

**INFLUENCE OF YOUTH CENTRE ACTIVITIES ON RISKY
SEXUAL BEHAVIOUR CHANGE, A CASE STUDY OF TUUNGANE
YOUTH CENTRE, KISUMU COUNTY, KENYA.**

**BY
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DECLARATION

This project is my original work and has not been presented for any award in any other University.

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DEDICATION

I dedicate this project to my daughter Ashley and my husband Josh for their understanding during the time away from them in order to complete this project.

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ABBREVIATIONS AND ACRONYMS

AIDS	-	Acquired Immune Deficient Disease Syndrome.
AMREF	-	African Medical and Research Foundation
ART	-	Anti retroviral Therapy
ARV	-	Anti Retro Virals.
B.C.C	-	Behaviour Change Communication.
CDC	-	Centre for Disease Control.
CHW	-	Community Health Workers.
DASCO	-	District Aids and Sexually Transmitted Infectious Diseases Coordinator.
GOK	-	Government of Kenya.
HAART	-	Highly Active Antiretroviral Therapy.
IDUs	-	Injection Drug Users.
HIV	-	Human Immuno-deficient Virus.
ICPD	-	International Conference on Population and Development.
KAIS	-	Kenya Aids Indicator Survey.
KNASP	-	Kenya National HIV/AIDS Strategic Plan.
MARA	-	Most At Risk Adolescents.
MDGs	-	Millennium Development Goals.
MOH	-	Ministry of Health.
MSM	-	Men having Sex with Men.
NACC	-	National Aids Control Council.
NASCOP	-	National Aids and STI Control Program.

PEPFAR	-	Presidents Emergency Plan for Aids Relief. (American).
PMTCT	-	Prevention of Mother to Child Transmission of HIV.
PSI	-	Population Services International.
STD	-	Sexually Transmitted Diseases.
STI	-	Sexually Transmitted Infections.
THIS	-	Tanzania HIV/AIDS Indicator Survey.
U.N	-	United Nations.
UNAIDS	-	United Nations programme on AIDS.
UNESCO	-	United Nations Educational, Scientific and Cultural Organization.
UNICEF	-	United Nations International Children’s Emergency Fund.
USAID	-	United States Agency for International Aid.
UYAAS	-	Uganda Youth Against AIDS
VCT	-	Voluntary Counseling and Testing.
WHO	-	World Health Organization.

ABSTRACT

Risky sexual behaviour is behaviour that increases ones risk of contracting sexually transmitted infections or experiencing unintended pregnancies. These includes having sex at an early age, having multiple sexual partners, having sex while under the influence of alcohol and or drugs and un protected sexual behaviour. Youth risky sexual behaviour is one of the catalysts of the rising HIV, other STI and unintended pregnancies. Youth centers and youth clubs are a viable cost effective way to reach out to the youth of all walks of life, both in school and out of school with the aim of changing their risky sexual behaviour. The purpose of the study was to assess the influence of youth centers activities on risky sexual behaviour change. The study looked into risky sexual behaviour change among the youth by assessing the quality of education and training, recreational activities, counseling and testing as well as outreach programs offered at Tuungane youth centre, Kisumu County. The study adopted a descriptive case study research design and targeted all the staff and youth members of Tuungane Youth Centre, and the people the youth interact with in the community i.e. at home and at school. Using a stratified random sampling procedure, the study sampled 187 respondents. Data was collected using a structured questionnaire as well as an interview schedule, the data was reviewed and cleaned at collection point and every evening prior to entry in data base to minimize errors of omission and commission. Data analysis was performed with the help of SPSS and findings presented in means and percentages in the form of tables, figures and charts. From the findings, more males (63%) than females (37%) access the youth centres, the majority of the youth are between 14-24 years (76%).all the four components are offered at the youth centre and each has an effective value. It is recommended that all the components should be offered simultaneously and peer groups should be formed in the community for the youth leaving the centre. It was concluded that all the four components influence behaviour change, community involvement in outreach programmes is important to the youth and youth centres are a viable tool for influencing risky sexual behaviour change in the youth.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Human behaviour is complex, widespread behaviour changes are challenging to achieve, yet research to date clearly documents the impact of numerous behavioral interventions in reducing HIV infection and there are cases in which national HIV epidemics have been reversed, broad based behaviour changes were central to this success (Achmat Z, 2008). Risky sexual behaviour includes, having more than one sexual partner, changing sexual partners frequently, having oral, vaginal, or anal sex without using a condom and using unreliable methods of birth control (Hamilton B.E, 2010).

To reduce sexually risky behaviours and related health problems among the youth, schools and other youth serving centres can help young people adopt a lifelong attitudes and behaviours that support their health and well-being (Frieden T.R et al, 2014). Sexual behaviour is a sensitive topic among the youth, which they find difficult discussing with adults. The youth present unique challenges to policy makers and programme planners, experts believe that the needs youth are often neglected in favor of approaches that focus on children and adults. The key components of behaviour change strategies for youth include use of peers, parents, educators, school based sex education and development of youth friendly services. (Hamilton B.E, 2010).

Globally, the strategies being employed to prevent risky sexual behaviour in youth mainly targets efforts to decrease or delay sexual activity, increase condom use, reduce the number of sexual partners, and increase sex and HIV education (Grey J et al, 2011).

In America, 46.8% of adolescents in high school surveyed in 2013, had ever had sexual intercourse, 34% had had sex during the previous three months, and 40% did not use condoms the last time they had sex while 15% had had sex with 4 or more people during their life. An estimated 8300 youth between 13-24 years in the 40 states reported to CDC had HIV infection in 2009. Nearly half of the 19 million new STIs each year are among young people and more than 400,000 teen girls between 15-19 years gave birth in 2009. In 2011 CDC noted that behavioral change intervention was necessary to reach a wider

population and especially those outside schools, they noted need for youth centres and youth clubs, thus Advocates for Youth was formed and targeted the youth, this they said would increase youth awareness to key sexual health services and establish safe and supportive environments for all (Eaton D.K, 2011). A recent evaluation of the effectiveness of after-school programs designed to develop personal and social skills among young people in the United States found that such programmes succeed in improving feelings, attitudes and aspects of behaviour and performance in school (Alford S, 2008).

In the United Kingdom, 31% of males and 29% of females have had their first sexual encounter before age 16 (Mercer C.H et al, 2013). 80% of youth 18-24 years old said they used condoms at first sexual encounter. The peak for STIs in females is between 19-20 years and males 20-23 years (Wellings K, 2013).The rate of STI infection among the London youth is increasing dramatically. Research shows that this young people do not feel comfortable accessing sexual health services and therefore need for specialized youth centers (Hindin M.J 2009). In University College of London there is a centre for behaviour change, where studies show the need for positive impact of the youth centres on behaviour change.

More than a third of reported HIV/AIDS cases in India are among the youth,35% of all reported cases are among age group 15 to 24 years(Yader S.B ,Makwena et al, 2011).Interventions in India involves BCC, access to condoms, STI services and HIV treatment, care and support and provision of enabling environment through drop in centres and community mobilization strategies (Goodwin, J. 2010), due to this aggressive risky behaviour change interventions the HIV prevalence is slowing down with 57% decline between 2000 and 2001 (Kumar, R. 2011).

In Africa, youth friendly services are needed for young people to offer reproductive health services, they need trained providers in youth friendly service provision, privacy and confidentiality, convenient locations, hours of operations, affordability and availability at all times(Carnegie Motzoi, 2006).In 1998, the USAID concern was that life

expectancy will drop to 30 years or less by 2010, unless HIV prevalence rates are drastically reduced (Agot, K & Odhiambo, J.O. 2001). In West Africa, the median of first sexual intercourse varies, in Mali, it is 15.9, in Burkina Faso it is 17.5, and 19.6 in Senegal. A number of efforts have been made to reach the youth who mostly live in the rural areas, where they don't have access to information and services and therefore at risk of negative outcomes. In Burkina Faso, a National Adolescent Reproductive health program was launched in 1995. Other efforts include youth centres that provide family planning education, counselling, and peer education (Bankole A, 2004).

In South Africa, a study done with youth between 14- 35 years, concluded that 50% of youth are sexually active by 16 years of age and between 50%-60% of them report never using condoms (Eaton, 2012). 20-25% of adults are infected with HIV. In South Africa, some of the youth centers established are Masiphumele youth centre that provides recreation, education, skills and sexual health services to youth between 8 to 24 years (Buga G.A. 1996). A later study in 2010 focusing on youth in grade 8 to 11 revealed that, rate of having sex had declined from 41% to 38% compared to 2002, those who had 2 or more sexual partners reduced from 45% to 41%, incidence of sexually transmitted infections also reduced from 7% to 4%, while consistent condom use increased from 29% to 30%, this was attributed to the interventions at the youth centres (Booyesen F and Summerton J. 2002).

In Uganda, a study done at Mbarara University showed that a large number of males (62.9%) than females (51.3%) reported having sex, more females (23.4%) than males (14.8%) reported that a condom was not used on their latest occasion of sexual intercourse (Agartha, A. 2012). The study suggested that sexual behaviour changes can take place where a comprehensive behavior change based strategy was employed, involving high level government, the community and various other stakeholders (Luyiga, F. 2012). This strategy has seen the reduction of HIV prevalence, increase use of condoms and reduced cases of STIs.

In Kenya as in most African countries sexuality discussion is a taboo subject, many parents and religious communities fear that if the youth are exposed to such talk, it will encourage promiscuity among them, in 1999, sex education subject was introduced in the school curriculum, in spite of this and the current universal access to primary schools, not all the youth are able to attend schools to access this education and therefore the need to provide a forum for the youth to access information that will help contain the epidemic (KAIS Report, 2007). Apart from HIV there are cases of unintended pregnancies, abortions, and other STIs, in secondary schools, therefore the need to clearly understand youth sexual behaviour and how it can be changed, as the statistics show that 66% of high school youth are already having sex. There are various youth groups, targeting different activities e.g. Pamoja youth group based in Dandora, Nairobi, and their mandate is to source for funds from donors and help the youth start income generating activities. Youth Initiative Kenya (YIKE) is another umbrella youth organization that empowers youth groups to engage in development in the community. Some of the activities they advocate for are create and sustain income generating activities, lead a healthy life style, access the benefits of ICT, and have a better understanding of their rights as citizens (www.YIKES.com). Youth Alive Kenya (YAK) has many activities that deal with environmental, justice and human rights, health, and democracy

In Kisumu, there are various youth groups which run different activities e.g. in Nyando district there are 30 youth groups, they mainly deal with environmental management and conservation (www.nyando youth groups). The FHOK has a clinic in Kisumu, started in 2001, it focuses on reproductive wellbeing of the youth, and their mandate is big and not specific to the youth. Tuungane youth centre mainly targets the youth and is very specific for youth who are HIV positive. They use an integrated system to tackle behaviour change, they use B.C.C to come up with activities and programs that are used at the centre. Tuungane is a Kiswahili term meaning, “let’s join hands”, initiated in 2004 and targets 14 to 24 year olds. It was initially funded to promote behavior change, i.e. abstinence and faithfulness, thus there was training on life planning skills, peer counseling, health talks, referrals for treatment of STIs and voluntary counselling, distribution of information, provision of recreational activities to reduce idleness and

divert attention from potentially risky activities and environments. It was noted that those referred for STIs and VCT were reluctant to go to Government facilities, as they were seen as not youth friendly, therefore Tuungane was expanded to address variety and reproductive health needs of young people (Agot K & Odhiambo J, 2002). The activities that are provided here are education and training, outreach programs, recreational activities and voluntary counselling and testing. Due to its specificity Tuungane is a centre that can be emulated for the youth country wide to tackle their risky sexual behaviour and bring about positive sexual behaviour changes.

1.2 Statement of the Problem

Risky sexual behaviour is behaviour that increase the risk of contracting sexually transmitted infections and experiencing unintended pregnancies. They include having sex at an early age, having multiple sex partners, having sex while under the influence of alcohol, and unprotected sexual behaviours (Hamilton B.E, 2010).

Research has revealed that the main reason for that are lack of information, embarrassment, fear of possible pain, cultural and psycho-social reasons, complications and other undesirable consequences, therefore the need for youth friendly centres to tackle sexual behaviour change among the youth (Otyek, M.C et al. 2010)

The youth are beginning to experiment with risky sexual behaviour at an early age, in part due to mass media, peer pressure, lack of supervision by parents, lack of knowledge etc. Not only are the youth at risk of infections and unwanted pregnancies, but they are also experimenting with drugs, alcohol which may lead to unprotected sex. Therefore the problem becomes how we can change this behaviour of risk among the youth (Romer D, 1994).

In terms of HIV, there are programs and initiatives targeting adults in the HIV prevention programs, there are media awareness campaigns, Provider initiated counselling and testing (PITC), etc. there is also the PMTCT programme that handle pregnant women and their babies, while there is a big gap at the youth level. These youth do not want to be

lumped together with adults their parents' age and definitely not children, they need their own forum where they can freely discuss their sexual and reproductive health. Young people are not given sufficient voice, they do not have access to enough correct information, and they do not have access to youth friendly health services (Tebes, J. 2007).

1.3 Purpose of the Study

The purpose of the study was to assess the influence of youth centers activities on risky sexual behaviour change.

1.4 Objectives of the Study

The study was guided by the following objectives:

- i. To establish the extent to which education and training at the youth center influences risky sexual behavior change among the youth.
- ii. To establish the extent to which recreational activities at the youth center influences risky sexual behavior change among the youth.
- iii. To establish the extent to which counseling and testing provided at the youth center influences risky sexual behavior change among the youth.
- iv. To establish the extent to which outreach programs as component of youth centers influences risky sexual behavior change among the youth.

1.5 Research Questions

The study aimed to answer the following questions:

- i. To what extent does education and training at the youth center influence risky sexual behavior change among the youth?
- ii. To what extent does recreational activities at the youth center influences risky sexual behavior change among the youth?
- iii. To what extent does counseling and testing services provided at the youth center influence risky sexual behavior among the youth?
- iv. To what extent do outreach programs provided at the youth centre influence risky sexual behavior change among the youth?

1.6 Significance of the Study

The challenge of risky sexual behaviour in youth still remains a major challenge worldwide. Governments, policy makers, and programme planners need a lot of information in order to implement programs aimed at the youth, since majority of the new infections and unintended pregnancies are in the youth.

This study on the role of youth centres in influencing risky sexual behaviour among the youth is useful to the government to look at the health policy afresh and make changes where necessary for its smooth implementation. NGOs implementing behaviour change programs can also benefit from this study in that the findings can be applied or replicated elsewhere while implementing and operationalizing a youth centre programme in other regions of the world while enhancing their capacity for sourcing more resources from funders to support behaviour change programs. Moreover, this study is of value to scholars, researchers and students interested in undertaking similar studies on the role of youth centres in risky sexual behaviour change.

1.7 Assumptions of the Study

The researcher assumed that all the targeted participants in the youth center would be willing to take part in the study. In addition the researcher assumed that the study participants would provide honest information. It also assumed that components under investigation will be directly involved in observed behavior change or lack thereof. No conflicts, extreme weather or tragedies would occur during the undertaking of the study was another assumption.

1.8 Limitations of the Study

The study was confined to Kisumu County. Kisumu is one of the counties with the highest prevalence of HIV/AIDS which is one of the consequences of risky sexual behaviour. The findings from the study are thought to be more valuable and easily generalizable to other high prevalence areas.

The HIV/AIDS policy in Kenya cites youth centers as an integral component in the fight against the scourge. However this component has not been well implemented and as such Tuungane Project is the only available youth center available to the researcher in the area that deals with change in risky sexual behaviour of the youth. As such, the research was limited to the activities of Tuungane youth center in Kisumu County. The study was further limited to the 1 month in which the data collection took place.

1.9 Delimitations of the Study

The study took place in a youth center and the target population being the youth themselves and the people they interact with, the study was delimited in this aspect. The study was delimited in the fact that all the staff, youth members of the youth centre and selected community people comprise the target population of the study and thus this are the accessible population.

1.10 Definition of significant terms used in the study

Risky Sexual behaviour: having sexual contact that predisposes one to sexually transmitted infections or unintended pregnancies.

Education and training: Refers to the knowledge about sexual behaviour imparted to the youth at the centres.

Recreational activities: These are undertakings that are stimulating and rejuvenating for an individual. In this study recreational activities will refer to such activities as games, drama and other interactive activities.

Counseling and testing services: In this study counselling will refer to advice given to the youth in order to influence their sexual behaviour. Testing will refer to the medical test designed to diagnose one's HIV sero status.

Outreach programmes: These are activities aimed at reaching members of the community who are not necessarily members of the youth centre.

Influencing risky sexual behaviour change: Transforming the actions or mannerisms of a youth that may put him/her at risk of sexually transmitted infections and unintended pregnancies.

Youth in Kisumu County: In this study, the word youth will refer to young people in the community preferably men and women below the age of 30 years.

1.11 Organization of the Study

The study was organized in five chapters. The first chapter is the introduction that gives the background of the study, statement of the problem, purpose of the study, objectives of the study, research questions, significance of the study, delimitations and limitations of the study, basic assumptions of the study, organization of the study and lastly the definitions of the terms used.

Chapter two of the study is a literature review of existing material on the role of youth centers in promoting behaviour change among the youth. An empirical review provides results of similar studies carried out across the world while a theoretical review details existing theories on behaviour change. A conceptual framework shows the independent variables (education and training, recreational activities, counseling and testing as well as outreach programmes), their indicators as well as how they interact with the intermediary variable (prevention of STIs and unintended pregnancies) and the dependent variable (behaviour change).

The third chapter details the research methodology used, involving the research design, target population, sample size, sample selection, research instruments, pilot testing of the instruments, reliability of research instruments, data collection procedures, data analysis techniques and ethical issues in research. The fourth chapter presents findings of data analysis, presentation, interpretations and discussions, it focuses on the questionnaire response rate. The fifth chapter summarizes the findings, conclusions, recommendations, contributions of the study to the body of knowledge and suggestions for further research emanating from the research study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

A youth centre is an open access or universal service for all young people as opposed to a targeted service or programme for a few young people. It must have a physical space in a fixed geographical location that the youth can use. Youth centres can play an important preventative role because for some youth in difficult personal or domestic circumstances, the centre is the only place where they can meet safely and obtain the support that they need. Outcomes for young people are improved by engaging in structured activities (Sorhaindo and Feinstein, 2007).

Sexual behaviour knowledge to youth aged 14 to 35 years, studies conducted concluded that the young are aware of sexually transmitted diseases but unaware of how it is physically transmitted from person to person, especially the asymptomatic phase and methods of preventing infection, it showed moderate to high levels of misconceptions about the risk of casual contact (Douglas K, 2002).

In Limpopo province, South Africa, it was found that the main source of information on sexual behaviour was television and radio, the study advised for use of practical and visual aids in passing the risky sexual behaviour message (Peltzer, K and Changa, R.2003). There is need for use of peer educators for passing on messages to the youth as there is a gap in the youth, between knowledge and practice among youth on STIs, and therefore the need for a vehicle to target information specifically for the youth (Afenyadu, 2003). Participatory approach to HIV/AIDS prevention among the rural youth, done in 28 counties, the programme discouraged cultural premature and immoral sexual behaviors, educating the youth of prevention and promoting safe sex, active participation of youth was encouraged, a dispensary in each county was turned into information center for the youth. It concluded that youth participation through policy formulation and implementation can be successful at all levels if properly facilitated on their roles (Amuri O et al, 1998).

2.2 Education and training at youth centres on influencing risky sexual behaviour change among the youth.

Education is a complex concept, defined as the process of becoming critically aware of ones reality in a manner leads to effective action upon acquiring it. It is defined as the process of learning to be self-reliant person in society (Paulo Freire, 1970). Some of the functions of education are; bringing about individual development, preserving culture and values of the society (passing on accumulated knowledge and wisdom from one generation to another), bringing about change (social, political, economic, behavioural etc.) and catering for specific needs of people. These functions point to education contributing to the development of an individual and the society in which one operates (Bennars and Njoroge, 1980).

Education can take place formally i.e. organised education activities within established systems, informally whereby its unorganised learning where individuals undergo throughout their lifetime due to reaction of physical and social environment, Non formal, its organised educational activity outside the established formal educational system, its flexible and diverse and adapted to particular needs of its clients e.g. on job training. In schools behaviour and life skills education is infused in existing subjects and not taught as a separate subject. Safe sexually behaviour education for young people plays a vital role in global efforts to sex related problems (Houa, 2010).

AIDS education also helps to reduce stigma and discrimination, by dispelling false information that can lead to fear and blame. This is crucial for prevention, as stigma often makes people reluctant to be tested for HIV and individuals that are unaware of their HIV infection are more likely to pass the virus on to others (Kalichman S.C. 2006). There is empirical evidence of the impact of these youth centres in some countries of Sub Saharan Africa like Zambia, Kenya, Uganda, and Malawi. Assessment done on behaviour change communication for adolescents in terms of programs policies in Uganda, Malawi, and Zambia, clubs have been proven to be good and have great potential for reaching a large numbers of youth in an effectively and culturally acceptable manner (Nasibi, 2004).

In a study on the effectiveness of youth clubs in East and Southern Africa, it was found that the evaluation of youth clubs on training have shown that youth center members have more knowledge, but risk taking behavior changes minimally; study results also showed that youth rush through learning activities and spend a lot of time on the fun activities at the clubs while curriculum implementation of information is not there. The authors concluded that Knowledge level of risky behaviour is (80% - 90%) in most Subs Saharan African region, but this knowledge has not been translated into evident behaviour change. Knowledge of the importance of using condoms in sexual encounters is also quite high among youth in Africa, but it is difficult to motivate adolescents in their behavior change and lives, because of poverty being the immediate goal of prime importance in the communities. Hence, the selling of sex for money, lack of access to health services (Nduati and Kiai, 1996).

In 2006, PSI international carried out a survey on youth centers achievements in molding behaviour change across the continent. The study found that In Cameroon, youth of both sexes who were exposed to the program were more likely to know how to use condoms correctly and less shy to buy condoms. After 18 months of program activities, 69 percent of young men with high levels of exposure to the program reported using a condom the last time they had sex with a regular partner, compared with only 56 percent of those with low program exposure. (Meekers D, 2003) In Rwanda, young people exposed to the program were more likely to believe condoms are effective for preventing STIs, believe their friends and family support condom use, and know where to find condoms and how to use them. Youth of both sexes who were exposed to the program were also more likely to use counseling and testing services: Eight percent of young women ages 15 to 24 with high program exposure had an HIV test, compared with only 2 percent of those with low exposure. Madagascar, the number of youth ages 15 to 24 seeking STI treatment and other reproductive health services at youth-friendly clinics rose dramatically, from 122 youth in the first month to 716 youth (predominantly female) in the 24th month of program activities (Ntaganira, J. 2012).

In Malawi, a youth club intended to produce behaviour change in the community in the fight against the HIV/AIDS scourge was studied. The Rakaia AIDS information network was started in response to the needs of people of Rakaia. The activities included counselling, community health care project and IEC among adolescents. The targeted people were the out of school youth age 17 – 25 years. The target activities included: AIDS information, prevention of HIV with emphasis on condom use and safer sex practices and negotiations skills and group facilitation skills. An evaluation and follow up which was done after one year showed that trained youth were more knowledgeable about HIV and condom use and were more likely to use condoms than youth who had not been trained. Older members of the community observed positive change in behaviour of the youth (Bello G, 2012).

2.3 Recreational Activities at youth centres on influencing risky sexual behaviour change among the youth.

Recreation activities in schools fall under creative arts subject. These are mainly music, art and craft, physical education i.e. games and sports, poetry etc. Creative Arts Education, he states that communicating the safe sex message through creative arts is important because; creative arts inspire an individual to seek new unique approaches to solutions of problems, it leads to individuals developing a relationship with the environment, gives an opportunity for self-expression and alleviate inner emotions that can't be expressed in theory and lastly it contributes to good use of leisure time (Digoto Obonyo, 1980).

Many programs offer behaviour change education but often the information is not delivered in an effective manner. Sport is the most popular activity among youth and has a unique chance to educate and influence the future generation of people. Sports give the children joy and hope, opportunities to learn while they play with others. Sport, physical activity and educational games offer a unique, non-threatening, fun, safe environment where safe and responsible sex can be openly discussed where they can acknowledge the risk factors and learn the life skills to survive it. Sport can also be a positive input in the lives of those already infected and affected by STIs (Banda D and Lindsay I, 2010).

Recreational activities are uniquely poised to spread crucial knowledge and prevention messages about responsible sexual behaviour to young people. They can increase young people's access to services, teach life skills, bring communities together, and, particularly, address young people in a language they understand. Life skills education can be provided during practices, through coaching sessions, during events and at half-times. It can be done through several means, including by teachers, coaches and peers.

The youth are more likely to respond to STI-prevention messages conveyed by their coaches and peers on the playing field than messages conveyed by their teachers in the classroom. An open discussion about risky sexual behaviour can also counteract stigma and discrimination and promote care and support for those affected by these diseases. At the same time, sports participation provides young people infected or affected, including orphans and other vulnerable children, a safe and supportive space where they can feel a sense of belonging and be protected from exploitation and harm (Hindin, 2009).

In Nairobi, the Mathare Youth Sports Association has created safe spaces for around 16,000 adolescents who live in the poorest neighborhoods of Nairobi. More than 1,000 youth sports teams play over 1,000 matches a year on weekends and holidays and association teams have won many youth tournaments in Kenya and abroad. In fact, the programme, which links youth development, sports and environmental activism, is so innovative and successful that in 2003 it was shortlisted for the Nobel Peace Prize. When not on the field, players clear garbage and blocked drainage ditches in their neighborhoods', earning the organization the United Nations Environmental Programme's Global 500 Award in 1992. Part of the group's philosophy is helping its members develop life skills on and off the playing field. Over the years, the association has increased the scope of its programme. Today, in addition to sports, it operates an HIV/AIDS education programme, an educational scholarship programme, a photography project and numerous community service and environmental education activities.

A similar study in Malawi found that Although most youth centers and programs offer some sort of recreational activity for adolescents and young people, and many of them

have a small space appointed for reading/studying, majority of the adolescents and many of the young people interviewed stated that this is an area that requires even greater attention. Such facilities could help to keep young people active, provide them with alternatives to sexual activity, and give them a place where they can gather to talk, vent, brainstorm, learn, and share with each other their experiences (Munthali, K 2011).

Lack of recreational facilities was cited as making the youth to have an idle mind, hence, indulge in sex. The youth also want to experiment with sex how it feels like especially after watching blue movies in illegal places in the locations. Girls went to the extent of saying that poor counselling by health workers on HIV/AIDS makes some girls become reckless, to spread the disease to more people. Poor counseling by parents on life skills and hospitals not being youth friendly was also cited as a contributory factor to high-risk sexual behavior. Transactional sex due to poverty was also cited by the girls and peer pressure that the girls want to like others in terms of trying sex in relationships with the boys (Choi, D. 2011).

2.4 Voluntary Counselling and Testing at the youth centre on influencing risky sexual behaviour change among the youth.

Voluntary counselling and testing is a powerful tool in fighting the STI pandemic. It has three principles; it is voluntary that means that no client coerced or persuaded to go to the VCT, rather they are educated on the importance of having a test, and if ready one consents to having the test. The other is confidentiality, the clients are tested anonymously and no report is written and the results are discussed with the client. The last principle is education and counselling, education clarifies facts around safe sex behaviour and helps equip the client with the necessary knowledge to reduce the risk of infection or re-infection while counselling assess the clients personal risk behaviour and exposure to infection and helps them to explore ways of how to reduce it (KAIS Report,2012).

Counseling and testing is an important component of youth centres and youth clubs. The main aim of this exercise is to manage those already infected and prevent the non-

infected from acquiring the diseases. In Kenya, this is done through integration of the Voluntary Counselling and Testing Program (VCT) into youth centers and clubs (Houa, 2010).

Voluntary counselling and testing is a crucial intervention strategy for promoting safe sex behaviour, providing personalized support, and serving as an entry point for care and treatment for those infected. VCT is largely aimed at the asymptomatic individual and offers those wishing to be tested for STI both pre and post-test counselling as well as on-site rapid HIV testing (Taegtmeyer, Kilonzo, Mung'ala, Morgan, & Theobald, 2006). Since their implementation, VCT programs have demonstrated their ability to promote safe sexual behaviour and provide care and support services among adults (Kamenga & Coates, 1998). In spite of this progress, up to 80% of Kenyans aged 15 to 54 still do not know their HIV status and the particular successes and challenges of VCT in Kenya must be further scrutinized before the system can be improved. When considering the vast amount of resources that have gone into making VCT widely available and accessible, the remaining barriers to the uptake of VCT must be identified (KAIS Report, 2007).

The task of counselling young people on the topic of well-being is not an easy one. Counsellors need to understand the thinking and behaviour of young people in order to respond appropriately, which is sometimes difficult to do, as young people often vacillate between child-like and adult thinking and behaviour (Van Dyk, 2001). Youth with infected with STIs, especially HIV are sometimes referred to as *resistant* patients. This is often due to the extensive development that takes place during this phase and also to the many difficulties they need to overcome in their search for identity. They may demonstrate feelings of resistance, skepticism and distrust towards counselling, and counsellors are required to be understanding of this type of behaviour that is considered "normal" in people of this age group (Bor et al., 1992).

In addition, there are many young people who, as a result of their own experiences, and also as a result of information they have received from others, hold unfavorable perceptions of health-care workers (Russell & Schneider, 2000).

This is likely to increase the amount of resistance they demonstrate towards counsellors themselves and also towards the counselling process. In this situation, the counsellor is encouraged not to precipitate an argument by trying to agree with the young person regarding his/her skepticism about counselling. While maintaining this approach the counsellor also needs to try to maintain a balance with firmness, which conveys boundaries and limits.

One of the aims of counselling an adolescent infected with HIV virus is to help normalize the situation for him/her without denying reality. The counsellor's purpose is to help the young person grow and develop as a person and to have hopes and dreams for the future (Bor et al, 2005).

2.5 Outreach programs at the youth centre on influencing risky sexual behaviour change among the youth.

Outreach programs are another important component of youth centers or clubs. The main aim of these programs is community sensitization. A growing number of youth groups and centers are involving community groups explicitly to improve project outcomes of behaviour change and help sustain the interventions. Organizations are increasingly recording, evaluating, and sharing lessons from these efforts (Houa, 2010). Community outreach and mobilization can encompass a range of interventions and approaches, including: community meetings; training or sensitization sessions with traditional authorities, community or religious leaders; street theatre and other cultural activities and marches and demonstrations. Mass media campaigns normally use radio, television, billboards or other media to reach a wide segment of a community. It also offers individuals, especially young people, anonymous access to valuable information and resources without having to go through others they may not trust e.g. doctors, teachers, etc. (Nasibi W.M.W, 2004).

2.6 Theoretical Framework

Behaviour change is important because the solution of social problems depends on the measure in what people are persuaded to adopt new behaviour patterns. The existing theories and patterns of behaviour change show that behaviour change of an individual, group or society is a long term process that is implemented in stages. Adolescents are exposed to sexual exploitations daily including, music, magazines, internet, friends etc. (Burton C.W, 2012).

There are various theories and models of behaviour change. The models are built on different assumptions but state that behaviour changes occur by altering potential risk producing situations and social relationships, risk perception, attitudes, self-efficacy beliefs (Kalichman, 2006).The models are useful to program designers in that they suggest specific areas for educational interventions, although presented separately, they are not mutually exclusive and may operate simultaneously in influencing behaviour change (Hornik, 1991).Behaviour Change Communication (BCC) is a tool used in various youth centres in planning for activities that will be employed at the youth centres. BCC entails use of communication approaches and tools with a view to empowering young people with skills and capabilities to enable them promote and manage their own health and development. A number of functions or activities are deployed to achieve BCC goals e.g. interactive approaches, group activities, educational material dissemination, entertainment, connecting to communities etc. (Wangulu, E. 2008).

Theory of planned behaviour.

The study will be based upon The Theory of Planned Behavior (TPB) by Ajzen (1991). The Theory of Planned Behaviour has often been applied to predict the likelihood of healthy behaviour (Hardeman, 2002), including condom use (Albarracin, 2001), dieting (Bagozzi, 2004), product choice, supportive behaviours, and voting (Cooke & Sheeran, 2004).The Theory of Planned Behaviour built upon the earlier Theory of Reasoned Action (Ajzen & Fishbein, 1970), focuses on the theoretical constructs that are concerned with individual motivational factors as determinants of the likelihood of performing a specific behaviour.

According to the theory, an individual's intention to perform a specific behaviour is a direct determinant of whether he or she will act. To accurately assess the behaviour, one must take into account the target, time, context and behaviour on which the intent is being judged (Ajzen & Fishbein, 2000; Ajzen & Fishbein, 1970). The theory predicts that the intention to perform behaviour is a function of three salient beliefs: the person's attitude, subjective norms and perceived behavioral control. This theory is relevant to this study because behaviour change is a subject of investigation in this research. According to the authors of this theory, behaviour change is controlled by a person's attitude, subjective norms and perceived behavioral control. All these aspects are controlled by the amount of information one has concerning the item in question in this case risky sexual behaviour. Tuungane youth center aims at reducing the spread of HIV/AIDS by primarily imparting knowledge to the youth members about the disease and consequences of risky sexual behaviours. This is done in several ways be it lecturers, role plays, peer groups, TV/radio and cinema as well as recreational activities. Knowledge is power. Possession of such knowledge hinders misleading attitudes and helps the youth understand subjective norms and how they put them at risk.

2.7 Conceptual Framework

A conceptual framework was suggested for the study.

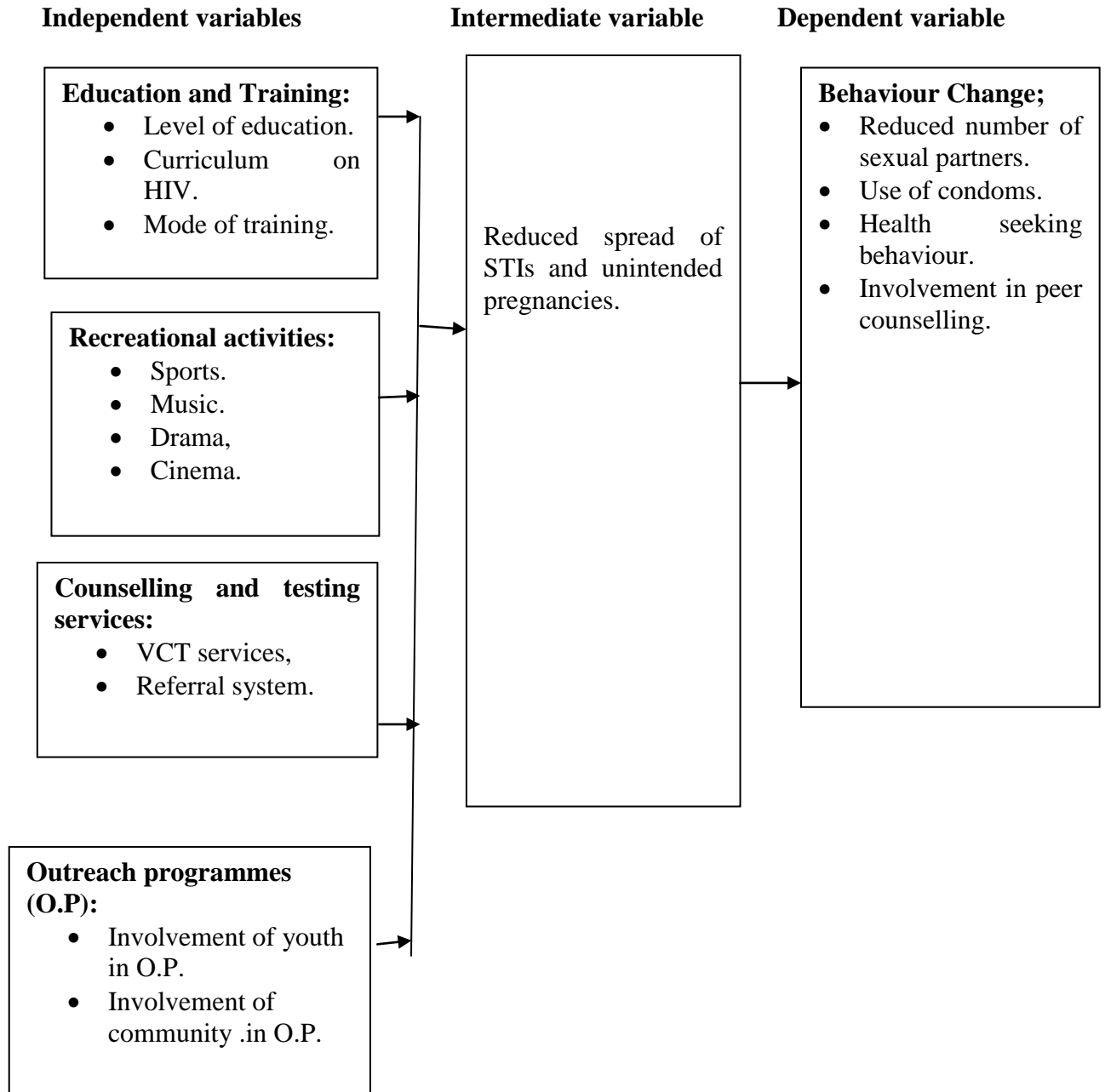


Figure 1: Conceptual Framework

The independent variables in the study are mainly the components of the youth centres: education and training, recreational activities, counseling and testing and outreach programmes. The dependent variable is the risky behaviour change while the intervening variable are the reduction in STI, and unwanted pregnancies.

2.8 Summary of gaps to be filled

Reviewed literature has established that to reduce sexual risk behaviours and related problems among the youth, youth serving organizations can help young people adopt lifelong attitude and behaviours that support their health and well-being (Frieden T.R, 2012). Providing the youth with basic healthy sexual behaviour enables them to protect themselves from becoming infected. Young people are often particularly vulnerable to risky sexual behaviour. Acquiring knowledge and skills encourages young people to avoid or reduce behaviors that carry a risk of STI infection and unintended pregnancies. Even for young people who are not yet engaging in risky behaviors, behaviour education is important for ensuring that they are prepared for situations that will put them at risk as they grow older (Hindin M.J, 2009).

Through recreational activities at the youth centres such as sports young people have the opportunity to talk about sexual behaviour openly and with sensitivity and learn ways to protect them from diseases, including how to resist unwanted pressure and intimidation. This improves awareness thus eliciting behaviour change (Digoto Obonyo,1980). By informing clients of their HIV serostatus and creating personalized STI prevention plans, testing and counselling can provide the support necessary to change risky sexual behaviours and prevent the transmission of STDs (KAIS Report 2012).

Community outreach programmes result in behaviour change by offering individuals, especially young people, anonymous access to valuable information and resources without having to go through others they may not trust (Gupta G.R. 2008). The area of HIV/AIDS has been extensively researched for the last two decades. However, studies in the area of behaviour change have looked into the end result in a holistic approach without assessing the factors contributing to the observed behaviour change or lack thereof. This study intends to look into behaviour change among the youth by assessing the quality of education and training, recreational activities, counseling and testing as well as outreach programmes offered at a youth centre, the biggest gap currently is lack of youth centres that provide risky behaviour change activities.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter explains how the researcher carried out the study in terms of research design, sampling, data collection instrument and data analysis.

3.2 Research Design

The study employed a case study technique. A case study is an in depth investigation of an individual or phenomenon (Mugenda and Mugenda, 2003). This case study is an example of group on individuals under study. The purpose of the case study is to determine factors and relationships that have resulted in the behaviour under study. The researcher settled on this design because youth centers that specifically deal with risky sexual behaviour change targeting the youth in Kenya are few and far between. In addition, the design provides a great amount of description and detail about a particular case. This helps to set the groundwork for future studies. A case study would therefore provide the best design for this study.

3.3 Target Population

Target population refers to a group of individuals with having common observable characteristics. The study targeted all the members of Tuungane Youth Centre, youth and the counsellors, and also the community whereby they stay and attend school. Tuungane Youth Centre which is located in Kisumu County. Kisumu is located on the shores of Lake Victoria. It is the third largest town in Kenya and the capital of Nyanza province. It has a Population of 500,000 with 2.8% growth rate. 60% of the populations live in slums. Key economic activities include fishing, agriculture and trade. As of October 2014, Tuungane youth centre had 12 employees and attended to 426 youth on ART therapy and 1119 on care, from this target population or accessible population, a sample population was selected and considered a representative of the whole population.

3.4 Sample size and Sampling procedure

This section details how the researcher arrived at a sample from a target population

3.4.1 Sample size

A sample is a small portion of the target population selected for analysis. The main objective of education research is to learn something about a large population of subjects by studying a smaller group of its subjects called a sample. According to Mugenda and Mugenda (2003), the following formula should be used to determine the sample size; For this study the researcher specified the confidence level as 95%, an error margin of + / – 5% as being acceptable and its expected that 90% of the sampled population will answer the questions.

$$n = \frac{Z^2_{\alpha} P (1-P)}{m^2} \quad \text{Whereby;}$$

n=the desired sample size.

Z=the standard normal deviate at the required confidence level for which probability of falling above α is 95%.

For $\alpha = 0.05$, $Z_{0.05} = 1.96$ that is for 95% CI, $Z = 1.96$

P=the expected proportion in the target population or estimated to have characteristics being measured.

M= degree of precision or tolerance error margin or width of the confidence interval. The width of CI is always 2 times of the precision.

$$N = \frac{1.96^2 \cdot 0.9(0.1)}{0.05^2} = 138$$

Anticipating a percentage of non-participation plus use of purposive sampling for the community, the sample size increased to 187 as explained below.

3.4.2 Sampling Procedure

The study employed stratified random sampling technique to select a representative sample as shown below. This is due to the different subgroups in the population, i.e. the staff at the centre, youth on care, youth on ART, and the community they are involved in.

This method ensured inclusion in the sample of all the subgroups which would otherwise be omitted by other sampling methods.

In addition purposive sampling was employed to choose the community respondents. Out of the youth selected 10% were given questionnaires to take home to their guardians and another 10% to teachers in their schools. This is purposive to ensure that we capture the community that the youth interact with and no generalizations occurring. Mugenda and Mugenda (2003) advocated that in a stratified random sampling technique, samples size should range from 10-30 percent of the entire population. Therefore taking a share of 10% in each zone gave the sample as shown in table 3.1:

Table 3.1 Sampling frame

Category	Population	Sample (n=10%*population)
Staff	12	2
Youth on ART	426	43
Youth on care	1119	112
Community (Home)	155	15
Community (School)	155	15
Total	1867	187

The study collected data from 187 respondents.

3.5 Research Instruments

Questionnaires and an interview schedule was used to collect data. The questionnaire was used to collect data from the sampled youth members and was divided into two sections A and B. Section A contained demographic information concerning the respondents. Section B contained questions concerning components of the youth center and their influence of behaviour change. The areas included education and training, recreational activities, counseling and testing services and outreach programs. Likert scale was used to assess the influence of the components to behaviour change. An

interview schedule was used to collect data from the 2 sampled members of staff. In the case of the communities a similar format of questionnaires as the youth was employed with different set of questions.

3.5.1 Pilot testing of instruments

Ten questionnaires were administered to 7 youths, 1 counsellors and 2 in the community as a pilot test at Lumumba health centre prior to its implementation. This helped the researcher to identify any unclear or confusing questions. It also helped to capture important comments and suggestions from the respondents. It also helped in enhancing the reliability of the instruments. The data collected during piloting was analysed and interpreted thus leading to further review of the instrument in readiness for the main data collection activity.

3.5.2 Validity of instruments

According to Borg and Gall (1996), Validity is the degree to which a test measures what it ought to measure. For this study, content validity was used. The research established content validity for the instrument by conducting a pilot study for pre-testing it in order to identify any vague, ambiguous or difficult items in the questionnaire. The piloting was done at Lumumba health centre and the community on 10 respondents. Mugenda & Mugenda (2003) stated that any measurement contains an error, which has two components, random and systematic. Invalid instruments lead to enormous systematic errors that reduce accuracy of findings. Valid instruments generate data that corresponds to reality. The researcher ensured content validity by consulting her supervisors. The researcher also sought input from colleagues and statisticians.

To avoid instrumentation as a threat to internal validity, the same research team was involved from piloting through to the main study. This ensured consistency and uniformity. The youth in the centre were assumed to be a representative of the youth in Kisumu County.

3.5.3 Reliability of instruments

The reliability of an instrument refers to the extent to which the instrument gives constant results (Mugenda & Mugenda, 2003). It also denotes the variance attributable to the true measurement of a variable and estimates the consistency of such measurements overtime (Mugenda, 2008). The instrument were pretested in a pilot study. According to Orodho (2005), a share of 10% of a study's sample is sufficient to be carried out a pilot test upon.

Test-retest technique of reliability testing was employed in the pilot questionnaire, which was administered to the respondents twice with a two weeks interval. Instrument reliability is influenced primarily by random errors. Random errors occur when the researcher has not addressed certain factors in the research effectively. The pilot study provided necessary data that enabled calculation of reliability using the Pearson Correlation formula (r). Any research instrument with correlation coefficient between 0.7 upwards is accepted as reliable enough (Mugenda and Mugenda, 2003).

$$r = \frac{\sum XY - \frac{\sum X \sum Y}{N}}{\sqrt{\left(\sum X^2 - \frac{(\sum X)^2}{N}\right)} \sqrt{\left(\sum Y^2 - \frac{(\sum Y)^2}{N}\right)}}$$

Where,

r= degree of reliability

N= the number of observations or subjects of x and y

Y= scores obtained during the second test

X=scores obtained during the first test

Σ = summation sign

3.6 Data Collection Procedures

The researcher sought clearance to carry out the research from the University of Nairobi. The researcher also obtained a research permit from the National Commission for Science and Technology (NaCoSTI) after which she presented the permit to the County

commissioner. And a request for introductory letter to the county medical director of health sought. The researcher then made an introductory visit to the facility, on an agreed date the researcher gave the counsellors the questionnaires to distribute to the respondents and collected them at the end of the day for two weeks, the questionnaires to the community were also collected as soon as brought back. The researcher also recruited 2 research assistants to help in the data collection and analysis. The assistants were trained prior to the data collection.

The research team visited the research stations in person for introduction to the counsellors at the centre, questionnaire distribution and administration and collection of completed questionnaires at the end of the day. The team also orally explained the importance of the study to the counsellors, requesting the respondents to fill the tool honestly and to the best of their understanding and also assured them that utmost confidentiality would be maintained. Each day the researcher consulted with the assistants before proceeding to the centre and every evening they sat down to do the analysis of what they had collected that day.

3.7 Data Analysis Techniques

Descriptive statistics was used to analyze the quantitative data which was presented in form of frequency and percentage tables. The data presented helped explain the relationship between the variables of study. Qualitative data was organized into themes and patterns, categorized through content analysis and then tabulated. Data obtained from qualitative techniques was useful in making conclusions and recommendation on factors influencing behaviour change. Computer software, Statistical Package for Social Sciences (SPSS) version 19.0 was employed for speed and accuracy.

3.8 Ethical Considerations

HIV/AIDS is a highly sensitive subject in the society, the study was implemented only upon approval by the faculty board following successful defence of the project proposal. Ethical clearance and research authorization permit was obtained from the Ministry of education under the national commission for science and technology who verified ethical considerations in the research

An informed consent was sought from respondents by providing a detailed explanation of the study. All the respondents were made aware of voluntary participation and the confidentiality of information obtained by ensuring them that this information was only to be used for the purposes of the study. The study ensured all the ethical standards were upheld. The respondents had the freedom to ignore questions that they did not wish to respond to. Codes instead of names were used as identifiers to ensure a high level of confidentiality.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION.

4.1 Introduction

This chapter presents the research findings which have been discussed under the thematic subsections in line with the study objectives. The sub sections include results from an evaluation of activities that influence behaviour change among the youth in Kisumu County. The results of the data collected were presented under each of the four objectives of the study.

The subsections include, the questionnaire return rate, demographic characteristics of the respondents , the extent to which education and training at the youth centre influences behaviour change among the youth, the extent to which recreational activities at the youth centre influences behaviour change among the youth, the extent to which counselling and testing at the youth centre influences behaviour change among the youth and the extent to which outreach programs as a component of the youth centre influences behaviour change among the youth.

4.2 Questionnaire Return Rate

This section presents the questionnaire return rate for the different categories of respondents that were targeted during the study. Quantitative primary data was sought through administration of questionnaire to the available respondents. Out of the respondents available 187 responses were obtained. Naichmais and Naichmais (2008) states that a response rate of 75% is acceptable for academic surveys. The researcher decided to analyze the data based on this response rate as it was considered to depict a true picture of the study variables interaction with the available population with minimal non response error.

The interview schedule that targeted the counsellors was used to elicit detailed qualitative information relating to determinants of activities that influence behaviour change at the centers .There was 100% response rate for this interview session. This was possible because the questionnaires were administered at the pharmacy, the respondents were

given the form to fill as they awaited their medication, once they were through they returned the questionnaire and picked their drugs, this ensured that all the questionnaires were filled and returned by the youth, they were also given the community questionnaires to be returned as they picked their next medication in two weeks' time.

The findings are in table 4.1:

Table 4.1 Questionnaire Return Rate:

Respondents	No. of questionnaires administered	No. of questionnaires returned.	Percentage.
Youth	155	155	100%
Counsellors	2	2	100%
Community	30	30	100%
Total	187	187	100%

From the table 4.1, the total number of questionnaires administered were 187 and all were returned, this was because the centre informed the respondents a week prior to the activity and a follow up reminder a day prior so most were prepared. They were made aware of the objectives of the study and fortunately they all accepted to participate. They were explained that their identity will not be disclosed and utmost honesty is required. The respondents were also given enough time to answer the questionnaires and handed them back at the end of the day. The questionnaires to the community were given to 30 of the youth and returned after 2 days.

4.3 Demographic Characteristics of Respondents;

This section describes the demographic characteristics of the respondents by age, gender, and academic qualifications of the counsellors.

4.3.1 Distribution of the respondents by age;

The study sought to describe the age distribution of the respondents. This was necessary for the researcher in order to have appropriate background understanding of the demographic feature among the respondents and how they relate to the activities offered. The findings are in the table 4.2

Table 4.2: Distribution of youth by age

Age Bracket	Youth Frequency	Percentage
Below 14	3	1.6%
14 -19	68	36.4%
20 -24	75	40.1%
25 -30	9	4.8%
Above 30	0	17.1%
Total	155	100%

In terms of age, 3 (1.6%) were below 14, 68 (36.4%) were between 14 and 19 years , 75 (40.1%) were between 20 and 24 years old, 9 (4.8%) between 25 to 30 years, all in the youth bracket, Above 30 years were reported in the community and counsellors. Therefore the youth age ranges mostly between 14 and 30 years and a majority are between 14 to 24 years, accounting for over 76% of the respondents.

4.3.2 Distribution of respondents by gender

This study sought to establish the respondents by gender, in order to provide background for analysis of determinants of the gender of those who access the centre. The results were presented in the table 4.3;

Table 4.3: Gender of the youth who access the youth centre

Gender	Frequency	Percentage
Female	58	37.4%
Male	97	62.6%
Total	155	100%

The table 4.3 shows that 58 (37.4%) of the youth sampled were female while 97 (62.6%) of the youth sampled were males. This indicates that mostly males access the youth centre. In recognition of gender equality and equity in all areas of development, the Government and the other stakeholders should develop strategies and initiatives to address gender mainstreaming at the youth centers. Among youth aged 15–24 years, HIV prevalence was higher among women than men from the age of 17 years. Among women, HIV increased linearly with increasing age, with the highest increase between the ages of 22 and 23 years. This shows that though the prevalence is high in females while more of the males are accessing the centres (KAIS Report, 2012)

4.3.3 Academic qualification of the counsellors

The study also sought to establish the highest qualification of the counsellors, they were therefore asked to state their highest professional qualifications in behaviour change counselling and HIV/AIDS training. The findings are presented in Table 4.4

Table 4.4: Academic qualifications of the counsellors

Highest Academic qualification	Frequency	Percentage
Form four certificate	0	0%
College diploma	2	100%
University degree	0	0%
Total	2	100%

The table 4.4 shows that 2 (100%), of the sampled counsellors had college diplomas, from this findings it can be said that the counsellors are qualified to impart the necessary

knowledge to the youth, A teacher needs the necessary training in the respective subject in order to meet the set objectives (Omulandu 1992).

4.3.4 Length of time at the youth centre.

The study sought to find out how long the youth have been at the youth centre. The findings are presented in the table 4.5 below;

Table 4.5:Length of time at the youth centre

Length of time at the centre	Frequency	Percentage
Less than 1 year	18	12.9%
1 – 3 Years	61	43.9%
4 – 6 Years	45	32.4%
7 – 9 years	18	12.6%
Over 10 Years	7	0.05%
Total	139	100%

The results in table 4.5 show that most of the youth, 61 (43.9%) have been at the centre for 1 – 3 years. This results collaborates with the answer given by the counsellors that most of the youth leave upon attaining 24 years, most of them join at around 15 years of age and after an average of 8 years leave the centre, some remain to be trained as counsellors and help out as team leaders during the outreaches in the community.

4.3.5 Length of time in the community

The study sought to find out how long the youth has been a member of the particular community, so as to find out if the effect of his involvement there has any significant effect of those he interacts with in the community. The 30 youth respondents who took the questionnaires to the community were chosen from the ones who have been at the centre for 4 years and above, 15 were given to take to their schools and 15 were given to take to their parents or guardians. The findings are as stated in table 4.6

Table 4.6 Length of time in the community

Length of time in the community	Frequency	Percentage
Less than 1 year	1	3.3%
1 – 3 years	2	6.6%
4 – 6 years	14	46.7%
7 – 9 years	5	16.7%
Over 10 years	8	26.7%
Total	30	100%

It was deduced from table 4.6 that a majority of the youth, 14 (46.7%) have been in the community for between 4 to 6 years, this length of time interacting with the same people would give the people they interact with adequate time to observe any behaviour change. As noted earlier for any behaviour change to manifest it must be repeated severally until it becomes a habit. The community interacting with the youth would also require ample time to observe this behaviour change therefore for majority, 4 to 6 years would be adequate to conclude that there is marked behaviour change.

4.4 Education and training at the youth centre and risky sexual behaviour change.

It was important to understand how education and training offered at the centre influenced the youths' risky sexual behaviour, the type of education offered, if the members behaviour changed, if the member had a positive influence to others in the community. The findings are presented in the table 4.7

Table 4.7: Education and training at the youth centre on influencing risky sexual behaviour change.

	YES		NO		NOT SURE	
	Freq.	%	Freq.	%	Freq.	%
Is education and training offered at the youth centre?	170	92%	3	1.6%	11	5.9%
Is the education and training on HIV/AIDS?	168	91%	2	1.1%	12	6.5%
Has the education and training influenced the behaviour of the youth?	23	76.7%	2	6.7%	3	10%
Has the youth's behaviour changed positively?	21	70%	1	3%	4	13%
Has the youth influenced others in the community?	22	73%	2	6.7%	4	13.3%

From the table 4.7, out of the 185 respondents asked if education and training is offered at the youth centre, 170 (92%) said yes while 11 (5.9%) were not sure while 3 (1.6%) said no. Out of the 185 asked if the training was on HIV/AIDs, 168 (91%) said yes, 2 (1.1%) said No while 12 (6.5%) were not sure. Out of the 30 asked if the training influenced the behaviour of the youth 23 (76.7%) said yes, 2 (6.7%) said No while 3 (10%) were not sure.

Out of the 30 asked if their behaviour changed positively 21 (70%) said yes, 1 (3%) said No and 4 (13%) were not sure. Out of the 30 asked if the youth influenced the community positively, 22 (73%) said yes, 2 (6.7%) said No and 4 (13.3%) were not sure.

This shows that a majority of the respondents believed that education and training offered at the centre influenced the youth's behaviour positively and this also had a positive effect in the people they interacted with at the community. This is in line with Durlak and Weissberg (2007), who stated that education and training or a school environment causes

positive change in behaviour of an individual, it states that an environment that offers education will improve one's social and personal development and therefore youth clubs or centres should provide this opportunity to young people. This is also in line with the programmes offered in the USA, which have succeeded in improving the youth behaviour and attitudes through education and training (Alford, 2009).

In addition, out of the 155 youth sampled for the mode of training offered at the centres, 138 (89%) chose lectures, 105 (68%) chose focus groups, and 81 (52%) chose audio visual, this shows that more than one mode of training is offered at the centre, it's a combination of all the three as more than half of the respondents chose more than one mode of training. A combination of interactive tactics such as problem solved learning, simulation along with reinforcement strategies such as commitment to change instruments and follow up reminders must be incorporated into the design of educational programs in order to successfully change the behaviour of an individual (Deluca, M.J et al., 2009).

Out of the 155 youth sampled on who offers the trainings 143 (92.3%) said the counsellors or Tuungane staff, therefore we can conclude that most of the training is done by the staff at Tuungane, also 138 (89%) of them said the trainings are done weekly while 15 (0.1%) said daily.

Out of all the 185 respondents asked about the effectiveness of education and training in causing behaviour change 98 (53%) said it was very effective, 61 (33%) said it was effective, 5 (0.03%) said it was neutral, 3 (0.02%) said it was ineffective while 1 (0.01%) said it was very in effective. From this the majority 159 (86%) said it was effective and very effective.

One of the major objectives of education and training is to change the behaviour of an individual, team or department, training is the start in the process of awareness, it helps establish the blue print for changing behaviour and how various components of the desired behaviour are incorporated in the daily process of an individual (Shoemaker

D.2010).Educational programs can help the youth adopt lifelong attitudes and behaviour that supports overall health and wellbeing including behaviours that can reduce their risk of STD (Eaton D.K, 2010).

Education is a process of becoming critically aware of one’s reality, and leads to effective action upon acquiring it. One of the functions of education is to bring about positive change, whether social, political, behavioral or economic. It contributes to development of an individual and the society he is involved in (Paulo Freire, 1970).

4.5 Recreational activities at the youth centre and risky sexual behaviour change.

This section discusses how the recreational activities e.g. sports, drama, music etc. as a component of the youth centre influences the behaviour of the youth. The results of this are presented in table 4.8

Table 4.8 Recreational activities at the youth centre on influencing risky sexual behaviour change.

	YES		NO		NOT SURE	
	Freq.	%	Freq.	%	Freq.	%
Is recreational activities offered at the centre?	143	77%	17/185	9.2%	7/185	3.8%
Has recreational activities influenced the behaviour of the youth?	17	56.7%	5/30	16.7%	5/30	16.7%
Has the youth’s utilized this activities positively to influence community?	15	50%	6/30	20%	3/30	30%
Has the youth involved others in community?	15	50%	5/30	16.7%	2/30	6.7%

As shown in the table 4.8, out of the 185 respondents questioned, 143 (77%) are aware that recreational activities are provided at the centre. 17 (56.7%) of the 30 respondents in

the community, said that the activities influenced the youths behaviour, while 15 (50%) said the youth interacted with others using this activities, therefore able to influence others using the activities. Some of the community respondents also added that after the said activities, the youth gathered the rest of their peers who were taking part in the activity and others who were spectating and give talks on HIV/AIDS and joining the youth centres.

The most popular of the activities at the centre was found to be sports and games 74 (47.8%), then music and dancing at 40 (25.8%) and lastly drama at 33 (21.3%). On Frequency of the games, 57 (36.8) said daily, 46 (29.7) said weekly, 4 (0.03%) said fortnightly while 16 (10.3%) said monthly.

On the effectiveness of recreational activities, out of the 185 respondents asked this question, 96 (51%) said it was very effective, 42 (23%), said it was effective, 5 (0.03%) were neutral, 2 (0.01%) in effective and 3 (0.02%) very ineffective. Overall the perception is that recreational activities is very effective and effective in causing behaviour change. It was reported that youth who take part in physical activities were less likely to take part in a range of risky health behaviours, also active youth were less likely to have low self-esteem and more likely to have high grades in school (Paedriatics, 2007). This is supported by study done at the Masiphumele youth centre in South Africa, which showed that recreational activities, education and health services offered to the youth, caused a positive impact in their behaviour (Buga G.A, 1996).

The Manyata youth group in Mombasa, Kenya also advocates for use of recreational activities to influence behaviour, they use drama to engage both the youth and community and give talks on HIV/AIDS in different schools (www.manyatta youth group, Mombasa).

Recreational activities are important in communicating the HIV/AIDS message, creative arts inspires an individual to seek new, unique approaches to solutions of problems, it gives an opportunity for self-expression and alleviating inner emotions that cannot be

expressed theoretically, it also contributes to good use of leisure time and this ensures the youth are kept away from socially ill activities (Digoto Obonyo, 1980).

The various recreational activities that can be offered are sports and games, music and drama, films or cinemas etc. This is also supported by (Bandi, 2010), which states that sports, games and drama gives a non-threatening and fun environment where HIV/AIDS can openly be discussed. It was also found that in Malawi the youth centres provided recreational activities e.g. drama and sports that pulled a lot of interest of the youth to join the centres and also gave them an avenue to express themselves (Munthali, 2011).

4.6 Voluntary counselling and testing at the youth centre and risky sexual behaviour change.

This section discusses the findings of voluntary counselling and testing offered at the youth centre and the influence it has on the behaviour of the youth.

Table 4.9 shows the findings

Table 4.9 Voluntary testing and counselling at the youth centre on influencing risky sexual behaviour change.

	YES		NO		NOT SURE	
	Freq.	%	Freq.	%	Freq.	%
Is testing and counselling offered at the centre?	154	83%	7/185	3.8%	9/185	4.9%
Has testing and counselling influenced the behaviour of the youth positively?	21	70%	4/30	13%	2/30	6.7%
Has the youth's influenced others to go for counselling and testing in community?	23	76.7%	3/30	10%	2/30	6.7%
After the VCT, are you referred to another facility?	0	0%	123/155	79%	6/155	3.9%

From the table 4.9, we can conclude that testing and counselling is offered at the facility 154 (83%) of youth centre respondents and 21 (70%) of the respondents from the 30 in the community believe that it has influenced the behaviour of the youth, as most wrote that once the youth were counseled and tested they were able to make informed decisions. Also 23(76.7%) of the community respondents said that the youth encouraged the community members to go for counselling and testing. On the effectiveness of VCT, to cause behaviour change, of the 185 respondents, 63 (34.1%) said it was very effective,72 (38.9%) said it was effective,4 (0.02%) were neutral, 3 (0.02%) said it was ineffective and 5 (0.03%) said it was very ineffective. Therefore, it can be concluded that a majority of the respondents find counselling and testing effective in causing behaviour change. By combining personalized counselling and knowledge of ones HIV status, VCT is designed to motivate people to change their behaviour to prevent the acquisition and transmission of HIV (Asante, K. 2013).

On the issue of referral system, 123 (79%) of the youth said they were not referred elsewhere but that all the processes were done at the youth centre. Learning ones status and receiving counselling at the same time is an important step to receiving care and treatment and also an important intervention for potentially changing risk behaviour(Fonner, V.A et al. 2012).This is also in line with FHOK objectives of offering counselling and testing to the youth as a component of their facilities. According to UNAIDS, 2008, counselling and testing is an important component of youth centres and youth clubs, aimed at managing those already infected and preventing the non-infected from acquiring the disease. This can be done by integratingVCTs in the youth centres. Majority of Kenyans up to 80% do not know their status (KAIS Report, 2007). The aim of counselling is to normalize the situation without denying the reality (Bor et al, 1988).

HIV testing and counselling is an important component of the control of HIV epidemic and essential to reduce HIV related morbidity and mortality. This knowledge enables the infected person to access lifesaving HIV care and treatment and provides an opportunity for HIV prevention counselling to reduce HIV transmission risk among both HIV infected and uninfected persons (KAIS, 2012).

4.7 Youth centre outreach programmes and risky sexual behaviour change.

This section shows the influence of outreach programmes conducted by members of the youth centre involving the community. The findings are presented in table 4.10

Table 4.10: Influence of youth centre outreach programs on risky sexual behaviour change.

	YES		NO		NOT SURE	
	Freq.	%	Freq.	%	Freq.	%
Do the youth take part in outreach programs?	129	69.7%	19/185	10.3%	14/185	7.6%
Are the outreach programs on HIV?	133	71.9%	20/185	10.8%	13/185	7%
Has the youth's influenced others in community during the outreach programs?	21/30	70%	2/30	6.7%	3/30	10%

From the table 4.10, it can be deduced that the youth take part in outreach programs 129 (69.7%) Of the 185 respondents questioned. In addition the programs are mostly on HIV/AIDs 133 (71.9%) of the 185 respondents questioned and this activity has an influence in the community 21 (70%) of the 30 community respondents questioned. The respondents also added that the youth, the counsellors at Tuungane and the community help one another during such sessions.80% of the respondents also said that the sessions were effective or very effective in their mission of identifying those in need of their services and referring them to the centre.

Outreach programs provide education and awareness to the targeted group of people. In Indiana, USA, there is a youth awareness program that works with youth between 13 to 19 years old, on issues surrounding HIV/AIDs. It has a rural outreach program that targets 10 counties. They provide HIV prevention education, HIV testing, counselling

etc. They are able to reach individuals who are infected but are unaware of their status (Cheryl, 1985).

A study done to find out the effect of outreach programs concluded that individuals who had engaged in more outreach programs were less likely to report risky sexual behaviour compared to those with 2 or less participation (Coleman, S.M et al., 2009).The main aim of outreach programs is community sensitization .Community outreach programs include meetings, trainings, or sensitization sessions with the members of the community. Outreach programs are also innovative strategies for bringing PLWH into HIV primary care. Creative and intensive outreach efforts can assure timely and continued treatment for people facing persistent barriers to areas of care, and new innovative outreach strategies have been developed to engage and retain PLWH in care. These include peer educators, street outreaches, community outreach workers etc. (Houa, 2010). Wide spread prevention outreach programs and education efforts are required to reduce the spread of STDs and HIV among the youth.

The respondents were also asked to choose the component that has the most influence in causing behaviour change and preventing the spread of HIV/AIDs. The results are in table 4.11

Table 4.11: Component that is most influential on risky sexual behaviour change.

Component:	Freq.	%
Education and training	63	34%
Counselling and testing	48	26%
Recreational activities	35	19%
Outreach programmes	31	17%
Total	177	97%

From table 4.11,out of the 185 respondents asked the component that mainly promotes behaviour change,63 (34%) chose education and training, 48 (26%) chose counselling and testing, 35 (19%) chose recreational activities while 31 (17%) chose outreach

programmes, the centre provides a combination of all the components therefore able to fully cover the desired effect.

Correct knowledge of and perceptions of personal risk for STDs and unintended pregnancies are essential for making behavioral choices that reduce the risk of acquiring and transmitting diseases (KAIS Report 2012).The youth centres provide all these services and are therefore a good resource the Government can use, in particular to engage the youth. Individual behaviour change is central to improving sexual health.

Efforts are needed to address the broader determinants of sexual behaviour especially those related to social context, no general approach to sexual health promotion will work everywhere. There are comprehensive behavioral interventions needed that take into account the social context into mounting individual level programs that will tackle factors that contribute to risky sexual behavior (Kaye, W. 2006).

4.8 Behaviour Change Component.

This section discusses the different behaviour components that changed after the youth began attending sessions at the youth centre. The components show a reduction in risky sexual behaviour Table 4.12 Behaviour change indicators.

Table 4.12: Behaviour Change Indicators

	YES		NO		NOT SURE	
	Freq.	%	Freq.	%	Freq.	%
Did you have more than one sexual partner before joining the centre?	98	63.2%	18/155	0.12%	5/155	.03%
Do you have more than one sexual partner currently?	8	0.05%	86/155	55.5%	4/155	0.03%
Did use condoms before joining the centre?	17	0.12%	95	61.3%	6	0.04%
Do you use condoms currently?	92	59.4	3	0.02%	4	0.03%
Were you on medication (ARVs or O.Is) before joining the centre?	9	0.06%	106	68.4%	7	0.05%
Are you on medication (ARVs or O.Is) currently?	107	69%	2	0.01%	4	0.03%

The strategies being employed to prevent risky sexual behaviour in youth mainly targets efforts to decrease or delay sexual activity, increase condom use, reduce the number of sexual partners, and increase sex and HIV education (Grey,J. 2011).

Table 4.12 shows that out of the 155 youth respondents,98 (63.2%) had more than one sexual partner before joining the youth centre, but after joining the youth centre this number reduced to 8 (0.05%), on condom use 17 (0.12%) used condoms during sex but after joining 92 (59.4%) use condoms, on use of medication before joining the youth centre 9 (0.06%) were taking medication but after joining the youth centre 107 (69%) are taking medication.

Research has shown that given the right tools young people have the potential to take responsibility for their sexual and reproductive health. Parental involvement and cultural sensitive programs that provide complete and accurate information can go a long way towards helping the youth make good decisions, an example of an organization that has done this is the Global Youth Coalition on HIV/AIDS (GYCA), a youth led network of over 8392 youth and adults, works to address HIV/AIDs in over 170 countries. The network targets youth engaging in risky sexual behaviour such as injecting drug users (IDUs), Men having sex with men (MSM), sex workers, youth in resource constrained areas without access to information (<http://www.gyca.org>).

Behavioral intervention is a specific collection of prevention activities developed or implemented with a clear aim to promote positive changes in behaviour either directly or indirectly. Most behaviour interventions have been found to be useful in reducing unprotected sex and increasing condom use, reducing number of sexual partners, and reducing new STD infections (Dreisbach, S. 2009).

CHAPTER FIVE

SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS.

5.1 Introduction.

This chapter contains summary of findings, conclusions, recommendations, contributions to knowledge and suggestions for future research, based on the objectives of the study.

5.2 Summary of findings.

The main objective of this study was to assess the influence of activities at Tuungane youth centre in causing risky sexual behaviour change among the youth in Kisumu County. Establishing the influence of education and training, testing and counselling, recreational activities and outreach programmes in causing risky sexual behaviour change. In order to establish this relationship, data related to education and training, testing and counselling, outreach programs, recreational activities was sourced. This data was subjected to preliminary analysis and summarized in form of frequency tables.

The first objective of the study sought to establish how education and training component of Tuungane youth centre promoted risky sexual behaviour change among the youth in Kisumu County.

Results obtained indicated that out of the 185 respondents asked 64 (34%) indicated that education and training was the most influential as it helped equip the youth with knowledge for themselves and also to influence the community they interact with. The teaching on importance of safe sexual behaviour ensured that the youth were equipped to deal with the challenges that face them on a day to day basis and they are able to impart the correct information to their peers.

In establishing the influence of recreational activities on behaviour change, out of the 185 respondents 35 (19%) indicated that recreational activities was the most influential, the study found that the following activities influenced the youth view of risky sexual

behaviour, drama was effective as it passed on messages that they were able to relate with on a daily basis, it gave them a visual of daily living and interactions as they come face to face with the consequences associated with the risky sexual behaviour, sports gave them a forum for free talks and interactions.

Regarding the influence of counselling and testing, out of the 185 respondents, 48 (26%) said it was most influential in causing risky sexual behaviour change, counselling and testing is a way of making an individual aware and reduce stigma. Once this is done the individual can be acceptable and agreeable to other forms of interaction. It was found that the counselling and testing sessions equipped the youth with knowledge of their status and were then advised on how to live positively.

On the influence of outreach programmes, 31 (17%) of the 185 respondents found this most useful, they indicated that when the youth were involved in the programs, they were able to freely talk to other youth in the community and this caused a positive change in their behaviour.

5.3 Conclusion

From the findings of the study, Behavioral change is a dynamic process from effective design and implementation of education. In order to achieve behaviour change, effective learning methodologies must be incorporated in the program design, Participating in a range of physical activity under supervisions associated with favorable youth risk profiles. Enhancing opportunities for physical activity and sports may have a beneficial effect on leading youth risk behaviour.

It was therefore concluded that the activities at Tuungane Youth centre have caused risky sexual behaviour change among the youth in Kisumu County, and this has been seen through increased use of condoms, reduced number of sexual partner and getting medication.

Strategies that increased youth involvement seems to be a sure way towards stopping the risky sexual behaviour consequences in youth and to a larger extent the future generation.

A combination of education and training, counselling and testing, recreational activities and outreach programs influences the behaviour of the youth. The findings from the study concludes that education and training enhances behaviour change by giving specific knowledge on safe behaviour and equips one with tools of awareness and engagement, counselling and testing makes them aware, recreational activities gives them a visual perspective while outreach programs gives an avenue of interaction with the community.

5.4 Recommendation

In view of the study findings, there is no single strategy geared towards risky sexual behaviour change among the youth. Having looked at the main components of the study, the following recommendations are arrived at;

1. A youth targeted awareness strategy towards informing the youth on availability of the centres and its advantages, putting together the youth with adults or pediatric has proved to be a sure way to fail as the youth are undergoing a sensitive period in their lives and their needs have to be looked at separately.
2. The community needs to be encouraged to take part in the outreach programs, so as to have an all rounded participatory approach. This also gives the youth an opportunity to pass on what they have learnt at the centre and gives the community awareness of what the centre is about. It also creates a forum whereby those not able to access the centre get the necessary services.
3. Peer groups can be formed in the community by the youth, once they leave the centre so that there is continuity in terms of knowledge sharing.

5.5 Contribution to Knowledge

Research plays a vital role in either confirming the existing body of knowledge and/or contributing to the body of knowledge.

The contribution to knowledge by the Kisumu County study is summarized in table 5.1

Table 5.1 Contribution to knowledge.

Objective	Contribution to knowledge
To establish the extent to which education and training influences behaviour change.	The study found out that education and training equipped the youth with knowledge that resulted in behaviour change.
To establish the extent to which recreational activities influences behaviour change.	Recreational activities have a significant role in creating visual awareness and long lasting memories and thereby causing behaviour change.
To establish the extent to which counselling and testing influences behaviour change.	Lack of awareness creates stigma, therefore testing and counselling creates awareness thus eradicating stigma.
To establish the extent to which outreach programs influence behaviour change.	Community involvement gives opportunity for the youth to impart the knowledge they have acquired to bring positive change to their peers in the community.

5.6 Suggestions for Further Research

The researcher suggests that further research can be carried out in the following areas;

1. A study should be carried out to establish gender access to the youth centres, and how gender mainstreaming can be included during recruitment of the youth.
2. A study should be carried out to find out factors that influence the youth accessing the youth centres, so as tackle the challenges and increase the number of participants.
3. A study should be carried out to show influence of poverty on risky sexual behaviour.
4. A study should be carried out to show influence of education of an individual on risky sexual behaviour.

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APPENDICES

Appendix I: Letter of introduction

Judith Anyango Oyugi

Cell phone:

Date.....

Dear Respondent,

RE: INFLUENCE OF YOUTH CENTRE ACTIVITIES IN RISKY SEXUAL BEHAVIOUR CHANGE.

I am a post-graduate student in the University of Nairobi pursuing a master's degree in project Planning and Management. I am carrying out a study on the above subject. You have been selected to take part in the study as a respondent.

Attached is a questionnaire aimed at gathering information, which will be vital for the above research. I am kindly requesting you to respond to the questionnaire items as honestly as you can and to the best of your knowledge. The questionnaire is for the purpose of research only and therefore the responses shall be absolutely confidential and anonymously given.

In case the study will be of interest to your organization it can be availed once the study is complete. Your participation in this survey is highly appreciated.

Yours faithfully

Judith Anyango Oyugi.

Appendix II: Questionnaire A (Youth)

The objective of these questionnaires is to collect data on INFLUENCE OF YOUTH CENTRE ACTIVITIES IN RISKY SEXUAL BEHAVIOUR CHANGE. Kindly read the items carefully and provide a response that best represents your opinion. To provide confidentiality do not indicate your name on the questionnaire. Thank you for your cooperation.

The questionnaire has several sections. Please answer accordingly with a tick in the provided gaps.

SECTION A: RESPONDENTS PROFILE

1. How old are you?

Below 18 years [] 18 – 24 years [] 25-30 years []

31 – 35 years [] Over 35 years []

2. What is your gender?

Male [] Female []

3. How long have you been member of Tuungane centre?

Less than 1 year [] 1-3 years [] 4-6years []

7-9year [] Over 10 years []

SECTION B: LIKERT SCALE QUESTIONS

Education and Training

4. Do you have education and training activities at the center?

Yes [] No [] I am not Sure []

5. What mode of training is mostly employed?

Lectures [] Seminars [] Focus groups [] Audio/Visual [] Others (specify).....

6. Who conducts the trainings?

Tuongane staff [] Tuongane youth members [] External trainers []

Others (specify).....

7. How often do you have education and training sessions?

Every day [] Weekly [] Fortnightly [] Monthly []

8. Are you trained on HIV/AIDS?

Yes [] No [] Not sure []

9. How effective would you say is the training and education in promoting behaviour change against the spread HIV/AIDS?

Very effective [] Effective [] Neutral []

Ineffective [] Very ineffective []

Recreational activities

10. Do you have recreational activities at the centre?

Yes [] No []

11. What are the most popular recreational activities at the center?

Sports and games [] Drama [] Music and dancing
[]

Outdoor activities e.g. hiking [] Others (specify).....

12. How often do you have recreational activities?

Every day [] Weekly [] Fortnightly [] Monthly []

13. How effective would you say is the recreational activities are in promoting behaviour change and stopping the spread HIV/AIDS?

Very effective [] Effective [] Neutral []

Ineffective [] Very ineffective []

Counseling and testing services

14. Is voluntary counseling and testing services offered at the center?

Yes [] No [] Not sure []

15. Has your behaviour changed positively after counselling and testing?

Yes [] No [] Not sure []

16. Have you encouraged others in the community to go for the testing and counseling services?

Yes [] No [] Not sure []

17. How effective would you say the counseling and testing services are in promoting behaviour change against the spread HIV/AIDS?

Very effective [] Effective [] Neutral []

Ineffective [] Very ineffective []

18. After the testing and counselling are you referred to another facility?

Yes [] No [] Not sure []

Outreach Programmes

19. Do you take part in community mobilization outreaches?

Yes [] No [] Not sure []

20. Do you take part in community mobilization outreaches on HIV/AIDS?

Yes [] No [] Not sure []

21. Who conducts the outreach programmes?

Tuongane staff [] Tuongane Members [] Tuongane staff and members []

Collaboration with churches and organizations []

22. Which groups in community take part in community outreaches?

Religious leaders [] Other youth [] Parents and Guardians []

23. How effective would you say the outreach programmes services are in promoting behaviour change against the spread HIV/AIDS?

Very effective [] Effective [] Neutral []

Ineffective [] Very ineffective []

24. Which of the following components of Tuungane youth center would you say promotes behaviour change the most?

Education and training [] Recreational activities []

Counselling and testing [] Outreach programmes []

Behaviour change

25. Did you have more than one sexual partner before joining Tuungane youth centre?

Yes [] No [] Not sure []

26. Do you have more than one sexual partner currently?

Yes [] No [] Not sure []

27. Did you use condoms before joining Tuungane youth centre?

Yes [] No [] Not sure []

28. Do you use condoms currently?

Yes [] No [] Not sure []

29. Were you taking medication (ARVs/O.Is) before joining Tuungane youth centre?

Yes [] No [] Not sure [] 25.

30. Are you taking medication (ARVs/O.Is) currently?

Yes [] No [] Not sure []

Appendix III: Interview schedule (Tuungane staff/counsellors)

1. Please describe the problem of HIV/AIDS in the area especially the youth?
.....
.....
2. For how long do the youth attend the centre
.....
.....
.....
.....
3. What is the highest academic qualification you have on HIV/AIDS?.....
.....
4. What is your age ...
5. How is the center using education and training in promoting behaviour change and curbing the spread of HIV/AIDS?
.....
.....
.....
.....
6. How is the center using counseling and testing services promoting behaviour change and curbing the spread of HIV/AIDS?
.....
.....
.....
.....
7. How is the center using recreational activities in promoting behaviour change and curbing the spread of HIV/AIDS?

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

8. How is the center using outreach programmes in promoting behaviour change and curbing the spread of HIV/AIDS?

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

Appendix IV: Questionnaire B (Community)

The objective of these questionnaires is to collect data on INFLUENCE OF YOUTH CENTRE ACTIVITIES IN RISKY SEXUAL BEHAVIOUR CHANGE. Kindly read the items carefully and provide a response that best represents your opinion. To provide confidentiality do not indicate your name on the questionnaire. Thank you for your cooperation.

The questionnaire has several sections. Please answer accordingly with a tick in the provided gaps.

SECTION A: RESPONDENTS PROFILE

1. How old are you?

Below 18 years [] 18 – 24 years [] 25-30 years []

31 – 35 years [] Over 35 years []

2. What is your gender?

Male [] Female []

3. How long have you known member of Tuungane centre since he joined the centre?

Less than 1 year [] 1-3 years [] 4-6years []

7-9 years [] Over 10 years []

4. What is your relationship to member of Tuungane centre?

Parent /Guardian [] Neighbor [] Teacher []

SECTION B: LIKERT SCALE QUESTIONS

Education and training

4. Is education and training activities offered at the center?

Yes [] No [] I am not Sure []

5. Is the education and training activities at the center on HIV/AIDS?

Yes [] No [] I am not Sure []

5. Has education and training activities at the center influenced the behavior of the Tuungane member?

Yes [] No [] Not sure []

6. Has the member's behavior changed positively?

Yes [] No [] Not sure []

7. Has the member influenced the behavior of people he interacts with through education and training?

Yes [] No [] Not sure []

8. How effective would you say is the training and education in promoting behaviour change against the spread HIV/AIDS?

Very effective [] Effective [] Neutral []

Ineffective [] Very ineffective []

Recreational activities

9. Are you aware of the recreational activities at the centre?

Yes [] No []

10. Which activities does the member take part in?

Sports and games [] Drama [] Music and dancing []

Outdoor activities e.g. hiking [] others (specify).....

12. Has the activity influenced the member's behaviour in the community?

Yes [] No [] Not sure []

13. Does the member involve others in the community in this activity?

Yes [] No [] Not sure []

14. Does the member utilize the activity out of the centre in the community?

Yes [] No [] Not sure []

15. How effective would you say is the recreational activities are, in promoting behaviour change and prevent the spread HIV/AIDS?

Very effective [] Effective [] Neutral []

Ineffective [] Very ineffective []

Counseling and testing services

16. Do you know of the counseling and testing services at the center?

Yes [] No [] Not sure []

17. Has the testing and counselling influenced the behaviour of the member positively?

Yes [] No [] Not sure []

18. Has the member's encouraged others in the community to go for the testing and counseling?

Yes [] No [] Not sure []

17. How effective would you say the counseling and testing services are in promoting behaviour change against the spread HIV/AIDS?

Very effective [] Effective [] Neutral []

Ineffective [] Very ineffective []

Outreach Programmes

19. Are you aware of the outreach programmes by the centre?

Yes [] No [] Not sure []

20. Does the member take part in the outreach programmes?

Yes [] No [] Not sure []

21. Do you take part in outreach programme activities?

Yes [] No [] Not sure []

22. Are the programmes on HIV/AIDS?

Yes [] No [] Not sure []

23. Has the member influenced others in the community during the outreach programs?

Yes [] No [] Not sure []

24. Which of the following components of Tuungane youth center would you say promotes behaviour change the most?

Education and training [] Recreational activities []

Counseling and testing [] Outreach programmes []

Appendix V: Research Authorization



UNIVERSITY OF NAIROBI
COLLEGE OF EDUCATION AND EXTERNAL STUDIES
SCHOOL OF CONTINUING AND DISTANCE EDUCATION
KISUMU CAMPUS

The Secretary
National Council for Science and Technology
P.O Box 30623-00100
NAIROBI, KENYA

22ND August, 2014

Dear Sir/Madam,

RE: JUDITH A OYUGI - REG NO: L50/64963/2010

This is to inform you that **Judith Oyugi** named above is a student in the University of Nairobi, College of Education and External Studies, School of Continuing and Distance Education, Kisumu Campus.

The purpose of this letter is to inform you that **Judith** has successfully completed her course work and Examinations in the programme, has developed Research Project Proposal and submitted before the School Board of Examiners which she successfully defended and made corrections as required by the School Board of Examiners.

The research title approved by the School Board of Examiners is: *"Influence of activities at Tuungane Youth centre in promoting behavior change and stopping the spread of HIV/AIDS among the youth in Kisumu County"*. The research project is part of the prerequisite of the course and therefore, we would appreciate if the student is issued with a research permit to enable her collect data and write a report. Research project reflect integration of practice and demonstrate writing skills and publishing ability. It also demonstrates the learners' readiness to advance knowledge and practice in the world of business.

We hope to receive positive response so that the student can move to the field to collect data as soon as she gets the permit.

Yours Faithfully

Dr. Raphael O. Nvonje, PhD
SENIOR LECTURER & RESIDENT LECTURER
DEPARTMENT OF EXTRA-MURAL STUDIES
KISUMU CAMPUS





**NATIONAL COMMISSION FOR SCIENCE,
TECHNOLOGY AND INNOVATION**

Telephone: +254-20-2213471,
2241349, 310571, 2219420
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Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

Date:

24th September, 2014

NACOSTI/P/14/4364/3316

Judith Anyango Oyugi
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "*Influence of activities at Tuungane Youth Center in promoting behaviour change and stopping the spread of HIV/AIDS among the youth in Kisumu County,*" I am pleased to inform you that you have been authorized to undertake research in **Kisumu County** for a period ending **30th October, 2014**.

You are advised to report to **the County Commissioner and the County Director of Education, Kisumu County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.


**DR. S. K LANGAT, OGW
FOR: SECRETARY/CEO**

Copy to:


The County Commissioner
The County Director of Education
Kisumu County.

Appendix VI: Research Clearance Permit


THIS IS TO CERTIFY THAT:
MISS. JUDITH ANYANGO OYUGI
of UNIVERSITY OF NAIROBI, 9458-100
NAIROBI, has been permitted to conduct
research in Kisumu County


on the topic: INFLUENCE OF ACTIVITIES
AT TUUNGANE YOUTH CENTRE IN
PROMOTING BEHAVIOUR CHANGE AND
STOPPING THE SPREAD OF HIV/AIDS
AMONG THE YOUTH IN KISUMU COUNTY.

for the period ending:
30th October, 2014


Applicant's
Signature

Permit No : NACOSTI/P/14/4364/3316
Date Of Issue : 24th September, 2014
Fee Received : USD 11




Secretary
National Commission for Science,
Technology & Innovation

CONDITIONS

- 1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit**
- 2. Government Officers will not be interviewed without prior appointment.**
- 3. No questionnaire will be used unless it has been approved.**
- 4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.**
- 5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.**
- 6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.**


REPUBLIC OF KENYA
National Commission for Science,
Technology and Innovation

RESEARCH CLEARANCE
PERMIT

Serial No. A: 3311

CONDITIONS: see back page