COMMUNICATION PATTERNS ON HIV/AIDS ISSUES AMONG ADOLESCENTS IN NAIROBI SECONDARY SCHOOLS

By
Catherine M. Kiragu

Research project submitted in partial fulfillment of the requirements for the degree of Masters of Arts (Medical Sociology) of the University of Nairobi

2004

Research project submitted in partial fulfillment of the requirements for the degree of Masters of Arts (Medical Sociology) of the University of Nairobi

By Catherine .M. Kiragu
C/50/P/8850/99

Kiragu

.....

Supervisor:

Dr. Pius .M. Mutie

.....

TABLE OF CONTENTS

CHAPTER THREE

CHAPTER FOUR

CHAPTER FIVE

LIST OF TABLES

Acknowledgements

I wish to acknowledge and thank all those individuals who contributed to the production of my project paper.

I would like to thank my parents for their financial and moral support. I am grateful to my supervisor Dr. Pius Mutie, for the support and the useful suggestions that were needed to be incorporated in my project.

Special thanks go to Mr. & Mrs. Gichuki whose support made it possible for the completion of my project.

1.0 BACKGROUND

Many countries in Africa are largely affected by HIV pandemic because of the socioeconomic, political and cultural factors that facilitate the explosion of the disease. In particular, poverty and illiteracy are major contributing factors to lack of access to information and ability to modify lifestyles in order to reduce the risk of infection. Additionally, the governments are unable to provide sufficient health care and as a result sexually transmitted diseases, which are significant co-factors in the transmission of HIV/AIDS epidemic, are rampant.

It is also evident that many sexually transmitted infections occur among the youth, more so in the age group of 16-29 years UNAIDS (1999). This is because young people still run the risk of infections by engaging in unsafe pre-marital sexual activities due to their need to experiment, peer influence, lack of guidance and poor role modeling by adults.

Secondary school education usually starts at fourteen years of age and under the 8-4-4 system of education, it runs for four years. The current secondary education program is geared towards meeting the needs of both the students that terminate their education after secondary school and those that proceed for higher education. In this context, the new secondary school curriculum lays greater emphasis on job-oriented courses, such as business and technical education.

There has been a tremendous increase in both the number of secondary schools and in student enrolment in response to the rapidly increasing number of primary school leavers

seeking entry to the secondary level. In 1963, there were only 151 secondary schools, with a total enrolment of 30,120 students. Today there are nearly 3,000 secondary schools with a total enrolment of 620,000 students (Population census; 1999).

AIDS affects the education system in many ways. Some children infected with HIV at birth do not live to enrol in school. Many youth have to drop out of school when they become orphans or to tend to sick family members. Education therefore becomes one of the solutions to the problem. School-based programs can help young people understand how to avoid the risks of unsafe sex.

The definition of young people is broad, and the age criteria that brackets this category varies according to life situations such as marriage, voting, military service, employment, etc. If defined as individuals between the ages of 10 and 19 (WHO; 1995), young people comprise almost half of Kenya's population. Because they are neither adults nor children, they have traditionally been overlooked in policy and programmatic priorities (Kekovole and Kiragu; 1997).

The current HIV/AIDS situation has shown that new infections occur mostly among youth of age 15-24 (UNAIDS; 1999). Most of these youth are found in schools all over the country. In most urban areas, students tend to indulge in sexual activities with matatu drivers and conductors, teachers, fellow students and other adults in pursuit of financial or other luxuries. Furthermore, sexual activity, often unprotected, is thought to be common among

young Kenyans. Data from the 2003 Kenya Demographic Health Survey show that 46 percent of unmarried women between 19 and 24 years of age are sexually active, and that sexual activity usually precedes marriage among both men and women (NCPD; 2003).

While most young Kenyans grow up to be healthy responsible adults, an increasing number are ruining their lives through unwanted pregnancies, abortions and sexually transmitted infections, including HIV/AIDS. At the same time, most of them appear to be misinformed and only access inaccurate information about sex and sexuality being in circulation within the society. This makes it difficult and puts the young people at risk as it makes them make misinformed choices about sex and sexuality (Kekovole and Kiragu; 1997).

It is noteworthy that levels of sexual knowledge, attitudes and behaviour differ from one youth to the next. Therefore, multiple common strategies are essential depending on the individual and the desired behaviour change. Communication therefore becomes a vital tool for promoting and sustaining risk-reducing behaviour in individuals and communities by distributing tailored health messages. In addition, communication is a process for partnership and participation that is based on two-way dialogue, where there is an interactive interchange of information, ideas, techniques and knowledge between senders and receivers of information on an equal footing, leading to improved understanding, shared knowledge, greater consensus and identification of possible effective action (UNAIDS; 1999).

In order for change to happen, individuals and communities have to take an active role in simulation exercises, that is, they are challenged to come up with their own proposals on

how to avoid risky behaviours that could lead to HIV/ AIDS and other sexually transmitted infections. It is a process of using communication approaches and tools to:

- Develop the skills and capabilities of individuals and communities to promote and manage their own health and development;
- Foster positive change in individuals and communities as well as in their knowledge and attitudes.

Communication makes use of a combination of techniques, designed to encourage and facilitate a voluntary adaptation of the behaviour that is being promoted.

1.1 PROBLEM STATEMENT

Approximately 50% of HIV infections worldwide occur in young people between the ages of 10 to 24 (GOK; *2000*). It is during this period that they learn, explore, experiment and make decisions that have life-long impact on their lives. Access to reliable or unreliable information at this crucial stage of their lives may be a matter of life and death. Communication through interpersonal, group and mass media is at the heart of these processes, for people take decisions for change once they have been motivated and empowered by information they have internalized and found relevant to themselves and their interests (Fraser and Estrada 1998; 39).

In her efforts to curb the spread of HIV/AIDS, the Government of Kenya through the Ministry of Health has developed the National Reproductive Health Strategy, which runs to the year 2010. This became necessary after an alarming number of people get infected daily while the current death rate is estimated to be 700 people daily (NASCOP, The facts; 2002).

Tremendous progress has been made in awareness creation but evidence shows that this has not translated into prevention of HIV infection. This clearly indicates that knowledge does not necessarily translate into behaviour change thus spurring a need for all key stakeholders within the health sector to revise the approaches in program design, development, implementation and evaluation. Emanating from the above grim picture, the government, international as well as civil society organizations have embraced communication approaches in their prevention programs.

Globally, there has been a shift from technologically tailored strategies to dialogue. There is the recognition that if there is going to be HIV/AIDS management, the notion of dialogue has to take center stage. The crux of it is the participation of the targeted youth in identifying their own knowledge, attitudes, beliefs, misconceptions, intentions, risk participation and developing consensus of change options through interactive and multimedia communication strategy.

For many years, the key message to adolescents in secondary schools and colleges has been abstinence and avoidance of other risks such as shared instruments and many sexual partners (UNAIDS; 1999). There has been conscious recognition that adolescents require both information and skills like assertiveness, communication with peers, teachers and other adults, rational decision-making and a coping mechanism in the face of HIV/AIDS. However, there has been lack of explicit information on HIV/AIDS, sexuality and safer sex negotiating skills and especially in school based.

Communication patterns and messages need to be tailored to meet the age and sex of the adolescent. This is because adolescents at different developmental stages have different health service needs. For instance, young adolescents 10-13 years may need sex education to build self-esteem and provide reassurance they need to understand the physical changes they are experiencing. On the other hand, after the age of 15 years, both HIV/AIDS and sexually transmitted diseases have been shown to increase rapidly among the youth. This increase corresponds to the initiation of sexual activity thus; these young people need information about sexually transmitted diseases and HIV, family planning services as well as confidential services for safe motherhood.

The use of various communication patterns in response to HIV/AIDS requires making changes related to very personal and intimate practices, and bringing about these changes requires eliciting people's confidence and empathy. Awareness generating activities alone are rarely enough to make people at risk take safety measures. Raising awareness is merely the first step; adolescents must be motivated to examine their own risks and behaviours and to identify options of safe behaviour. They must also have the necessary skills to negotiate and feel capable of adopting these behaviours. Social, cultural, political and economic factors all influence behaviours as they do also the ability of individuals to bring about change (Rosen; 1998:48).

Educational communication can be used to help people acquire the knowledge and skills they need to be able to put change and development decisions into action. It takes educational content for specialist and presents it in various media forms, particularly using

audio-visual technology, to help people understand, learn and remember. It is an essential element in training programmers at all levels (Fraser and Estrada 1998; 62).

Clear communication patterns with adolescents on HIV/AIDS are an important step in helping them adopt and maintain protective sexual behaviours. In addition, because HIV/AIDS does not exist independently, topics such as sexually transmitted diseases and unintended pregnancy should be integrated and ongoing for all adolescents in primary schools through college. Communication, whether verbal or non-verbal, has the greatest impact on young people and as such has the ability to shape values, attitudes and perceptions of adolescents. Indeed, it raises awareness, generate discussion and increase knowledge (Rosen; 1998:49). Communication therefore is vital to HIV/AIDS prevention and can set the tone for compassionate and responsible intervention.

It is against this background that this proposed project seeks to understand:

1. To what extent are students sharing information among themselves on HIV/AIDS related issues?
2. To what extent are teachers sharing information with students on HIV/AIDS related issues?
3. What factors inhibit or promote interpersonal communication between students and between teachers and students?

1.2 OBJECTIVES OF THE STUDY

The overall objective of this proposed project is to understand the communication patterns on HIV/AIDS issues among adolescents (15-19) in Nairobi secondary schools.

Specifically the study will seek to

1. To investigate and document the extent to which the students in secondary schools share information among themselves about HIV/AIDS related issues

2. To investigate the extent to which students communicate with their teachers and vice versa on HIV/AIDS related issues

3. To suggest ways through which communication among students and between teachers and students could be improved.

1.3 RATIONALE

In this era of HIV/AIDS, trends indicate that the scourge is increasing most rapidly among young people in their most reproductive years (those below the ages of twenty-five). This is because many are infected during their teens through unprotected sex. It is important to note that the future of the country clearly depends on providing information so as to empower young people to take charge of their sexual and reproductive health. In addition, communication would create awareness to adolescents that certain attitudes and behaviour can place them at risk of getting infected with HIV/AIDS.

Therefore, communication is a key factor in halting the spread of HIV/AIDS. This is because it shapes how people conduct their daily lives, even their sexual behaviour. Communication experts concur that the power of communication lies in its ability to change behaviour. Given the increase of HIV/AIDS as a sexually transmitted infection, effectively

communicating salient messages about it is of great importance to the targeted audience (Piotrow and Kincaid; 1997).

Against the above background, it is important to focus attention on the communication patterns on HIV/AIDS issues among adolescents (15-19) in Nairobi secondary schools. This is because better health depends on changed practices of individuals as well as having adequate knowledge that can be used to adapt to the real need of improved behaviour.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 HIV/AIDS among adolescents

Adolescence represents a period of physical, psychological and social transformation. As one moves from childhood to adulthood, new sexual and reproductive health challenges emerge. According to Evelia, "over half (51.2%) of Kenya's population is aged below 24 years, with a larger majority being adolescents" (1998:54). The growing adolescent population has major health, demographic and socio-economic implications. For instance, the high pre-marital sexual activity is associated largely with majority of adolescents. In addition, they tend to encounter sexual consequences like unplanned pregnancy, school dropouts, curtailed career advancement and risk of infections from sexually transmitted infections and HIV/AIDS.

HIV/AIDS seriously affects adolescents throughout the world. One-third of all currently infected individuals are youth, aged 15 to 24, and half of all new infections occur among people of the same age group/category. Besides, more than five adolescents acquire HIV infection every minute; over 7,000 each day; and more than 2.6 million each year (UNAIDS; 1999).

AIDS today is seen as a social crisis as well as a problem of the individual behaviour. It is complex and thus it is through a combination of approaches that success of controlling HIV/AIDS can be achieved. In addition, it is clear that the youth need to be at the center of these strategies to control HIV/AIDS as well as for countries to develop the strategies in

addressing the epidemic. The health sector alone cannot overcome the epidemic; therefore action must be taken to control it so as to ensure that today's adolescents will have a future as adults.

Piotrow and Kincaid state that

> "AIDS has become generalized among adolescents in almost half of Sub-Saharan Africa. In a generalized HIV epidemic, 5% or more of the population are infected in nearly twenty Sub-Saharan countries; an estimated 5% or more of young people between the ages of 15 to 24 are infected with HIV… as each new generation of young people reaches reproductive health age, another wave of infection becomes more likely" (1997:34).

More than 10 million people aged 15-24 are now living with HIV/AIDS. Adolescents are at the greatest risk because they often become sexually active without information and skills necessary to protect them from HIV infection. In addition, for those who wish to obtain information often encounter insensitive health care providers and a lack of confidentiality. Caldwell supports this saying

> "Although HIV/AIDS rates vary considerably throughout sub-Saharan Africa-generally lower in western Africa and higher in southern Africa-the epidemic has had a devastating effect on most African youth who often lack access to sexual health information. In

particular, unmarried youth have difficulty getting needed sexual health information and services" (2000:20).

At the same time, risky sexual behaviour is part of a larger pattern of youth behaviour, including challenging authority, alcohol and drug use. Nevertheless, adolescence is a period of transition, creating confusion and conflicts. Moreover, their behaviour is affected by social norms and expectations along with peer opinion thus increasing their health risk.

Experts estimate that half a million African youth will die from AIDS by the year 2005. This is because African countries with long, severe epidemics, half of all infected people acquire HIV before their 25th birthday and die by the time they turn 35 (Pathfinder International; 2000). Over 60 million people, who have been infected with HIV in the past 20 years, about half are the youth. This means that today's young people are the AIDS generation, because they have never known a world without HIV. Yet the HIV/AIDS epidemic among the youth remains largely invisible to adults and to the young people themselves. It is therefore important to come up with comprehensive strategies that will focus on the youth. [1]

Many adolescents are at risk because some adults - including parents, educators, counselors, health care workers or the media – have not taught them about HIV/AIDS or about how to protect themselves and others. While the importance of education about HIV/AIDS is widely recognized, 44 of 107 countries studied recently did not include AIDS education in their school curricula. [2]

---

[1] www.jhuccp.org
[2] www.jhuccp.org

The physical, psychological and social attributes of adolescents makes them vulnerable to HIV and other sexually transmitted infections (STIs). They are not able to comprehend fully the extent of their exposure to risk. Most African societies often compound adolescents' risk by making it difficult for them to learn about HIV/AIDS and reproductive health. In addition, majority of adolescents are dependent on others and they are still socially inexperienced. Most adolescents carry HIV for years without knowing of their positive status. Moreover, these youth become exposed to the risk of HIV because the older group assumes that younger sexual partners are less likely to be infected with the virus. Furthermore, adolescents themselves often are not able to fully comprehend the extent of their exposure to risk and the potentially dangerous results (Rosen; 1998:26).

While the youth are among the most vulnerable groups to HIV infection, they are also the most promising agents of behaviour change. They are vulnerable to HIV infection because they tend to begin sexual activities at an increasingly younger age. In addition, they tend to have restricted access to information on safer sexual practices. Lack of opportunities, erosion of social values and lack of sex education contribute to high-risk sexual behaviour (Erulkar; 1998:36).

Attitudes towards AIDS help predict change of behaviour. However, the existing literature is inconclusive. Studies have found high levels of empathy, tolerance, acceptance and positive attitudes towards AIDS or persons with AIDS. However, other findings show neutral, unfavorable or unsympathetic attitudes towards AIDS or those persons with AIDS. Knowledge level is one possible predictor of attitude, indicating that increasing knowledge

levels of AIDS may produce more positive attitudes towards individuals with AIDS (Erulkar; 1998: 37).

Adolescents are much more likely to be infected than the adult population. Lack of access to appropriate information and services coupled with a reluctance to address sensitive issues such as youth sexuality seriously hamper the fight against HIV/AIDS. Therefore it is important to ensure that young people have access to information and services to help them avoid HIV infection, including: condoms, voluntary testing, counseling and follow-up (UNAIDS; 1999). As young people enter adulthood, education and information can influence when they marry, how many children they will have, and the well being of their future families and the countries in which they live. In addition, the right to exercise greater control over their sexual and reproductive lives, free of coercion, discrimination and violence is the key to a better future.

All young people are not the same. Many are sexually active and many are not; some are already married and some are not. Some live at home and others are on their own, even at an early age. Many go to school and many do not; some are in crisis or difficult circumstances. While their situations vary, all adolescents need and want information about their sexuality, their reproductive health and how they can take control of their lives. [3]

2.2 Communicating HIV/AIDS to Adolescents

Since the onset of the HIV/AIDS epidemic, different patterns of communication have played

[3] www.fhi.org/

a prominent role in raising awareness and providing information on HIV/AIDS among secondary school adolescents. More years into the epidemic, there is still no cure, and major advances in the treatment mainly benefit technologically advanced countries. Thus, the main thrust in HIV/AIDS is prevention through the use of different communication patterns to promote HIV prevention. Mixing education with entertainment has been used successfully for young people, who have become a priority audience for population issues in recent years (Fraser and Estrada 1998; 118).

Studies in communication have evolved over time from the view that communication is a powerful key to the current situation, where it is regarded as being multifaceted and dependent on other variables in a given environment. A significant shift that is relevant to the use of communication patterns on HIV/AIDS issues among adolescents (15-19) in secondary schools is that students are no longer viewed as being passive and recipient to any messages as determined by project/program initiators. Adolescents are active people who are influenced by various factors, and who are capable of being part of the communication process. This has given rise to participation as a key component in the development of the communication process, in its implementation and in the monitoring and evaluation (Nduati and Kiai; 2000: 16).

Through various communication patterns, information is shared, new knowledge is created and mutual understanding is generated. This then becomes the foundation for mutual agreement and joint action. This works well when a real exchange occurs, a dynamic

process of feedback and adaptation takes place, and the roles of sender and receiver of messages are constantly changing (Piotrow and Kincaid; 1997:58).

For many years, communication has focused on the ways to deliver messages about good practice and policy to a variety of audiences; community members, opinion shapers or policy makers. More recently, the focus of communication has moved away from the channel or the medium being used and the message or product being conveyed to the process of dialogue and discussion that is fundamental to communication. As a result, more attention is being paid to the social and political environments in which people live and work and the influence those environments have on positive changes on HIV prevention (Piotrow and Kincaid; 1997:60).

For adolescents, effective communication patterns can help raise awareness of health risks and provide motivation and skills needed to reduce these risks, help them find support from other students in similar situations and affect or reinforce attitudes. In addition, it can increase the demand for appropriate reproductive health services and decrease demand for inappropriate health services. For the community, communication patterns can be used to influence the public agenda, advocate for policies and programs, promote positive changes in the socioeconomic and physical environments as well as encourage social norms that benefit health and quality of life (Kekovole and Kiragu; 1997:14).

The dissemination of messages through education campaigns tries to create awareness, change attitudes and motivate adolescents to adopt recommended behaviors. This is unlike before where campaigns traditionally have relied on educational messages in printed

materials (such as pamphlets) to deliver health messages. Fraser and Estrada, supports this saying "Key criteria for communicating with any audience are to produce transparent messages, work through multimedia channels-including interpersonal communication and use credible source for information"(1998:181).

Communication occurs in a variety of contexts (for example, school); through a variety of channels (for example, interpersonal, small group, organizational, community and mass media) with a variety of messages; and for a variety of reasons. In such an environment, adolescents do not pay attention to all communications they receive but selectively attend to and purposefully seek out information. One of the main challenges faced in the design of effective mass media communication programs is to identify the optimal contexts, channels, content and reasons that will motivate adolescents to pay attention to and use information (Erulkar; 1998:23).

The general goal of communication in this context is to promote and support appropriate changes in HIV/AIDS prevention, especially among young populations with high-risk behaviour. In most situations, fear campaigns are initiated with the reasoning that adolescents would be shocked into changing their behaviour.

Messages may also turn away the very adolescents one wants to reach or deny life-saving information to those in need. AIDS education necessitates talking about sexual behaviour and methods of protection from HIV through sexual intercourse. To date, the only

known method, barring abstinence, is condom use. However, in many countries, governments and religious organizations have prohibited the promotion of condom use with the argument that it would promote promiscuity (Erulkar; 1998:28). This has led to disastrous results in some countries. Studies have conclusively demonstrated that education on sex and methods of contraception in schools do not lead to an increase in sexual activity among youth; only to an increase in the use of contraceptive methods. In some cases, such education has instead led to an increase in the postponement of initiating sexual activity (Rosen; 1998:27).

Experience shows that communication alone does not have a significant impact on the spread of HIV infection unless making available health and other services, which address factors contributing to vulnerability to STD and HIV infection complements it. In addition, communication patterns should lead to action, and the means to facilitate that action must be in place and easily accessible.

2.3 Improving Knowledge towards HIV/AIDS

In many parts of the world, school curricula are highly theoretical and not closely related to everyday life. Channels of communication between teachers and students are hierarchical, and discussion is limited. The concept of guidance and counseling from teachers to students is also lacking. School programs may fail to address certain sensitive issues because parents, educators, religious leaders or policy makers may be reluctant to address them. Consequently, many youth-oriented programs do not offer the information and services that are needed, and education on sexuality, sexually transmitted diseases and HIV/AIDS is

limited. Therefore, it is vital to have programs working to overcome these constraints (Erulkar; 1998: 30).

Kenya Demographic Health Survey (2003) research shows that 66 % of men and 52 % of women have their first sexual encounter by age 16 placing them at high risk of contracting HIV/AIDs at a young age. It also shows that the knowledge about HIV/AIDS transmissions is very high as well as their knowledge on ways to prevent HIV/AIDS.

To curb the epidemic, those not infected should know how it spreads and act on this knowledge, and those infected should learn to become protective of others. The highest priority is the age group between 10 and 25, in which about half of new infections take place. This is also an age group that to a large extent can effectively be reached through schools. But the basis for knowledge, skills and attitudes about what an epidemic is and how infectious diseases spread must start at lower age levels (Hawkins; 1997:58).

The period of being a youth provides an excellent opportunity for shaping behaviour. Therefore, it is important for media communication programs targeting the youth to aim at developing a fundamental set of skill and competencies to deal with the challenges of young people's health and sexuality. Hawkins, (1997:60), however points out that the diverse cultures in Kenya pose great challenges in designing relevant communication approaches in matters relating to sexuality among the youth. It is further complicated by rapid social cultural transformation, urbanization and exposure to foreign culture. For instance, the knowledge, attitude and practice of young people towards sex are closely shaped by peer pressure, media influence among other environmental factors.

2.3.1 School programs

Adolescent health and behavioural has attracted considerable attention in recent times particularly due to the HIV/AIDS epidemic coupled with the turbulent physiological as well as social change experienced at this period in life (Mutie; 1996). As a result school programs have been introduced because they have the potential to reach a large number of adolescents in countries, where school enrollment rates are high. The structured school environment is conducive to sending educational messages to youth, offering a potential captive audience for sexuality and reproductive health programs. Many issues relating to sexuality and HIV education still need to be resolved. For instance, programs vary widely in what is taught, at what age, in what setting, by whom and in what manner (Rosen; 1998:30).

Often, teacher training is lacking, involvement of parents and youth is low. Sometimes programs are offered only in high school after many youths are sexually active. Despite these problems, school-based programs offer a chance to reach larger numbers of young people and their teachers as well as an opportunity to institutionalize sexuality and HIV education as well as broaden its impact when ministries of education make it an official policy.

2.3.2 Community and peer programs

Community and peer programs range from small-scale awareness-raising activities too much broader community mobilization efforts where large segments of the community, including young people are involved in identifying needs and designing programs to meet them. These programs may address factors influencing young peoples' sexual and reproductive health behaviour because they encourage participation of youth, parents, teachers and others. Peer

programs typically include several elements important to health promotion and development, strong identification with social and cultural environments of the target group, promotion of social norms and values supportive of positive attitudes and health behaviours and involvement of young people in programs that are designed for them [4].

In conclusion, communication patterns, in the fight against HIV and other communicable diseases, is essential between young people dealing in possibly unsafe behaviors. It spawns prevention through healthy choices, responsible behaviors and self-awareness. Moreover, it empowers young people to make wise decisions and protect themselves from the risks of HIV infection and sexually transmitted diseases.

[4] Youth issue paper 1, 2002

2.4 THEORETICAL FRAMEWORK

2.4.1 HEALTH BEHAVIOUR MODEL

It was developed in the 1950's and it attempts to explain and predict health behaviour by focusing on attitude and beliefs of individuals. The health belief model has been adapted to explore a variety of long and short-term health behaviour including sexual risk behaviors and the transmission of HIV/AIDS. According to Rosenstock, Strecher and Becker, (1994), the following are variables of the health belief model

- **Perceived threat** which consists of two parts

  Perceived susceptibility- this is one's subjective perception of the risk of contracting a health condition.

  Perceived severity - these are feelings concerning the seriousness of contracting an illness or of leaving if untreated
  (Including an evaluation of both medical and clinical consequences and possible social consequences.

- **Perceived benefits** - the belief that there are some effective strategies designed to reduce the threat of illness.

- **Perceived barrier** - negative consequences that may result from talking particular health actions, which could be physical, psychological as well as financial demands.

- **Cues to Action** – these are events either bodily (like physical symptoms of a health condition) or environmental (for example media publicity) that motivate people to take action. This aspect of the health belief model has not been systematical studied.

- **Other variables** –these are diverse demographic, socio-psychological and structural variables that affect individual perceptions and indirectly influence health-related behaviour.

- **Self-efficacy** - the belief in being able to successfully execute the behaviour required to produce the desired outcomes.

The health belief model has been used to gain a better understanding of sexual risk behaviour.

2.4.2 AIDS RISK REDUCTION MODEL (ARRM)

This model was introduced in 1990. It provides a framework for explaining and predicting behaviour change efforts of individuals in relationships to the sexual transmission of HIV/AIDS. It also incorporates variables from other behaviour change theories, including the health belief model, "efficacy" theory, emotional influences and interpersonal process. According to Catania, Kegeles and Coates (1990), the AIDS Risk Reduction Model has three stages that influence its success;

1. Recognition and labeling of one's behaviour as high risk

   The hypothesized influences are:

   - Knowledge of sexual activities associated with HIV transmission.

- Belief that one is susceptible to contracting HIV
- Belief that having AIDS is undesirable
- Social norms and values.

2. Making a commitment to reduce high-risk sexual contracts and to increase low-risk activities.

The hypothesized influences are

- Cost and benefits – in term of enjoyment, for example will the changes affect my enjoyment of sex?
- Response efficacy – for example will the changes successfully reduce my risk of HIV infection?
- Self efficacy
- Knowledge of health utility and enjoy ability of a sexual practice as well as social factors (group norms and social supports) believed to influence an individual's cost and benefit and self efficacy belief.

3. Taking action

This takes place in three phases, which may occur concurrently or may be skipped. These are

i. Information seeking

ii. Obtaining remedies

iii. Enacting solutions

The hypothesized influences are

- Social networks and problem solving choices (self-help informal and formal help).
- Prior experiences with problem and solutions.
- Self esteem level.
- Resource requirements of acquiring help
- Ability of communication verbally with sexual partners.
- Sexual partner beliefs and behaviour.

The AIDS Risk Reduction Model beliefs that external motivators i.e. public education campaigns, informal support groups, images of a person dying from AIDS may cause one to potentially change their sexual activities.

2.4.3 THEORY OF REASONED ACTION

This theory has been used since 1967. It is based on the premise that humans are rational and that their behaviours are under volitional control. The theory provides a construct that links individual's beliefs, attitudes, intentions and behaviour (Fishbein and Stadtand Hitcheok, (1994). The theory variables are described as follows

- **Behaviour** – specific behaviour is defined by a combination of four components: action, target, context and time.
- **Intention** – the intent to perform a behaviour is the best predictor that a desired behaviour will occur. In order to measure it accurately, intent should be defined using action, target, control and time.

- **Attitude** – this is the person's positive or negative feeling toward performing the defined behaviour.

  The behavioural belief - are a combination of a persons beliefs regarding the outcomes of a defined behaviour and the person's evaluation of potential outcomes.

- **Norms** - this is a person's perception of other people's opinion regarding the defined behaviour.

  Normative belief – these are a combination of a person's beliefs regarding other people's views of behaviour and the person's willingness to conform to those views.

The theory of reasoned action provides a framework of linking the variables together. It also supports a linear process in which changes in individual behavioural and normative beliefs will ultimately affect the individual actual behaviour.

2.5 ASSUMPTIONS

1. Schools positively influence HIV/AIDS information sharing.
2. Students and teachers frequently share information on HIV/AIDS.

CHAPTER THREE

3.0 METHODOLOGY

This study sought to understand the communication patterns on HIV/AIDS issues among adolescents (15-19) in secondary schools. The study involved interviewing 100 sampled adolescents. For gender balance, fifty were boys and fifty girls were selected. Respondents were asked questions about the communication patterns on HIV/AIDS issues used in school and any other information that would be helpful. Examples of questions asked included:

1. Have you ever received HIV/AIDS related information?
2. What was the source of HIV/AIDS related information from?
3. Do your teachers provide you with all the information you need about HIV/AIDS?

3.1 SITE DESCRIPTION

Data was collected from selected public secondary schools situated in Westlands Division in Nairobi. Nairobi is the capital city of Kenya and one of the biggest cities in Africa. With regard to education, Nairobi province is unique because it hosts most institutions of learning. This study focused on boys and girls attending public secondary schools in Westlands division in Nairobi, where only government schools were selected. Given the limitations of time and money, the researcher selected public schools, which host students from diverse backgrounds and therefore more representative.

3.2 SOURCES OF DATA

The study used both primary and secondary data. It employed both qualitative and quantitative techniques of data collection. The qualitative methods used included:

1. Open ended questions
2. Informal interviews with teachers

The study was also quantitative in nature. This was done to allow an exploration of information statistically regarding the communication patterns on HIV/AIDS issues among adolescents in secondary schools. The following methods were applied:

- Interviewed the target adolescents using closed questions.

  These consisted of questions on keenly selected issues with selected informants in order to obtain data, opinions and perspectives on the topic.

- Review of published and unpublished literature. This material was identified through electronic websites searches, the various libraries and researches in the different institutions. The researcher analyzed relevant information in order to give more required information that could not be captured by the techniques of primary data collection.

3.3 UNIT OF ANALYSIS

The unit of analysis in this study was secondary school students - boys and girls learning in the selected public schools found in Nairobi. Secondary schools were selected because basing on the current state of the problem; secondary schools especially urban-based have

been seriously affected. The reason for taking students as the unit of analysis was because this is the most affected group and it is important to get the information directly from them.

The table below shows the number of the respondents interviewed from both sites.

Table 3.1 Number of respondents from different classes

Class	Form 1	Form 2	Form 3	Form 4	Total
Males	10	12	15	13	50
Females	11	13	10	15	50
Total	22	25	25	28	100

3.4 SAMPLING

The study used two sampling procedures namely, simple random sampling and purposive sampling. Nairobi Province has six divisions namely Kasarani, Dagoretti, Westlands, Lang'ata, Central and Embakasi. The public secondary schools were purposively selected from Westlands division due to limited resources and time as well as their convenience in terms of proximity. The schools selected were provincial in nature and these were

1. Parklands Arya Girls High School
2. Jamhuri High School

For purposive sampling there was reliance on expert judgment to select the schools that acted as representatives.

The students were randomly selected. Each school had a sample size of fifty students. The students were categorized into two

1. Juniors (Form one and two)
2. Seniors (Form three and four)

The reason for differentiating the seniors and juniors was due to their level of education. It was possible that the form one and two could have similar experiences compared to their seniors in form three and four.

Using the class register, the students were randomly selected from the two categories using a suitable sample interval. The reason for using simple random sampling was to ensure that all possible combination of cases (adolescents) had an equal chance of being included in the sample as well as ensuring heterogeneity in the responses so that the data obtained could be more representative.

3.5 JUSTIFICATION OF METHODOLOGY

Qualitative methods assessed trends and processes, which were important in providing information useful to understand the communication patterns on HIV/AIDS issues in secondary school from the adolescent's perceptive.

In addition, they were important in clarifying quantitative findings. For instance, the open-ended questions encouraged the youth to express their own perceptions about communication patterns on HIV/AIDS in their own words and at the same time allowed the interviewer to collect detailed data systematically and facilitate comparability among all respondents.

On the other hand, the quantitative approaches were designed with sensitivity to the challenges of measurement and a thorough appreciation for the metrics that were used to capture the attitudes and knowledge. Surveys were very useful because of their flexibility to gather data on almost any issue and when done correctly, they were an efficient and accurate means of collecting data.

In conclusion, a combination of qualitative and quantitative approaches was the best way to collect data for this study. Quantitative and qualitative data have their advantages and disadvantages and it is a good option to consider using both, as they complement each other. Usually, qualitative data tends to add depth and a fuller understanding of the complexities to the quantitative information that straightforwardly defines the issue.

CHAPTER FOUR

4.0 DATA PRESENTATION AND ANALYSIS

4.1 INTRODUCTION

This chapter presents the findings of the study and the data analysis.

Most of the data processing and analysis was carried out on a daily basis in the course of the fieldwork. This was necessary because the type of data collected were mostly qualitative. Information elicited was coded, decoded and categorized according to the major thematic issues, which emerged in the course of the study. Nevertheless, simple descriptive statistics, mainly percentages and frequencies of itemized responses from some close – ended questions were also computed. In this way inferences were drawn from the analytical descriptions of the study questions, for instance, the sound of HIV/AIDS related information and whether the adolescents thought this information was relevant and adequate.

During the course of the study, interesting anecdotes and experiences, which showed insights into the major questions of the study, were grouped together. Consistencies and discrepancies of key informants and discussions were recorded and whenever there was doubt, an alternative explanation was sought.

The chapter is divided into four sections, namely; general livelihood, health and well being, health, HIV and health care services, access to information and finally stigma and impact of HIV/AIDS on adolescents.

4.2 GENERAL WELL-BEING, HEALTH AND LIVELIHOOD

Currently, over 25% of the world's population consists of the young people between the ages of 10-24. In Kenya, young people below the age of 24 years consist of 18.8 million while children below the age of 18 years make up 52.7% and those between 10-24 years constituted 36%. As in other parts of the world, Kenyan adolescents face serious challenges, which severely affect their growth and development. The transition to adulthood has with many dangers for young people. Economic decline, increasing poverty and marginalization, HIV/AIDS, the break down in the traditional family and inadequate health care constitute some of the problems adolescents face as they grow and develop. Furthermore, lack of adequate and proper information on these issues compounds the problems even further.

The findings from this study show that young people perceive themselves as having priorities and special needs, especially in this era of HIV/AIDS. Health and other issues affecting adolescents vary according to age, sex and residence and to some extent, religion. However among adolescents in secondary schools, major concerns revolve around sexual and reproductive health. This is because they (adolescents) feel the need for accurate and adequate information about sexual and reproductive health. They also require accessible and affordable reproductive health services. Without easy access to accurate information, adolescents are at risk of being misinformed about sexual and reproductive matters, which may lead them to make decisions that could have negative effects on their lives. Moreover, they need information about safer sex practices, including negotiation skills to protect them from potentially dangerous and abusive relationships.

One of the most important reasons why young people lack adequate access to information, sexual health services and protective resources such as condoms, derives from the stereotypical and often contradictory ways in which they are viewed. It is popularly believed that most young people are risk-taking pleasure seekers who live only for the present. Such views tend to be reinforced by the uncritical use of the term adolescent (with its connotations of "storm and stress") in the specialist psychological and public health literatures. This term tends not only to affect our understanding of young people and their needs, it encourages us to view young people as possessing a series of "deficits" (in knowledge, attitudes and skills) which need to be remedied.

Adolescents are also concerned about privacy and confidentiality regarding reproductive health care. This is particularly important for unmarried adolescents who confront negative attitudes for being sexually active. Such attitudes only serve to alienate adolescents from seeking reproductive health care. These same adolescents also require access to contraception to protect themselves from unwanted pregnancies and sexually transmitted infections, including HIV/AIDS.

Most of the respondents in the study clearly knew how HIV/AIDS is transmitted. There were no disparities according to age or sex. Nevertheless, more girls, (45%) compared to boys (40%) reported to be careful about their well being in regard to contracting HIV/AIDS. As such, most of the girls reported having the knowledge about how to prevent the transmission.

4.3 HIV/AIDS AND HEALTH CARE SERVICES

From the structured interviews, about 30% of the adolescents reported that they had access to medical attention whenever they needed it. While more girls (45%) than boys (39%) reported to have received medical attention at all times, the older adolescents had limited access to medical attention. The leading reason they gave for not getting needed care was they did not want to tell their parents about the problem. However, uninsured and low-income adolescents were most at risk for access problems. When they received care, they often indicated discomfort with discussing a health problem with a provider, concerns about confidentiality, and a gap in communication with physicians. The study therefore concluded that a substantial proportion of adolescents are in need of improved access to health care and services sensitive to their needs and concerns.

Health services are rarely designed specifically to meet the needs of the adolescents, and health workers only occasionally receive specialist training in issues pertinent to adolescent sexual health. It is perhaps not surprising therefore that there are particularly low levels of health seeking behaviour among young people. For example, even where they are able to recognize signs and symptoms of STDs, young people recently interviewed in Nairobi indicated that they were hesitant to go to public clinics or hospitals, but were more likely to treat themselves with over-the-counter medicines. Similarly, young people in a variety of contexts reported that access to contraception and condoms is difficult. Most importantly, policies which prevent sex education taking place, or which restrict its contents, prevent many young women and men from maximizing their sexual and reproductive health.

However, in key informant interviews that were teachers, it emerged that it was easier for girls to report illness including sexually transmitted diseases as temporary setbacks that would eventually go away. The interviews also showed that the girls perceived themselves as more vulnerable to HIV/AIDS compared to boys. This is so despite the girls reporting lower frequency of (unprotected) sex compared to the boys. The girls' attributed their safety against the HIV/AIDS scourge. As for the boys, the chances of being sexually abused were lower. In addition, their reactions to the abuse varied from the girls. The girls had different kinds of experiences from boys, and they perceived sexual incidents in a more negative light. This is because in general girls are traditionally more conservative in sexual habits and sexual politics, and hence are more likely, as they grow up, to develop anxiety about previous childhood experiences with adults. They also must face the consequences of lost virginity and the risk of pregnancy.

However, for boys, rather than feeling victimized for being seduced by an adult, they may feel a sense of accomplishment. Anecdotal evidence suggests that boys tend to be less inhibited and more adventurous than girls, and express less guilt and anxiety about sexual contact.

4.4 ACCESS TO INFORMATION CONCERNING HIV/AIDS

In the course of the study, it was important to find out whether the adolescents had ever obtained information on AIDS. Most of the respondents (98%) had received information regarding HIV/AIDS. Their sources of information varied. They had received information from peers, parents, schoolteachers, siblings and society leaders. According to more than

half (57%) of the respondents, information from peers was deemed to be more reliable. This study showed that peers could be well-respected sources of information and support on AIDS-related concerns. Peer-led education has been shown to be effective in the ability to bring about changes in HIV-related knowledge and attitudes. The other categories were parents, teachers and siblings, in that order.

Table 4.1 Sources of HIV/AIDS related information

Source of information	Frequency	Percentage (% of 100)
Peers	57	57
Parents	23	23
Teachers	18	18
Siblings	22	22

According to the students, often some parents do not provide much information, in the belief that they are 'protecting' them from information, which they believe, may lead to sexual experimentation. However, evidence suggests that young people, who openly communicate about sexual matters with their parents, are less likely to be sexually active or (if girls) become pregnant before marriage. For instance, some students claimed that in many societies today, the family provided them with information and guidance about HIV/AIDS and sexuality. This provision of information through the family was more informal, though not always detailed.

The respondents were also asked whether in their estimation, they thought they required information on HIV/AIDS. More than half (54%) of the respondents responded that they required the information. Those who did not require information on HIV/AIDS gave various reasons for their position. The most common reason was that they had already received information on the epidemic through specialized clinics, youth advisory services, general practitioners (doctors) and through local outreach work. In addition, the kind of information services that was found most acceptable and appropriate by these young people were those that offered a range of integrated services, were accessible at weekends/holidays, were close to public transport, had an appropriate image and atmosphere, and had approachable, non-judgmental and reassuring staff. Other respondents in this category stated that they already practiced abstinence, thus they did not require information on HIV/AIDS. For example, a student asked, "Why do I need HIV/AIDS information while am doing the right thing of abstaining?" The respondents were also asked the nature and content of the information received. Their responses are summarized in the table below.

Table 4.2: Content of information received on HIV/AIDS

Content	Frequency	Percentage (% of 100)
Risks of STDS	70	70
Abstinence	50	50
Safer sex	20	20

The respondents were also asked about the kind of information and health services available to them. Their responses were as follows:

Table 4.3: Information on services available to adolescents.

Information	Frequency	Percentage (% of 100)
Contraceptives	55	55
Counseling	72	72
STDS and HIV	27	27

The study also sought to find out whether the respondents understood and practiced HIV/AIDS preventive behaviour. About ¾ of the respondents (75%) reported that they did practice HIV/AIDS preventive behaviour while 20% did not and 5% did not know. For those who practiced HIV/AIDS preventive behaviour, they understood that the epidemic was dangerous to their well-being and a threat to their future. They also understood that AIDS is real and it does not discriminate against race, sex or ethnic group thus there was need to be careful. Again they reported that HIV/AIDS preventive behaviour included using a condom every time one had sex, being faithful to one sexual partner and abstinence from sexual activities.

In addition, the study sought to find out when and where it was convenient for the respondents to talk about issues related to HIV/AIDS. The most cited response (by 85% of the respondents) was when schools have closed (during school holidays). This is because it provided them with ample time to attend the HIV/AIDS discussions. The respondents also

said that the most convenient place to talk about these issues was in social halls where everybody would be free to express their views and opinions regarding HIV/AIDS. For instance, a student had the following to say regarding where it was convenient to talk about HIV/AIDS issues

> "Sam (not his real name) said he preferred getting information on HIV/AIDS in social halls or in guidance and counseling sessions. This provides a free environment in the sense that there is openness among individuals without them pointing a finger on you. In addition, one is able to ask questions about any issue. In fact, if one is not comfortable asking a question directly, there is always the opinion of writing it down on a piece of paper and being provided with answers without the rest of the group knowing the writer. We find that being in a guiding and counseling session or social hall enables us students to be open because confidentiality is highly observed. Not only that we receive information that enables us make informed choices and decisions".

It was also important to find out whether the respondents shared information about HIV/AIDS related issues with other students. Most of the respondents (90%) reported that they shared this information. They further reported that they shared information on matters on safer sex especially the use of condoms. They also discussed abstinence and faithfulness to one sexual partner.

The respondents were asked whether their teachers provided them with information related to HIV/AIDS. Slightly more than half (55%) of the respondents reported that a few teachers provided them with such information, while 45% reported that their teachers did not provide them with information related to HIV/AIDS issues. Approximately 5% did not have an opinion on whether teachers provided them with information. See table below for breakdown.

Table 4.4 Teachers providing information to students

Responses	**Frequency**	**Percentage**
Yes	55	55
No	45	45
No opinion	5	5
TOTAL	100	100

The respondents were further asked whether they thought teachers were reliable sources of this kind of information. Again more than half (60%) of the respondents were in agreement. They justified this saying that they spend most of their time in school thus the teachers would be a good source of providing them with information that would enlighten them on HIV/AIDS issues. See the table below for the breakdown.

Table 4.5 Reliability of teacher information

Response	Frequency	Percentage
Yes	60	60
No	35	35
Don't know	5	5
TOTAL	100	100

Those who responded that teachers were reliable sources of information on HIV/AIDS also gave diverse reasons for their answers. Some respondents felt that they spent most of their time in school and this provided reliable information. Furthermore, the respondents felt that the teachers were reliable because they were well informed. At the same time, the students argued that the teachers were free with them, subsequently, they became more relaxed and open about a lot of issues with the students, including issues related to HIV/AIDS information.

For those who felt that teachers were not reliable sources of information, the argument advanced was that teachers handled many subjects thus they were hampered because information related to HIV/AIDS required experts. Besides, some teachers made sexual ventures to students using this as an excuse. Furthermore, some teachers were shy and, therefore could not explain everything clearly to the students. Others said that their teachers were not free with them thus making the discussion uncomfortable. One of the students had this to say

"I think our teachers are not a reliable source of information because most of them are not free with us. They tend to be too authoritative and this makes us uncomfortable. There is also the fear of discrimination because once a teacher knows about your sexual activities, they will always use it against you even if it was an off the record issue. In addition, they will judge your character on the basis of your sexual behaviour. I also feel that teachers have a lot of work preparing the syllabus therefore would not be a good source of information. This is because they have insufficient time to well prepare or gather information on HIV/AIDS issues thus making the information they intend to deliver misinformed".

4.5 STIGMA, IMPACT OF HIV/AIDS ON ADOLESCENTS

While not seen as a problem at the onset, the HIV/AIDS, the epidemic is now clearly more serious among young people. Although young people suffer most from HIV/AIDS, the epidemic among them remains largely invisible both to young people themselves and to the society as a whole. For one, they are more likely to carry the virus for years without knowing they are infected, consequently spreading the scourge beyond high-risk groups to the broader population thus making control even harder.

This study found that obstacles to sharing information are to blame for this state of affairs. Young people can manifest the success of HIV/AIDS awareness campaigns in the near

universal knowledge of the disease. Common sources of HIV/AIDS information for the adolescents include the radio, friends, relative, print media, health workers, community workers, drama performances and the church (or Mosque).

Despite the high level of awareness, misconceptions still thrive among the youth. For instance, self-perception of risks to HIV infection among adolescents has been inconsistent with their reported sexual behaviour. In this study, 40% (as shown in the table) reported to be at no risk with a higher proportion of females than males.

Table 4.6 Perception of risk to HIV infection

Sex	No risk	Small Risk	Moderate	High Risk	Don't Know
Male	22 (44%)	14 (28%)	7 (14%)	1(2%)	6 (12%)
Female	25 (50%)	12 (24%)	4 (8%)	2 (4%)	7 (14%)

The respondents felt that cultural beliefs and ignorance is contributing to a hindering effort to curb the spread of HIV/AIDS. This is more so in the area of information sharing owing to the stigma associated with those with the virus and the fact that sex is a taboo topic in many communities.

According to discussions with some teachers, although the AIDS curriculum has been introduced in schools, to be implemented by teachers, young people and the communities in general have a different perspective. One of the teachers summed up the dilemma.

> "Teachers are some of the most promiscuous people and use their position to have the girls into sex. How can they implement this and yet have actions that contradict with the norms?"

The adolescents themselves pointed to some set backs in sharing information regarding HIV/AIDS. According to those who do not share information regarding HIV/AIDS with fellow students, the fact that many young people want to have sex reduces the chances of sharing information on HIV/AIDS. Some of them feel that the information on the scourge is tailored to specific people, thus they are reluctant to share such information. It also emerged that some of the adolescent do not share information for fear that their peer will think they are hypocrites who preach water but drink wine. In addition, they fear sharing information because they are at risk of contracting or may have already contracted the virus or may be victims affected by HIV/AIDS. For instance, there was a student who did not feel right sharing information with her fellow students because she was an orphan due to AIDS. She narrates her story saying

> "In December last year, Carol lost her mother to AIDS. Her father had divorced the mother due to issues that both could not solve. This put her in the hands of her relatives since she and her brother could not support themselves. As a result of her mother death, this disease has affected Carol. Because of the

> stigma attached to AIDS, she has sought to conceal and deny the cause of her mothers' illness. Denial, anger, guilt and shame are some responses that she is undergoing though most of the emotional support comes from her relatives with whom she lives, particularly her aunt. It is from this perspective that Carol feels that sharing information is not important because her friends will look at her differently".

For those who share information on HIV/AIDS, they restrict themselves to the statistics on the number of people infected or dying from HIV/AIDS related complications in the country. They also occasionally discuss the virtues of abstinence.

The respondents, however, suggested ways through which sharing information on HIV/AIDS could be enhanced. Proper understanding between students and teachers was touted as one of the most effective approach. A number of students also signed for honesty and integrity as well as openness amongst the students themselves. Still other students advocated that teachers being free with students and flexibility on the part of the teachers in accessing more information on the subject.

CHAPTER FIVE

5.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 SUMMARY OF FINDINGS

The youth comprise over a quarter of the world's six billion people. This means that young people between the ages of 10-24 are over 1.5 billion. The findings indicate that, just like any other part of the world, the young people in Kenya face difficult challenges in their growth and development. Young people's growth into adulthood is fraught with dangers and the youth are aware. Among the pitfalls young people face includes increasing poverty and marginalization. Nevertheless, HIV/AIDS the breakdown in the traditional family bonds, accompanied by inadequate healthcare, provide yet another obstacle to the fulfillment in the developing lives of young people in Kenya. Furthermore, the death of information on this aspect further compounds the situation.

It is however, worth noting that young people perceive themselves as having priorities and are concerned, especially so in this age of HIV/AIDS. Thus, as the study findings indicate, health and other issues affecting young people vary according to age and sex. This fact is very crucial in understanding reproductive health issues among the youth. Nevertheless, major concerns among adolescents in secondary school revolve around sexuality and reproductive health. Yet, as the study findings indicate, adolescents are aware of the dangers of HIV/AIDS in their lives. At the same time, they clearly know how this scourge is

transmitted in the human population. This disputes the fact that there are discrepancies in the way boys and girls perceived effective methods of transmission.

The AIDS campaign need to disseminate information on abstinence, postponing of the first sexual intercourse, reduce the number of sexual partners, consistent use of condoms and sexual fidelity. In addition to providing adequate information, campaigns should also provide examples of modeling expected behavior to increase the student's ability of replicating them. The critical factor for an effective strategy on preventive education is the sustained support of political authorities at the highest national level. The critical test is the extent to which the key messages reach the grass roots, particularly the most exposed groups. Changing conceptions and attitudes require effective communication patterns– knowing the audience, developing the message and getting it across. Effective communication is needed to translate knowledge into changes in HIV/AIDS prevention.

HIV/AIDS may not be seen as a problem at the outset. But it is now clearly seen as serious among young people. Although young people suffer most from HIV/AIDS, the epidemic among the youth remains largely invisible both to the young people themselves and the society as a whole. Nevertheless, the youth bear the greatest brunt of the scourge. They are orphaned and, therefore, lose opportunities in their quest to fulfill their life ambitious. Furthermore, they are themselves infected and are more likely to carry the virus for years without knowing, consequently spreading the epidemic beyond high risk groups to the broader population. This makes control even harder.

Perception of health needs among adolescents is also crucial. As the study findings show, boys and girls view the need for health care differently. While the girls attach a lot of importance to this need, boys calibrate their needs to hierarchies. Thus for the boys, there are health needs that require urgent attention compared to others. As the boys become more mature, more independence is bestowed upon them by their lives away from home.

As the teachers reported, it is easier for girls to report illness than boys. It is thus possible that the macho image the boys cultivate in adolescence makes them eschew medical attention for "minor" diseases, including sexually transmitted diseases.

The study findings also recall that girls are more vulnerable to HIV/AIDS compared to boys. This is mainly attributed to chances of being raped or being manipulated by men into unprotected sexual liaisons. However, when it comes to personal decision-making, boys become more vulnerable. This is because they report more sexual unions compared to the girls. Whether this is true or not remains a matter of conjecture.

The fight against HIV/AIDS cannot be successful without access to information regarding the epidemic. This study reveals that access to information is hampered by a number of factors. One major problem is sharing information among the adolescents themselves. It clearly emerges that they rarely share information. This is because some of them are shy. Furthermore, since they feel vulnerable, they believe sharing what they know may expose them to ridicule.

On the other hand, the flow of information from teachers to students is largely inadequate. For one, the teachers are said to be too busy, harsh or downright ill equipped to handle the

topic of HIV/AIDS. Thus the students are condemned to be content with a variety of sources. These include the mass media, parents and peers. The study findings indicate that information from peers is more reliable because they can seek feed back through questions. All the same, the adolescents participate in HIV/AIDS discussions as passive recipients thus limiting their active search for more information. The HIV/AIDS syllabus is also shallow, as the findings indicate. Information in the syllabus is restricted to risks of AIDS, safer sex and abstinence. They need more strains of the virus and nutrition.

According to the findings, discussions on the HIV/AIDS topic require convenient time and place. The most preferred time is the holidays, as it will give the discussants enough time. At the same time, being away from the school environment, the discussants will be free to air their opinions and feelings. Social halls are preferred as venues for such discussions.

There is also the stigma and the impact of the HIV/AIDS on the young people. For those infected and affected in other ways, the larger society tends to show them. They then acquire pariah status in the community with all the negative epithets thrown their way, with or without their knowledge.

Obstacles to sharing information on HIV/AIDS largely contribute to this state of affairs. However, young people can manifest the success of the HIV/AIDS awareness campaigns in the near universal knowledge of the disease. This information is accessed from the radio, TV, print media, billboards, parents, and drama and religions services. Despite the high level of awareness, misconceptions still thrive. And on these misconceptions as noted the

stigma, hinders effective control campaigns. At times cultural norms are to blame for this state of affairs.

5.2 CONCLUSIONS

The fight against HIV/AIDS especially among the youth cannot succeed without the access to adequate and accurate information on the scourge. A number of factors stand in the way of sharing this information among the youth. One of the factors is the fear of sharing information that may lead one to be shunned by peers. Parents and other leaders only share scant information with adolescents.

At times, opinion leaders are not willing to talk to the adolescents about pertinent sexuality issues, including HIV/AIDS. The government has endeavored and introduced the HIV/AIDS syllabus in schools. However, this syllabus is not enough as it contains little information on certain aspects of the epidemic. The adolescents also participate in HIV/AIDS discussions as passive recipients. This clearly denies them a chance to ask pertinent questions for feedback.

One of the major setbacks of the fight against HIV/AIDS is the stigma affecting those infected and affected. It is very crucial to fight this counter epidemic. The stigma impedes the fight against this counter epidemic. More often than not, the impressionable adolescents are confused by the latent and obvious discrimination against those infected and affected by the virus. Of course this closes the channels of information flow as some segments of the society recede into cocoons.

5.3 RECOMMENDATIONS

- The school authorities should provide information as well as skill-building opportunities for responsible decision-making and promote communication skills that will enable the youth to respond to pressure, counseling and needed reproductive health services.

- The government should ensure that the youth receive accurate HIV/AIDS information irrespective of whether they are in school or not.

- The parents should interact and communicate with their adolescents in order to assist them make informed decisions and choices regarding reproductive health issues.

- The NGOs and churches should come up with programs for adolescents that focus directly on sexuality and sexual behaviour as well as non-sexual contextual factors.

6.0 REFERENCES

Amuyunzu, M .1997. ***Community Perceptions Regarding Critical Adolescent Sexual And Reproductive Health:*** Needs And Solutions. Promotion and Education Pp.4-20

Caldwell J.C .2000. ***Rethinking the African AIDS epidemic***, Washington: Population Development Review.

Catania, J.A, Kegeles and Coates T .1990. ***Towards Understanding of Risk Behaviour: An AIDS Risk Reduction Mode***, New York: Pergamon Press

Erulkar Annabel S, et al .1998. ***Adolescent Experiences and Lifestyles in Central Kenya***. Nairobi: Population Council, Vol. No. 2.

Evelia Humphrey .1998. ***Adolescent Sexual and Reproductive Health in Kenya***: Nakuru: Present Legislative and Policy Environment, Vol. No. 1.

Fishbein M and Hitchcock .1994. ***Using Information To Change Sexually Transmitted Diseases Related Behaviours*** in Di Clemente and J. K Peterson (Eds) ***Preventing AIDS: Theories and Methods of Behaviour Interventions***. New York: Plenum Press (pp 61-78)

Fraser Colin and Resrepo-Estada .1998. ***Communicating For Development: Human Change For Survival.*** London: I.B Tauris & Co. Ltd, Victoria House Bloomsbury Square

Hawkins, Kristen .1997. ***Review of Adolescent Reproductive Health in Kenya Report***. London: Options Consultancy Limited.

Invention strategies that work for youth .2002. Youth issue paper 1-Family Health International, Washington: Youth Net program

Kekovole John, Karungari Kiragu .1997. ***Reproductive Health Communication in Kenya: Results of a National Information, Education, and Communication Situation Survey,*** *NAIROBI:* FIELD REPORT NUMBER 9

Kenya, Republic of .1999. ***The Kenya Population Census,*** Nairobi: Government Printer

Kenya, Republic of .2000. ***National Reproductive Health Strategy – (2000 – 2010)***. Nairobi: Ministry of Health.

Mutie, Pius .1996. ***Prevention of HIV/AIDS Among Adolescents in Kenya: A Review of Role Modeling Patterns in*** Social Behaviour and Health. Kenya: Inter-Faculty Collaboration Programme Conference.

National HIV/AIDS and STI Control Programme .2002. – ***NASCOP, HIV/ AIDS,*** Nairobi**: The Facts**

NCPD/CBS .2003. ***Kenya Demographic and Health Survey2003.*** Ministry of Planning and National Development, NAIROBI: Government Printers.

Nduati Ruth and Wambui Kiai .2000. ***Communicating With Adolescents About AIDS***. Experience from Eastern and Southern Africa: Canada, CRDI

Pathfinder International .2000. ***Adolescent Reproductive Health in Africa.*** Paths into the next century. Kenya: Africa Regional Office-Nairobi.

Piotrow and Kincaid .1997. ***Health Communication***; Lessons from Family Planning and reproductive Health, Maryland, U.S.A: John Hopkins School of Public health

Rosen JE, Conly SR .1998. ***Africa's Population Challenge: Accelerating Progress in Reproductive Health***. Washington, DC: Population Action International, Country Study Series, No. 4

Rosenstock, Strecher V and Becker .1994. ***The Health Belief Model and HIV Risk Behaviour Change*** in R.J. Di Clemente and J.L Peterson (Eds) ***Preventing AIDS: Theories and Methods of Behavioural Interventions***, NewYork: Plenum Press, pp 5-24

UNAIDS .1999. ***Listen, Learn, Live! World AIDS Campaign with Children and Young People: Facts and Figures***. Geneva: UNAIDS, 1999.

UNAIDS .2000. ***Sex and youth: Contextual factors affecting risk for HIV/AIDS:*** SWITZERLAND: UNAIDS.

World Health Organization .1995. ***Global strategy framework on HIV/AIDS,*** The World Health Report, GENEVA.

APPENDICES

Appendix I

INTERVIEW SCHEDULE

Communication Pattern On HIV/AIDS Issues

Among Adolescent (15 – 19) In Nairobi Secondary Schools

GENERAL INFORMATION

Date of Interview:.....

Name of respondent:.....

Age: .....

Name of School: .....

Sex : Male ☐ **Female** ☐

Level of Education: ☐ **Form One**

☐ **Form Two**

☐ **Form Three**

☐ **Form Four**

---

1. Have you ever received HIV/AIDS related information:-

   Yes ☐ **No** ☐

2. What was the source of HIV/AIDS related information from:-

   ☐ Peers

   ☐ Parents

   ☐ Schools

☐ Siblings

☐ Teachers

3. Of the above sources, which is the most important/reliable source?

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

4. What was the content on information received: -

☐ Risks of STDs including HIV/AIDS

☐ Abstinence

☐ Role of Safe Sex

☐ Other (explain)

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

5. Do you need information of HIV/AIDS Yes ☐ No ☐

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

If **No,** when do you think you will require this information?

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

6. What are the chances of you contracting HIV/AIDS?

☐ High

☐ Medium

☐ Low

☐ No Chance

7. Which of the services are available to you as an adolescent

☐ Information about contraceptives

☐ Information about free counseling services

☐ Information about STDs and HIV/AIDS

☐ Access to free counseling services

☐ Access of reproductive health clinics

Other explain

.....

.....

.....

8. Do you understand and practice HIV/AIDS preventive behaviours?

Yes ☐ No ☐

Why

Explain.....

.....

.....

.....

.....

.....

9. What is your attitude towards HIV/AIDS?

.....

.....

.....

.....

.....

10. What is your favourite source of information about HIV/AIDS?

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

11. When is it convenient to talk about HIV/AIDS issues?

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

12. Where is it convenient to talk about HIV/AIDS issues?

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

13. Do your teachers provide you with all the information you need about HIV/AIDS?.....

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

14. Do you think teachers are reliable sources of information? **Yes/No.** Explain;

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

15. Do you ever share information with other students about HIV/AIDS related issues? **Yes/No**.

a. If yes, what kind of information

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

b. If No, Why?

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

15. What factors promote communication between students and teachers?

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

16. What factors inhibit communication between students and teachers?

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

====== Thank you ===

Appendix II

KEY INFORMANT DISCUSSION GUIDE

1. Do students ever receive HIV/AIDS related information?
2. What is the source of HIV/AIDS related information from?
3. Do students require this information?
4. If No, when do you think they require this information?
5. What is the content on information received?
6. What are the chances of them contracting HIV/AIDS?
7. Which services are available to the students?
8. Do they understand and practice HIV/AIDS preventive behaviours?
9. What is their attitude towards HIV/AIDS?
10. What is their favourite source of information about HIV/AIDS?
11. When is it convenient to talk about HIV/AIDS issues?
12. Where is it convenient to talk about HIV/AIDS issues?
13. Do you teachers provide students with all the information they need about HIV/AIDS?
14. Do you ever share information with students about HIV/AIDS related issues?
15. What factors promote communication between students and teachers?
16. What factors inhibit communication between students and teachers?