

FACTORS INFLUENCING RISK PERCEPTION AND
VULNERABILITY TO HIV INFECTION AMONG KENYAN YOUTH

Lucy Wanjiku Mung'ala

Student Number: N69/72802/2008

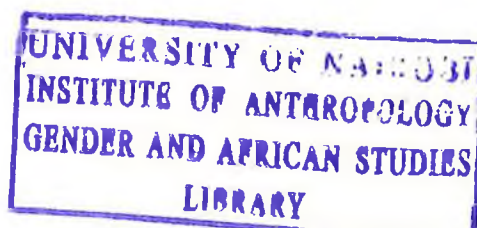
A Project Report Submitted to the
Institute of Anthropology, Gender and African Studies
in partial fulfilment for requirements of the degree of
Masters of Arts in Gender and Development Studies
of the
University of Nairobi

November 2011

University of NAIROBI Library



0549465 3

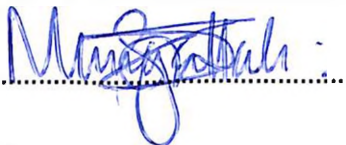


DECLARATION

I Lucy Wanjiku Mung'ala do hereby declare that this project paper is my original work and has not been submitted to any other institution, college or university.

The paper is of my own effort and where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

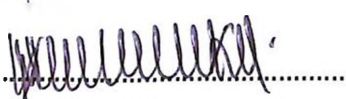
Date:.....25/11/2011.....

Signature:..........

Lucy W. Mung'ala
N69/72802/2008

This project has been presented for examination with my approval as a University Supervisor.

Date:.....28/11/2011.....

Signature:..........

Dr. W. Subbo

DEDICATION

Dedicated to

Poul Hagen Thisted

For the friend you have been over the years.

As you rest in the hearts of people you have touched, inspired, supported, mentored and loved.

Your humour and courage combined with a devilish smile are infectious!

I also want to dedicate to all the study participants who confided in us with intimate details, fears and hopes in their lives.

TABLE OF CONTENT

ACKNOWLEDGMENTS	6
ABSTRACT.....	7
ACRONYMS.....	9
GLOSSARY: DEFINITION OF KEY TERMS USED	10
CHAPTER ONE	12
1.1 INTRODUCTION.....	12
1.2 STATEMENT OF THE PROBLEM.....	13
1.3 STUDY OBJECTIVES	15
1.3.1 GENERAL OBJECTIVE.....	15
1.3.2 SPECIFIC OBJECTIVES.....	15
1.3.3 RESEARCH QUESTIONS	15
1.4 STUDY JUSTIFICATION.....	16
1.5 STUDY SCOPE	16
1.6 STUDY LIMITATIONS.....	17
CHAPTER TWO	18
LITERATURE REVIEW.....	18
2.1.1 TRENDS AND DRIVERS OF HIV EPIDEMIC IN KENYA.....	18
2.1.2 YOUNG PEOPLE IN KENYA	19
2.1 HIV AMONG YOUNG PEOPLE IN KENYA	19
2.2 STIGMA, DISCRIMINATION AND VULNERABILITY TO HIV	20
2.3 GENDER, SEX AND SEXUALITY	21
2.3.1 BIOLOGICAL DIFFERENCES IN ACQUISITION AND TRANSMISSION OF HIV INFECTION	23
2.4 THEORETICAL APPROACH.....	24
2.4.1 THE CONCEPTUAL FRAMEWORK.....	25
FIGURE 1-THEORETICAL FRAMEWORK	25

CHAPTER THREE	26
METHODOLOGY	26
3.1 STUDY TYPE	26
3.2 STUDY SITE	27
3.2 RESEARCH DESIGN.....	28
3.4 DATA COLLECTION METHODS.....	30
3.4.1 TELEPHONE IN –DEPTH INTERVIEWS	30
3.5 DATA PROCESSING AND ANALYSIS	31
3.6 ETHICAL CONSIDERATIONS.....	31
3.7 QUALITY ASSURANCE AND DISSEMINATION OF RESULTS.....	32
CHAPTER FOUR	33
FACTORS INFLUENCING HIV RISK BEHAVIOURS AMONG YOUNG PEOPLE.....	33
4.1 SECTION I: QUANTITATIVE ANALYSIS OF HOTLINE CALLERS QUESTIONNAIRE.....	34
TABLE 4.1: DEMOGRAPHIC CHARACTERISTICS AND REASONS FOR CALLING THE HOTLINE.....	35
4.1.1 GENDER DIFFERENCES: SEXUAL RISK BEHAVIOURS AND PERCEIVED RISK FOR ACQUIRING HIV.....	36
TABLE 4.2: AGE OF SEXUAL DEBUT, CONDOM USE, AND PERCEIVED SUSCEPTIBILITY TO HIV	37
4.1. 2 YOUNG PEOPLE PERCEPTION TOWARDS HIV TESTING AND COUNSELLING	38
TABLE 4.3: HIV TRENDS AND REASONS FOR TESTING	38
4.2 SECTION II: ANALYSIS OF THE FOCUS GROUP DISCUSSION	39
TABLE 4.4: CHARACTERISTICS OF THE FOCUS GROUP PARTICIPANTS	39
4.2.1 INDIVIDUAL ATTITUDES TOWARDS HIV: INFLUENCE ON HIV RISK TAKING BEHAVIOURS.....	39
4.2.2 ATTITUDES TOWARDS YOUTH SEXUALITY	42
4.2.3 YOUNG PEOPLE ATTITUDES TOWARDS HEALTH CARE PROVIDERS	43
4.3 SECTION III: ANALYSIS OF KEY INFORMANT INTERVIEWS.....	44
4.1.3 CHARACTERISTICS OF THE KEY INFORMANTS'	44
CHAPTER FIVE	47
SUMMARY, CONCLUSION AND RECOMMENDATIONS	47
RECOMMENDATIONS	52
REFERENCES	55
ANNEX 1: QUESTIONNAIRE FOR TELEPHONE INTERVIEWS.....	57
ANNEX 2: A GUIDE TO IN DEPTH INTERVIEWS AND FOCUS GROUP DISCUSSION	58
ANNEX 3: ILLUSTRATIVE ACTIVITY PLAN AND TIME SCHEDULE	59
ANNEX 4: A GUIDE TO PRE-TESTING THE METHODOLOGY	60
ANNEX 5: CONSENT FORM	61

ACKNOWLEDGMENTS

Embarking into a master's program, writing a project paper and completing the program are not undertakings done in a void. This has come together through the support and help from many people. I express my love and appreciation to the most important people in my life: my mother, Wanjiru, for always believing in me and her dedicated prayers; my siblings who always look up to me hence keep me grounded. To my best friend Poul Thisted for his encouragements, support and never changing concerns to see me excel in my studies and life.

I am grateful to the management team and staff at Liverpool VCT, Care and Treatment for an opportunity to utilize the helpline and its network of young people. Special thanks go to the Youth Programme, the Coordinator and the hotline counsellors who were instrumental in data collection, assistance in data entry and analysis of qualitative data.

My sincere gratitude goes to my supervisor who constantly ensured that I was moving in the right direction and who spent time to review my drafts, providing further insights on the topic and became more of a counsellor to me throughout my study period.

Finally my sincere appreciation goes to University of Nairobi and especially faculty members at the Institute of Anthropology, Gender and African Studies from whom I learned and derived a lot of inspiration.

ABSTRACT

HIV and AIDS programming for youth is surrounded by great controversy as a result of the interplay between moral discourse surrounding sexuality and the reality of sexual activities that youth engage in. The median age of sexual debut among the Kenyan youth is 17.5 years for both young men and women. Significantly by age 15 years, 22% of young men and 20% of young women will have had sex (NASCO, 2008). While proper and consistent use of condoms has been shown to reduce the risk of HIV associated with unprotected sex, controversy surrounding condom access by young people continues to be a heated debate in Kenya especially among religious groups.

Gender roles that require young men to exhibit their masculinity and sexual prowess as well as generally acceptable notions on gender based violence against young women continue to put them at increased vulnerability to HIV. HIV and AIDS campaigns rarely target most at risk youth and those living with HIV and AIDS continue to be neglected by mainstream behaviour change interventions. Amid under resourced youth programmes in Kenya, there is little evidence on how best to HIV prevention programmes can respond to the needs of young people and challenge harmful social cultural behaviours that exacerbate HIV vulnerability among youth in Kenya.

The overall aim of the study is to explore attitudes towards youth sexuality, sexual risk behaviours and perceived vulnerability to HIV among young people aged 15-24 years in Kenya. This is an exploratory study that aims to provide insight on HIV risk perceptions, acquisition and transmission among youth aged 15-24 years in Kenya. This project paper sets out to gain this understanding from the published literature as well as use of interviews and focus groups discussions in order to identify the above factors. Findings are presented according to the themes identified and recommendations made.

Young people in Kenya are exposed to HIV in different ways depending on their geographic location, age, sex and educational levels. Drug and use of alcohol are also on the rise. Controversies surrounding youth sexuality continue to influence how and what type of information young people receive. This has an influence on access to services as well as service providers' biases towards providing sexual health information to young people reducing their chances of making informed decisions on matters affecting their reproductive health.

Apart from inadequate social support structures, for young people living with HIV and AIDS social stigma exists, making it difficult for them to disclose their HIV status sometimes even to their own parents for fears of being rejected. These factors are likely to have an influence on how young people negotiate for safer sex and ultimately increase their vulnerability to HIV infections amongst other consequences.

Potential risks for HIV vulnerability among youth in Kenya might be reduced, through targeted non judgemental programmes that address young people's acquisition and use of condoms, availability of youth-friendly services and centres, screening and treatment for STIs/HIV.

A critical analysis of the already existing policies, forms of social support and addressing harmful social cultural practices may be the most beneficial approaches to dealing with investigations into the relationship between information and risk-taking behaviour in young people. This has the potential to confront individuals' perceptions of their personal vulnerability that is often at considerable odds with reality, not only because of misinformation but also other cultural factors or peer influence. Hence combinations of social, psychological, economic and interpersonal factors are necessary to inform youth programmes.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus Syndrome
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic Health Survey
KMOT	Kenya Modes of Transmission
KNASP	Kenya National AIDS Strategic Plan
LVCT	Liverpool VCT, Care and Treatment
MGDS	Millennium Development Goals
MSM	Men who have sex with Men
NACC	National AIDS Control Council
NASCOP	National AIDS and STIs Control Programme
NGO	Non-Governmental Organization
PEPFAR	President’s Emergency Plan for AIDS Relief
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	United Nations Aids Programme
VCT	Voluntary Counselling and Testing for HIV
WHO	World Health Organization

LOSSARY: DEFINITION OF KEY TERMS USED

adolescent, youth and young people: WHO approach to adolescents, is well formulated with recognition of the overlapping definitions of youth, adolescents, and young people. Thus the above terms will be used interchangeably in this report.

Gender: Gender is not a synonym for sex. Therefore gender in this paper will be referred to as, the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics, and roles. Hence gender is defined as a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other (Cited in Gupta, 2000).

Gender relations: Will be considered as ways in which a culture or society defines rights, responsibilities, and the identities of men and women in relation to one another (Bravo-Baumann, 2000). This paper will refer to gender relations in the context of socio cultural norms which have a significant impact on women and men's sexual behaviour, respective sexual responsibilities, sexual education and their ability to access information about sex and resources, including sexual health care.

Sexuality: Refers to a core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love, and reproduction. It is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles, and relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors (PAHO, 2000). The term will also refer to the explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors, and how such factors influence individual's sexuality (Zeidenstein et.al, 1996; Dixon Mueller 1993).

Support groups: In a support group people with the same problem find ways to cope with and defeat the problem. For example, the support groups describe in this report are those formed by young people living with HIV to help each other cope with their status. These HIV, support groups provide psychological support and also focus on improving services received by those living with HIV. Such groups also have to ensure the rights of people living with HIV are respected.

HIV Risk: Based on UNAIDS description, risk is defined as the probability or likelihood that a person may become infected with HIV. Certain behaviours create, increase, and perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown, multiple sexual partnerships involving unprotected sex, and injecting drug use with contaminated needles and syringes.

Vulnerability: The term is considered as a range of factors outside the control of the individual that reduce the ability of individuals and communities to avoid HIV risk. These factors may include: (1) lack of knowledge and skills required to protect oneself and others; (2) factors pertaining to the quality and coverage of services (e.g. inaccessibility of service); and (3) societal factors such as human rights violations, or social and cultural norms.

These norms can include practices, beliefs and laws that stigmatize and dis-empower certain populations, limiting their ability to access or use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV (UNAIDS, 2007).

Telephone help lines: (also known as hotlines) are telephone lines set up to take calls from people seeking information on specific topics—such as HIV/AIDS; reproductive health and sexuality concerns.

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

HIV and AIDS programming for youth is surrounded by great controversy as a result of the interplay between moral discourse surrounding sexuality and the reality of sexual activities that youth engage in. While there are varying definitions for what age bracket constitutes youth, United Nations and World Health Organization define youth as 15-24years¹. Kenya defines youth as those aged 15-24 (KDH, 2003). Youth represent not only one of the highest HIV prevalence age brackets but are also indicative of how the HIV epidemic will change in the coming years (UNAIDS, 2006; KNBS, 2010a).

Youth sexuality exists within a context in which it is predominantly considered taboo (Campbell, et al., 2003). This serves to heighten youth vulnerability to HIV, due to both their inability to access services for engaging in stigmatized activity, and also to push youth sexual activity further into secrecy. This secret nature of youth sexuality makes HIV prevention programming more challenging, as the ability to have open and constructive dialogue is less likely and the reality of youth sexual experience remains harder to determine.

Social economic status and cultural factors continue to place young people at increased vulnerability to HIV and other sexual reproductive health complications. Early marriages before 18years in some Kenyan communities continue to exist. Transactional sex involving exchange of sex for money, favours, or gifts is common among young people.

¹ The UN/WHO uses the term adolescents for people aged 10–19 years, young people for those aged 10–24 years, and youth for those aged 15–24 years. WHO also recognizes the problems of interchanging the definition of youth and adolescence; this has been countered by accepting that the dynamic transitions of this stage of life have as much to do with biological aspects as with socio-cultural conditions. Therefore, the health of youth and adolescents are often taken together and can be used interchangeably.

This presents compromised power relations and the tendency to have multiple partnerships which is associated with high risk of contracting HIV/STIs (NACC, 2007).

It is therefore essential to understand youth sexuality and dissect the multiple influences, in order to understand the norms, perceptions, practices and beliefs which form the reality of their sexual experiences and their vulnerability to STIs/HIV in order to design appropriate targeted interventions.

1.2 Statement of the problem

In Kenya, number of sexual partners, inconsistent condom use, and age of sexual debut as well as low rates of male circumcision are all factors associated with acquisition and transmission of HIV infection (NASCO, 2008). Currently, the median age of sexual debut among the Kenyan youth is 17.5 years for both young men and women. Significantly by the age of 15, 22% of young men and 20% of young women will have had sex (NASCO, 2008).

Results from Kenya Demographic Health Survey (KDHS 2008/2009) show that knowledge of all key HIV prevention methods is lower among youth aged 15-19 years than among those aged 20 years and older (KNBS, 2010a). Likewise, knowledge of how people can reduce the risk of getting HIV is lower among those who have never had sex yet in their developmental stages (KNBS, 2010a).

While proper and consistent use of condoms has been shown to reduce the risk of HIV associated with unprotected sex, controversy surrounding condom access by young people is a heated debate in Kenya especially among religious groups. Nevertheless, most young people support the notion of condom use with over 70% of those aged 15-24 strongly agreeing that children aged 12-14 years should be taught about using a condom despite opposition of some adults and religious leaders (KNBS, 2010a).

Young people also engage in other forms of sexual activities such as oral and anal sex which are often not addressed by mainstream media and behaviour change communication strategies in Kenya (NACC, 2008). This leads to inadequacy in knowledge on how to protect themselves thus increasing their vulnerability to STIs including HIV.

Educating youth about sexuality and safer sex options is critical; yet some argue that it promotes early sexual experimentation. This leaves youth with fewer options for prevention messages.

A lot of information that youth receive tends to be biased more often from a moral or cultural perspective. Thus it depends on where; how and from whom they receive information from. Young men in Kenya aged 15-24 years account for 1.9% of the population surveyed for KDHS to have paid for sex within the last 12 months prior to the study (KNBS, 2010a). Their risk is further exacerbated by gender roles that require men to exhibit their masculinity and sexual prowess.

Cultural and social norms that accept violence against women including rape exacerbate women's vulnerability to HIV and other forms of psychological disorders. For instance, one third of circumcised women in Kenya are between the ages of 14-18 years old at the time of the operation. This has consequences for their reproductive health and risk of contamination from unsterilized equipments (KNBS, 2010a). All the above factors are associated with increased vulnerability to HIV.

1.3 Study objectives

1.3.1 General objective

The overall study aim is to explore attitudes towards youth sexuality, sexual risk behaviours and perceived vulnerability to HIV among young people aged 15-24 years in Kenya.

1.3.2 Specific objectives

1. To explore perceived risks for STI/HIV among youth aged 15-24 years in Kenya.
2. To describe social, cultural and economic factors that influence STI/HIV vulnerability among young people in Kenya.
3. To determine the extent to which formal and informal sexual reproductive health services address the needs of young people and conditions in which they operate.
4. To recommend appropriate strategies for addressing psychosocial and STI/HIV vulnerabilities among young people in Kenya including those who test HIV positive.

1.3.3 Research questions

1. What do young people consider as some of the sexual risks for acquiring STIs/HIV?
2. What are the perceptions of young people towards HIV testing and counselling?
3. How do young people perceive the widely used HIV prevention models targeting them?
4. What could be the best /appropriate strategies for addressing psychosocial, reproductive health and STI/HIV vulnerabilities among young people in Kenya?

1.4 Study justification

A fundamental goal for HIV prevention is to change the behaviour that puts individuals at risk of infection (UNAIDS, 2008). Therefore the study examined structural and social concerns that shape or constrain individual's behaviour such as gender, age, policy, and power relations as these factors are likely to influence individual vulnerability to HIV.

The study gives a critical look into how society shapes and interprets youth sexuality as well as how young people themselves negotiate and engage in sexual activities. This study is simply therefore not only of public health concern but also one that has implications on gender and development milestones of young Kenyans. The study findings will therefore make additional value to HIV/AIDS prevention programs and relevant future studies that seek to challenge harmful social cultural behaviours that exacerbate HIV vulnerability among young people.

1.5 Study scope

The study was limited to young people aged 15-24 years –but gave emphasis to both male and female. In depth interviews were conducted through telephone thus not limited to any particular geographical region; however focus group discussions were only conducted in Nairobi due to budget limits to travel to other parts of the Kenya. However most questions that were in the FGD guide were also included in the in depth interviews and all these data has been triangulated.

1.6 Study limitations

This study has several limitations. Because of the sensitive nature of the study topic, findings are subject to social desirability bias. There is also the possibility of recall bias since respondents were expected to provide information on previous behaviours. However, most callers interviewed were very willing to provide further details even if they may have considered it to be out of their interest when calling the hotline.

Consent was gathered from all the sampled participants to be part of the study and counsellors were well trained to explore sensitive issues. Confidentiality was maintained, through coding of the data and instead of real names.

Incomplete calls or questionnaires have not been included in the analysis however; they have been indicated as a proportion of the total recorded forms. FGDs were conducted within natural groups where members were familiar with each other. In our experience, this type of setting provided a safe zone especially since the issues discussed were very sensitive and considering some group members were HIV positive. The study team ensured that the study subjects were constantly reminded and assured of confidentiality throughout the process (from proposal development to report writing).

CHAPTER TWO

LITERATURE REVIEW

This chapter contains reviewed literature based on local and international publications around HIV, sexual reproductive health and gender analysis of HIV risk perceptions and influencing factors among young people aged 15-24years. Furthermore, intensively use of the Kenya Demographic Health Survey -KDHS (2010), UNAIDS reports and local reports from NGO's and recent Ministry of Health policy documents. Most examples provided are selected as sub-themes which are context specific.

2.1.1 Trends and drivers of HIV epidemic in Kenya

Kenya's HIV prevalence has been declining in the last two decades, with national estimates in 1997-98 being 10% among the 15-49 age group according to Sentinel Surveillance, which declined to 6.7% (KDHS, 2003), and currently stands at 6.3% with an estimated 166,000 new infections annually (KNBS, 2010a). Gender disparities in HIV infection exist; overall HIV prevalence in women is 8.0% and 4.3% in men. This female-to-male ratio of 1.9 to 1 is higher than that found in most population-based studies in Africa (ibid).

The Kenyan epidemic is 'generalized' among the general population and is 'concentrated' in 'most at risk populations'² (MARPs) –such as men who have sex with men (MSM), sex workers (SW); injecting drug users (IDUs) and fishing communities (NASCO, 2007). In the general population, HIV is driven by unprotected casual sex, multiple concurrent partnerships, couple discordance, and low rates of male circumcision in some communities while MARPs register twice as high HIV prevalence and incident rates than the general population (KNBS, 2010a).

² In Kenya MARPS include sex workers, prison inmates and truckers, men who have sex with men, injecting drug users and fishing communities.

2.1.2 Young people in Kenya

Kenya is characterized by a youthful population with those aged 15-24 representing 21% of the total population (KNBS, 2010b). This has major social and demographic implications for health policies and systems which are critical aspects in guaranteeing the ability to exploit their full potential and contribute significantly to the development of the nation.

However, the emergence of HIV&AIDS epidemic has continued to threaten to reverse the previous gains towards improving the health and wellness status of this particular segment (UNAIDS, 2008). For instance, Kenya's country-level data shows that continued investment is needed for effective prevention and treatment strategies essential to protect adolescents' sexual and reproductive health; hence strategies must be tailored to the developmental needs of this age group and in well defined social contexts (NACC, 2006).

2.1 HIV among young people in Kenya

Global estimates indicate that 33 million people are living with HIV and 67% of them live in Sub-Saharan Africa (UNAIDS, 2008). Age-related heterogeneity in Kenya is evident with young women in the 15-19 age range being 3 times more likely to become infected with HIV than young men while women in the 20-24 age groups are more than 5.5 times likely to become infected. Among the Kenyan youth sexual debut is mostly higher in the age group 15 to 19 years, with less than 25% using protection during first time sex.

While condom promotion is not optimal and difficulties in promoting condom use within steady partnerships continue to exist, difficulties in promoting condoms to youth is even higher compounded by promulgation of abstinence virtues. Yet, empirical evidence is still lacking on the behaviour change by the youth and others to effectively adhere to abstinence (NACC, 2008).

Access to adolescent reproductive health services and the general lack of counselling, testing and treatment services aimed at youth, especially those who are already HIV positive continue to affect young people. This is further compounded by the cultural, religious and political influences which intersect to create norms and perceptions around youth sexuality in Kenya.

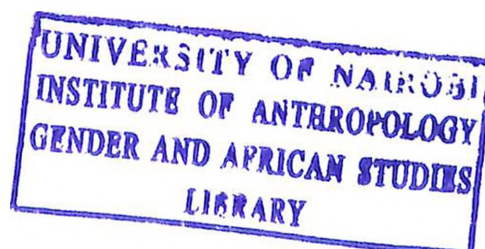
2.2 Stigma, discrimination and vulnerability to HIV

Stigma, discrimination and social marginalization are causes of HIV risk and vulnerability, and consequences of being HIV positive (UNAIDS, 2008). Mainly because human beings are inherently social animals, and their physical and psychological health is damaged when they are isolated and cut off from their social group (Jenkins & Sarkar, 2007). Stigmatizing attitudes to HIV and those most at risk of HIV infection derive from two principal sources.

The first is fear of infection, which has been a source of disease-related stigma through the ages. The second is negative, values-based assumptions about people living with HIV, which fuels prejudice and discrimination (ICRW, 2006).

HIV related stigma and discrimination undermines HIV prevention efforts by making people reluctant to be tested (Ford et al., 2004; Wolfe et al., 2006; Ma et al., 2007; Pulerwitz & Barker, 2008); or to seek out information about how to protect themselves from infection; and in some cases, reluctance to use condoms for fear of being identified with the disease or with marginalized parts of the population that are most heavily affected (Nyblade et al., 2003).

Fear of stigma and discrimination also makes both young and adult population living with HIV to less likely seek care and treatment, adhere to treatment, and disclose their HIV status to their sexual partners (White & Carr, 2005; Liu et al., 2006; Mills, 2006).



2.3 Gender, sex and sexuality

Kenya's total population as of 2009 was 38.6 million (KNBS, 2010b) characterized by a very youthful population aged 15-24 years; male 3,877,758 (48.8%) and female 4,066,888 (51.2%) most of them still undergoing a transition from childhood to adulthood. This transition carries profound significance for their current and future sexual and reproductive health and well-being (Lloyd, 2005). Gender and sexuality are significant factors in the sexual transmission of HIV and despite HIV being a biological entity responsive to medical interventions the epidemic continues to expand, largely due to the failure to tackle societal conditions that increases HIV risk and vulnerability (Mann, et al., 1996).

Aspects of development characterize adolescence sexual behaviour and risk which can vary by gender, ethnicity, geography, socioeconomic status as well as their relation to traditions and norms (Marston, et al., 2006). These social factors differ in their manifestation, intensity, and impact within Kenyan regions for example in rural areas or regarding girls with less education background being adversely affected (NAS COP, 2008; KNBS, 2010a).

The reality for sexual abuse or coercion cannot be ignored especially when dealing with young people. For instance, age differences between heterosexual partners' such as younger girl with an older male partner and gender differences in sexual norms as well as early marriage for girls could all heighten the possibility of sexual coercion. Moreover, in much of the developing world, some young people experience pressure to become sex workers as the only available option for contributing to the food and shelter needs of their family (WHO, 2002). Those who become sex workers are at heightened risk of STIs, pregnancy and violence but they may also avoid health care for fear of being judged or stigmatized.

In Kenya, gender disparities in different sectors, such as health and education amongst boys and girls continue to be profound. In low and middle income countries, girls are 19% less likely than boys to be in school and girl's education has been associated with vulnerabilities to HIV acquisition (UNDP, 2007; Hargreaves, et al. 2006). Evidently it has been shown that girls who complete primary education are more than twice as likely to use condoms, while girls who finish secondary education are between four and seven times more likely to use condoms, and are less likely to be infected with HIV (Hargreaves, et al., 2006). Unfortunately also some Kenyan girls they have systematically been denied equal educational opportunities especially in communities where early marriages and female genital mutilation practices still exist.

In the past years, HIV prevalence has increased significantly among Kenyans with no education from 3.9% in 2003 to 8.2% in 2007 (NASCOP, 2007). Such trends could indicate that those who are most vulnerable to HIV infection may lack the education and resources to protect themselves from infection. Young Kenyans who have no education show much lower levels of knowledge of HIV/AIDS prevention methods than those with some education (KNBS, 2010a). However, early sexual debut among Kenyan youth compounded with less than 25% condom use during first sex are all factors that influence the transmission and spread of HIV in Kenya (NASCOP, 2007; KNBS, 2010a).

Traditional expectations related to masculinity and male sexual behaviour also increase the risk of infection among men and the harmful nature of some gender norms underscores the importance of involving men and boys in any effort towards behaviour change (ICRW, 2007). Typical male roles that call for men and boys to be tough, aggressive, sexually dominant, and risk taking are often associated with behaviours that increase men's risk of HIV infection. Such behaviours include a high number of sexual partners, use of drugs or alcohol, and refusal to seek medical care for sexually transmitted infections (ICRW, 2007; WHO, 2007).

2.3.1 Biological differences in acquisition and transmission of HIV infection

Young women as well as women in general are more biologically vulnerable to HIV infection than men as stated by Padian et al. (1987). As the receptive sexual partner in heterosexual intercourse, women are at greater risk than men of acquiring HIV. Royce et al. (1997) associated receptive risk with unequal exchange in genital secretions. Padian and colleagues have also documented that the risk of acquiring HIV from a single act of intercourse is at least 8 times greater from men to women than from women to men. The soft tissue in the female reproductive tract tears easily producing a transmission route for the virus.

Additionally, vaginal tissue absorbs fluids more easily including sperm, which has a higher concentration of the HIV virus than female vaginal secretions and may remain in the vagina for hours following intercourse (UNAIDS, 1998). Wira et al. (2008) also found that HIV infection in women was increased during certain phases of menstrual cycles (7-10 days) following ovulation because of hormonal interactions with the immune system.

Furthermore, women are more likely than men to have untreated STIs that increase the risk of HIV-infection. This is because women tend to wait longer than men before seeking treatment, both because of the asymptomatic nature of STIs in women and the perceived shame or fear of visiting a doctor (WHO, 1998). While there is a close correlation between the presence of STIs and HIV transmission the Kenyan national HIV reporting tool, do not record treatment of STIs as a prevention intervention (NACC, 2008) creating a missing link towards prevention both in men and women. Women's increased biological vulnerability is compounded by their subordinate social status. Hence a woman is more likely to have sexual contact even though she does not want to, whether she is raped or because she lacks the power to refuse her partner's demands (forced sex). When the vagina is not lubricated the tissue tears more easily increasing women's risk of exposure to HIV.

2.4 Theoretical approach

This study was guided by constructs from social cognitive model and in particular—the Health Belief Model (HBM) to explore factors that influence youth sexual and reproductive health behavioural outcomes. Developed by Rosenstock, (1966) the HBM was used to study and promote the uptake of health services and subsequent amendments have so far been made.

The HBM is a psychological model which explains and predicts health behaviours by focusing on the attitudes and beliefs of individuals (Strecher & Rosenstock, 1997): The theory is used to explain the lack of public participation in health screening and prevention programmes (e.g., a free and conveniently located HIV testing /screening project). Thus this theory has been adapted to explore young people’s health behaviours, including sexual risk behaviours, social constructs influences and how they impact or fuel HIV/AIDS transmission.

Based on the foundation that there exist factors that influence the likelihood that a young person will adopt a recommended preventive health action and in this particular study, these factors included, but were not limited to:

1. That young people must feel personally threatened by the HIV virus that causes AIDS i.e. they must feel personally susceptible to HIV infection or the AIDS disease with serious or severe consequences.
2. Secondly they must believe that the benefits of taking the preventive action outweigh the perceived barriers to (and/or costs of) preventive action.
3. Perceived efficacy –that young people have the ability to successfully adopt to a desired behavior
4. Cues to action –these are the external influences promoting the desired behavior, may include information provided or sought, reminders by powerful others, persuasive communications and personal experiences.

Refer to the diagrammatic presentation of the above concepts in figure 1 below.

2.4.1 The Conceptual Framework

Developed by the researcher, the theoretical framework is based on the works of Rosenstock, (1966); Becker, (1974); Strecher & Rosenstock, (1997).

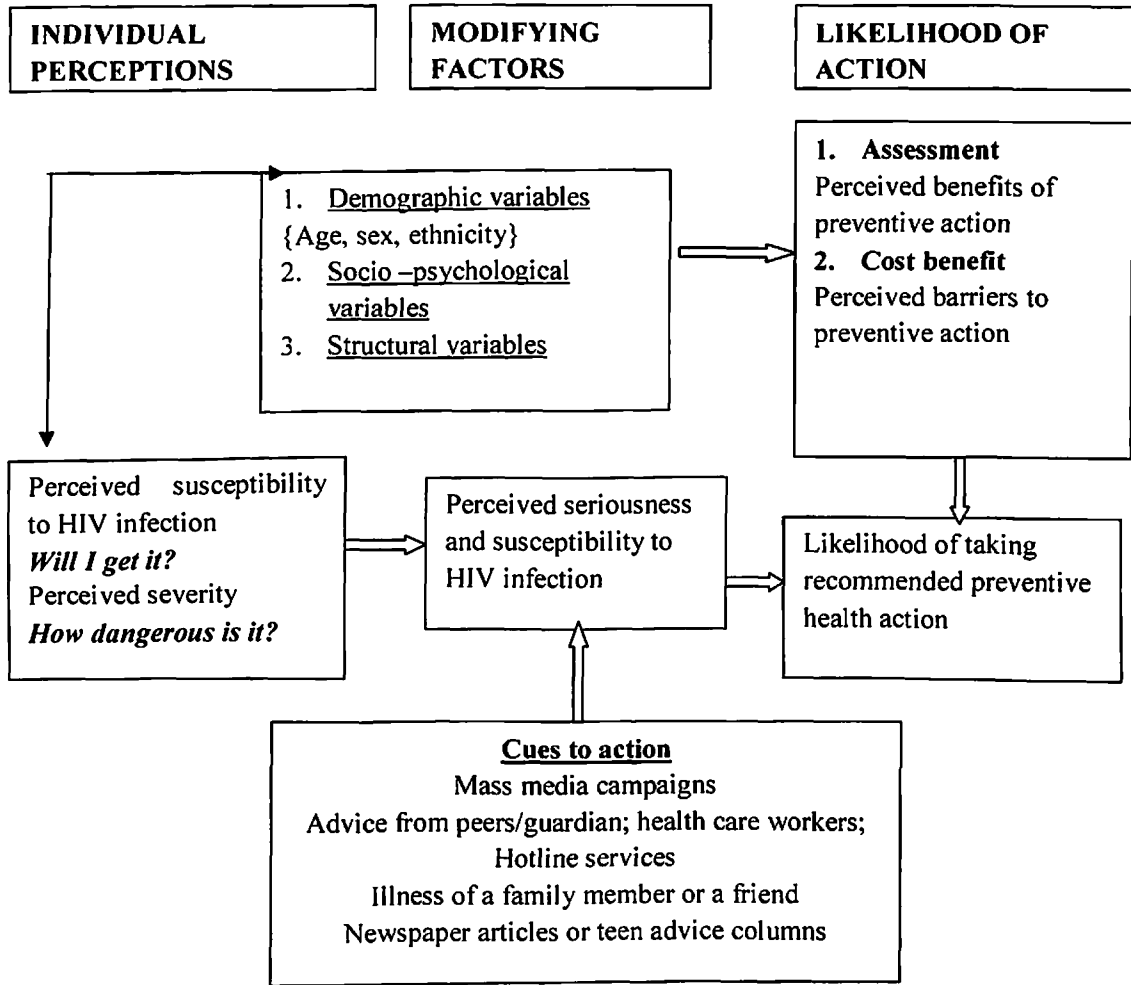


Figure 1-Theoretical Framework

CHAPTER THREE

METHODOLOGY

This chapter deals with the procedures that were used in carrying out the study. It involves a description of the research site, study population, sample population and sampling methods, methods of data collection and data analysis, and presentation of the findings. The problems encountered in the field and solutions are presented.

Kenya's country profile

Kenya lies on the equator in Eastern Africa with a total area of 582,650 square kilometres bordered by Ethiopia (north), Somalia (northeast), and Tanzania (south), Uganda and Lake Victoria (west), Sudan (northwest) and on the east by the Indian Ocean as shown in figure 1. As of 2009, the country's population was projected to reach 38.6 million and administratively Kenya is divided into 8 provinces and 158 districts (KNBS, 2010b).

It is estimated that youth aged 10 – 24 years account to nearly 31% of total population; this is about 11,000,000 young people living in Kenya as of 2009.



Figure 2 Map of Kenya

3.1 Study type

To meet the study objectives, a qualitative exploratory study was carried out to provide insight and comprehension related to experiences of young people aged 15-24 years in Kenya including their perceived risk for HIV acquisition and transmission. Four key informants from youth serving organisations and ministry of health provided an insight into accessibility of youth friendly services in Kenya. Findings are presented in quotations, graphs, tables of frequency and percentages across the report.

3.2 Study site

All interviews were conducted in Nairobi, which is the capital city of Kenya and an urban centre with an estimated 3.2 million occupants (Kenya National Bureau of Statistics, 2010). While the hotline is located in Nairobi, calls are received from across Kenya through the safaricom and telecom lines.

A further description of the study population and site: Located in Nairobi, the core functions of the “**One2One Youth Hotline**” is to provide youth with credible source of information creating a forum for open discussion through which young people can explore HIV/AIDS concerns, sexuality, reproductive health choices and options confidential and free of charge.

Group A: “**Pamoja Youth Support Group**” is a group of HIV positive young people aged 15-24years. The group meets every once a month at LVCT HIV specialized clinic in Hurlingham, Nairobi. The group provides targeted information and psychosocial support. A trained counsellor facilitates this group and a peer to peer approach is adopted.

Group B: “**Youth Peer Education Network (Y-PEER)**” is a groundbreaking and comprehensive youth-to-youth initiative formed by a group of youth representatives from different NGOs in Nairobi with branches in other regions of Kenya. Y-PEER members advocate for youths’ sexual and reproductive health rights including HIV/AIDS programming in Kenya.

Key informants: Four different individuals from diverse backgrounds were interviewed based on their expertise and experiences of working with young people. Those interviewed were two managers in youth serving organisations and 2 officials from the Ministry of Health. In-depth interviews were conducted to seek information on the availability and gaps in providing effective reproductive health services including HIV related services to young people in Kenya. All key informant interviews were conducted in Nairobi. Interviewed key informants were two male and two female respondents.

3.2 Research design

Specific -Objective	Issues Explored	Methods	Respondents
1. To explore perceived risk of STI/HIV among youth aged 15-24years in Kenya.	1. What young people consider as risk factors for acquiring HIV/STI	In-depth interviews	Individual callers from One2One hotline
	2. Safer sex definitions, knowledge and practice. <ul style="list-style-type: none"> ➤ Perceived safer sex. ➤ Reasons for or not practising safe sex. ➤ Commonly used protection /barrier methods. 3. Types of sexual behaviours practiced 4. Disclosure of sexual behaviours to current & potential partners and health care workers. <ul style="list-style-type: none"> ➤ Fear or stigma ➤ Health seeking behaviour 	FGD	Total of 2 FGDs with young people. 6-12pax
2. To describe social cultural and economical factors that influence STI/HIV vulnerability among young people aged 15-24years.	Attitudes towards pre-marital sex. Taboo nature of pre-marital sex. Social norms and gender roles.	In-depth interviews	Individual callers from One2One hotline
	Contextual concerns <ul style="list-style-type: none"> ➤ Transactional and cross generational sex. ➤ Drugs /alcohol use. ➤ Forced marriages. ➤ Gender based violence and rape 	FGD	2 FGDs with young people. Group 1= 7 participants Group 2=10 participants
3. To determine the extent to which formal and informal sexual and reproductive health services address the needs of young people and conditions in which they operate.	Availability of appropriate Behaviour Change Communication strategies <ul style="list-style-type: none"> ➤ Availability of prevention information and methods-such as condoms/dental dams etc. 	FGD	2 FGDs with young people. Group 1= 7 participants Group 2=10 participants
	Availability of appropriate youth friendly and non-discriminatory health services and policies.	Key Informant interviews	4 Key informants – health care workers, relevant NGO program managers, staff at the youth organizations were sampled Responses collected from In-depth interviews, FGDs and key informants interviews
	Access to family and psychosocial support networks.		
	Access to targeted HIV/AIDS prevention, treatment and care programmes.		
	Health care providers' attitudes and perceptions towards youth sexuality concerns.		
	Training or skills health facility /programs working with young people.		

3.3 Study population, sample population and sampling procedure

The study is both qualitative and quantitative. Sampling was done purposively for all the respondents. 100 questionnaires were filled out and provide most of the quantitative data, while qualitative data is derived from the FGDs and key informant interviews. Data was collected through identification and selection of Liverpool VCT, Care and Treatment (LVCT) One2One Youth Toll Free Hotline as a possible and cheaper means of data collection.

One2One youth hotline is accessible country wide and the services is dedicated to provide young people with information and service referral for HIV and other reproductive health concerns including psychosocial support and career counselling options. The hotline served as the main source of primary data. Data was collected between November–December 2010 from the hotline callers aged 15-24 years.

A total of 100 clients aged 15-24 years were interviewed. Twenty other young people were interviewed from the two earlier mentioned organized youth groups. Of these groups, one was exclusively for HIV positive youth. Four key informants from youth serving organisation and ministry of health officials from Nairobi were interviewed.

A supplement questionnaire (attached in appendix 1) was developed to address the objectives of this study along with the currently used standard data collection form at the hotline. In addition two focus group discussions with at least a minimum of six per group (both HIV positive and negative youth) were conducted in Nairobi using a support group and an organized youth group.

Informed consent was sought and confidentiality emphasised throughout the study period and after obtaining the results. Using snowball technique, in-depth interviews with a minimum of five key informants working with youth serving organisations or Ministry of Health officials were conducted.

3.4 Data collection methods

3.4.1 Telephone in -depth interviews

Mobile phone data collection methods are rapidly becoming abundant and popular especially in market research. On the other hand, in-depth interviews are ideal for investigating personal, sensitive, or confidential information which is unsuitable to be covered in a group setting and are the best method for seeking individual interpretations and responses.

In total 100 questionnaires from every 10th caller who consented for inclusion in the study were filled from telephone based in-depth interviews.

In-depth interviews cover five broad areas:

- Background characteristics of the callers
- Reasons for calling the hotline
- Individual attitudes towards HIV/STI and how it influences young people risk taking behaviours
- Attitudes towards youth sexuality and experiences within the social, cultural and economic contexts
- Young people's perceptions and attitudes of healthcare providers towards young people when seeking STI/HIV or other sexual reproductive services.

3.4.2 Focus group discussion

Focus group discussions (FGD) are useful for exploring peoples' knowledge and experiences. FGDs examine not only what people think but how they think and why they think the way they do (Kitzinger, 1994). Two FGDs were conducted with a minimum of six participants and not exceeding 12 in the group. Group confidentiality was sought, although this type of confidentiality cannot be fully guaranteed the interviews reemphasized its importance. The FGD guide was flexible and acted as a follow-up to some issues raised on individual telephone in-depth interviews.

3.4.3 Key informant interviews

Interviews with people from diverse backgrounds of stakeholders and opinions were conducted in order to ask in-depth/probing questions around youth HIV/ sexuality programming. A minimum of four key informants was sort from managers in youth serving organisations and Ministry of Health officials in relation to availability and gaps in providing effective HIV/reproductive health services to youth in Kenya.

3.5 Data processing and analysis

All interviews and filled questionnaires (data forms) were recorded/ entered to Epi-Info computer software. Focus group discussions were tape-recorded with subject's consent and subsequently transcribed after the sessions manually. Notes were taken during each session and used to contextualize the analyses. Transcripts were reviewed for completeness and accuracy – “cleaned” – and major themes and subthemes identified. Further content analysis was allowed for the identification of mutually exclusive categories and comparative analyses. Epi-Info data analysis package was used.

3.6 Ethical considerations

The study ensured confidentiality was maintained. Individual's details considered private were kept as such and un-disclosed. Codes were used as identifiers both in data collection and reporting to avoid discriminating against or stigmatizing the One2One callers; the Pamoja Youth Support Group members and the Y-PEER. Counsellors assisting in data collection were encouraged to be non judgemental throughout the process.

Ethical clearance was sort from LVCT Research Review Committee prior to the commencement of the study. The study proposal was defended before the IAGAS faculty members at the University of Nairobi who provided the go ahead for data collection.

3.7 Quality assurance and dissemination of results

Research instruments were pre-tested and the process served as a trial run that allowed the identification of potential problems in the proposed study design. The pre-test exercise enabled necessary revisions of the tools, methods and logistics in data collection before actual fieldwork hence providing insight of how analyses were to be conducted. Annex 4 shows the key elements that were assessed during the pre-test process. Data validity was maximized through the careful selection of various sampling methods and techniques applied on different aspects of the study. Additional refresher training for hotline counsellors and pre-testing of the data collection instruments ensured internal validity was achieved and maintained.

All study guides were peer reviewed by those familiar with the target population before administration. The proposal developed for this study was defended in the presence of faculty members, lecturers and other student critically evaluating the methodology and study objectives. This provided insight for further revision on the proposal. Triangulation of data was achieved by categorizing different variables, study units and methods as stipulated above. Cross checking of responses and recording of actual quotes from participants was emphasized while analyzing and reporting data. Supportive and peer supervision among counsellors was encouraged and conducted during the data collection period. Study results were disseminated to the study population using the One2One website and through this project report

As part of the dissemination plan, a summary of findings and recommendations were developed and adapted to the level of understanding and interests of different audiences. It is also anticipated that the study results will be used to inform policy and practice among the key stake holders. Moreover, the analysis of the hotline callers characteristic data will give LVCT an indication of how the hotline services are perceived (positively) by the young people; which could then be used to source for more funds to continue supporting the initiative.

CHAPTER FOUR

FACTORS INFLUENCING HIV RISK BEHAVIOURS AMONG YOUNG PEOPLE

This chapter presents and discusses data –collected from in-depth telephone interviews, focus group discussions and key informants interviews. Analysis are divided into three sections and presented in line with a specific objective or a research question. This is then linked to the corresponding data collection method used. The data presented gives:

Section I:

- Background characteristics of the callers, sexual risk behaviours and perceived HIV risk.
- Reasons for calling the hotline
- Condom use and perceived barriers to condom use.

Section II:

- Background characteristic of the FGD respondents
- Individual attitudes towards HIV/STI and how it influences their risk taking behaviours
- Attitudes towards youth sexuality and experiences within social, cultural and economic contexts
- Young people's perceptions and attitudes towards healthcare providers when seeking STI/HIV or other sexual reproductive health services.

Section III:

- Key informants' interviews provide a critical look at the availability and gaps in providing effective AIDS response and reproductive health services to Kenyan youth.

4.1 Section I: Quantitative Analysis of Hotline Callers Questionnaire

Data was drawn from One2One youth hotline callers. One hundred questionnaires were filled out in the period from March – April 2011. Fifty four were male (54%) and 46 female (46%) with a range of 15-24years. The majority of the callers were from the rift valley province (71%) followed by province Nyanza (21%) and Nairobi (18%) respectively.

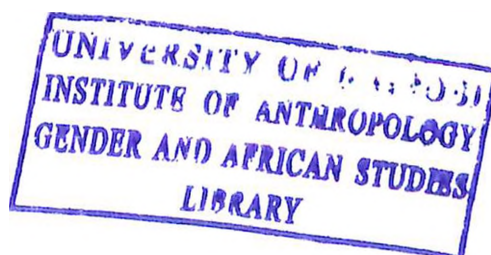
Most of the respondents were first time callers (65%) which meant that they had never used the hotline services before. 28 of the 46 female callers had called the hotline before. Of these 13 said they had called for a different reason while 5 said they had called for the same reason when they had lastly called the hotline. 37 male were repeat callers and 11 of them called for a different reason.

Forty five respondents (45) said they had received an HIV test within <3months. Of these 26 were male and 19 female. The highest category of female to have had an HIV test in < 3month were those with a post secondary education (15 out of 19) and for male the highest category to have had an HIV test in <3months were those who had completed secondary education (13 out of 19).

Overall 22 out of the 45 respondents had post secondary education compared to only 1 respondent who had completed primary school. There was an indication of the higher the level of education the more likely the respondents were to get an HIV test. Other demographics and reasons for calling can be summarised below as:

Table 4.1: Demographic characteristics and reasons for calling the hotline

Characteristic	Number*of respondents	Percentage
Age		
▪ 15-19	76/100	76%
▪ 20-24	24 /100	24%
Educations level		
▪ Pri. Complete	5/100	50%
▪ Sec. Complete	35/100	35%
▪ Some Sec	12/100	12%
▪ Post Sec.	48/100	48%
Occupation		
▪ Employed	15/100	15%
▪ Self employed	8/100	8%
▪ Student	44/100	44%
▪ Unemployed	33/100	33%
Ever called the hotline before		
▪ Yes	65/100	65%
▪ No	35 /100	35%
Reasons for calling		
▪ Interpersonal relationship	62/82	75.6%
▪ Took a sexual risk	20/82	24.4%
▪ HIV /AIDS information	65/90	72.2%
▪ STI concerns	45/100	45%
▪ Pregnancy and Birth Control	24/100	24%
Where calling from		
▪ Rift valley	50/100	50%
▪ Nairobi	35/100	35%
▪ Eastern	12/100	12%
▪ Nyanza	48/100	48%
Caller referred to		
▪ Ongoing counselling	15/100	15%
▪ Family planning	8/100	8%
▪ HIV/VCT Services	44/100	44%
▪ Other outpatient services	33/100	33%



4.1.1 Gender Differences: Sexual Risk Behaviours and Perceived Risk for Acquiring HIV

Perception of personal susceptibility to HIV was quite low. Only about one participant in ten perceived the risk of acquiring HIV infection from one unprotected sexual encounter to be higher than 50%. Although close to over 50% of the participants perceived HIV as a problem in their region requiring urgent responses. Furthermore, the perceived effectiveness of using condoms to prevent HIV was also relatively high. Most of the participants said they would use condoms any time they had sex. However, some girls said it was difficult for them to insist on their boyfriends to use condom. This was seen as if they didn't trust them, so they choose to use a birth control instead.

But both male and female respondents said they stopped using condoms once they were both tested or they considered themselves to be in a serious relationship. Despite this, at least 20% of the participants said they felt that talking about condoms especially with their partners and friends it's a bit embarrassing but that didn't stop them from using condoms.

From the hotline callers sample of those sexually active (n=82), it was noted that 75% of callers had their first sexual encounter at the age of 15-19 and 24.4 % at the age 20-24 years. Thus most young people will have had their first sexual activity while in secondary school. Within the same sample, 84% of the respondents felt that they were at risk of contracting HIV based on their previous risky sexual practices, an aspect that instilled fear of seeking VCT services. Some of the risk factors for engaging in unsafe sexual activities among the callers were associated to the use of alcohol and substance abuse and partner characteristics such as steady versus non steady partner.

Further observed was that peer pressure played a significant role in participant's sexual behaviours. It was noted that most male participants were more concerned over sexual heroism and competed as to who would have the highest number of girls attached to them. Pornographic materials were also mentioned as an influencing factor. Most of it was supplied by friends and watched during parties. This was seen as catalysts towards engaging in sexual activities although male participants were more likely to report watching pornographic than female respondents.

The table below represents the age at which the participants reported having had sex, condom use among those who reported engaging in sexual intercourse and their perceived risk to HIV infection.

Table 4.2: Age of sexual debut, condom use, and perceived susceptibility to HIV

Characteristic	Number*of respondents	Percentage
Age at sexual debut		
▪ 15-19 years	62/82	75.6%
▪ 20-24 years	20/82	24.4%
Condom use		
▪ Used condom first vaginal sex	56/82	68.2%
▪ Used condom most recent sex	76/82	92.6%
▪ Use condom most or all the times	79/82	96.3%
Perceived benefits of using condoms		
▪ Condoms prevent HIV	86/100	86%
▪ Condoms prevent pregnancy	88/100	88%
Perceived barriers to condom use		
▪ Condoms often break	25/100	25%
▪ Condoms difficult to use	31/100	31%
▪ Condoms too expensive	30/100	30%
▪ Talking about condoms is embarrassing	20/100	20%
Substance use		
▪ Lifetime use of at least one substance	43/74	58.1%
▪ Lifetime use of at least 2 or more substances	47/74	63.5%
Perceived susceptibility to HIV		
▪ Chance of getting HIV = 50% or less	95/100	95%
▪ Chance of getting HIV > 50%	5/100	5%

*Denominator may vary due to missing values

4.1. 2 Young people perception towards HIV testing and counselling

Most of the callers had been tested before as recent as 3 months before calling the hotline. This indicates a higher uptake of HIV testing services by young people. Engaging in unsafe sexual acts was mostly reported as the reason why most of the callers were tested for HIV in the first instance. Most of those who received their HIV test results reported as to have adopted safer sex. This is reflected as shown above through the high numbers of those using condoms every time they have sex.

Participants also mentioned that it was embarrassing if they were known to have never had an HIV test. There seems to a lot of peer pressure among young people to ‘chanuka’ -a slag phrase meaning ‘*get sharp*’ used to refer taking an HIV test and control of one’s life. It seemed as though it was cool to have had an HIV test and this could be attributed to the ongoing HIV campaigns that portray taking an HIV test as taking control of your life. This study did not however measure whether this move influenced a sustained positive behaviour change. Hence recommends further research.

Table 4.3: HIV trends and reasons for testing

	Number of respondents	Percentage
Ever tested for HIV	75/100	75%
▪ Yes	25/100	25%
▪ No		
Last time tested for HIV	45/76	59.2%
▪ <3 months	24/76	31.5%
▪ 3 - 11 months	6/76	7.8%
▪ 1 - 5 yrs	1/76	1.3%
▪ > 5 yrs		
Reasons for HIV testing	75/100	75%
▪ Had unprotected sex	25/100	25%
▪ Condom broke	45/76	59.2%
▪ I think it’s useful to know own status	24/76	31.5%
▪ Peer pressure		

*Denominator may vary due to missing values

4.2 Section II: Analysis of the Focus Group Discussion

Two focus group discussion (FGDs) were conducted. Group A comprised of youth representatives' from different NGO's in Nairobi. While group B comprised of HIV positive youth attending a support group in Nairobi. In total 20 participants participated in the FGDs.

The table below shows a summary of each group by age and sex.

Table 4.4: Characteristics of the Focus Group Participants

GROUP A			GROUP B		
	Age	Gender		Age	Gender
1.	19	Male	1.	21	Male
2.	18	Male	2.	23	Female
3.	16	Male	3.	23	Male
4.	21	Female	4.	21	Male
5.	24	Female	5.	19	Male
6.	25	Female	6.	22	Female
7.	25	Female	7.	22	Female
Total Male	4		Total Male	4	
Total Female	3		Total Female	3	

4.2.1 Individual attitudes towards HIV: influence on HIV risk taking behaviours

Most of the participants mentioned that they would start most relationships with a caution, however, once they felt that they were familiar with someone and or they had been in a relationship, which could be as less than a year then down the line they stopped using condoms. Some would ask their sexual partners to get tested while other reported that it just happened and they could continue from there having unprotected sex until they had a reason to suspect their partners and then they would get tested for HIV.

Participants expressed that they would rarely engage in sex with people if they didn't know their HIV status and if it happened they cited peer pressure and 'bad company' and seen as uncool and foolish in this era where testing services are readily available.

'Lack of use of condoms simply because you think that you have known this person or because you have dated for a while –but then if they are not tested for HIV, both of you are foolish and taking a big huge risk!' Female 22 years-Nairobi.

Across all discussions and interviews it's evident that young people rate condom use highly with very high condom utilization among this age group no matter the reason.

.....Of course most people don't want to have sex with condoms. Why eat sweets with wrappers? Anyway am not one of those people..I always use a condom-I never trust girls that much; and also because I have more than one girlfriend...chuckles...male 20 years.

The issue of exchanging sex for money came up constantly. This was seen as one of the things that puts girls at increased risk of HIV and other diseases. However, it was shocking to realize that most of the participants considered prostitution not a big deal if one chose to do so out of their 'own' choice. However, 'street' prostitution such as those in Koinage and river road brothels was considered risky and non-lucrative compared to tourism sex. Some male participants in the group also jokingly said they would consider having a sugar mummy if she was cute and smart enough and with lots of cash!

Originally I come from the coast. There is a lot of tourist and most people want to 'hook up' with them. I know my friends who started having sex with tourists at age 14 and they got a lot of money than the older girls. Tourists like 'small girls'. But you can't blame me or anyone who has sex for money; most come from poor backgrounds and never went school. But you have to know that it's only girls who sleep with tourists –even boys, especially sleep with old women and some sleep with other men too. Female 18 years.

Trust among sexual partners was seen to play a huge role for the couples to stay safe and free of infections. Arguments in this case were from a very moralistic point of view with participants reinforcing that it was important to people to be genuine about their HIV status and sexual experiences to avoid misleading us. More so participants seemed to encourage each other that it was everyone's responsibility to also take care of themselves.

Sentiments expressed about dishonesty in relationships

Not opening to your sexual partners –being truthful about your previous sex life and if you have any disease is very wrong and an evil thing to do. Most young girls pretend they have never had sex before. They want us guys to think they are innocent and yet she knows too much about sex. Where did she learn this from? I think it's just fair for people to open up and not put others at risk. Male 24 years.

Effects of non-disclosure of HIV status among sexual partners

I went for a HIV test so as to get the Gje wrist band, that's when I knew I was HIV positive. The worst part is that I know the person who infected me. She was my neighbour and I guess she already knew her HIV status and still let me have unprotected sex with her! I really hate her! I had planned to really mess her up, but my brother talked me out of it. My brother and mother are very supportive, my brother counselled me in the initial days, and they have walked with me all along. Male 19 years.

4.2.2 Attitudes towards youth sexuality

Analyses are hereby made from the participants' experiences within social, cultural and economic contexts. Financial dependence or precariousness of some youth was mentioned as key factor that led to exchange of sex for money, latest /fancy mobile phones and other digital equipments, food, clothing and shelter. A lack of open discussion about sex among family members and the wider community was seen as a barrier to the information and knowledge support needed by both HIV negative and positive youth. Although sex education programs have been implemented to tackle information barrier, study participants felt that it was not adequate and they wished their parents would pay more attention to the physical and emotional developments rather than leave it completely to those running health programs for youth.

Some barrier for accessing RH and HIV services were mentioned. Among them were fears of serious implications of testing HIV positive, judgemental attitudes for engaging in sexual activities, fear of stigma if found to be suffering from an STI or becoming pregnant. Teenage mothers described how they are shunned by the society and branded as failures. Teenage mothers suffered double stigma as some of them dropped out of school while their male counterparts went about to finish school and they didn't have to take any responsibility for their actions.

Other sentiments of struggles were expressed by some HIV positive youth and one openly gay man who talked about their struggles with stigma and discrimination. They narrated how sometimes they were forced to move away from one residential place to another for security reasons. Other factors that seemed to exacerbate stigma directed towards them were associated with the societal disapproval of youth sexual activity. Such frustrations led to non-disclosure to parents and peers for fear of rejection and also led to low self-esteem and hopelessness about the future for those affected.

Social stigma and discrimination experienced by HIV positive youth

I was ailing from TB and the health care worker suggested that I get an HIV test. After undergoing a HIV test I was found to be positive, I was in denial for 1 week then I decided to go to another VCT centre for another test and the results were the same! I was disappointed with myself and very scared. However, I got support from my friend who is HIV positive; I disclosed my HIV status to my step mother whom I thought I could trust. Unfortunately she didn't keep her word. She was the one spreading news to everyone that I was HIV positive. This came as a shock as I didn't want everyone to know. But I only noticed when people started treating me differently and speaking behind my back. I went into depression for a very long time until I joined the support group. Male 20 yrs old.

4.2.3 Young people attitudes towards health care providers

A lot of participants felt that services providers felt and acted as though young people were not supposed to be having sex. Yet, the reality is the opposite and health care workers should work on their non verbal and judgemental attitudes towards young people. Participants also lamented that most of programmes that were supposed to provide youth friendly services were directly manned by older people, yet there are very highly qualified young people who can provide peer lead services and manage such programmes. However, the sentiments were very different and positive among HIV positive youth. Most of them felt that the service providers they are in contact with are very supportive and understanding.

I was tested together with my aunt during the door to door testing in our home compound, my results turned out to be positive I trusted my aunt and disclosed my status to her unfortunately she was the one who came to my area of employment to disclose to everyone about my status, for my parents they are not aware that I am HIV positive. The door to door counsellors were very supportive to me. Female 18 years.

4.3 Section III: Analysis of Key Informant Interviews

4.1.3 Characteristics of the Key Informants'

A minimum of four (2 female and 2 male) key informants were interviewed. Two are managers in youth serving organisations and 2 are Ministry of Health officials. The four KI were interviewed in relation to availability and gaps in providing effective HIV and reproductive health services to Kenyan youth. Analyses of all the four interviews are combined and grouped into the themes as described below.

Lack of adequate funding: All the four key informants lamented about lack of adequate funding towards youth programming. For example only 4% of the total AIDS budget being set aside for youth programs. Whereas there have been efforts to establish counselling and testing (CT) and RH sites across the country, their distribution is skewed. For instance 60% of CT sites are in the urban and semi-urban areas where only 20-30% of the population live, while only 40% in rural Kenya where 70-80% of the population lives. This was seen to create a very big challenging in reaching out to rural youth who were considered more vulnerable. Yet the national HTC target for young people was 5 million by end of 2010 which narrowly missed the mark.

The success of the HTC and RH services was seen to inherently be linked to the availability of commodities. However, the KI complained of regular stock outs which affected services and caused inconveniences to their clients. They urged the DRH, NASCOP and NACC to ensure that national procurements systems are effective for optimal utilization of services.

Some commodities are just laying at the Kenya Medical Supplies Agency distribution stores, for lack of transport. The commodities are likely to expire before they reach to the health facilities. Something has been be done and done quickly! That is a lot of money going into waste!

Referral services for young people seem to be a challenge for most health care providers. Particular emphasis was placed on the lack of a clear referral directory in most health facilities. Another challenge is the lack of standardized delivery of youth friendly services, with different organisations having varying models that are sometimes confusing to young people but also leading to duplication of services which was considered ineffective. While the KI interviewed stressed on the fact that their staff had been trained well to deal with youth related concerns, they valued their organisations as exceptional and feared that there were many organisations that did not train their staff to effectively deliver youth friendly services.

Although data collection for HIV and RH has significantly improved, there is still difficulties in ensuring that organisations and the government continuously analysis accurate disaggregation of 15-24 year olds. This will provide a much better situation on what is happening and hence design appropriate interventions. There exist no quality control and assurance approaches especially with all the peer educations manuals out in use. Thus, quality assurance for service delivery through evaluation of protocols and procedure, systems and client level need to be embedded in all YFS.

'The MoH has already developed information charts and YFS guidelines but this haven't been revised in a while. And even that, their distribution has not reached many providers on the ground. So how then are we expected to deliver quality services?'

DISCUSSIONS SUMMARY

HIV prevention interventions targeting the youth are few and under-resourced accounting for less than 4% of all HIV resources. Uptake of HIV treatment services is minimal with limited access to sexuality, reproductive health information and peer-led friendly services. Various cultural and socioeconomic factors are easily seen to be responsible for sexual risk taking behaviours among young people such as sexual relationships involving multiple and older partners both of which increase risk of infection. Such notions are also socially supported by widespread unchallenged belief that males are biologically programmed to need sexual relations regularly with more than one woman and often concurrently.

However, men and women's sexual behaviours are judged differently. It seemed culturally men are allowed to have more than one partner but in case of women they are branded as 'loose or sex workers'. Group discussions clearly showed that relatively young and poor girls (and to a lesser extent men) are induced into taking more than one sexual partner concurrently, as this is one of the only options available to them to secure basic necessities or luxurious life styles.

Barriers associated with stigma and discrimination exists, particularly in relation to young people at high risk of infection. Most at risk youth include men who have sex with men, sex workers and HIV positive youth. Stigma has driven them underground often preventing them from accessing HIV services. There is also limited services targeted towards these groups and those that exist are far in between and mainly concentrated in main cities. Training of health care workers to provide youth friendly services is called for, but also ensuring there are no stock outs of essential medicines such as those for family planning or other commodities. HIV services for HIV positive youth should also include reproductive health components which seem inadequate and supported disclosure for HIV especially to parents encouraged. This could help enhance their social support but also improve adherence to ARVs especially for those taking medication in secret or hiding.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Young people in Kenya are exposed to HIV infection in different ways depending on geographic location, age, sex and to some extent level of education. For instance, most participants in the focus group discussions acknowledged that being college/university environment provides them with space and freedom. The distance from parents offers great opportunities to explore a different life away from home and watchful eye of parents. This includes experimenting with alcohol as well as engaging in high-risk behaviour, including unsafe sex and multiple partnerships. Most respondents gave an excuse citing that they were still in their developmental stages; they wanted to exercise their freedom while they are away from home.

Therefore a clear understanding of the situation of young people and their needs is required to design and successfully implement interventions to stem the tide of infections among young people. Without this information, the scale of the response required, the focus and relative urgency of the interventions will remain unknown.

Providing access to youth-friendly health services is an integral part of the national prevention programme. The main services necessary to prevent HIV and other STIs include providing access to information, condoms and access to counselling and testing, treatment and care for STIs and HIV/AIDS. However, access to services remains insufficient. Interviews with KI revealed young people's access to effective health services is lower than that of adults, and this is particularly true for adolescents.

Young people living with HIV relented how difficult it is for them to disclose their HIV status for fear of rejection, blame and abandonment. Yet, limited programmes targeting them exist posing a major challenge in responding to their needs.

Insufficient knowledge and information: An important but not sufficient, foundation for any prevention effort aimed at young people is to provide them with basic information on how to protect themselves and their partners from acquiring HIV and other STIs. Although significant progress has been achieved during the past decade, misconceptions about HIV and AIDS are widespread especially in rural areas. These vary from one culture to another, and specific rumours gain credibility among young whose risk of perception is low despite the knowledge of HIV. For example, participants from the hotline callers and focus group discussions seemed to agree that pregnancy prevention rather than disease prevention was an impetus for them to use a condom.

Implications of cross generational sex, sex work and 'mpango wa kando': Group discussions also indicated the high presence of sexual relationships between young women and older men, whether inside marriage or outside. Such relationships seem to be coupled with gender power relations, which have an influence in factors such as condom negotiations. As such this kind of relationships have the potential to drive the spread of HIV and other STIs including unwanted pregnancies that might result into young women seeking 'back door' abortion services that could eventually have dire reproductive health consequences.

A previous HIV test or the willingness to get an HIV test was seen as factors that had an impact on participants' sexual behavior or use of condom. Peer pressure to take an HIV test was common. For instance some felt they had to be tested –just because their peers were taking an HIV test and they did not want to be the odd ones out or suspected of being HIV positive or promiscuous to a point of fearing to take an HIV test. A common notion among the participants

was that those who had concurrent sexual partners had a higher risk of infections and were likely to be advised to take an HIV test by their peers (*this was said jokingly*).

If you see your friend has mpango wa kando..manze tell them to go get tested...round hii ni kubaya' implying this time around HIV is real! Male respondent 22years.

HIV/AIDS information and life-skills education was considered critical by health managers and the ministry of health officials interviewed. Recommendations from the key informants were firm emphasizing that such services should essentially be provided to young people in a number of ways, including through peer education or counselling, community activities and through the mass media/interactive social media and school-based education programmes.

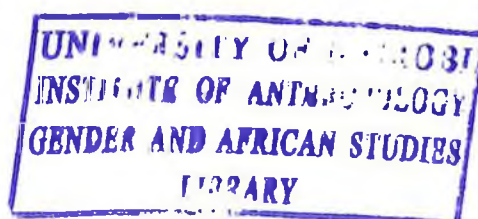
It was however evident that often these interventions are dispersed across many organizations, community groups and their effects are difficult to measure and evaluate consistently. Thus youth serving organisations should be supported to monitor, evaluate and report progress made in their programming efforts. Such data would not only inform service delivery interventions but could be used to lobby for more funds to support youth programming initiatives.

Use of helpline services prove/seem popular with young people: Unlike face-to-face counselling, the use of hotline services to access HIV and sexuality information was praised by many participants. Participants said that the hotline services allowed them to interact at their own convenience and to remain in an environment of their choice or even anonymous. This anonymity was seen to be especially valuable in situations where frank discussion of sexuality, challenges, cultural norms and taboos, as well as wherever HIV carries a strong stigma.

The counsellors were perceived to be very open-minded and non-judgemental towards the callers, respected their reasons for calling and addressed participants' issues in a professional manner. As such a recommendation to expand such services to reach more young people are needed because sometimes the phone is too busy causing callers to give up since it takes a while to get through.

Drug and alcohol abuse on the rise: Despite high presence of HIV prevention programmes targeting youth in Nairobi, not many young people knew the existence of the ONLY drugs and alcohol hotline service provided by SAPTA where they could seek support. For those who mentioned knowledge of this service, most perceived cost as a barrier and hoped that this services would be provided free of charge as most of them could not afford. This meant that they were less likely to use these services even if they had an alcohol problem.

Parents and teachers are thus called to be vigilant in recognizing drug and alcohol problems in order to support those in need especially since cost is a barrier and many young people cannot afford rehabilitation costs on their own. Those considered alcoholic or drug users continue to face social stigma and Kenyan's are yet to acknowledge that their condition is a disease that requires treatment for many to quit.



CONCLUSION

Although the findings of this study cannot be generalised beyond the population interviewed they do nonetheless reveal the extent of sexual risk taking behaviours among young people, access to health services and challenges faced by those who test HIV positive.

The participants in the study had several risk factors for HIV and STI infections and transmission and paradoxically poor risk perception for HIV infection. HIV risk behaviours varied by age, gender and level of education. Condom use was generally regarded highly as a means of protection, while alcohol and drug use were seen as the most common inhibiting factors for one to take a risk. The findings suggest that young people in general cannot be considered a homogenous population for which one type of intervention will be effective. This is because; vulnerability greatly varied geographically, by age, gender, socio-economic status and even HIV status with those already HIV positive requiring different prevention, care and treatment interventions.

Various behavioural change interventions are ongoing in different quarters aimed at changing behaviours to reduce the risk of HIV-related sexual, alcohol and drug-use. However, such behavioural change interventions need to be enhanced, scaled up and be more targeted. Challenges exist, that the above services are to some level judgemental, morally dictated especially those geared towards delaying the onset of sexual intercourse and condom use-this has to change if necessary gains are to be made. Further still these interventions may also be used to change social norms by seeking the involvement of opinion leaders or peer to peer interventions.

This study reveals mechanisms that contribute to vulnerability and varied agency that may help in understanding why and how young people are at risk of contracting HIV. Public health strategies, which consider the role of gender and social background in the context of risky behaviours, could be developed from these findings.

RECOMMENDATIONS

- 1. Lobby for adequate funding to support youth programmes:** Youth programmes are under resourced in Kenya. Thus the Government must strategically target their resources to interventions that respond to the specific situation of its young generation. Donor programmes on the other hand should put resources through a rigours process in which youth are consulted about their needs and the type of services they would prioritize. Special attention should however be given to those at increased vulnerability.
- 2. Need for supportive policy environment towards youth friendly services:** Adequate funding on its own is not sufficient. The government and other stakeholders need to ensure that the health sector is able to provide the evidence base and examples of good practice in relation to issues which promote or obstruct the development and implementation of effective policies and programmes for prevention and care among adolescents and young people.
- 3. Invest in girls empowerment programmes that challenge gender norms:** Based on the study findings, girls were more disproportionately affected than their male counterparts in relation to access of information, social isolation, risk of dropping out of school and lack of power to negotiate for condom use especially with their much older 'boyfriends' who are mostly married men. Investing in adolescent girls' programmes is crucial for alleviating social isolation, poverty and promoting gender equity. This could lead to improved social and health outcomes. For example, such programmes would include use of sports as an entry point to building social networks, allowing the girls and the community at large to challenge gender norms which dictate that a woman's place is the kitchen.
- 4. Support male involvement in sexual reproductive health interventions:** The study clearly shows that there are few programmes that promote the role of men in SRH and where they exist they are limited in terms of scope of issues addressed as most are in their

early stages of implementation. Although men are less likely to be targeted in reproductive health services, men are more likely than women to be sexually active, have multiple partners and begin sexual activities early. Given current gender power imbalances “women empowerment “and “male involvement” need to be seen and implemented with critical eye, both from the point of view of men and women as sexual partners, and as part of service provision and policy setting.

5. **Market the use of helpline:** The one2one youth hotline was seen as very critical tool for passing information to young people free of charge. The counsellors were considered non-judgemental and very supportive. However, the callers recommended that the service be 24hour as some had emergency concerns that needed immediate responses. As for the SAPTA hotline for drugs and substance help, respondents seemed not to be aware of this service. Hence more marketing of this service is needed. Further still the service cost made it difficult for youth to call and hoped it could be free of charge.
6. **Interventions that target youth living with HIV are warranted:** As the number of youth infected with HIV rises interventions to support them exist but are still limited. Thus efforts to scale-up such services are needed. This should incorporate measures to create awareness of existence of such services across Kenya. Comprehensive secondary prevention programs are needed to meet the needs of youth living with HIV. Such interventions should focus on reducing sexual behaviours that may transmit or enhance transmission of the HIV virus; enhance self care and medical or ARVs adherence leading to quality of life. Strategies to reduce stigma towards HIV positive youth should also be implemented.
7. **Young people particularly those aged 15-19years should be educated on how to protect themselves from being infected with HIV:** Most of those in this age group are still in school. While most of them are sexually active, there is still high controversy surrounding sex education programmes and condom distributions in Kenyan schools. Evidence based policies to tackle such hindrances are needed urgently before the situation worsens and more

young people get infected or end up with unwanted pregnancies. Such policies would enhance condom promotion efforts and educate young people on proper and consistent use early in advance before they become sexually active and if already sexually active then they will be empowered to protect themselves or make informed choices about their sexuality. Further still, there is a need to incorporate education on HIV/AIDS and sexual health in the school curriculum, for greater outreach.

8. **Scale up preventive interventions for drug and alcohol use:** Data shows that there are high levels of drug and alcohol use among those interviewed. Therefore harm reduction strategies for substance use should be integrated within other HIV and SHR youth friendly services coupled with efforts to promote consistent condom use and partner reduction. Such interventions can provide skills and support to high-risk youth to enhance levels of protective factors and prevent escalation to drug abuse.

9. **Link sexual reproductive health and HIV programmes with income generating projects for young people:** Integrating such projects as kazi kwa vijana which are designed to improve the overall living conditions of youth. Such projects would elevate unemployment among young people and in return deal with issues of economic dependency that seemed to drive most to exchange sex for favours and other monetary gains.

Further research: Further research is needed to better understand the social context within which young people engage in substance use, risky sexual behaviour and the factors that drive young people to engagement in sex work. Based on findings of this study, it is clear that there is a need to determine the accessibility and availability of youth friendly services especially for those already living with HIV/AIDS. This could also help identify viable social support networks for youth in general to reform positive behaviour change. This information would help programme planners to design integrated HIV, reproductive health, psychosocial support and substance abuse prevention programmes for young people.

REFERENCES

- Becker, M. H., ed. (1974). "The Health Belief Model and Personal Health Behavior." *Health Education Monographs* 2:324–473.
- Campbell, C., MacPhail, C. (2003). 'Condoms are Good, But I Hate Those Things': Sexuality and HIV Transmission among Young People. Letting them die: Oxford, International African Institute.
- Carovano, K. 1992. "More Than Mothers and Whores: Redefining the AIDS Prevention needs of Women." *International Journal of Health Services* 21(1): 131- 142.
- Coates TJ, Richter L, Caceres C. (2009) Behavioural Strategies To Reduce HIV Transmission: How to Make Them Work Better. *Lancet* 60886-7. Published Online Aug 6 2009. Pubmed.
- Ford K et al. (2004). Voluntary HIV Testing, Disclosure, and Stigma Among Injection Drug Users in Bali, Indonesia. *AIDS Education and Prevention*, 16(6):487–498.
- Gupta Rao. (2001). Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How. In *Global Perspectives on Gender, Sexual Health, and HIV/AIDS*, SIECUS Report 29(5).
- ICRW (2006). *HIV/AIDS Stigma: Finding Solutions to Strengthen HIV/AIDS Programs*. Washington DC, International Center for Research on Women.
- Jenkins C, Sarkar S (2007). *Interventions for HIV prevention and Support for Vulnerable Populations: Focus on Asia and the Pacific*. Bangkok, Alternate Visions.
- Kenya Demographic and Health Survey. (2003). Central Bureau of Statistics, Ministry of Health, and ORC Macro.
- Kenya National Bureau of Statistics (KNBS 2010a) and ICF Macro. 2010. *Kenya Demographic and Health Survey 2008-09*. Calverton, Maryland: KNBS and ICF Macro.
- Kenya National Bureau of Statistics (KNBS, 2010b). 2009. *Population and Housing Census*. KNBS, Nairobi Kenya.
- Kitzinger, J (1994) 'The Methodology of Focus Groups- The Importance of Interactions Between Research Participants' *Sociology of Health and Illness* 16; 103-21.
- Liu, H., Grusky, O., Li, X., & Ma, E. (2006). Drug users: Potentially important bridge population in the transmission of sexually transmitted diseases, including AIDS, in China. *Sexually Transmitted Diseases*, 33(2):111–117.
- Lloyd (2005) 'My Father Didn't Think This Way': Nigerian Boys Contemplate Gender Equality." *Quality* No. 4. New York: The Population Council.
- Ma W, Deteis R, Feng YJ, Wu Z, Shen LM, Yu Li Y, (2007). Acceptance of and Barriers to Voluntary HIV Counselling and Testing among Adults in Guizhou Province, China. *AIDS* 2007; 21(Suppl 8):S129-S135.
- Mann J and Tarantola D eds (1996). *AIDS in the World II: Global Dimensions, Social Roots and Response*. New York, Oxford University Press.
- Marston C, King E. (2006). Factors that Shape Young People's Sexual Behaviour: A Systematic Review. *Lancet* 2006; 368: 1581–600.

- Merson MH, O'Malley J, Serwadda D, Apisuk C. (2009). The History and Challenge of HIV Prevention. *Lancet* 60884-3. Published Online Aug 6 2009. Pubmed.
- Murphy, E.M., Greene, M.E., Mihailovic, A., (2006). "Was the 'ABC' Approach (Abstinence, Being Faithful, and Using Condoms) Responsible for Uganda's Decline in HIV?" *PLoS Medicine* 3 (9):1443-1447.
- Mills EA (2006). From The Physical Self to the Social Body: Expressions and Effects of HIV-Related Stigma in South Africa. *Journal of Community & Applied Social Psychology*, 16:498–503.
- National AIDS Control Council NACC 2008. Kenya Modes of Transmission Study: Analysis of Prevention Response & Modes of Transmission. Nairobi, Government of Kenya.
- National AIDS and STI Control Programme NASCOP 2007. Ministry of Health, Kenya; Kenya AIDS Indicator Survey KAIS 2007: Nairobi, Government of Kenya.
- Nyblade L, Pande RP, Mathur S (2003). Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia. Washington DC, International Center for Research on Women.
- Padian, N., Marquis, L., Francis, DP., Anderson, ARM., Rutherford, GW., O'Malley, PM. (1987) Male-to-Female Transmission of Human Immunodeficiency Virus. *JAMA*; 258:788– 790.
- Pulerwitz J, Barker G (2008). Measuring Attitudes Toward Gender Norms among Young Men in Brazil. *Men and Masculinities*, 10:322–338.
- Rosenstock IM (1966), "Why People Use Health Services", *Milbank Memorial Fund Quarterly* 44 (3): 94–127.
- Royce, RA., Sena, A., Cates, W., Cohen, S. (1996) Sexual transmission of HIV. *N Engl J Med*: 336:1072-8
- Strecher, V. J., and Rosenstock, I. M. (1997). "The Health Belief Model." In *Health Behavior and Health Education: Theory, Research, and Practice*, eds. K. Glanz, F. M. Lewis, and B. K. Rimer. San Francisco: Jossey-Bass. 17(6), 691–695
- UNAIDS (1999) *Gender and HIV/AIDS: Taking Stock of Research and Programs*. Geneva.
- UNAIDS. (2006). *Report on Global AIDS Epidemic 2006*. Geneva, UNAIDS.
- UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention, Towards Universal Access*. March. Geneva, UNAIDS.
- UNAIDS (2008) *Report on Global AIDS Epidemic 2008*. Geneva. Accessed 15th September 2010. http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.
- Weiss, E. and G. Rao Gupta. (1998). *Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention*. Washington, DC: International Center for Research on Women.
- Wira CR, Fahey JV. (2008). A New Strategy to Understand How HIV Infects Women: Identification of a Window of Vulnerability During the Menstrual Cycle. *AIDS*. 2008; 22:1909–1917.
- White RC, Carr R (2005). Homosexuality and HIV/AIDS Stigma in Jamaica. *Culture, Health & Sexuality*, 7(4):347–359.
- Wolfe W et al. (2006). Effects of HIV-Related Stigma among an Early Sample of Patients Receiving Antiretroviral Therapy in Botswana. *AIDS Care*, 18(8):931–933.

ANNEX 1: Telephone Interview Questionnaire

Date -- Caller's ID // Counselor's code

Time (24Hrs) Call start: : Call end time: : Call duration :

Caller Location: Province: _____ District: _____ EAC: _____ Phone No: _____

1. Sex
 Male Female
2. Age
3. Education
 None Some Pri
 Pri. Complete Some Sec.
 Sec. Complete Post Sec.

4. Occupation
 Employed Self employed
 Unemployed Student

5. What do you think is the chance that you would get the HIV virus?
 >50 chance 50/50 <50

(b) Have you ever been tested for HIV?
 No Yes

(c) Did you receive your HIV test results?
 No Yes

(d) Last time tested
 <3 months 3 - 11 months
 1 - 5 yrs > 5 yrs

6. Reasons for testing HIV
 Had unprotected sex Condom broke
 Think its useful to get tested
 Peer pressure Other specify _____

7. (a) Have you ever called this service before?
 No Yes

(b) When you called did you talk to a counselor?
 No Yes

(c) When was the last time you called?
 < 1 month 1-3 months
 4 - 6 months 6-12 months
 >1 year

(d) Reason for calling today?
 Same Different

8. Reasons for calling
 a) Interpersonal Relationships
 Family
 Sexual risk
 Sexual Relations
 Same sex
 Heterosexual

b) Sexual Practice
 Vaginal
 Anal
 Oral
 Non penetrative

c) HIV & AIDS Information
 HTC
 Condoms/Safer sex
 Abstinence
 HIV Status
 Modes of transmission
 ARVs treatment

d) STI Concerns
 Known Infection Specify _____
 Unknown
 Symptoms
 Specify _____

e) Pregnancy & Birth control
 Pregnancy
 Contraceptive
 Emergency Contraceptive
 Pills
 IUDs
 Injectables
 Nonplant/ Jadelle
 Natural method
 Vasectomy
 Tubal ligation
 Condoms
 Abortion

f) Sexual Abuse/ GBV
 Survivor
 Non-survivor
 Known Perpetrator
 Unknown Perpetrator
 Client on PEP
 Client called in time for PEP/EC
 Client disclosed/reported specify

who _____
 g) Psychosocial support
 Substance abuse e.g. Alcohol, drugs
 Has used at least one substance
 Has used 2 or more substances
 Educational/ career
 Prevention with Positives
 Supported disclosure
 Positive living
 Sexual Organ
 Specify _____
 Menstruation
 Pornography
 Suicidal
 Abuse/Violence

9. Have you ever had sex?
 Yes No

b) How old were when you first had sex? Between
 15-19 20-24

10. The first (or only) time you had sex, did you use a condom?
 Yes No

11. Did you use a condom the most recent time you had sex?
 Yes No

12. Used a condom any time had sex
 Never Sometimes Always

13. How do you perceive condom benefits?
 Useful
 Prevent HIV
 Prevent Pregnancy
 Not Useful

14. What are your perceived barriers to condom use?
 Condoms often break
 Difficult to use
 Embarrassing to talk about them
 Too expensive

15. Where did you learn about this service?

One? One Poster
 Sexual Partner
 Another client
 Leaflet: Which one? _____
 Health worker/ Counsellor
 Peer educator Where _____
 Insyder Magazine
 Friends
 Social media
 Mass media

15. Client referred to -tick all that apply

- Legal services
 STI services
 Family planning services
 Post test club /support group
 Bursary/ Youth funds
 Child Line
 Other outpatient services
 Ongoing counseling
 HIV Care
 VCT/CT
 PRC services
 LGBTI services

16. What factors do you consider as risks for HIV /STI among young people aged 15-24yrs in Kenya?

17. What would you describe as factors influencing STI/HIV vulnerability among young people in Kenya?

18. Are you aware of any other formal or informal sexual and reproductive health services that address the needs of young people -please mention

19. Are you familiar with the processes or conditions in which they operate in? kindly explain

20. What would you recommend as appropriate strategies for addressing psychosocial and STI/HIV among young people in Kenya -especially those who test HIV positive?

Annex 2: A guide to in depth interviews and focus group discussion

1. What do young people consider as some of the risks for acquiring STIs/HIV through sexual activities that include anal, oral and vaginal penetration?
2. What, how and where do youth learn about symptoms (or the lack of symptoms) of STI/HIV? Have you ever accessed such information? If yes -what was the source? How was it delivered to you? If not explain why.
3. Are you aware of any available sources of information for HIV prevention and reproductive health for young people in your area or residence? Have you been able to access it? Elaborate your experiences.
4. What is your understanding of the term gender? Or when the term gender is mentioned what comes into your mind?
5. What do young people understand by the term gender roles?
Using your own understanding explore how gender roles, identities and cultural factors influence young people's sexual behaviours and decisions to seek help or information.
6. What are the perceptions of youth towards HIV testing and counselling (HTC), and what factors influence uptake of HTC services among young people?
7. What strategies' are young people aware of that are used to target them for HIV prevention, care and treatment as well as other reproductive health services?
8. How do young people perceive these widely used prevention models targeting them?
Do these strategies acknowledge the realities in which they negotiate and make sexual choices?
9. In your opinion, what could be the best /appropriate strategies for addressing psychosocial and STI/HIV vulnerabilities among young people in Kenya especially those who test HIV positive?

Annex 3: Illustrative activity plan and time schedule

Activity	Jan-Apr 2010	May-Jul 2010	Aug -Oct 2010	Sept-Oct 2010	Nov-Dec 2010	Mar-Jun 2011	Jul –Dec 2011
Conduct systematic literature review	X						
Develop project proposal		X					
Receive feedback from the supervisor			X				
2 nd draft proposal developed and approved				X			
Pre- testing tools					X		
Proposal defence						X	
Data collection /field work						X	
Data analysis						X	
Complete final report							X
Dissemination of the results							X
Hand in a final complete copy to the Library							X

Annex 4: A guide to pre-testing the methodology

Adopted from the: International Development Research Centre.

1. **Reactions of the respondents to the research procedures can be observed in the pre-test to determine:**
 - availability of the study population and how respondents' daily work schedules and confidentiality are respected.
 - acceptability of the methods used to establish contact with the study population.
 - acceptability of the questions asked; and
 - willingness of the respondents to answer the questions and collaborate with the study.
2. **The data-collection tools will be pre-tested to determine:**
 - Whether the tools planned for use allow collecting the information needed and whether those tools are reliable. You may find that some of the data collected is not relevant to the problem or is not in a form suitable for analysis. This will help decide not to collect this data or to consider using alternative techniques that will produce data in a more usable form.
 - How much time is needed to administer the interview guide/questionnaire, to conduct observations or group interviews, and/or to make measurements?
 - Whether there is any need to revise the format or presentation of interview guides/questionnaires, including whether:
 - The sequence of questions is logical.
 - The wording of the questions is clear.
 - Translations are accurate.
 - Space for answers is sufficient.
 - There is a need to pre-categorise some answers or to change closed questions into open-ended questions.
 - There is a need to adjust the coding system.
 - There is a need for additional instructions for interviewers (e.g., guidelines for 'probing' certain open questions).
3. **Sampling procedures can be checked to determine:**
 - Whether the instructions concerning how to select the sample are followed in the same way by all staff involved.
 - How much time is needed to locate individuals to be included in the study?
4. **Staffing and activities of the research team can be checked, while all are participating in the pre-test, to determine:**
 - How successful the training of the research team has been.
 - What the work output of each member of the staff is.
 - How well the research team works together.
 - Whether logistical support is adequate.
 - The reliability of the results when instruments or tests are administered by different members of the research team.
 - Whether staff supervision is adequate.
5. **Procedures for data processing and analysis can be evaluated during the pre-test. Items that can be assessed include:**
 - Appropriateness of data master sheets and dummy tables and the ease of use.
 - Effectiveness of the system for quality control of data collection.
 - Appropriateness of statistical procedures (if used).
 - Clarity and ease with which the collected data can be interpreted.
6. **The proposed work plan and budget for research activities can be assessed during the pre-test. Issues that can be evaluated include:**
 - Appropriateness of the amount of time allowed for the different activities of planning, implementation, supervision, co-ordination and administration.
 - Accuracy of the scheduling of the various activities.

Annex 5: Consent form

You are invited to participate in a research project entitled

EXPLORING FACTORS INFLUENCING RISK PERCEPTION AND VULNERABILITY TO HIV INFECTION AMONG KENYAN YOUTH

Please read this form carefully, and feel free to clarify with the researchers should you have ANY questions.

Researcher PI: Lucy Mung'ala

Email: mungalla@gmail.com Tel: +254 722 655659

Purpose and Procedure: I am currently a Master of Gender and Development Studies student at University of Nairobi (UoN) and partnering with One2One team from Liverpool VCT, Care and Treatment-Nairobi. We are here to conduct a study whose purpose is to explore factors influencing risk perception and vulnerability among young people in order to recommend appropriate targeted HIV/ sexual reproductive health services.

Once you have read the Consent Form and indicated that you have understood it, you will be invited to proceed to the interview or group discussion. It is anticipated the interviews will not take longer than 1 hour to complete and for the group discussion not more than 2 hours. Those participating on life history narratives will take a maximum of 2 1/2 hours. To ensure that we capture your views correctly, we will take notes or audio record all will be kept confidential. Findings and feedback will be reported back to you. Given the importance of the issues covered in the study, we will summarize the observations and present them to a potential larger gathering of stakeholders, other researchers, and organizations in your communities that might be interested. No data or communication will be traceable back to you.

Confidentiality: Although the data from this research project will be published and presented at UoN, LVCT and conferences, it will be reported in a manner that it will not be possible to identify individuals. Where there are direct quotations coming from any participants' responses, all identifying information (e.g., geographic location of participant, individually identifying information) will be removed. However, to ensure that the study process remains anonymous, your data/copies of your interviews/discussion will not be given to you at the end of the session.

Right to Withdraw: Your participation is voluntary, and you can answer only those questions that you are comfortable with. You may withdraw from the interview for any reason, at any time, without penalty of any sort. If you have any questions concerning the research project, please feel free to ask at any point; you are also free to contact the researcher at the numbers provided above.

I, consent to participate in the above study. I have understood the nature of this study and wish to participate. My signature below indicates my consent.

Signature.....
Date _____
Participant _____

Signature.....
Date _____
Principal Investigator

