adopted by APHIA Plus KaMili program to push for youth participation
- The extent to which the youths participate in the programs
- The social and economic factors that determine youth participation
- The challenges that may hinder the participation of the youth.

Engagement Questions

1. Are you affected in anyway by HIV and AIDS? How?
2. Does preventing the disease have any importance to your society? Explain why it is important to prevent it
3. Which APHIAplus KaMili programs on HIV prevention do you know of?
4. If you have participated in any of the APHIAplus KaMili programs on HIV prevention initiative, how were you involved?

Exploration Questions

5. How have the APHIAplus KaMili programs on HIV prevention been designed to encourage you participation? In what ways?
6. Is your participation to the maximum of your potential or you feel left out in the programs for HIV prevention initiatives offered by APHIAplus KaMili.
7. To what extent are you involved as a participant in the HIV prevention programs (initiation, development, implementation and evaluation of the programs)

8. How does your social environment determine your participation in the APHIAplus KaMili HIV prevention programs (peer pressure, poor judgment, ignorance of the disease)

9. What are the economic factors that determine your participation in the APHIAplus KaMili HIV prevention initiatives? (Unemployment and lack of education)

10. What are the challenges that you face in the participation in the APHIAplus KaMili HIV prevention response programs? Can they be addressed? How?

Exit Questions

11. Do the programs initiated by APHIAplus KaMili on HIV prevention effective in drawing your participation?

12. Anything else you think should be done to enhance and improve your participation.

THANK YOU FOR YOUR PARTICIPATION