A REPORT ON SCHOOLGIRL HIV/AIDS RISK PERCEPTION AND SEXUAL BEHAVIOUR IN KOROGOCHO AREA OF NAIROBI

BY

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DECLARATION

I pledge that this is my original work. It has not been presented at any other University for a degree course.

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DEDICATION

This work is dedicated to my daughters, Effie and Louisa

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First and foremost, I am grateful to Almighty God for having accorded me the time, strength and will to accomplish this work.

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ABSTRACT

This report sought to establish whether schoolgirls are aware of how vulnerable they are to HIV/AIDS transmission and if they are, whether their sexual behaviour is showing this. In assessing their perception, the study evaluated their knowledge of modes of HIV transmission, the methods of prevention and how to establish whether one is infected or not.

The area of study was Kariobangi North of Korogocho area. This is a slum area. The area was chosen with the view that HIV/AIDS is more rampant in the low-income residential areas. The target group was secondary school girls in a local secondary school.

Structured questionnaires were administered to the girls. The questionnaires were filled unanimously to encourage honesty. The data was then analysed by running frequencies and cross-tabulation using SPSS computer package.

The report came up with the observation that the majority of schoolgirls (96%) are much informed about risky behaviour, the ways of prevention and the dangers of HIV/AIDS. This clears the fear that schoolgirls may be exposed to HIV infection due to their ignorance. The study also brought the realization that unlike the view that premarital sex is prevalent today, most of the girls in this study (80%) were not sexually active. The concern should be about the girls (4%) who despite being sexually active use no protection.

The conclusion was that awareness among the schoolgirls could be indebted to the school. The recommendation is that a study should be done among girls who are not school going to establish their level of risk perception.

CHAPTER ONE

1.1.0 INTRODUCTION

HIV stands for Human Immunodeficiency Virus. HIV is a virus that belongs to the class of infectious agents called Retrovirus. HIV infects and takes over the normal survival mechanisms of the body's defense system. It completely incapacitates the body's defense mechanism consequently causing AIDS.

AIDS stands for Acquired Immune Deficiency Syndrome, Acquired means not born with; Immune Deficiency means lack of body defense against diseases; Syndrome means a combination of illness.

No cure has been found yet for AIDS. Effective drugs and vaccines have been difficult to develop because the virus cannot be destroyed without destroying the white blood cells that host the virus. The white blood cells are the embodiment of the body's defense system. Another reason for the failure to come up with a cure is because the virus changes characteristics rapidly.

AIDS was first reported in Kenya in 1984. The first case ever reported in the world was in the United States of America in 1981. Since then AIDS has become a pandemic, affecting the whole world. Since the 1980s the number of AIDS cases have increased from hundreds to thousands to millions. It is estimated that about 2 million people in Kenya are infected with HIV and about 1.5 million had died of AIDS since the first case by the year 2000 (NACC, 2000).

The HIV virus is transmitted from one person to another through contact of blood and other body fluids of an infected person with the blood stream of another person. The body fluids are blood, semen, vaginal and cervical secretions, tears, saliva, urine, breast-milk, sweat, mucus and pus.

Blood is the most infectious body fluid, though semen vaginal and cervical secretions and pus also have very high concentration of the virus. The most common mode of transmission is sexual intercourse accounting for over 80% of adult infections (The Global Programme on AIDS 1994). This is either heterosexual or homosexual intercourse. Other modes of transmission are: -

- Blood transfusion or organ transplant from an infected donor;
- The body fluids of an infected person getting into contact with one's blood stream;
- An infected mother to her baby before, during or after birth (when breastfeeding).

There are many theories explaining the origin of HIV. One theory states that HIV/AIDS is as a result of a biological warfare during the World War 11 1939 – 1945 between Germany and Britain. Another theory is that it was ordered for by the German tyrant, Adolph Hitler, to bomb America. The HIV bomb was unfortunately bombed in Congo (Africa) on its way to America. The monkeys in Congo then tested positive. It was then transmitted to human beings from the monkeys. A third theory is that HIV is the making of an American scientist Robert Gallo for the Americans to fight the Russians.

Christians also claim that HIV/AIDS is God's weapon to fight evil in the world as prophesied in the Bible. All said and done, there is no absolute proof yet as to the origin of HIV.

One unique aspect of AIDS is that it is a disease that has seen the historical involvement, in curbing its spread, of all sectors of life. Each of them is just as zealous and enthusiastic as the other. Be it political, scientific, educational, economic or religious. HIV/AIDS has brought the world of the scientist and the world of the humanist very close. This is attributed to the all round ravaging effect that the disease has caused governments.

1.2.0 PROBLEM STATEMENT

1.2.1 CHARACTERISTICS OF ADOLESCENCE

The rate at which the HIV spread is prevalent in the 15 – 19 years age group is making the age group a high risk group. This is the period of adolescence or puberty characterized with very rapid physical, physiological and psychological growth or changes. This stage signals sexual maturation. The body changes which occur at puberty create adult sexual characteristics resulting in hormonal surges in boys and girls. Adolescence is a stage characterized by high-level activity and risk taking behaviour e.g. smoking, night escapades. It is a stage where the adolescents rely so much on peer alliance. This is a stage where they rely so much on short-term risks than long-term risks. For example, they will avoid smoking because they do not have the money and not because they risk getting lung cancer. These changes do not occur in a vacuum. The social context in which they occur now is very different from earlier times. There have been many changes in the family, economic structure, the media and the cultural set-up. These changes have brought changes in the attitudes towards sex.

1.2.2 EPIDEMIOLOGY OF HIV INFECTION AND AIDS AMONG ADOLESCENT GIRLS

The AIDS scourge though pandemic is more serious in Africa than in any other part of the world. Of the about 34.3 million infected with HIV in the world, more than 20 million are from sub-Saharan Africa with Kenya ranking number 5 globally. Currently, it is estimated that 2 million people are infected with HIV in Kenya, that is 1 in every 8 adults is infected with HIV. An estimated 20% of youth aged 15 – 19 years (mainly secondary school students) are infected with HIV, the virus that causes AIDS (Ministry of Education Annual Report). Teenagers constitute 35% of all AIDS reported cases in Kenya (NASCOP 1992 Preliminary Data, MOH). Young women in the age groups 15 – 19 and 20 – 24 are 2-3 times more likely to be infected than males in the same groups. That is, for every 1 boy of 15 – 19 and 20 – 24 age group infected there are 2 – 3 girls of

the same age group infected (NCPD/GOK ,1998) In some parts of the country the ratio of infection between boys and girls aged 15 – 19 is 1:6 (WHO, 1990; Mwale et al ,1992, UNAISA, Bakau, 2000) It is estimated that 60% of new infections among women and 40% among men in the next 5 – 6 years will occur among those under 20 years of age.

Sexuality is said to have undergone a revolution. Even as careless sexual intercourse is becoming more and more risky, the age at first sexual contact is getting lower and lower. (Gupta, 2000; A B C Ochola-Ayayo, 1989; Khasiani, 1985). A study carried out in Kenyan secondary school estimates the age of the first sexual intercourse for girls and boys at 15 years (AMREF, 1997, Lema and Hassan, 1994)

The high teenage sexual activity is reflected in the incidence and prevalence of HIV/AIDS infection, pregnancy, abortion and sexually transmitted diseases.

Girls are becoming more and more vulnerable to HIV/AIDS than boys of their age. Young women in the age group of 15 – 19 years old are three times more likely to be infected than males their age (UNAIDS, 2000; Mwale et al ,1992; WHO 1990).

Many researchers have looked at sexual practices as only the practice of coitus. There is however, more to sexuality than coitus Many teenagers have come up with many sexual activities to substitute coitus, some refer to these practices as "safer sex" This is because they will not lead to pregnancy yet bringing sexual pleasure or satisfaction. Such sexual activities may look obnoxious to the older generations but they are becoming more and more popular These include voyeurism, masturbation, fellatio, cunnilungus, pornography, homosexuality (Rubin I. B , 1994) Some of these practices allow for blood contact and therefore the risk of contracting HIV though safe from conceiving

Due to the erosion of traditional and religious values, sex is no longer confined to marriage. In a study among church going adolescents, most of them refused to brand sex outside marriage as morally unacceptable, 55% of them accepted having had sexual

intercourse (Rubin L. B , 1994). A survey on youth who attended church came up with the following results: 43% of them thought that they had "good" chance of getting HIV/AIDS because they had multiple sex partners The average age of first sexual encounter among them was 14 years (Dotzbach (ed), 1998)

One question may be, why do adolescents engage in sex yet social values, though loose, do not favour adolescent sexual activity. Many social researches have looked into the problem of adolescent sexual activity and have come up with much explanation (Ochieng', 1989, Ajayi et al., 1991; T. Johnston, 2000; Gupta, 2000, Gomez et al., 1998).

The increase in mobility and influence of the pornographic media has been blamed for the loose sexual morals in the society. Studies amongst Kenyan youths have shown that their "main sources of information about sexuality are friends, movies, pornography and the mass media (Braddock et al., 1995; Emma and Hassan, 1994). Watching or listening to pornographic pictures and music excites the body to yearn for sex. One survey also found out that those adolescents who are in the company of the sexually active ones are more likely to engage in sex earlier and more frequently. This is peer-pressure. Peer pressure may not just be direct persuasion to engage in sex but also include the style of dress, the language use, the music listened to and the neighborhood which entice the need to belong and the temptation to conform (Rubin, 1994; Gupta, 2000)

Drug and substance abuse also promotes sexual activity among adolescents. Johnston T (2000) posits that regular drug users are twice more likely to report sexual activity, drug use within families leads to physical and sexual abuse of the family's young Adolescents who are regular users of drugs and alcohol find themselves in places where sexual trickery and unwanted touch are common-place (like bars, brothels, discos). In a study of primary, secondary and vocational schools, females were four times more likely to engage in sexual activity if they used drugs (Kiragu, 1993).

Mood altering drugs can impair judgement and lead to risky behaviour for HIV infection. Although not a direct risk, alcohol may serve to free inhibitions against engaging in sexual activity (Johnston T , 2000). Adolescents who reported heavy drinking and use of psychoactive drugs were more likely to report unprotected sexual intercourse.

Use of intravenous drugs is also another serious mode of transmission because of the sharing of unsterilised needles and syringes.

1.2.3 ADOLESCENTS' KNOWLEDGE AND ATTITUDES

There have been very few studies that survey adolescents' knowledge, attitudes beliefs and perceptions about HIV/AIDS, it's transmission, how to prevent it and how to control its spread

In a study among adolescents secondary school goers in Massachusetts (Lee Strunin, 1991), about ½ of the students did not understand transmission of the virus although they were able to identify all groups with high-risk behaviour Those adolescents with more knowledge about AIDS were more likely to perceive themselves at risk for contracting the disease.

Although knowledge is high among adolescent concerning transmission of HIV few adolescents view themselves at risk of contracting HIV And even among adolescents who are sexually or who use drugs few are using effective methods to reduce the risk of contracting HIV (Zelnik et al., 1981) Antonovysky (undated) Orubuloye et al. (1994), Anderson et al. (1990), Lalai-Momon (1997) Gupta (2000), Hulton et al (2000), Lee Strunimn (1991); USAID (2001).

1.2.4 ADOLESCENTS EXPERIENCE OF HIV/AIDS

- Apart from the seropositive population among the teenage girls, there are many other ways in which schoolgirls are affected by HIV/AIDS.

- Some schoolgirls are dropping out of school due to ailments related to HIV/AIDS but others are also dropping out to take care of their ailing family members suffering from AIDS or to take care of their siblings orphaned by AIDS
- Schoolgirls are also seeing some of their teachers die of AIDS. It is estimated that 4 to 6 teachers are dying of AIDS every day in Kenya (UNAIDS, 2001).

1.2.5 INTERVENTION

One may be tempted to think that nothing has been done to avert the above scenario but this would be a wrong conclusion. Many sectors of the society have had many programmes towards intervention; these are government instituted organizations, non-governmental organizations, church organizations, community-based organizations, educational institutions and even infected individuals have gone round spreading the message of protection against HIV/AIDS.

1.2.6 MATTERS ARISING

More adolescent girls are engaging in premarital sex. The age at the first sexual intercourse is getting lower. As low as 9 years old and at an average of 13 years (UNAIDS, 2000). Factors that promote adolescent sexual activity are:-

- drug, alcohol and other substance abuse
- permissiveness and erosion of traditional values
- The pornographic media
- Peer influence
- Lack of parental guidance
- Ignorance

There is very little on behaviour change despite having enough knowledge on HIV/AIDS. Girls are more vulnerable to HIV/AIDS than boys their age. Sex is no longer left within the boundaries of marriage. The society has become very permissive.

Prevalence of HIV/AIDS among adolescent girls is rising. The girls' subordinate position and ignorance makes her more vulnerable to HIV/AIDS. Schoolgirls engage in premarital sex for financial and other material gain.

1.3.0 BACKGROUND OF THE STUDY AREA

1.3.1 OUR LADY OF FATIMA

The school was founded by the Catholic Church for the purpose of giving the slum children an opportunity to have access to formal education. Almost 75 percent of the students are given bursaries by the Church and other organizations.

Housing facilities in these areas are very poor. The students live in congested rooms, which give loopholes for sexual wrongs like rape and incest. The infrastructure in those areas is also very poor. There is hardly tapped clear water in every household, most of the houses have no electricity. The feeding habits are not satisfactory, some students have to engage in basic economic activities in the evenings and over the weekends to subsidize their parents or guardians' expenses. Living in poverty has dehumanizing effects. Poverty lowers the poor people's ambitions and feeling of self worth. One finds that the students even as much as they would want to get out of that labyrinth of problems they lack the motivation.

There have been cases of girls dropping out of this school due to pregnancy. Since the year 1996,30 girls have dropped out due to pregnancy. However, the most pronounced problem is of girls who drop out of school or who are perpetually absent from school for having lost parents or guardians to AIDS or for taking care of relatives ailing from the disease. In sub-Saharan Africa today, many girls have withdrawn from school to care for ailing family members suffering from AIDS. Others have left school to head households where both parents have died as a result of AIDS.

Some of the students come from homes where illicit brew is made and sold. Such places make them more prone to sexual abuse. The issue of drug abuse is also prevalent in these areas. Slums offer dens to drug purchase.

The video shows kiosks are a common feature in these areas. These video shows offer a cheap entertainment joint for the slum dwellers who can hardly afford the legitimate entertainment awareness. They are very popular. These video shows are however, notorious for screening pornographic and violent scenes. For lack of parental guidance, these students are left subject to the propaganda and myths about sex imparted on them from these entertainment media and from their peers.

However, working against all these setbacks, the school has programmes to counteract these and elevate the living standards and the feeling of self worth of the students. Apart from academic subjects like Social Education and Ethics and Christian Religious Education, the school has introduced the un-examinable Aids Education. The school also takes part in many extra-curricular activities like sport, drama and music. Such activities expose the students to life's survival skills because they are always thematic.

Almost ¾ of the students are beneficiaries of sponsors who pay their school fees. The ministry also gives bursaries to a few needy cases. The school also has in place the Guidance and Counseling department whose members (from the teaching staff) try as much as possible to guide and counsel the students about their personal lives and academic excellence.

1.4.0 PROBLEM IDENTIFICATION AND JUSTIFICATION

Despite the efforts being made by the Government, NGOs/CBOs, religious institutions and individuals to prevent the transmission of HIV and to mitigate the impact of HIV/AIDS, behavior change has remained the greatest challenge reckless sexual behaviour. This is worrying because over 80% of HIV infections occur through sexual intercourse (The Global Programme on AIDS, 1994)

Adolescent sexuality is one area that needs proper attention. The proportion of adolescent girls infected with HIV/AIDS is worrying. The adolescents should be taken as a special need group in the area of sexuality. This is because, despite the fact that their bodies are mature for sexual involvement, they are still ignorant and naïve. Sex, because of its very serious consequences, needs very genuine intimacy that the adolescents cannot offer because they are still dependent.

It would be important to find out how the adolescent girls respond to the risks they face and their initiative to stay away from danger. This is important because the way they view the situation may be different from the way adults do. Their perception of the danger may actually design their remedial response to it.

Francois Delaport when investigating the 1832 cholera epidemic in Paris once said "I assert to begin with, that 'disease' does not exist. It is therefore illusory to think that one can 'develop beliefs' about it 'to respond to it'. What does exist is not disease but practices."

This assertion is partly true to an extent where HIV/AIDS exits as perpetuated by the cultural, economic and or political practices and responses. Just as the above practices can help perpetuate the spread of HIV/AIDS so can they control its spread.

The study of Kariobangi North in Korogocho area was driven by the reason that the problem of HIV/AIDS is typical to low-income residential areas. The study therefore seeks to find out the valuables associated with the problem. The choice of co-educational schools is to seek how the proximity of girls to boys affects their behaviour.

1.5.0 SCOPE AND LIMITATION

This study will only be carried out in one mixed school in the low-income region of the city Kariobangi North in Korogocho area.

The study methodology will involve only one tool, a structured and semi-structured questionnaire. This is because sex being a very sensitive subject, the more open tool, Focus Group Discussion, may not yield very representative results. The other more productive tool maybe the in-depth interview. This may also not be possible given the short time allocated for the study and the students are also in full school session and may not avail themselves for interview.

Apart from the constraint of time, the study has also faced the constraint of funds. This means that the students' household will not be under study. The study aims at getting the adolescents word without going into observations. This may give rise to distortions of information gathered.

The self- administered questionnaire to be used, though lacking in detail, has the advantage of anonymity thus encouraging honesty about sensitive items on sexual behaviour.

CHAPTER TWO

2.1.0 OBJECTIVES

2.1.1 MAIN OBJECTIVE

The overall goal of this study is to establish the relationship between awareness of HIV/AIDS risks and sexual behaviour of high schoolgirls in Korogocho Area in Nairobi with the view of helping to increase programmes that would curb vulnerability to the scourge.

2.1.2 SPECIFIC OBJECTIVES

The study is carried out:

a) to assess the relationship between knowledge of HIV/AIDS modes of transmission and sexual activity.

b) to assess the relationship between HIV/AIDS risk perception and condom use.

c) to assess the relationship between the knowledge of HIV/AIDS prevention and sexual activity

2.2.0 LITERATURE REVIEW

2.2.1 INTRODUCTION

The emergence and the subsequent rapid spread of HIV/AIDS has given a new dimension to the study of adolescent reproductive health. Earlier on before the early eighties, studies on adolescent reproductive health focussed on issues like abortion, contraceptive use, rape, early marriage, fertility and commercial sex. Now the adolescent reproductive health has an extra enemy and a more fierce one in the name of HIV/AIDS

2.2.2 DEMOGRAPHIC FACTORS AND HIV/AIDS

According to the 1999 census report 34% of the Kenyan population consists of the young aged 10 – 24 years while the 10 – 19 age group are 25% of the population (Republic of Kenya/CBS/Ministry of Finance and Planning (2001).

The Age Specific Rate (ASFR) for adolescents aged 15 – 19 years is 111/100 (NCPD/CBS, 1999). The average age for sexual initiation is 16.2 for boys and 16.8 for girls. Nearly 80% of young people have sexual intercourse before age 20.

Surveys of Kenyan adolescents undertaken over the past 6 years indicate that some 80% of sexually active teenagers (13 – 19 years) have had one or more acts of unprotected intercourse and hence have been at risk of accidental pre-marital pregnancy and HIV/AIDS (PCA /NYS, 1994/2000).

Adolescents account for 1/3 of hospital obstetrical cases. There are about 252, 8000 terminations of pregnancy among girls aged 15–19 years old (FIDA– K, 1997).

According to a 1988 Division of Family Health GTZ study, nearly 80 percent of girls who dropped out of school did so due to pregnancy. 50 percent of girls who dropped out of school due to pregnancy could not go back to school due to lack of fees and someone to care for their babies (Division of Family Health, 1988)

Since the first reported case of AIDS in Kenya in 1984, the virus has made worrying in roads among the youth 2/3 of teenagers between the ages of 10 and 19 years are likely to die of AIDS (NCPD/GOK, 1998) Of these teenagers, the young women are even more likely to die than the men Females are about 2-3 times more likely to be infected than males in the 15 – 24 age group (NCPD/GOK, 1998)

New reports indicate that 60% of new infections occur among young people aged between 15 and 24 (NASCOP/MOH, 1999). In some parts of the country the ratio of

infection between boys and girls aged 15 – 19 is 1 to 6 i.e. for every 1 boy infected, there are 6 girls infected

2.2.3 LITERATURE REVIEW ON CONTRACEPTIVE USE AND HIV/AIDS

A question to answer may be "why do some girls face all the above setbacks to maintaining their sexual purity yet come out unscathed i.e. do not give in to sexual temptations. Even without the danger of contracting HIV/AIDS, there are so many discouraging consequences of adolescent sexual activities that it would be more reasonable for a girl to avoid sex than to engage in it. Another question to ask may be "how much of the consequences have the adolescents been exposed to or experienced in order to be more weary?

Although Kenya's laws and policies do not explicitly restrict the provision of service to adolescents, the government does not provide reproductive health programs or services especially geared towards their needs. "Kenya's Health Policy Framework" does, however, identify the need for promotion of family planning services to examine the sensitive issue of youth contraceptives (Laws of Kenya Chapter 10 verse 3, 7) FIDA – K (1997).

Despite early sexual initiation, not many young people are taking precautions that would enable them prevent the consequences of sexual activity. Effective contraceptives among adolescents has increased though. Unfortunately sexual activity has even increased more than contraceptive use resulting in an increase of consequences of teenage sexuality (Zelnik et al., 1981). In a study among adolescents in Sierra Leone, 520 of the subjects who had intercourse reported using condoms; factors cross-tabulated to condom use being age, knowledge about HIV/AIDS, and fear of HIV/STD problems. In a study among adolescent women in Northeast Brazil, by 1996 condom use had become widespread due to knowledge about HIV/AIDS (Gupta, 2000).

Low contraceptive use among adolescents can be explained by the lack of access to information and services and the inconsistent nature of adolescent sexual behaviour among other factors. There are also negative attitudes associated with the use of contraceptive as a show of promiscuity (Khasiani, S. A., 1985); Lema, V. A., 1986)
In a study carried out by the National Council for Population and Development/CBS (1999) 96% of all women aged between 15 – 49 years knew at least one method of family planning but there is a very low use of contraceptives among adolescents. Contraceptive use is higher among married adolescents than unmarried ones and it is higher among men than women. The most commonly used contraceptives being condoms, the pill and the injectables.

Adolescents get most of the information about contraceptives from friends, brochures, newspapers and magazines.

In a study carried out by Khasiani (1985) over 70% of adolescents aged 15 – 19 believe family planning information and services should be made available to them.

Several studies show that knowledge about contraceptives may help eradicate some of the problems they get themselves into. A study carried out by Zelnik in 1989 revealed that a small percentage of the adolescents interviewed believed that the use of pills may help prevent the transmission of HIV/AIDS. This is very dangerous for them.

Other youth also believe that condoms can be washed and reused (NCPD/CBS, 1999) *Contraceptive knowledge encourages safer sexual behaviour among sexually active* adolescents. The pornographic surveys cite condoms as an important element in the prevention of HIV transmission.

2.2.4 SOCIO – CULTURAL FACTORS

HIV/AIDS EDUCATION SYSTEM AND HIV/AIDS

There has been much controversy in Kenya about the inception of sex education in schools. Many, especially the churches and other religious bodies have condemned the move claiming that it will induce more sexual activity among the youth while the proponents claim that the introduction of sex education or family life education (FLE) in schools will help the adolescents make wiser decisions about their reproductive health.

Zelnik and Kim (1989) in their study among American adolescents noted that young people who have had sex education are no more likely to have sexual intercourse than those who have never taken a course. However, sexually active young women who have had sex education are less likely to have been pregnant than their counterparts who have had no such instruction.

Sex education is not explicitly included in school curricula in Kenya, although sex and sexuality are addressed in subjects such as Social Education and Ethics, Biology and Christian Religious Education (FIDA – K 1997).

Lalai-momoh and Ross (1997) and Gupta (2000) voice the due need for reproductive education and health programming at the earliest possible opportunity.

Neeru Gupta (2000) also observes that adolescent women having more education may better appreciate the health and social advantages of delayed sexual activity and are equally more likely to protect themselves from unsafe sex.

Due to the negative impact of HIV/AIDS on the life of the people of Zimbabwe, the government established school-based AIDS programmes. Evidence from assessments of the school-based AIDS programmes from various parts of the world has shown that the

inclusion of good quality sexual health education and AIDS prevention activities into the general school curriculum gives the following results:

- Delays onset of sexual activity
- Reduces the number of sexual partners
- Raises contraceptive use among those who are sexually active.

Senegal, which has one of the lowest HIV prevalence rates in Africa South of Sahara at 1.8% has long emphasized sex education in schools from the time the first cases appeared in that country in the second half of the 1980s (FAWE News Vol. 80 No 2, 2000). In the above cases HIV infection is reduced drastically. These results point to the need for reproductive health education at the earliest possible opportunity.

2.2.5 OTHER SOCIO-CULTURAL FACTORS RELATED TO HIV/AIDS

PARENTING

Atonovsky's study in Israel sees a young person's sexual behaviour and attitudes in the context of the entire maturation process in which that development occurs and by the sex roles played by those who act as socialization agents. In her theory, family structure affects the maturing child differently depending on how central the family is in his/her socializing process and on the nature of the relationship the child observes between parents. She observes that those of the lower socio-economic status and educational levels have more traditional values and therefore with lower levels of sexual permissiveness.

SUBORDINATION OF WOMEN

The impact of HIV/AIDS on women is soon surpassing that on men. This is attributed to the subordinate position of women in the society, which restricts their ability to protect themselves from sexual transmission of HIV because they have little autonomy about sexual matters, Mwale and Burnaid (1992), FAWE News 8(2) April – June 2000,

Gomez and Meachan, (2000), Orubuloye et al , (1994), FIDA – K (1997), WHO, (1990). Many women in Kenya have no say as to whether the husbands should use condoms or not. This is whether they know that their husbands are unfaithful or not. The women fear advocating for condoms for the fear that they may be accused of unfaithfulness themselves (NCPD/CBS, 1999).

There has been an increase in sexual abuse and violence against women and young girls. According to United Nations (UN) violence against women and young girls is any act of gender-based violence that violates their decency and privacy in public or private places. e.g. wife-battery, rape, incest, forced marriage, forced wife inheritance, female genital mutilation (FGM) or female circumcision and indecent assault. All these acts have deep health consequences on the women and young girls. Since 1995, sexual assault of young girls has been on the increase. In Kenya, prevalence of abuse among girls is at least 1.5 - 3 times more than that of boys. Nearly 40% of girls who have been raped, were raped by HIV positive men who superstitiously believe that having sex with a virgin would heal their HIV status. (FIDA-K, 1998). There has been an outcry by many human rights agencies over the recent changes for defilement or rape of minors claiming that they do not deter the increase of sexual abuse and violence against children especially young girls Approximately two Kenyan females are raped every hour of the day and night in Kenya (Tony Johnston, 2001)

FEMALE GENITAL MUTILATION (FGM)

FGM or female circumcision as practiced in a number of Kenyan ethnic communities has greatly been condemned for the damages it has on the girls The incidence of FGM for girls in the 15 – 19 age group is common among the Kisii, the Meru, the Kalenjin, the Maasai, the Taita and the Borana. FGM has a number of health complications. These include risk of HIV/AIDS because of the use of unsterilised knives on more than one initiate and failure of the wound to heal thus giving breaks and openings to HIV virus during intercourse (GOK/MOH, 1999 June)

EROSION OF TRADITIONAL VALUES

Another explanation that has been given to the increasing effect of HIV/AIDS on young women as compared to men their age is the erosion of traditional and religious values placed on maintaining virginity until marriage. In a study among church going adolescents, most of them refused to brand sex outside marriage as morally unacceptable. 55% of them accepted having had sexual intercourse (Rubin L. B, 1994). In another survey among youth who attended church, 43% of them thought that they had a "good" chance of getting HIV/AIDS because they had multiple sex partners. The average age of first sexual encounter among them was 14 years (Dortzbach (ed., 1998).

PEER-PRESSURE

This is another crucial factor contributing to the fast spread of HIV/AIDS. Girls are three times more likely to be pressured than boys their age. (Tony Johnston, 2000). Adolescent boys are the most prevalent source of "sexual pressure". Girls are in most cases duped into engaging in sexual relations because of lack of information about sexuality and lack of specific knowledge about protection They fall for myths and misconceptions told to them by their peers (PCA, 1999).

2.2.6 SOCIO-ECONOMIC FACTORS AND HIV/AIDS

The African governments have been accused of the lukewarm response with which it has received the HIV/AIDS scourge. Orubuloye, Caldwell and Santon (1994) attributes the lack of the African governments to raise an alarm on the following reasons

- Too much publicity may result in loss of tourist revenue.
- Africa has survived many disasters including warfare, drought, famine and cholera epidemics that AIDS deaths have not yet raised too much anxiety
- Economic difficulties faced by governments leading to healthcare systems being strained without the potentially immense burden that AIDS could place on them

Studies in many countries have realized that for a positive impact against HIV/AIDS there is need to have full intervention of the government like in the case of Senegal Politicians in Senegal were quick to move against the epidemic once the first cases appeared in the second half of the 1980s. The government involved religious leaders. Sex education was included in the school curriculum. HIV voluntary and confidential counseling and testing were made widely available. STDs moved up the list of health priorities. HIV infection has remained low in Senegal since the start of the epidemic and show no signs of upward trend. FAWE News (volume 8 No. 2000).

Many studies have linked the HIV/AIDS epidemic to poverty. This is because the prevalence of HIV/AIDS is very high in the developing countries and even within the developing countries the prevalence is high among the poor. In the developed countries also, the prevalence is concentrated among the poor social class. For example in a study among secondary school students in America, the prevalence was found to be highest in the black community (Lee Strunin 1991).

HIV/AIDS is also related to poverty at household level. Some girls engage in sexual relationships with economically able men who could subsidize for them their expenses. Girls in most cases are the ones who bear the biggest load of the households economic difficulties. This is because while boys are more socially favoured to do odd jobs like car wash, conductors, hawkers and drivers, girls, in most cases take to hidden prostitution. These open the girls to threats of sexual exploitation with the risks of pregnancy and diseases (FAWE News 8 2, 2000). Some girls however, engage in sexual relationships with older economically active men who may provide them with money to buy little-girl-wants besides food and school fees (Ochola-Ayayo (1989); Khasiani (1985)

Poverty also denies the poor access to primary health care Proper management of sexually transmitted diseases is directly related to controlling the spread of HIV/AIDS (Population and Health Services, 1996). With the introduction of Structural Adjustment Programmes in Kenya, healthcare has become unaffordable to many due to cost-sharing.

Poverty has dehumanising effects on the victims. It lowers their self-esteem. It makes them less weary of any risks. It makes them just care for short-term solutions to problems ignoring the long-term consequences. This is why drunkenness is very common among the poor. Drinking with its mood altering effects makes them more vulnerable to sexual risks (Johnston, 2000). They even resort to other risky behaviour such as prostitution (commercial sex) and drug abuse. A study carried out by the PCA (1999/2000) revealed that a big proportion of sexually active Kenyan urban slum girls mainly engage in sex for cash, repayment or obligation.

2.3.0 THEORETICAL FRAMEWORK

Many studies have employed various theoretical models to explain the adolescent's tendency to ignore the dangers of irresponsible sexual behaviour and to have a tendency of taking risks.

Some theories view risk-taking as a dispositional trait. They explain that an individual may engage in risky behaviour as deviance. The reason for defiance include poor self-esteem, depression or inadequate social skills. Other theories also postulate that the acquisition of either risky behaviour or preventive behaviour is the result of a rational decision making process. These are for example Bandura's social learning theory (1992) and Fishberi and Ajzen's theory of reasoned action (1975).

These theories are however inadequate because they assume a logical pattern of decision making which is unrealistic in the complex field of sexual relations. Others also look at ecological theoretical models which consider human beings in their social and environmental context. These theories propose the contextual factors such as economic factors, cultural factors, social factors which include the social norms and reinforcements for adolescent participation in risky behaviour. Such theories include professor Ochola-Ayayo's HIV/AIDS model, (1996), Zaltman and Marlow's socialization theory (1971; Adeokun et al's framework of sexual behaviour among

adolescents (1995) Siegel and Siegel reference group theory (1969); Mwendwa's theory (1997) Weisner, (1991).

The cultural and ecological theories are the closest to my study. This is because sexual behaviour is so intricate that it cannot be confined to logical reasoning alone. Relating irresponsible sexual behaviour to deviance, depression or low self-esteem may also not be closer to it because even though it is more prevalent among the society's lower class it is also found among the society's "morally upright" class and socio-economic upper class.

2.3.1 CONCEPTUAL FRAMEWORK

The contextual and ecological conceptual models which consider the adolescents within their social, economic, cultural and environmental contexts, are more pertinent to the explanations (Ochola-Ayayo, 1996); Adeokun et al., 1995).

Conceptual Model

Source: Modified from Bronfenbrenner (1973)

2.3.2 HYPOTHESES

1. Schoolgirls who are aware of the modes of HIV/AIDS transmission may not engage in sexual activity.

2 Schoolgirls who feel that they are at risk of contracting HIV/AIDS and are sexually active are more likely to use condoms.

3. Schoolgirls who are aware of the measures of HIV/AIDS prevention are less likely to be at risk of contracting HIV/AIDS.

4. Schoolgirls who site HIV/AIDS as one of sexually transmitted diseases are more likely to avoid sex.

5. Schoolgirls who disapprove may not engage in premarital sex.

CHAPTER THREE

3.1.0 SAMPLING AND METHODOLOGY

The study, seeking a very sensitivity issue, sexual behaviour, may be bogged by a number of inconsistencies.

The study design involved doing a thorough literature review in order to come up with different aspects on the topic of adolescent sexuality and HIV/AIDS. A questionnaire was then built up to test and simplify the theoretical framework.

The study population was chosen with a bias. The aim was to target a day and mixed school in a low-cost residential area. The bias was also on girls within the school. Sampling was done by stratification to include all the three classes, form one to three. By random sampling, there were 16 respondents out of each class giving a total of 48 respondents.

Data collection was done by the use of self-administered questionnaire. Student anonymity was ensured to encourage more sincere response.

Although Focus Group Discussions are more successful in understanding sexual behaviour because they reveal attitudinal and motivational information, they may not be viable in this case. This is because of the sensitiveness of the issue on study. The study, being carried out in a secondary school, the girls who may fear victimization for their views and ideas.

Quantitative research, though lacking in answering the "why" question is important in giving a two-dimensional view and also helps in ensuring more sincere responses due to anonymity.

3.2.0 DATA ANALYSIS

DEFINITION OF VARIABLES:

1. Independent Variables
    i) Grade - this is the class one is in e.g. Form one
    ii) Education of parent – this is the highest level of education of the parent or guardian.

2. **Proximate Variables**
    i) Parent involved – this is to establish whether the parents are involved educating their daughter on sexual behaviour.
    ii) Knowledge about HIV/AIDS
    iii) Knowledge about risky behaviour
    iv) Knowledge about prevention of HIV/AIDS
    v) Knowledge about modes of transmission of HIV/AIDS
    vi) Attitude about pre-marital sex
    vii) Attitude about the consequences of pre-marital sex

3. **Dependent Variable**
    i) Sexually active
    ii) Use condom

3.2.1 METHOD OF DATA ANALYSIS

Data analysis was done with the help of the SPSS computer package by running frequencies and cross-tabulation. The frequencies were run to establish the distributions of each variable.

3.2.2 FREQUENCIES

Table 3.1: Percentage frequency distribution of girls living with their parents

Living with parent	Not living with parent
80%	20%

Of the 50 girls, interviewed only 20% do not live with their parents. This implies that most of the girls (80%) come from relatively stable homes.

Table 3.2: Percentage Distribution of girls whose parents are involved in their awareness about sexual behaviour

Involved	Not involved
58%	42%

Of the 50 girls interviewed, 58% of them had their parents involved in educating them about sexual behaviour while for 42% of them their parents were not involved.

Table 3.3: Percentage frequency distribution of the parents' highest level of education

No education	2%
Primary level	30%
Secondary level and above	68%

This shows the majority of the parents 98% have at least some basic education. The implication is that the girls come from families that are less ignorant.

Table 3.4: Frequency distribution about the knowledge about STDs and HIV/AIDS

STD	HIV as an STD	Risky sexual Behaviour	Prevention of HIV	Modes of HIV transmission
98%	66%	96%	100%	96%

This report shows that there is an above average awareness about HIV/AIDS. This confirms studies which show that schoolgirls are knowledgeable about HIV/AIDS (Gupta, 2000).

Table 3.5: Frequency distribution on the attitude towards sex

Pre-marital sex	8% approve
AIDS as the worst consequence	56%

Only 8% of the girls think that sex should not only be confined to marriage while 56% think that AIDS is the worst consequence of pre-marital sex.

Table 3.6: Distribution of the sexually active by use of condoms

Sexually active	Use condoms
20%	16%

20% of the 50 girls interviewed are sexually active while only 16% use condoms. This means that a number of girls still engage in risky sexual behaviour. This is despite the fact that 100% of them are aware of how to prevent HIV. This could be attributed to other factors and not lack of knowledge.

Table 3.7: Distribution of the sexually active by attitude on pre-marital sex

Sexually active	Attitude on pre-marital sex
Yes-20%	Approve – 08%
No-80%	Disapprove-92%

The table shows that 20% are sexually active yet only 08% are not opposed to pre-marital sex. This means that about 12% of the girls engage in sexual intercourse against their wish. Why is this?

Table 3.8: Frequency distribution table

Those who feel vulnerable to HIV	40%
Those who are sexually active and use condoms	16%

This table displays the responses of those who feel that they can possibly get HIV as 40% yet only 16% use condoms. This means that 24% do nothing about their being vulnerable yet 100% are aware of what to do to prevent HIV. This confirms studies which postulate that teenagers have a disposition to risk taking (Mwendwa, 1997; Adeokun,1995; Ochola-Ayayo, 1996).

CHAPTER FOUR

CONCLUSIONS AND RECOMMENDATIONS

Schoolgirls in Korogocho have to jump a number of hurdles to excel in school as compared to the average schoolgirl in the country. This is because of a number of social, demographic and economic problems earlier discussed. One would therefore expect them to succumb to the various risks posed by HIV/AIDS. The study has however proved otherwise. This can be attributed to what the school does in creating awareness. This is because between 96% -100% of the girls interviewed have shown awareness of STDs, HIV and prevention of HIV.

Since the school has helped in creating awareness among schoolgirls then the worry should be about how to sensitize the girls who are not in school.

Something should however be done to help the girls who engage in sex and use no protection. This is a concern that needs to be addressed. I suggest that a study be done to establish the knowledge on HIV/AIDS, risk perception and the sexual behaviour of girls their age but who are not in school. This would help to come up with a policy which would aim at sensitizing the girls on the dangers of HIV/AIDS. Another recommendation is for a study to be carried out to establish why girls engage in risky behaviour yet they are knowledgeable about the dangers of risky behaviour.

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APPENDIX 1

QUESTIONNAIRE

This questionnaire is administered with the aim of establishing the knowledge and attitudes of schoolgirls concerning HIV/AIDS and sexual behaviour

Do not indicate your name

1. Tick the grade you are in:

Form One	Form Two	Form Three

2. I stay with (tick the correct column)

Both my parents	
My father / mother alone	
Any other (specify)	

3. My parents' highest level of education

	Mother	Father
No education		
Primary education		
Secondary education		
College / University		

4. Tick the correct column

	Always	Sometimes	Rarely	Never
My parents discuss with me sexual relations				
My parents caution me against premarital sex				

5. Which of the following have you learnt in school?

Sexually transmitted diseases	
Common misconceptions about sex and HIV/AIDS	
Modes of HIV transmission	
The early signs of HIV infection	
Risky sexual behaviour	

6. Which are the sexually transmitted diseases you know of?

.....

.....

7(a) What may be the consequences of engaging in pre-marital sex?

.....

.....

.....

(b) Of the above consequences, which one do you think is the worst?

.....

8(a) What can you do to avoid being infected by HIV/AIDS?

.....

.....

.....

(b) Of the above, which one is the most effective in preventing HIV?

.....

9. Tick the correct mode of transmission of HIV

Sexual intercourse with an infected person	
Mosquito bite	
Sharing injection needles	
Sharing seats	
Blood transfusion	
Breastfeeding	

10. How would you know for sure if one is infected?

If he/she is thin	
If he/she has skin problems	
If he/she coughs so much	
If he/she goes for a blood test	

11. Do you think you can possibly get HIV?

Yes	
No	

12. Do you have a boyfriend?

Yes	
No	

13(a) Have you ever had sexual intercourse

Never	
Only once	
Sometimes	
Always	

(b) Did you use any protection? ..... Which one? .....

14. Do you think sex should be left only for the married?

Yes	
No	

Why?

.....

.....

THANK YOU FOR YOUR COOPERATION

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