SEXUAL BEHAVIOUR AMONG UNIVERSITY OF NAIROBI RESIDENT UNDERGRADUATE STUDENTS IN THE ERA OF HIV/AIDS

By

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Declaration.

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

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Signature_____ Date 30/11/06

This project has been submitted with our approval as the University supervisors:

1. **Dr. Pius Mutie**

Signature: _____ Date 30/11/06

2. **Mr. Allan Korongo**

Signature: _____ Date 30/11/06

Dedication

I dedicate this work to all my family members and friends for the understanding and encouragement they offered throughout the study period.

Acknowledgement

There is a common saying among the intellectual fraternity that a degree is a product of concerted efforts from varied sources. With this in mind, I wish to acknowledge and thank the following persons for their unrelenting support without which this project would not have been possible.

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Abstract

University students constitute a high risk group for HIV infection. This is hugely contributed by their youthful age and lack of strict regulations in institutions of higher learning leading to students engaging in reckless sexual relationships. According to data from National Aids Control council, the most vulnerable age brackets to contract HIV are 18 to 25 years and that the virus is spreading at an a alarming rate among his age bracket.

The overall aim of this study was to investigate the sexual behaviour of the University of Nairobi students in the era of HIV/Aids. The specific objectives of this study were as follows: To establish self-risk perception by the university of Nairobi student community with regard to HIV/Aids infection, To determine the level of vulnerability/exposure to HIV infection among the University of Nairobi students and To determine the actions taken by the students to protect themselves from contracting HIV of University of Nairobi students because of HIV/Aids prevalence.

The study was conducted among University of Nairobi undergraduate students in august 2006. Only primary data was collected using both qualitative and quantitative methods. Qualitative data was collected from key informants while quantitative data was collected from the students. The quantitative data was analysed using SPSS and presented in form of frequency tables, percentages and cross tabulations. The data was interpreted and report written. The qualitative data was merged and then summarized then used in the report as complementary notes for the quantitative data.

The study has found out that the University students take the issue of HIV/Aids seriously. Many know that they are at risk of being infected and have taken precautionary measures such as abstaining, use of condoms and going for HIV test. Many are avoiding circumstances that predispose them to HIV infection such as drug use, alcohol, clubs and commercial sex.

Nonetheless, it was found that there are still a number of students have not taken any prevention measures. Some students have many sexual partners, engage in commercial sex, do not use condoms consistently, take alcohol/drugs before sexual intercourse, go to clubs and have never been tested for HIV. This is a group that is in danger of infection. Take consistent condom use for example, just 39.1% of the students practise this, meaning that about 60% of the students are at risk of contracting HIV. Only 20% have had an HIV test in the last three months, literally then 80% of the students do not know their status.

Following the study findings, the following recommendations were made in order to reduce the exposure to or even infection of students by HIV:

- Give health education to students on self risk perception, that everyone is equally prone to HIV.
- Educate students the importance of knowing their HIV status at all times. This is important so that they live positively if they are positive and avoid infecting others and if they are negative, they protect themselves from infection.
- Further health education to the students is done about ABC. That Abstinence is total avoidance of sex till marriage, that being faithful means having one sexual partner whose HIV status you know and they also know yours and that condom use means consistently using condoms.
- Educate students on the importance of avoiding circumstances that predispose them to engaging in sex such as clubs, alcohol and drug use.

The study also suggested that the following issues need to be researched further:

- Why students have the varied self risk perceptions to contracting HIV.
- Under what circumstances students fail to use condoms consistently.
- Circumstances that predispose students especially female ones to cases of forced sex.
- Why some students prefer to go for HIV testing out of campus even though they have testing facilities there.
- How commercial sex can be controlled or even eliminated among the University student community

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ABBREVIATIONS.

HIV: Human Immuno-deffiency Virus.

AIDS: Acquired Immuno Deffiency Syndrome.

STI: Sexually Transmitted Infection.

IEA: Institute for Economic Affairs.

SID: Society for International Development.

WHO: World Health Organization.

UNAIDS: United Nations Joint Programme on HIV/AIDS

NASCOP: National Aids and STI Control Programme.

ARVs: Anti Retro Viral drugs

HIPC: Heavily Indebted Poor Countries

Gok: Government of Kenya.

UNICEF: United Nations Children Education Fund.

ADEA: Association for Development in Africa.

JKUAT: Jomo Kenyatta University of Agriculture and Technology.

RCT: Rational Choice Theory

SLT: Social Learning Theory.

SCT: Social Cognitive Theory.

KDHS: Kenya Demographic and Health Survey.

MICS: Multiple Indicators Cluster Survey.

HIPCs: Highly Indebted Poor Countries.

G8: Group of Eight Richest Countries.

VCT: Voluntary Counselling and Testing

1.0 CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND

AIDS is an extraordinary kind of crisis; it is both an emergency and a long-term development issue. Despite increased funding, political commitment and progress in expanding access to HIV treatment, the AIDS epidemic continues to outpace the global response. No region of the world has been spared. The epidemic remains extremely dynamic, growing and changing character as the virus exploits new opportunities for transmission.

Rates of infection are still on the rise in many countries in sub-Saharan Africa. In 2003 alone, an estimated 3 million people in the region became newly infected. More than 20 years and 20 million deaths since the first AIDS diagnosis in 1981, almost 38 million people (range 34.6 – 42.3 million) are living with HIV. Even though the cure is elusive, we have learned crucial lessons about what works best in preventing new infections and improving the quality and care for people living with HIV. There have been some major developments, including antiretroviral medicines. Despite these signs of progress, there are still huge challenges to turning the tide of this epidemic. Funding has greatly increased but is still only half of what is needed and is not always effectively utilized. Many national leaders remain in denial about the impact of AIDS on their people and societies. Today we are faced with life and death choices. Without major action, the global epidemic will continue to outstrip the response. (UNAIDS/WHO.2003)

An estimated 25 million people are living with HIV in sub-Saharan Africa. There appears to be stabilization in HIV prevalence rates, but this is mainly due to a rise in AIDS deaths and a continued increase in new infections. Almost 80 percent of the 22 million deaths from AIDS since the beginning of the epidemic have occurred in Africa. In most of the highly affected countries of eastern and southern Africa, AIDS has caused life expectancy to decline by over twenty years from already low levels. In the last ten years, AIDS has been a more potent killer by several orders of magnitude than all of the armed conflicts in Africa together. The AIDS epidemic is distinctive among lethal epidemics in that most of the lives it takes are of adults from twenty to forty years old. (UNAIDS, 2004)

Prevalence is still rising in some countries such as Madagascar and Swaziland, and is declining nationwide in Uganda. Sub-Saharan Africa is home to just over 10% of the world's population – and almost two-thirds of all people living with HIV. In 2003, an estimated three million people

became newly infected and 2.2 million died (75% of the three million AIDS deaths globally that year). (UNAIDS, 2004)

In Kenya, HIV/AIDS is a national disaster. About 75 percent of the deaths from AIDS in Kenya so far have occurred in adults aged eighteen to forty-five. HIV/AIDS remains shrouded in denial and silence in much of Kenya, which complicates discussions of policy and legal measures to address the problem as well as the delivery of services to those affected. Since the emergence of HIV/AIDS in Kenya in 1984, the epidemic has spread unabated. Reliable estimation techniques put the number of adults and children living with HIV/AIDS at about 2.5 million by year 2001 according to WHO/UNAIDS (2002). Adults aged 15-49 account for 2.3 million of this number, and children account for 0.22 million, over half of all those infected are women. However, HIV prevalence rates declined nationally from 13.4% in year 2000 to 10.2% in year 2002. The slight decrease in prevalence rates in year 2000 is mainly due to high mortality rates (GoK 2001a) rather than low infection.

Young people are a high-risk group for contracting HIV/AIDS, particularly if they do not have regular access to appropriate and clear information on HIV transmission and safe sex, as is the case in much of Africa. Their risk is augmented when they are out of school, in learning institution that provide a lot of social freedom, impoverished, on the street, or otherwise in circumstances that have been associated with the presence of AIDS in the family. To guarantee acceptance by peer group members, the youth try to change their attitudes and behavior so that they conform to the standards of the group. As a direct result of changed interests and attitudes that accompany sexual maturity, social behavior during youth takes on a quite different pattern. The youth social behavior pattern is marked by heterosexual activity, conformity to the group, self-assertiveness, resistance to adult authority, prejudice and social competence. The most marked change in social behavior is in the area of heterosexual relationships. The youth develop a lively interest in members of the opposite sex. This comes early in girls than boys, partly explaining why many ladies will have sexual relationships with men much older than them, (The Population Reference Bureau and Population Services International, 2000)

At the University level, young men and women are usually made to socialize with no or limited restrictions or statutory control on their sexual relationships. Under this free environment, the university students are left on their own in matters related to sex. Bearing in mind that these youths

are just emerging from secondary schools where they were closely monitored by their parents or teachers, this newfound freedom of socialization is likely to be exploited to the maximum. With little or no prior experience in sexual relationships, these students are likely to engage in sexual practices that will predispose them to HIV/Aids infection. The fact that now they have rooms to themselves without any social surveillance, freedom of association without the close monitoring of parent or teacher, many students are very vulnerable to contraction of HIV especially if this coupled with lack of information on this issue (Pathfinder International, 1999)

According to a study carried out by Nzioka in 2000, the University of Nairobi was losing about two of its members every week, which translated into about 100 people per annum through HIV/Aids related illnesses. There had been an observed increase in the level of morbidity and mortality within the university community from HIV/Aids related illnesses such as Tuberculosis. Huge amounts of resources were being diverted by the university from activities which would otherwise enhance the welfare of its members and providing quality education into offering care, treatment and support for both staff and student affected and afflicted by HIV/Aids.

Since most HIV infections are through heterosexual contact, people are at risk of catching the HIV infection as soon as they become sexually active. The pattern to infection is similar everywhere in Kenya. From a study done in Kisumu, highest levels of infection were reported in women of ages 20-24 and men of 30-39. A significant percentage of prevalence is reported between the ages of 20-29 and 25-29 averaging the highest prevalence in both men and women at 35% (Aids in Kenya, 2001).

1.2. PROBLEM STATEMENT

Despite knowledge about HIV/Aids being very high among ages 15-24 continued indiscriminate sexual behavior is observed in this age group (Obudho, 1995). From KDHS 1998, it is reported that 99% of all men and women knew about HIV/Aids. Despite this high level of awareness, it's reported in the same study that only 23% of women and 10% of men said that they have changed their sexual behavior in this era of HIV/Aids.

In 2003, it was estimated that about 2.5 million Kenyans were living with the HIV virus, about six hundred Kenyans died of HIV/Aids related conditions and over 1 million children were orphaned

as a result of HIV/Aids related deaths. The epidemic remains rampant and how long it will stay like this will depend on the vigor, scale and effectiveness of prevention, treatment and care programmes. Alongside the huge challenge, stands the urgent need to boost prevention programmes. Prevention efforts can slow the spread to HIV0 (Aids Epidemic Update. December 2003; UNAIDS/WHO).

The principal mode of transmission of HIV is through heterosexual contact. This accounts for 75% of all HIV infections in Kenya (Kenya Demographic and health survey 1998). Research suggests that high proportions of Kenya's teenagers and adolescents are sexually active and their sexual behavior puts many of them at risk of HIV infection. The Kenya demographic and health survey (1998) reports that there is a significant period of sexual activity before marriage that exposes young people to risk of HIV infection (Aids in Kenya, 2001)
Young people – 15-24 year olds account for nearly half of all new HIV infections worldwide. They are the largest youth generation in history and need a protective environment; regular schooling, access to health and support services—if they are to play their vital part in combating the epidemic. (Futures Group International 1999)

In the year 2000, the then Vice Chancellor of the University of Nairobi was quoted in a study done by Nzioka saying that about 100 members of the university of Nairobi fraternity die of AIDS each year. The victims included teaching, non-teaching staff and students. Worst affected were the lower cadre staffs.

One in every ten university graduates dies three years after graduation, from Aids related sickness. This is a frightening assessment by employers and an indication of the toll Aids has at Universities, but this could even be just the tip of the iceberg the number of infected students and graduates could even be higher. At Kenyatta University for example, two HIV/Aids testing days have been held in the last one-year and the outcome was alarming. Many HIV positive cases were identified. The information source said, "Let the statistics join our classified documents. We do not want to cause a stir". (School and Career. The Standard, August 4, 2005)

There can therefore be no doubt that there is urgent need to combat the HIV/Aids problem not only at the University of Nairobi, but also in all the other public universities in Kenya. In 2000, the then

Vice-Chancellor of the University of Nairobi professor Francis Gichaga, on realizing that HIV/Aids was increasingly taking a heavier toll on his staff and students, started a campaign to confront the epidemic in the university. This campaign seeks intervention to establish voluntary counselling and testing services on campus and to intensify the distribution of condoms (Bollag, 2000)

This study sought to understand the sexual behaviour of University students in the era of HIV/aids. The study was guided by the following questions: -

a) What is the self-risk perception of University students in regard to contracting the HIV Virus?
b) How vulnerable/exposed are the University students to HIV/AIDS infection?
c) Which individual /personal behaviour mechanisms have the University students effected / employed to alleviate / minimize their chances of contracting the HIV Virus?

1.3. OBJECTIVES OF THE STUDY

1.3.1 GENERAL OBJECTIVE

The overall aim of this study was to investigate the sexual behaviour of the University of Nairobi students in the era of HIV/Aids.

1.3.2 SPECIFIC OBJECTIVES

The specific objectives of this study were as follows: -

a. To establish self-risk perception by the university of Nairobi student community with regard to HIV/Aids infection.
b. To determine the level of vulnerability/exposure to HIV infection among the University of Nairobi students.
c. To determine the actions taken by the students to protect themselves from contracting HIV of University of Nairobi students because of HIV/Aids prevalence.

1.4 JUSTIFICATION

There were 4 reasons to justify this study: -

i) As seen in the background of this project paper, the principal mode of HIV transmission is heterosexual contact, which accounts for 75% of all HIV infections in Kenya. Research also suggests that high proportions of Kenya's teenagers and adolescents are sexually active and their sexual behaviour puts many of them at risk of HIV Infection. Students at the university on Nairobi fall in this category of teenagers and adolescents, (12-24 years of age). This study gauged the level of risk of students as exhibited by their sexual habits/tendencies. This may form a background upon which any intervention at the university on behaviour change to prevent the spread of HIV /Aids may base on.

ii) Nzioka (2000) suggested that there is absence of systematically organized information on HIV/Aids. Devoid of such data, it is extremely difficult to assess the Impact of HIV/Aids or even monitor the prevalence. Nzioka suggested that, there is need for studies to document and quantify facts on HIV/Aids at the University of Nairobi. It is with this notion in the mind that this study quantified facts about the sexual behaviour and other habits among the University of Nairobi students to provide useful insights into critical target areas; and for this case behaviour change as an intervention to curb the infection and spread of HIV/Aids among the student Community.

iii) HIV/Aids was declared a National disaster in Kenya in 2001 by the then president Moi. It remains as such up to now. Today, the effect of HIV/Aids on the Kenyan Community is adverse. The country has lost many professionals at all levels to this scourge. These professionals are nurtured and developed at the country's institutions of higher learning such as the University of Nairobi. Through this study, prevention mechanisms can be used to reverse the spread of HIV/Aids on our young professionals; needed to replace those retiring and succumbing to other forms of attrition

iv) This study also intended to establish the validity of the notion that the university student community is a closed one and therefore infection of students by outsiders is minimal. When I was an undergraduate student at the University of Nairobi in the mid 1990s`, some students openly acknowledged this and I would want to know if this has changed now that there is a lot of information on HIV/Aids.

1.5. SCOPE AND LIMITATION

The study was conducted among university of Nairobi students and was interested in gathering information on their sexual behaviour in the era of HIV/AIDS. The survey method was used because of logistical and cost reasons. A census would have been the most accurate way to collect reliable data but because of the costs that might have been incurred in the preparation and materials to carry out the study it would have been very expensive. Also not all students are on campus at a particular time. This could have made the study period long and hence more costly.

Field research that could have also provided a more natural state of information could have been suitable but due to costs and time it could not be very efficient. The University population is quite large and students stay on different campuses, getting personnel to stay on campus and make observations would have been quite expensive coupled with the limited resources that were available for this exercise I preferred to use the survey method.

1.6. DEFINITION OF TERMS

Opportunistic infections: Diseases that attack the body after an individual is infected by HIV, these include Tuberculosis, sores, etc

Sexual behaviour: Sexual practices that involve intercourse among individuals.

Self-risk perception: Self-evaluation/rating of being vulnerable to infection or how one rates their possibility of being infected.

Risky sexual practices: Sexual practices that expose an individual to HIV infection.

Sexual behaviour change: The interface or end result from risky sexual practice to safe sex practices and acquisition or adoption of practices that enable one stay free from the risk of infection.

HIV/Aids incidence: Number of new cases or the rate of infection per year.

2.0. CHAPTER TWO: LITERATURE REVIEW

2.1. HIV/AIDS in Kenya

Since the emergence of HIV/AIDS in Kenya in 1984, the epidemic has spread unabated. Reliable estimation techniques put the number of adults and children living with HIV/AIDS at about 2.5 million by year 2001 according to WHO/UNAIDS (2002). Adults aged 15-49 account for 2.3 million of this number, and children account for 0.22 million, over half of all those infected are women. HIV prevalence among adults in Kenya was expected to increase from 5% in 1990 to 14% at the end of 1998, pointing to possible negative effects on the countries' human capital base. However, HIV prevalence rates declined nationally from 13.4% in year 2000 to 10.2% in year 2002. The rates are higher in urban centres than in the rural areas. The slight decrease in prevalence rates is mainly due to high mortality rates (GoK 2001a) rather than low infection.

However, sentinel data for sexually transmitted illnesses (STIs) for 1990-2001 shows that prevalence rates have been rising among all categories of marital status. Prevalence is highest among the widowed (implying that their spouses most likely died from AIDS-related ailments) and among people who are separated, followed by people in polygamous unions. It is lowest among single people and those in monogamous unions. These variations in rates between monogamous and polygamous unions may be explained by the fact that polygamous unions expose more people to infection from one person, whereas in monogamous unions the spread is limited to two people. The high rates among separated people are likely to be associated with the likelihood that they may engage in risky sexual behaviour following disruption of their normal life and as a way of consoling themselves.

Gender is an important factor in AIDS incidence. Young women aged 15-19 are five times more likely than men in this group to be infected with HIV, and women aged 20-24 three times more likely than men in the same age group. Various reasons, though devoid of reliable research evidence, have been put forth as to why young women are more at risk than men. These include gender-specific biological factors, the tendency for younger women to have sexual relationships with older men, and the poor economic status of women (UNAIDS/WHO, 2000) show that commercial sex workers are the hardest hit group by AIDS, and prevalence among this group has been rising since the first cases of HIV were reported in Kenya in 1984. In Nairobi, HIV

prevalence rates among sex workers had reached 62% in 1985 and increased to 86% by 1992 (UNAIDS/WHO, 2000).

2.2 DETERMINANTS OF HIV/AIDS PREVALENCE

There is no consensus on either the major causes of HIV prevalence in Africa or why Africa accounts for the overwhelming share of HIV/AIDS cases in the world. The main modes of transmission of HIV are sexual intercourse, re-use of contaminated syringes by drug users, mother to child infection through birth or nursing, re-use of needles in medical settings, and transfusion of contaminated blood or blood products. HIV cannot be transmitted by a sneeze, a handshake or other casual contact. However, it is believed that heterosexual sex, compounded by the unsafe sex practices dominant in Africa, is the leading transmission mechanism. HIV can be isolated from the saliva of an infected person. Although there are handful of cases of transmission through oral sex, there are no confirmed cases of transmission via saliva alone of HIV. This may explain why most anti-AIDS campaigns advocate sexual behaviour change and use of safe-sex options such as condoms (Family Health International/UNAIDS, 2001)

However, safe sex options are not widespread in Africa, where condom use is still 'taboo' and where the poor might not afford to spend Ksh 10 on a condom pack. A survey carried out by the Government of Kenya in collaboration with UNICEF covering the whole country in 2000 i.e., Multiple Indicators Cluster Survey (MICS) Report[1] shows that knowledge about the key means of prevention is low. Only 52% of women and 66% of men said they knew that a condom may be used to prevent transmission of HIV. More urban women than rural women are aware of the use of condoms in AIDS prevention. But the opposite is true for men. At the same time, both men and women claimed knowledge that faithfulness to one's partner or abstaining from sex was an option to prevent AIDS transmission. But knowledge of prevention mechanisms did not differ much with age, although it rose with education. For instance, only 39% of women without education were aware of the use of condoms for HIV prevention compared with 62% of those with secondary school education or higher. Similar trends were observed for other prevention methods. Some 83.3% of women and 93% of men were aware of at least one way of preventing HIV infection

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(Alexander Cockburn, 'Why Africans get AIDS?' Creators Syndicatewww.workingforchange.com)

(GoK/UNICEF, 2003). The process through which knowledge translates into adoption of safe behaviour is complex and cannot be deduced from these statistics.

Factors that may drive the spread indirectly include lack of treatment for people with HIV/AIDS or lack of access to HIV/AIDS testing facilities. It is argued that individuals who test positive have a high likelihood of avoiding unprotected sex, and those who test negative, (Alexander Cockburn, 'Why Africans get AIDS?' Creators Syndicatewww.workingforchange.com), have an incentive to stay that way. GoK/UNICEF (2003) gives percentages of men and women who knew of a place to take a HIV test and those who have ever taken a test. Women are more likely than men to test for HIV even though men are more knowledgeable about facilities for testing. About 64% of women know of a testing place but only 10.4% have been tested; for men, this is 76% and 8.2%, respectively. Further, fewer rural women and men have been tested. For both women and men, the higher the level of education the higher the numbers that have been tested.

Several factors are thought to influence the spread of AIDS, though none can be said to be dominant.

2.2.1 Cultural and gender factors

In Kenya, marriage increases exposure to HIV/AIDS, especially if one partner is not faithful. Women are disproportionately more vulnerable to infection. Primarily for them, a marriage may serve as a sure infection trap if the man is not faithful. This is made worse by cultural and socio-economic imbalances that favour men and leave women powerless in most decisions. Women in this context have little control over their own sexual behaviour let alone on that of their partner and cannot demand that their partner use preventive means to reduce chances of infection. Instances of physical violence are common in Kenya, including sexual violence. An unfaithful partner may endanger the other, but the problems faced by women in general include exposure to infection as they give care to infected people without sufficient protection or information. These are behavioural predictions that do not work independently of a maze of other factors; therefore, the direction of behaviour, especially in the long term, may be hard to predict a priori. (Family International/AIDSCAP, 1996)

The desire by Kenyan women for many children accentuates the HIV/AIDS problem in the country, since it discourages use of preventive options such as condoms. Other risky cultural factors include teenage marriage and forced marriage of young girls to older men. Gender inequities in distribution of wealth and power relations give rise to asymmetric age matching, fostering sexual relations between young women and older men who are likely to be infected (IEA/SID, 2001).

Widow inheritance is a risky cultural practice accounting for high HIV/AIDS infection rates. This rite is reinforced by taboos, superstition and fear of bad omen (IEA/SID, 2001). Studies like those undertaken by NASCOP (1998, 1999), though inconclusive, show some effect of male circumcision in reducing the chance of infection. In studies at a special treatment clinic in Nairobi on male circumcision and the risk of STIs and HIV, sero-conversion rates were 2.5% for circumcised and 29% for uncircumcised men. For men with genital ulcer disease, the rates were 13.4% for circumcised and 52.6% for uncircumcised (NASCOP, 1999). Female partners of uncircumcised HIV-positive men also run higher risk of infection. However, being circumcised is not a shield from HIV infection, since in some communities; circumcision rituals subtly encourage new initiates to seek sexual encounters as proof of their manhood.

In other communities, women are encouraged to secretly consider bearing at least one child from an extramarital affair, to spread the genes of their children. The collapse of positive traditional cultural value systems takes some of the blame for the spread of HIV/AIDS. For instance, replacement of traditional marriage practices with modern value systems has given rise to prevalence of cohabitation in both rural and urban Kenya.

These complex cultural norms and values are not always in the public domain and therefore are hard to stamp out, also includes degradation of traditional support systems, especially in urban areas, and lack of clear cultural identity among the youth, who are exposed to both traditional and western influences. Inadequate communication and awareness campaigns about HIV/AIDS and its prevention have also been responsible for the spread of HIV/AIDS. For instance, parents shy away from discussing sex issues with their children. Also, members of parliament, who play a crucial role in policy formulation and advocacy and who can be used to sensitise their constituents on the issues of AIDS are still shying away from discussing issues of HIV/AIDS. A media opinion poll,

in which 3,000 people throughout the country were, interviewed shows that religious bodies have played an insignificant role in creating awareness about AIDS. Churches and mosques were only responsible for creating awareness among 4.7 per cent of respondents. An analysis by age shows that 15.5 per cent of teenagers were not aware of AIDS (Daily Nation, 2001). Other factors that influence HIV transmission are age at first sexual intercourse, number of partners, drug use, among others (WHO/UNAIDS, 2002).

2.2.2 Biological factors

Some biological characteristics particularly for women increase the risk of HIV infection. Transmission of the virus from men to women is at least four times more likely than from women to men. Women are more vulnerable to infection because the features permit greater mucosal (surface) exposure to seminal fluids. This is coupled with prevalence of non-consensual sex, unprotected sex, and high-risk sex partners. Thanks to the media and particularly to the new information and communication technologies, the youth have to cope with vast and diverse information on sexual behaviour; forced sex may cause micro lesions that raise efficiency of infection.

Biological factors also influence the spread of the epidemic by increasing or decreasing susceptibility to the virus and hastening the progression of infection to disease and likely death. Such factors include the presence of sexually transmitted diseases, viral loads and type of HIV. Such factors should inform response and prevention strategies, which may include seeking use of microbicides in the case of women and antiretroviral therapy, among others. HIV may be transmitted from mother to child during pregnancy, birth or after birth. This transmission pathway is common but can be minimized using AZT or a combination of antiretroviral drugs. The risk of mother-to-child transmission is increased if the mother is at an advanced stage of HIV, uses drugs or suffers severe inflammation of foetal membranes during birth, or if the period between membrane rapture and delivery is prolonged, (Rosen , 1998)

2.2.3 Economic factors

According to a study conducted by the World Bank in 2000, economic factors play a pivotal role in the spread and control of HIV/ AIDS. To start with, globalization and migration have facilitated free movement of people, goods and services across countries, which have led to separation of families for long periods, predisposing people to risky behaviour. In the developing world, increased mobility in search of jobs, rural-urban migration and industrialization have been identified as major factors in the spread of HIV. Mobile workers who are the most vulnerable to HIV/AIDS include those in the transport, fishing and tourism industries and migrant labourers in mines, oil fields, roads and dam projects. Major development projects requiring large migrant labour have increased the rate of the spread of HIV/AIDS.

The economic aspect of the spread of AIDS is not restricted to globalization and migration, but includes indebtedness and high costs of HIV/AIDS-related drugs and equipment. For a long time, AIDS drugs such as AZT and ARVs, which delay progression of infection to fully blown AIDS, have been out of reach of most patients in sub-Saharan Africa. The drugs basically catered for the rich who could afford. Supporting infrastructure and equipment such as HIV testing kits, which may have no cheaper alternatives, are also not easily available or are inappropriate for Kenya. Shortage of items like blood transfusion equipment, syringes and equipment for medical procedures may pose transmission risks. In countries like Kenya therefore demand for drug therapy within the average person's purchasing power outstrips supply. Some of the poor, AIDS-ravaged nations are also the most indebted. The Heavily Indebted Poor Countries (HIPC) initiative created by G8 countries provides to waive the debt of some 33 poorest countries, with the reductions in debt commitment used in poverty and HIV/AIDS reduction. However, this misses the point because countries that qualify for the waiver are not necessarily the most affected by the scourge. For example, although the scourge has heavily affected countries such as Kenya, Botswana and South Africa, these countries are not among the 33 poorest countries. They would therefore not qualify for the waiver. (The World Bank, 2000)

Other problems that inhibit control and prevention of AIDS are poor access to medical care, inefficiency in delivery of medical services, and inadequate training of medical staff to handle AIDS patients. Provision of anti-AIDS drugs is a form of public service with high positive

externalities, which cannot be left to the markets and cannot be delayed without incurring heavy negative externalities.

2.2.4 Stigmatization

Stigmatization of people with HIV/AIDS leads to their discrimination and rejection at home, at the workplace and in the public. Workers infected with HIV/AIDS may be dismissed from employment or denied common benefits. In the family and community environment, discrimination takes the form of social ostracism and exclusion from the usual family or community networks. In any of the cases, gender biases become accentuated, as infected women face more rejection than men. The GoK/UNICEF (2003) report documents some aspects of discrimination perceptions. For example, some 39% of women and 51% of men believed that a teacher with HIV should not teach (GoK/UNICEF, 2003). Also, 33% and 42% of women and men, respectively, said they would not buy food from a person with HIV/AIDS. This shows that discrimination is marked between both genders, but is higher among men than women. This also points to clear misconceptions about how HIV is transmitted.

Stigmatization has had a big role in discouraging individuals from going public about their HIV status, which has been associated with avoidance of risky sexual behaviour. Also, going public about HIV status makes one avoid risky behaviour because one is aware that people know that you are HIV positive. In effect, stigmatization may cause dejected HIV positive people to strike back with vengeance, deliberately spreading the virus. Therefore, the costs of stigmatization go beyond psychological and emotional anguish of the infected person; they include the cost of new infections that would have otherwise been prevented if the community were more supportive and caring. It is important to appreciate the difficulty inherent in fighting stigmatization owing to its complex nature and that it is borne by AIDS patients. Many positive messages ostensibly designed to reduce stigmatization or raise awareness about HIV/AIDS and protection for those infected by the disease may subtly chide or torment those infected with HIV/AIDS.

2.2.5 Political and religious factors

There is a marked political dimension to the HIV/AIDS scourge. This mainly relates to disagreement over origins and causes of AIDS and how to tackle it. Sexual intercourse, an epitome of human privacy, is the main avenue through which AIDS is transmitted. Discussion about the role of sexual intercourse in HIV/AIDS transmission causes deep passions in both political and religious arenas. Failure by political and religious leaders to acknowledge the existence of the disease or to allow use of available preventive methods to curb the spread of the scourge attests to this, and has had bad effects on efforts to stop the spread of AIDS. For example, the Kenya government took long to concede to the fact that the HIV/AIDS pandemic was actually an economic, social and security problem. Religious leaders blame it on immorality and consider it a divine punishment for the promiscuous. Such views from opinion leaders influence the choice of prevention and intervention mechanisms for the AIDS problem, notwithstanding politics associated with AIDS drugs and funding for anti-AIDS efforts. (Government of the United Kingdom, 2001)

2.3 THE HIV/AIDS PANDEMIC AMONG YOUTH IN SUB-SAHARAN AFRICA

HIV/AIDS seriously affects adolescents throughout the world. One-third of all currently infected individuals are youth, aged between 15 and 24, and half of all new infections occur in youth the same age. More than five young people get infected every minute; over 7,000, each day; and more than 2.6 million each year. About 1.7 million new adolescent HIV infections, over half of the world's total, occur in sub-Saharan Africa. In fact, nearly 70 percent of people living with HIV/AIDS live in sub-Saharan Africa, and over 80 percent of AIDS deaths have occurred there. Although HIV/AIDS rates vary considerably throughout sub-Saharan Africa, generally lower in western Africa and higher in southern Africa, the epidemic has had a devastating effect on most African youth who often lack access to sexual health information and services. In particular, unmarried youth have great difficulty getting needed sexual health services. At the same time, cultural, social, and economic norms and pressures often put young African women at excess risk for HIV infection, (Akukwe C., 1999)

Leaders of some African nations, once unable to acknowledge the presence of HIV/AIDS, now publicly address HIV prevention and appoint task forces to mobilize and coordinate efforts against

the epidemic. In addition, business coalitions and non-governmental organizations (NGOs) often lead in utilizing peer education, advocacy, youth-friendly service delivery, and social marketing to battle HIV infection in sub-Saharan African nations. Some NGOs encourage youth to get involved in finding and implementing ways to stop the spread of HIV, (Government of the United Kingdom, 2001)

2.3.1 HIV Infection among African Youth

Experts estimate that half a million African youth ages 15 to 24, will die from AIDS by the year 2005.5 In African countries with long, severe epidemics, half of all infected people acquire HIV before their 25th birthday and die by the time they turn 35. The epidemic means that African youth face a bleak future. In 1997 in Zimbabwe, half of all 15-year-old males could expect to die before age 50 compared to 15 percent in 1983. Between 1983 and 1997, 15-year-old females' risk of death prior to age 40 quadrupled from 11 to over 40 percent. Infection with a sexually transmitted disease (STD), especially one that causes genital ulcers, such as herpes or syphilis, puts one at increased risk for HIV infection, and sexually active youth in sub-Saharan Africa are at high risk for STD infection. For example, 10 to 20 percent of the sexually active population of sub-Saharan Africa is infected with gonorrhoea. (UNAIDS, 2003)

2.3.2 Effect of HIV/AIDS on Young Women

Half of all HIV infections worldwide occur in women in Africa. In seven of 11 studies in Africa, at least one woman in five, ages 20 to 25 was HIV infected; most HIV-infected young women will not live to age 30. In one city in South Africa, six out of 10 women, ages 20 to 25, were HIV infected, among youth in their early 20's, women's rates were three times higher than men's. In Malawi, HIV incidence in teenage women is six percent compared to less than one percent in women over age 35. Throughout sub-Saharan Africa, HIV infection rates among teenage women are over five times higher than rates for teenage males. In Kenya, nearly one teenage woman in four is living with HIV, compared to one teenage male in 25. The physical immaturity of younger women and women's lower status in society may contribute to disproportionate HIV infection rates. Women's lower status may prevent them from having control of their sexual relationships.

For example, studies on women's first sexual experience show that over half of young women in Malawi and over 20 percent of young women in Nigeria experienced forced sexual intercourse,(Akukwe, 1999)

2.3.3 Obstacles to Lowering Adolescent HIV/STD Infection Rates

African adolescents cite lack of knowledge, inaccessibility, and safety concerns as primary reasons for not using contraception. For example, one study showed that less than 50 percent of youth in Madagascar and Nigeria know about contraception (Caldwell 2000). Limited resources also make contraceptive use lower in Africa than in other world regions. Many African health services workers feel it is inappropriate to provide contraceptives to adolescents, often making it difficult or impossible for youth to obtain condoms and other contraception. For example, a study in Kenya found that three-fourths of family planning workers were unwilling to provide contraceptives to young women who had not given birth.

In sub-Saharan Africa, only half of the population has easy access to health care. Africa has one-third as many nurses per capita as the rest of the world. Moreover, the current ratio of doctors is lower than one per 10,000 population; the world average is one per 800. Limited budgets, problems imposed by the HIV epidemic, and few health care providers mean that improving reproductive health services is a challenge for most sub-Saharan African countries(Caldwell, 2000).

2.3.4 Sexual Health Attitudes and Behaviors among Adolescents

In sub-Saharan Africa, as in other regions of the world, a culture of silence surrounds most reproductive health issues. Many adults are uncomfortable talking about sexuality with their children. Others lack accurate sexual health knowledge. Many Africans feel unable to discuss sexuality across perceived barriers of gender and age differences. Many Africans are also reluctant to provide sexually active adolescents with condoms. In several African countries, some people believe that men are biologically programmed to need sexual intercourse with more than one woman. Polygamy is a central, social institution that reinforces this belief. Moreover, some men believe that this "biologically programmed need" makes high-risk sex unavoidable. In some impoverished communities, high HIV infection rates may be partly explained by early sexual initiation, consensual or coerced. For example, in a survey of 1,600 urban Zambian youth, over 25

percent of 10-year-old children and 60 percent of 14-year-old youth reported already having sexual intercourse. One study of adolescents in 17 African countries showed that those with more education were far more likely to experience casual sex and to use condoms for casual sex when compared to less educated youth., (UNAIDS/WHO, 2003).

2.3.5 Cultural, Social, and Economic Factors

Some faith traditions in Africa teach that AIDS is a shameful disease and a punishment for those who have been sexually promiscuous, and many adults are reluctant to admit to a disease that seems to imply promiscuity. One study showed three quarters of Nigerian Christian leaders believe that AIDS is a divine punishment. Poverty and HIV transmission are linked in a variety of ways. Poverty often leads to prostitution or to trading sexual favors for material goods. Young women may be especially vulnerable due to societal practices that deny them education and work opportunities. Poverty also leads to poor nutrition and a weakened immune system, making poor people more susceptible to tuberculosis and to STDs. The costs of providing treatment for people with AIDS drains resources from education, agriculture, and other domains important to gross national product. By 2005, AIDS treatment costs were expected to account for more than one third of Ethiopia's government health spending, more than half of Kenya's, and nearly two-thirds of Zimbabwe's. In sub-Saharan Africa nearly eight million children, ages 14 and under, had been orphaned by AIDS by the end of 1997. Many of these youth must drop out of school, (Buckley, 2001)

2.4 HIV/AIDS IN KENYAN UNIVERSITIES

Young people 15-24 year olds account for nearly half of all new HIV infections worldwide. They are the largest youth generation in history and need a protective environment, regular schooling, access to health and support services—if they are to play their vital part in combating the epidemic.

According to findings of a case study commissioned by Association for the Development of Education in Africa (ADEA), on the way HIV/AIDS affects JKUAT, Information from JKUAT Hospital indicated that, then there were 130 to 150 (11.7% to 13.5%) staff members infected with HIV. Approximately 11% of academic staff, 13% of middle level personnel and 12% of ancillary

staff were living with HIV. In the undergraduate population of 1900 males and 365 females, the HIV prevalence was unknown. In Kenya, most teenagers are sexually active. A majority of them experience sexual intercourse by age 15/16 and over 90% are active by age 20 (Johnston 1999). Up to 22 percent of teenage girls in Kenya are estimated to be HIV positive (Daily Nation 14/7/2000). According to the JKUAT Hospital information pregnancies and sexually transmitted infections (STI) have been on the decline. Data collected from focus group discussions and in-depth interviews, conducted with undergraduate, postgraduates and student halls caretakers (mature females) revealed that majority of the students were sexually active, 100% knew what HIV/AIDS is and still engaged in risky unprotected sex. The students estimated that 10-15% of their colleagues were HIV positive. The female students felt that about 10% of the female student population engaged in sexual relationships because of poverty, peer pressure, looking for emotional support and sense of security. Some young females also did not enjoy relationships with their age mates, because they considered them immature. Every year at least 8 (2%) of female students got pregnant. This indicated the then levels of unsafe sex.

From the above studies, its quite clear that the effect HIV/Aids has had on the people of Kenya is adverse. Particularly the studies in the Universities show that there is prevalence of HIV/Aids among the student population at the Kenyan Universities. This study was intended to investigate the various coping mechanism by the student population to combat infection against HIV/Aids.

2.5 THEORETICAL FRAMEWORK

2.5.1 Social Learning/Social Cognitive Theory

Albert Bandura has been very instrumental in the development of the Social Learning Theory (SLT). Currently there are several versions of the SLT to which researchers subscribe; they all share three basic tenets/principles (Woodward, 1982; Jones, 1989; Perry et.al., 1990; Thomas, 1990; Crosbie-Brunett and Lewis, 1993).

Tenet 1: Response consequences (such as rewards or punishments) influence the likelihood that a person will perform a particular behavior again in a given situation.

Tenet 2: Humans can learn by observing others, in addition to learning by participating in an act personally. Learning by observing others is called vicarious learning.

Tenet 3: Individuals are most likely to model behavior observed by others they identify with. Identification with others is a function of the degree to which a person is perceived to be similar to one's self, in addition to the degree of emotional attachment that is felt toward an individual.

Social learning theory, later renamed social cognitive theory, proposes that behavior change is affected by environmental influences, personal factors, and attributes of the behavior itself. Each may affect or be affected by either of the other two. A central tenet of social cognitive theory is the concept of self-efficacy. A person must believe in his or her capability to perform the behavior (i.e., the person must possess self-efficacy) and must perceive an incentive to do so (i.e., the person's positive expectations from performing the behavior must outweigh the negative expectations). Additionally, a person must value the outcomes or consequences that he or she believes will occur as a result of performing a specific behavior or action. Outcomes may be classified as having immediate benefits (e.g., feeling energized following physical activity) or long-term benefits. But because these expected out-comes are filtered through a person's expectations or perceptions of being able to perform the behavior in the first place, self-efficacy is believed to be the single most important characteristic that determines a person's behavior change. Providing clear instructions, providing the opportunity for skill development or training, and modeling the desired behavior, can increase self-efficacy. To be effective, models must evoke trust, admiration, and respect from the observer; models must not, however, appear to represent a level of behavior that the observer is unable to visualize attaining.

Relevance of the theory in the Study

The SCT has been used to study a wide range of health problems, from medical therapy compliance, to alcohol abuse, to immunizations. One particularly fruitful area of investigation to which the SCT has been employed is the study of moral and value internalization among children. In fact, it has been argued that the greatest contribution of the SCT is its aid in understanding how children are socialized to accept the standards and values of their society (Johnston et.al, 1997).

The Social Learning Theory is relevant in this study because the study looks at human behaviour among University of Nairobi students in relation to the danger posed by the HIV/Aids pandemic. According to the Social Learning Theory, human behavior can be acquired by observing others, participation, modelling behaviour of others one identifies with and also response consequences,

that is rewards or punishments to a particular action will influence the likelihood of the individual repeating the particular action.

In the study of behaviour change among the University of Nairobi students, all the three principles of the Social Cognitive Theory are relevant in that most of activities and interaction among the students themselves and the larger community have a remarkable influence on the eventual HIV status of individual student and others. As earlier mentioned, the principal mode of transmission of the HIV Virus is through sexual intercourse. The rate and whether or not a student engages in sexual intercourse at the University is influenced among others by learning by observing what others do, modelling the sexual traits or orientations of those the students identify with and lastly the response consequences of indulgence or lack of it in sex. In this study, the consequences may include infection by the HIV Virus among others.

2.5.2 The Rational Choice Theory (RCT)

Abell defines Rational Choice Theory as "understand[ing] individual actors … as acting, or more likely interacting, in a manner such that they can be deemed to be doing the best they can for themselves, given their objectives, resources, and circumstances, as they seem them"
There are many different influences on RCT – A pioneering figure in establishing rational choice theory in sociology was George Homans (1961), who set out a basic framework of exchange theory, which he grounded in assumptions drawn from behaviourist psychology. While these psychological assumptions have been rejected by many later writers, Homans's formulation of exchange theory remains the basis of all subsequent discussion. During the 1960s and 1970s, Blau (1964), Coleman (1973), and Cook (1977) extended and enlarged his framework, and they helped to develop more formal, mathematical models of rational action, Coleman (1990). As soon as rationality is mentioned in sociology, Max Weber's approach comes to mind. For Weber, rationality was a driving social force in society, especially in modern society. He used rationality in several different senses but Holton notes that in all of these "its principal meaning … centers on the calculability, intellectualization, and impersonal logic of goal-directed action. The instrumental approach to action takes values as given and focuses instead on the efficient choice of means to reach such goals" (Turner, first edition, p. 43). In such action, a primary focus is on conscious action by the individual social actor, considering others and attempting to achieve his or her own goals in a considered and systematic manner. Weber regarded this as characteristic of

modern society, and tended to regard rationality as an overpowering social force that increasingly affects all aspects of society.

Assumptions of Rational Choice Theory

1. Humans are purposive and goal oriented.
2. Humans have sets of hierarchically ordered preferences, or utilities.
3. In choosing lines of behavior, humans make rational calculations with respect to: The utility of alternative lines of conduct with reference to the preference hierarchy, the costs of each alternative in terms of utilities foregone and the best way to maximize utility.
4. Emergent social phenomena -- social structures, collective decisions, and collective behavior -- are ultimately the result of rational choices made by utility-maximizing individuals.
5. Emergent social phenomena that arise from rational choices constitute a set of parameters for subsequent rational choices of individuals in the sense that they determine: the distribution of resources among individuals, the distribution of opportunities for various lines of behavior and the distribution and nature of norms and obligations in a situation.

Relevance of the Rational Choice Theory to the study

Abell also notes that RCT can be regarded as one way of working out an explanation of the social world in a Weberian manner. Weber argued that sociologists should develop an interpretive understanding of social action in order to explain "its course and effects". For Weber, action is social in that it takes account of the "behavior of others and is thereby oriented in its course". While most sociologists working in the Weberian tradition adopt a more complex view of meaning and interpretation and how social actors interact, Abell notes that RCT provides one possible way of explaining social action. RCT provides an interpretation for individual action, it shows what the effects of this are, and it certainly is focussed on goals and orientation. Abell reiterates this by outlining the aims of RCT: (i) interpretive understanding, (ii) social action, and (iii) causal explanation of its course and effects.

Following on Max Weber's propositions, in this study I will be looking at the behaviour of University of Nairobi students in regard to the prevalence of HIV/Aids in the society. The trends of behaviour taken by the students in regard to the scourge, is guided by purpose and anticipated goals or achievements in undertaking the actions. Individual students have preferred actions taking in account the utility of alternative actions, costs of each alternative in terms of foregone utility and with an ultimate aim of maximizing utility as individual actors in the entire student community. In

the process of each individual playing roles in the University community, there emerges a certain trend of character that may be attributed to the entire University as a social structure. In regard to the topic, each student has a set of options of actions they can take in regard the major mode of transmission of HIV that is through sexual intercourse. The action taken by the student will be rational and aimed at maximizing utility and also after weighing the costs of the alternative actions. The actions taken by the student may include either indulgence or not indulging in sexual intercourse, practising safe sex, going testing to know their HIV status, drinking of alcohol, drug use and abuse. The Rational Choice Theory is very relevant to the study in that students, who form part of the larger society, are rational and will take actions with lots of reasons and desired consequences in quest to maximize utility.

3.0 CHAPTER THREE: METHODOLOGY

3.1 RESEARCH SITE

This study was conducted at the University of Nairobi. University of Nairobi is a public university situated in the Kenyan capital, Nairobi. The University has six colleges established under it. The colleges are located within and around the city and these are: College of Education and External Studies located at the kikuyu campus, The College of Architecture and Engineering, College of Biological and Physical Sciences, College of Health Sciences, College of Agriculture and Veterinary Sciences at the Upper Kabete Campus and the college of Humanities and Social Sciences.

According to Students Statistics Summary 2005/2006 academic year, the University of Nairobi had a population of 15,064 under graduate students. There were 5,398(35.8%) female and 9,666(64.2%) male students. Table 3.1 shows student distribution by year of study and sex.

Table 3.1

Student distribution by year of study and sex

	SEX		Total	Ratio To Population
Year Of Study	Male	Female		
First	3724	2272	5996	0.40
Second	1844	1014	2858	0.19
Third	1837	1034	2871	0.19
Fourth	1909	991	2900	0.19
Fifth	329	85	414	0.03
Sixth	23	2	25	0.001
TOTAL	9666	5398	15064	1.00

Since the student sample was based on the Halls of residence, it is important to mention that students usually reside at the Main campus Halls of residence, Chiromo campus, Kenyatta National Hospital, Kikuyu campus, Lower Kabete campus, Upper Kabete campus and Parklands Campus.

According to the information from the Students Welfare Association, there are four units of halls of residence at the main campus. These are lower state house road unit that comprises of halls one, two, three, ten, eleven and SHRH. The upper state house road unit comprises of halls 4, 5, 6, 7, 8 and 9. The Mamlaka unit comprises of prefab 1 to 5, prefab 6 to 10, houses 1 to 10, mamlaka A and Mamlaka B. All the halls in the above units offered residence to male students only apart from

hall three that was mixed, halls four and six were occupied by female students only. The fourth unit is the women's halls which comprises of women's hall, Stella Awinja, Hall 12 and Hall 13. All offered residence to female students only. At the Parklands campus, there is one hall of residence that houses both female and male students. Chiromo campus also has one student residence that houses both male and female students. The Medical school has two halls of residence the Blocks and Soweto, both mixed. Upper Kabete campus has five halls of residence Wakulima, Tana, Mandela, Soweto and Mugabe, all mixed. Kikuyu campus has four halls which are University hall, Old Pioneer, 10 Pioneer units and Pioneer1 and Annex all mixed. Lastly the lower Kabete campus has three halls of residence, Kapenguria, Blocks and Malindi, all mixed.

The University of Nairobi was purposively selected as the study site due to its heterogeneous nature in composition. The University student population is drawn from varied Social, cultural, economic backgrounds and therefore it offers a reliable sample of the youth in the other public and even private Institutions of higher learning. Studying the behaviour of such heterogeneous institution can also be useful in expanding the information gathered to explain the behaviour of other youths in similar situations else in the country.

3.2 UNIT OF ANALYSIS

Unit of analysis for this study was the resident undergraduate university of Nairobi student from whom the data was collected. Data was collected from the sampled students and the aggregates used to describe the student population behaviour in this era of HIV/Aids.

3.3 UNIT OF OBSERVATION

The unit of observation for this study was the individual student. The eligibility criterion was that the student be enrolled at the University of Nairobi and residing on campus. The student personally responded to the questionnaire face to face with the researcher.

3.4 SAMPLING DESIGN

The University of Nairobi is a very large institution comprising of six colleges as mentioned earlier. These colleges for the sake of this study were divided into two strata, stratum one comprised of colleges situated around the city centre and the second stratum comprised of those situated at the outskirts of the city. The first stratum consisted of Main campus, Chiromo,

Parklands and the Medical School. The second consisted of Upper Kabete, Lower Kabete and Kikuyu campuses. From each stratum, one college was selected. The Main and Kabete campuses were selected. From the sampled colleges, all the Halls of residence were listed. The halls were further subdivided into males only, females only and mixed gender. Using simple random sampling, five halls: two males only, hall 2 and Mamlaka A were selected. Two females only, Stella Awinja and hall 13 were selected and one mixed gender, Mandela hall was selected to form a sub sample. This was to ensure that both male and female students were given equal chance of being selected since many halls of residence were gender specific and just a few were occupied by both genders. From the sampled Halls of residence, the researcher got lists of students who reside in these Halls. After establishing the population of the hall of residence, the researcher calculated as follows the number of interviews per hall: $\frac{\text{Number of students residing in hall x sample size}}{\text{Total student population.}}$

To get the sampling interval, the researcher then divided the number of students residing in the hall by the number to be interviewed per hall of residence. After randomly selecting a start point, the researcher systematically interviewed every nth student until the number required per hall was reached. This is called systematic random sampling. One hundred and seventeen students and ten key informants were interviewed. The key informants were purposefully sampled. These were people who are privy of the day to day students' lives on campus. They included five halls assistants, two medical officers from the student clinic, the In-charge the VCT centre, a nurse at the sickbay and an official of the students' organization against Aids.

3.5 SOURCES OF DATA

This study collected primary data using questionnaires and in-depth interview guide administered face to face to a sample of University of Nairobi students and key informants respectively.

3.6 METHODS AND TOOLS OF DATA COLLECTION

This study employed the survey research strategy to carry out the data collection. This study sought to collect quantitative using a questionnaire. The questionnaire comprised mainly of close and open-ended questions.

The researcher sampled eligible students and conducted interviews face to face at their halls of residence. In cases where students were not located on the first visit, follow up visits were

conducted to trace them to minimize none response. Ten key informants were also purposively sampled and interviewed using the key informant interview guide.

3.7 METHODS OF DATA ANALYSIS

After data collection, the data was keyed into the computer using the Statistical Package for Social Scientists [SPSS]. This was effected after the open-ended questions were assigned codes. Using SPSS the data was presented in form of tables, percentages and frequency distribution in form of descriptive statistics.

The in-depth interview/key informant interview data was summarised on the basis of the major themes and patterns of responses that emerged across the various respondents on each question. From these, the data was interpreted and a report written. The findings were then merged with quantitative ones to form the final findings.

4.0 CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

In this study, both quantitative and qualitative data were collected. One hundred and seventeen students and ten key informants were interviewed. The data collected from the students was quantitative while that from key informants was qualitative. The key informants included: halls wardens, custodians, student representatives, and medical staff working at the student clinic, sickbay and VCT.

In the analysis, quantitative data was presented in form of frequency tables and percentages and cross tabulations of variables. The qualitative data was summarized and used as complimentary data for the qualitative one on specific variables.

4.1. Social Demographic characteristics of the respondents

The socio demographic characteristics measured in this study were the sex, age, marital status, year of study, locality of upbringing and religion. The social demographic characteristics of an individual have varied influences on the behaviour of individual. Therefore it was pertinent that the social demographic characteristics of the students be established and some be used as bench marks or basis on which various sexual behaviours would be measured. Table 4.1 shows the number of students interviewed by year of study. Nineteen first, forty second, forty third, 14 fourth, three fifth and 1 other year students were interviewed. This trend may not be in tandem with the figures of the respective years of study populations, this is because as mentioned in the scope and limitations section of this study, the University of Nairobi uses the session system and not all students are in session at the same time. During the period of data collection, all second and third year students were in session, unlike the other years of study where by just a few were on campus. Since the study gave equal opportunity of being interviewed to those students on campus, the above numbers were interviewed.

Table 4.1: Year of study

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	First year	19	16.2	16.2	16.2
	Second year	40	34.2	34.2	50.4
	Third year	40	34.2	34.2	84.6
	Fourth year	14	12.0	12.0	96.6
	Fifth year	3	2.6	2.6	99.1
	Other	1	.9	.9	100.0
	Total	117	100.0	100.0	

Table 4.2 shows the ages of the University of Nairobi students. The student age ranges between 19 and 29, most students are aged 21and the average age is 22.16 years.

Table 4.2: Age

Mean	22.16
Median	22.00
Mode	21
Minimum	19
Maximum	29

Tables 4.3 show a cross tabulation of marital status versus the sex. From the tables, 94.0% of the respondents are single, 3.4% are cohabiting and 2.6% are married. This trend is similar for both sexes and discrepancies are there in numbers cohabiting and married whereby 4.4% of the girls while 2.8% of the men are cohabiting. The statistics also show that 4.2% of the males and none of the females are married. By year of study, the study findings show that most of the cohabiting and married students are in third year, 5.0% and 7.5% respectively. Most of the students are single and never married in the other years of study about, 100%.

Table 4.3: Sex * Marital status

			Marital status			Total
			single (Never Married)	Cohabiting	Married	
Sex	Males	% within Sex	93.1%	2.8%	4.2%	100.0%
	Females	% within Sex	95.6%	4.4%	.0%	100.0%
Total			94.0%	3.4%	2.6%	100.0%

Most students (62.1%) at the University of Nairobi were brought up in the rural areas while 37.9% were brought up in urban areas, as shown in table 4.4.

Table 4.4: Locality of upbringing

Locality	Valid Percent
Rural	62.1
Urban	37.9
Total	100.0

4.2. Self risk perception among University students

In terms of self risk perception, that is self conviction or rating that one is in danger of contracting HIV, 21.7%, 35.7%, 20% and 14.8% of the students think that they are at no risk, little risk, moderate and high risk respectively while 7.8% do not know how to rate their self risk. A higher

percentage of males than females think they are at no risk at 23.6% and 18.6% respectively, 34.7% of males and 37.2% of females think they are at little risk, 16.7% of males and 25.6% of females think that they are moderate risk. Also a bigger percentage of males than females think they are at high risk of contracting HIV, at 19.4% and 7.0% respectively. 5.6% and 11.6% of males and females do not know how to rate their self risk. Table 4.5 shows percentages of student self risk perception by sex.

From the key informant interviews, it came out clearly that students take HIV/Aids quite seriously. It was established that the students use condoms a lot, condoms from the dispensers get finished very fast. They fear being infected and think HIV can devastate their lives. The students have formed an organization, support groups and have peer education that teaches abstinence. The students also go for tests and when they test negative, they even celebrate. It also came out that there are those who think HIV is a normal thing and do not take it seriously.

Table 4.5: Own risk perception of contracting HIV * Sex

			Sex		Total
			Males	Females	
Own risk perception of contracting HIV	No risk	% within Sex	68.0%	32.0%	100.0%
		% of Total	23.6%	18.6%	21.7%
	Little risk	% within Sex	61.0%	39.0%	100.0%
		% of Total	34.7%	37.2%	35.7%
	Moderate risk	% within Sex	52.2%	47.8%	100.0%
		% of Total	16.7%	25.6%	20.0%
	High risk	% within Sex	82.4%	17.6%	100.0%
		% of Total	19.4%	7.0%	14.8%
	Don't know	% within Sex	44.4%	55.6%	100.0%
		% of Total	5.6%	11.6%	7.8%
		% within Sex	62.6%	100.0%	100.0%
Total			62.6%	37.4%	100.0%

4.3. HIV testing among University students

Taking an HIV test is needed in order for one to know their status, this may be done voluntarily or one may be required to. In this study, there was no difference put on whether the student took the test voluntarily or was required to. Taking an HIV test may be done so that one changes behavior to avoid being infected or infecting others. For one to be sure that they remain negative, they need to practice safe sex after the test or retest every time they engage in unsafe sex. That is the reason this study measured ever tested and tested in the last three months among the students. HIV is not transmitted just through sexual intercourse, so even if one has practiced safe sex, they could have been exposed to the virus in other circumstances, hence the need for constant testing.

From the data collected, 62.1% of the students reported to have ever been tested for HIV while 37.9% have never had a test. A higher percentage of lady students than their male counterparts have had the test at 68.2% and 58.3% respectively. In terms of the year of study, 50%, 57.5%, 70%, 71.4% and 33.3% of first, second, third, forth and fifth year students have ever had an HIV test. When it comes to having a test in the last three month, the percentages declined significantly. 20% of the student population reported to have had an HIV test in the last three month while 80% have not. This trend was also observed in the year of study whereby 11.1%, 23.1%, 22.5%, 21.4% and 0% of first, second, third, forth and fifth year students reported to have had an HIV test in the last three months. Table 4.6 shows the number of students who have ever been tested for HIV by sex.

From the qualitative interviews, it was established that the University of Nairobi has a VCT center with four counselors and there are rapid tests done at the laboratory. About ten students go for VCT daily, although some students say they rather be tested outside the university. It also came out that girls go for VCT much more than boys. This can be complemented by the quantitative findings, as 68.2% of girls have ever been tested compared to 58.3% of the boys.

Table 4.6: Ever had HIV test by Sex

		Sex		
		Males	Females	Total
Yes	% within Sex	58.3%	68.2%	62.1%
	% of Total	36.2%	25.9%	62.1%
No	% within Sex	41.7%	31.8%	37.9%
	% of Total	25.9%	12.1%	37.9%
	% of Total	62.1%	37.9%	100.0%

4.4. Age at first sex among University students

Sexual intercourse is a predisposing factor to HIV infection. The first step to a sex life is engaging in sex for the first time. This study sought to understand the age at which university students first had sex. The average age at first sex among the students was found to be 17.14, with males reporting to have had sex earlier than their female colleagues at 16.43 and 19.17 years old respectively. Most of the students started having sex at 18, with most ladies reporting to have started sex at 20 and males at 17 years of age. Lowest age at first sex reported was five for men and 16 for ladies, highest age was 22 for ladies and 25 for men. Therefore, even though ladies may start sex later than men, most are sexually active in their early twenties. Table 4.7 shows age at first sex of the students.

Table 4.7: Age at first sex

Sex	Grouped Median	Maximum	Mean	Median	Minimum
Males	16.85	25	16.43	17.00	5
Females	19.50	22	19.17	20.00	16
Total	17.91	25	17.14	18.00	5

4.5. Number of sexual partners among university students

This study sought to understand the number of people university students had had sex with in the period of three months preceding the study. The average number of sexual partners was found to be 1.83, with males having a higher average of sexual partners at 1.98 compared to the ladies 1.38. Most students had had one partner each the preceding three months, with both males and females reporting this number. Maximum number of sexual partners was 12 among males and 5 among ladies; the minimum was zero for both sexes.

By year of study, third, forth and fifth years are likely to have a higher number of sexual partners at an average 2.69, 2.75 and 3.0 respectively as compared to their compatriots in first and second year at 0.89 and 0.75 respectively. Tables 4.8 and 4.9 show the number of sexual partners the students have had in the past three months by sex and year of study respectively.

Table 4.8: Number of sexual partners in the last three months by sex

Sex	Grouped Median	Maximum	Mean	Median	Minimum
Males	1.00	12	1.98	1.00	0
Females	1.00	5	1.38	1.00	0
Total	1.00	12	1.83	1.00	0

Table 4.9: Number of sexual partners in the last three months by year of study

Year of study	Grouped Median	Maximum	Mean	Median	Minimum
First year	.57	3	.89	.00	0
Second year	.71	2	.75	1.00	0
Third year	1.29	12	2.69	1.00	0
Fourth year	2.33	6	2.75	2.00	1
Fifth year	3.00	5	3.00	3.00	1
Other	1.00	1	1.00	1.00	1
Total	1.00	12	1.83	1.00	0

4.6. Had student taken alcohol at time of last sex

When asked if they had taken alcohol at last sex, 17.2% of the students reported to have taken alcohol at last sex, 73.4% reported in the negative and 9.4% said they have never taken alcohol. By

gender, 17.0% and 17.6% of males and females respectively reported to have taken alcohol at last sex, 70.2% and 82.4% of males and females respectively said they had not taken alcohol at last sex while 12.8% and 9.4% of males and females respectively said they had never taken alcohol.
By year of study, third, fourth and fifth year students are more likely to have taken alcohol at last sex as, 28.6%, 20.0% and 100% reported positively as compared to none in first and second years.

From the qualitative data, it is indicated that there is alcohol use by both genders. But not common, students are broke, they want to drink but have no money. That many students drink at the beginning of the semester but later they become broke and can not afford alcohol. Table 4.10 shows student alcohol consumption at last sex.

Table 4.10: Alcohol consumption at last sex by Sex

		Sex		Total
		Males	Females	
Yes	% within Sex	17.0%	17.6%	17.2%
	% of Total	12.5%	4.7%	17.2%
No	% within Sex	70.2%	82.4%	73.4%
	% of Total	51.6%	21.9%	73.4%
Never taken alcohol	% within Sex	12.8%		9.4%
	% of Total	9.4%		9.4%
Total	% within Sex	100.0%	100.0%	100.0%
	% of Total	73.4%	26.6%	100.0%

4.7. Had student taken any drugs at time of last sex

The study sought to know the percentage of students who had used drugs at last sex. 6.1% of the students reported to have used drugs at last sex, 80.3% said they had not taken any drugs at last sex while 13.6% said they have never taken drugs. This does not mean that 86.4% of the students have used drugs since the study interest was only the percentage of drug use at last sex. The study did not ask ever drug use, that why it can not conclusively be said that those who said no to the question have necessarily used drugs. Males are likely to have taken drugs at last sex than females at 6.3% and 5.6% respectively.
The key informants said that bang smoking is quite common especially among boys but even girls.

"It is there, you can not get them ready handed but
when you observe their character you see signs",

said one. It was also established that some students have died, others have left school after taking bang and cocaine, and they become irresponsible and then get discontinued from school. Table 4.11 shows frequency of student drug use at last sex.

Table 4.11: Drug use at last sex by gender

			Drug use at last sex			
			Yes	No	Never used drugs	Total
Sex	Males	% within Sex	6.3%	77.1%	16.7%	100.0%
		% of Total	4.5%	56.1%	12.1%	72.7%
	Females	% within Sex	5.6%	88.9%	5.6%	100.0%
		% of Total	1.5%	24.2%	1.5%	27.3%
Total		% within Sex	6.1%	80.3%	13.6%	100.0%
		% of Total	6.1%	80.3%	13.6%	100.0%

4.8. Forced sex among university students

Forced sex is one of the predisposing factors to HIV infection because the victim has little or no choice of practicing safe sex. This follows, then that if the assailant does not use protection and is infected; chances of the victim getting infected are very high. In this study, students were asked if they have been forced to have sex against their will. 13.4% responded positively while 86.6% to the negative. A higher percentage of ladies reported to have been forced to have sex than the males at 27.8% and 8.2% respectively. In this connection then, ladies are more likely to be infected by HIV through forced sex than the males, assuming other conditions to be constant.

By year of study, 12.5%, 9.5%, 10.0%, 40.0% and 50.0% of first, second, third, forth and fifth years reported to have been forced to have sex. There is no clear pattern but apart from first years, the graph progresses upward with year of study. Hence it looks like the longer one stays at the University, the more likely that they will be forced to have sex. Table 4.12 shows the frequencies of ever forced sex among students by sex.

Table 4.12: Ever forced to have sex by gender

			Ever forced to have sex		Total
			Yes	No	
Sex	Males	% within Sex	8.2%	91.8%	100.0%
		% of Total	6.0%	67.2%	73.1%
	Females	% within Sex	27.8%	72.2%	100.0%
		% of Total	7.5%	19.4%	26.9%
Total		% of Total	13.4%	86.6%	100.0%

4.9. Multiple sexual partnering among University students

Sex is the most prominent way through which HIV is transmitted from one person to the other. Having more sexual partners therefore predisposes one more to infection. Just as much as one partner may be faithful to his or her partner; the other partner can equally expose him or her to HIV infection because of having other sexual partners outside the relationship. The chances of infection may even be further increased if safe sex is not practiced. In this study, students were asked if they think their partners have had sex with other partners. 25.8% and 53.0% of the students said yes and no respectively while 21.2% said they have no sexual partners. A bigger percentage of men think their partners are cheating on them than the ladies at 29.2% and 16.7% respectively.

By year of study, 12.5%, 30.0%, 23.3%, 20.0% and 100% of the interviewed first, second, third, forth and fifth years respectively, said they think their partner has had sex with other partners in the last three months. This follows no particular pattern but a majority of first years think that their partners are faithful than the rest of the students.

4.10. Paid sex among university students

Paid sex like forced sex, offers little or no choice to safe sex practice for the recipient of the pay. This may predispose the paid partner to infection by HIV if the buyer of the service chooses not to use protection. Therefore the more one engages in commercial sex, the more likely that they may be infected by HIV. In this study, students were asked if they have ever been paid or themselves paid someone for sex. Basically, this question sought to know the proportion of students that have ever participated in commercial sex. 20.9% of the students said that they have been paid or they have paid for sex. A bigger proportion of males than females have participated in commercial sex at 26.5% and 5.6% respectively. It follows then that male students are more likely than female students to be infected by HIV through commercial sex if safe sex is not practiced.

When key informants were asked if there is commercial sex at the university, this is what some of them had to say: *"The girls go to Koinange Street, they do not go to enjoy sex they go for money"*. Another said that he hears about it but has never witnessed.

When asked, who the sex workers are, one said: *"Rich family students engage in commercial sex work, those who are exposed and know much of Nairobi, those from rich families lead extravagant lives so they have to maintain it. Rural girls are not so much into commercial sex because they do not know much of Nairobi"*. Another key informant said, *"Boys do not want sex with responsibility so they look for commercial sex workers"*. The key informants also said that ladies usually have sex with rich outsiders working in town, while boys have sex with sex workers from town too. There is no reported commercial sex between students themselves. Table 4.13 shows frequencies of students ever been paid or paid for sex by sex.

Table 4.13: Ever been paid or paid for sex by gender

			Ever been paid or paid for sex		
			Yes	No	Total
Sex	Males	% within Sex	26.5%	73.5%	100.0%
		% of Total	19.4%	53.7%	73.1%
	Females	% within Sex	5.6%	94.4%	100.0%
		% of Total	1.5%	25.4%	26.9%
Total		% of Total	20.9%	79.1%	100.0%

4.11. Student_Non student sexual relationships at the University

One of concerns of this study was to find out whether students have sexual relationships just amongst themselves or even with non students. This was meant to measure whether the student community is socially closed or has links with the outside community. Students were asked if they have had sex with a non student for the period they have been at the university, 57.6% said yes while 42.4% said no. 60.4% of the males have had sex with non students as compared to 50.0% of the female students. By year of study, 55.6%, 42.9%, 62.1%, 80% and 100% of first, second, third, forth and fifth year students said they have had sexual intercourse with non students. Table 4.14 shows frequencies of student ever had sex with non students by sex.

Table 4.14: Had sex with a non student for period been at University by gender

			Have had sex with a non student for period been at University		
			Yes	No	Total
Sex	Males	% within Sex	60.4%	39.6%	100.0%
		% of Total	43.9%	28.8%	72.7%
	Females	% within Sex	50.0%	50.0%	100.0%
		% of Total	13.6%	13.6%	27.3%
Total		% of Total	57.6%	42.4%	100.0%

4.12. STIs among University students

When measuring vulnerability or exposure to HIV infection, STI infection is a good indicator since most STIs are got through sex just like HIV. The fact that one suffers from an STI, indicates high chances of the individual not practicing safe sex at one time or the other. In this study, students were asked if they have ever suffered from a sexually transmitted infection. 5.9% said they have ever suffered from an STI, 8.0% of the male students responded positively while no female student said they had suffered from an STI.

From the information gotten from key informants working at the student clinic and sick bay, girls especially those in main campus because of their sexual behaviours, come to the sick bay with STIs. Another key informant said, *"Also in Kikuyu campus boys befriend bar maids and get infected with STIs, some have even committed suicide after discovering that their sexual partners died of Aids"*. Table 4.15 shows the frequencies of students ever suffered STI by sex.

Table 4.15: Ever suffered a sexually transmitted disease by gender

			Ever suffered a sexually transmitted disease		Total
			Yes	No	
Sex	Males	% within Sex	8.0%	92.0%	100.0%
		% of Total	5.9%	67.6%	73.5%
	Females	% within Sex		100.0%	100.0%
		% of Total		26.5%	26.5%
Total		% within Sex	5.9%	94.1%	100.0%
		% of Total	5.9%	94.1%	100.0%

4.13. Condom use among University students

Condom use is one of the prevention mechanisms of HIV transmission. As much as condom use is important in prevention of HIV transmission, consistent condom use is emphasized. In this study, students were asked whether they have ever used a condom, how many times they use condoms and whether they used a condom at last sex. 85.5% said they have ever used a condom, 58.8% said they used a condom at last sex and 39.1% said they consistently use condoms. Looking at the statistics, condom use among the university students is very high, but consistent use is not as high therefore the number that is exposed to HIV infection is also high. Consistent condom use is considered pertinent in preventing HIV because one can get infected that single time they did not use a condom even if they had used a condom all the other times during sex.

From the key informant interviews, it came out clearly that students do take condoms from the dispensers placed in the halls of residence and some even go for them from the health facility. If the students take condoms for purposes of using them, then condom use is existent among the student community. Table 4.16 shows frequencies of student consistent condom use by sex.

Table 4.16: Sex * Consistent condom use Cross tabulation

			Consistent condom use			Total
			Always	Sometimes	Never	
Sex	Males	% within Sex	50.0%	25.0%	25.0%	100.0%
		% of Total	37.5%	18.8%	18.8%	75.0%
	Females	% within Sex	6.3%	50.0%	43.8%	100.0%
		% of Total	1.6%	12.5%	10.9%	25.0%
Total		% within Sex	39.1%	31.3%	29.7%	100.0%
		% of Total	39.1%	31.3%	29.7%	100.0%

4.14. Motivation of University students to engage in sex

One of the assumptions of this study is that University students engage in sex because they think it is their right as youths. To find this out, students were asked to state what reasons motivate them to engage in sex and more directly, they were asked if they think it is their right as youths to engage in sex. For the first question, 9.6% mentioned their right as students, 53.9% mentioned peer pressure, 27.0% mentioned to prove sexuality, 64.3% mentioned for pleasure, 36.5% mentioned to show love, 28.7% mentioned for financial gain, 24.3% said too much free time and 33.0% said is moral decay.

When the question was asked directly, 36.4% said yes they think it is the right of students as youths to engage in sexual intercourse. Therefore a majority of students think that it is not the right of students as youths to engage in sex and most of them think students engage in sex for pleasure.

Key informants gave similar reasons as the students themselves as to why students engage in sex. The divergent reasons included: they need love in preparation for marriage, looking for marriage partners, a lot of freedom compared to high school and home and economic hardships especially among ladies. Table 4.17 shows the percentages of students who think it is students' right to have sex.

Table 4.17: percentage that Think it is university students' right to have sex

		Valid Percent	Cumulative Percent
Valid	Yes	36.4	36.4
	No	63.6	100.0
	Total	100.0	

4.15. Frequency of night club visits among university students

There are some environments that are more alluring and may cause temptations for an individual to engage in sex than others. The night club environment is one such. Night club visits can influence an individual to engage in sex and gives one an opportunity of meeting more people. So night club visits is a predisposing factor to engaging in sex and hence likelihood of HIV infection if protection is not used.

In this study, students were asked how often they visit night clubs. Of those who responded to the question, 18.9% said they visit night clubs at least once per week, 10.8% once in every fortnight, 9.0% once per month, 9.9% once per semester and 51.4% said they have never visited nightclubs. A majority of male than female students have ever visited nightclubs at 51.4% and 43.9% respectively. Table 4.18 shows the frequency of student night club visit by sex.

Table 4.18: Frequency of Night club visit * Sex Cross tabulation

			Sex		Total
			Males	Females	
Frequency of Night club visit	At least once a week	% within Sex	71.4%	28.6%	100.0%
		% of Total	21.4%	14.6%	18.9%
	Once in every fortnight	% within Sex	75.0%	25.0%	100.0%
		% of Total	12.9%	7.3%	10.8%
	Once per month	% within Sex	60.0%	40.0%	100.0%
		% of Total	8.6%	9.8%	9.0%
	Once per semester	% within Sex	54.5%	45.5%	100.0%
		% of Total	8.6%	12.2%	9.9%
	Never visited night clubs	% within Sex	59.6%	40.4%	100.0%
		% of Total	48.6%	56.1%	51.4%
Total			63.1%	36.9%	100.0%

5.0 CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS/FURTHER RESEARCH

5.1 SUMMARY OF FINDINGS

In the summary of findings, the specific objectives of the study will be looked at and how the study findings address these objectives. The specific study objectives were:

- To establish self-risk perception by the university of Nairobi student community with regard to HIV/Aids infection.
- To determine the level of vulnerability/exposure to HIV infection among the University of Nairobi students.
- To determine the actions taken by University of Nairobi students to protect themselves from contracting HIV.

5.1.1 Vulnerability/Exposure of University Student to HIV Infection

The average age at first sex among the students was found to be 17.14. This means that most students are exposed to HIV infection by this age. It was also found that most students have 1.83 sexual partners, a sign that many students are unfaithful to their partners and hence keeping other conditions constant, then they are at risk or vulnerable to contracting HIV.

Substance use or abuse sets a favorable environment for HIV transmission especially if one is under the influence of alcohol or drugs during sexual intercourse. Alcohol and drugs impair decision making and one is more likely to avoid safe sex when under the influence of alcohol or drugs. 17.2% and 6.1% of students interviewed said they had taken alcohol or drugs respectively at last sex. Even though a majority of students reported not have been under substance influence at last sex, 17.2% and 6.1% are far too high a percentage to be exposed to HIV infection as loss of even one student is too dear for the parent, university and state that have invested heavily in the individual.

Forced sex is one of the predisposing factors to HIV infection because the victim has little or no choice of practicing safe sex. Then if the assailant does not use protection and is infected; chances of the victim getting infected are very high. 13.4% of interviewed students said they have been raped. This shows that as high as 13.4% of students have been exposed to possible HIV infection through rape.

Paid sex like forced sex, offers little or no choice to safe sex practice for the recipient of the pay, as the solicitor calls the shots. Decision of safe sex may be pegged on how much money he or she is ready to offer. This may predispose the paid partner to infection by HIV if the buyer of the service chooses not to use protection. Therefore the more one engages in commercial sex, the more likely that they may be infected by HIV. 20.9% of the students said they have been paid or they have paid for sex. Therefore these students (especially those who were paid) have been exposed to possible infection by HIV through commercial sex if safe sex was not practiced.

5.9% of the interviewed students said they have ever suffered from an STI. When measuring of vulnerability or exposure to HIV infection, STI infection is a good indicator since most STIs are got through sex just like HIV. The fact that one suffers from an STI, indicates high chances of the individual not practicing safe sex at one time or the other. In case this 5.9% of the students had sex with partners who were HIV positive, then they also would have been infected, since safe sex was not practiced.

There are some environments that are more alluring and may cause temptations for an individual to engage in sex than others. The night club environment is one such. Night club visits can influence an individual to engage in sex and gives one an opportunity of meeting more people. It does not matter how many times one visits night clubs, just one time is enough to cause the harm. 49.6% of the interviewed students have visited night clubs at least once. Even though night club visits can not be directly linked to HIV infection, it is a step towards possible engaging in sex. Therefore, 49.6% of students have exposed themselves to this danger.

5.1.2. Self Risk Perception of University Students to HIV Infection

In terms of self risk perception, that is self conviction or rating that one is in danger of contracting HIV, 21.7%, 35.7%, 20% and 14.8% of the students think that they are at no risk, little risk, moderate and high risk respectively while 7.8% do not know how to rate their self risk. For those students who said that they are at no risk, they are unlikely to take any precautionary measures against HIV contraction. Such students may not know the circumstances that predispose them to infection and hence are unlikely to say use condoms, change behavior by reducing number of

sexual partners or seeking to know their HIV status. On the other hand those who think they are at high risk are likely to take precaution against infection. In this connection, 21.7% of the students interviewed are unlikely to take precaution against HIV infection because they think that they are in no danger at all. Such students stand a high chance of being infected unless of course the reason they say they are at no risk is because they have taken all precautions against infection.

5.1.3. Prevention Mechanisms of University Students to HIV Infection

Prevention of HIV contraction through sex can be summarized as ABC that is abstinence, being faithful and condom use. Some attributes such as abstinence can be very challenging to gauge. Abstinence is actually self denial or restraint. In this case, it is denying one self sexual intercourse. The challenging bit is what length of time one is supposed to keep off from sex for it to be abstinence. For the sake of this study, there are students who said that they do not have sexual partners, this was about 33.7%. The number includes those who have never had sex. In terms of abstinence as a way of prevention against HIV, then successfully it can be put that about a third of the student population are abstaining.

Being faithful means having one sexual partner who is HIV negative. The average number of sexual partners is 1.83 for the student population. This is way above the required one, furthermore we do not know if the students know the HIV status of their sexual partners. Then the student community can be termed as unfaithful and hence vulnerable to HIV infection.

Condom use is one of the prevention mechanisms of HIV transmission. While condom use is important in prevention of HIV transmission, consistent condom use is emphasized. 39.1%of the interviewed students said they consistently use condoms. Looking at the statistics, consistent condom use among students is not high therefore the number that is exposed to HIV infection is high. Consistent condom use is considered pertinent in preventing HIV because one can get infected that single time they did not use a condom even if they had used a condom all the other times during sex.

Taking an HIV test is needed in order for one to know their status. Taking an HIV test may be done so that one changes behavior to avoid being infected or infecting others. For one to be sure that they remain negative, practice of safe sex after the test or retest every time they engage in

unsafe sex. From the data collected, 62.1% of the students reported to have ever been tested for HIV while 37.9% have never had a test. When it comes to having a test in the last three month, the percentages declined significantly. 20% of the student population reported to have had an HIV test in the last three month while 80% have not. HIV test just like condom use, has be consistent, it has to be done regularly because one may test negative today and be infected tomorrow. There are other ways of transmission besides sexual intercourse; therefore even if one has practiced safe sex, one can get infected through other ways. Therefore the 80%, who have not had a test in the last three months, can successfully be grouped under those who do not know their status, of course unless they tested positive the last time.

5.2 CONCLUSION

The overall objective of this study was to investigate the sexual behaviour of the University of Nairobi students in the era of HIV/Aids. The study has found out that the University students take the issue of HIV/Aids seriously. Many know that they are at risk of being infected and have taken precautionary measures such as abstaining, use of condoms and going for HIV test. Many are avoiding circumstances that predispose them to HIV infection such as drug use, alcohol, clubs and commercial sex.

Nonetheless, there are still a number of students who are oblivious of the fact that they are equally at risk of HIV infection and have not taken any prevention measures. Those students who have many sexual partners, engage in commercial sex, do not use condoms consistently, take alcohol/drugs before sexual intercourse, go to clubs and have never been tested for HIV are a group that is in danger of infection. An appropriate programme needs to be put in place by the university authorities to ensure that most students if not all change their behaviour so that they are not vulnerable to HIV infection. Even though the study did not establish the HIV prevalence rate among the students, it is quite clear from the study that the number predisposed to the virus is higher than those who have taken precaution. Take consistent condom use for example, just 39.1% of the students practise this, meaning that about 60% of the students are at risk of contracting HIV. Only 20% have had an HIV test in the last three months, literally then 80% of the students do not know their status. Many people live with HIV without their knowledge; this is the most lethal group because they will infect others unknowingly and are unlikely to use protection because they think they are HIV negative. Consequently, this study recommends the following actions and further research.

5.3 RECOMMENDATIONS

From the findings of this study, it is pertinent that the following actions need to be under taken by the government and the University in particular to reduce the exposure to or even infection of students by HIV.

- Give health education to students on self risk perception, that everyone is equally prone to HIV.
- Educate students the importance of knowing their HIV status at all times. This is important so that they live positively if they are positive and avoid infecting others and if they are negative, they protect themselves from infection.
- Further health education to the students is done about ABC. That Abstinence is total avoidance of sex till marriage, that being faithful means having one sexual partner whose HIV status you know and they also know yours and that condom use means consistently using condoms.
- Educate students on the importance of avoiding circumstances that predispose them to engaging in sex such as clubs, alcohol and drug use.

From the study findings, there were some issues that arose but could not be handled or addresses in this study due to limitations and mandate of the study. These issues may be addressed in other researches done among the student community. This study therefore recommends that further research needs to be done to establish the following:

- Why students have the varied self risk perceptions to contracting HIV.
- Under what circumstances students fail to use condoms consistently.
- Circumstances that predispose students especially female ones to cases of forced sex.
- Why some students prefer to go for HIV testing out of campus even though they have testing facilities there.
- How commercial sex can be controlled or even eliminated among the University student community

BIBLIOGRAPHY

1. Akukwe C. 1999; 3(3): 5-24. HIV/AIDS in African children: a major calamity that deserves urgent global action. J HIV/AIDS Prev Educ for Adolescent & Children
2. Bandura A. (1986) *Social Foundations of Thought and Action: A Social Cognitive Theory*. Englewood Cliffs, NJ: Prentice Hall.
3. Bandura A. (1989) Social Cognitive Theory. IN: Annals of Child Development (Vol 6, p1-60. (Vasta R, ed). Greenwich, CT: Jai Press LTD.
4. Bandura A. (1991) "Social cognitive theory of moral thought and action". IN: *Handbook of Moral Behavior and Development*. Kurtines WM and Gerwitz JL (eds). (Vol 1, p 45-103). Hillsdale, NJ: Erlbaum.
5. Bollag, B.2000. "University of Nairobi starts campaign against aids epidemic on campus." Chronicle of Higher Education. London.
6. Caldwell JC. 2000. Rethinking the African AIDS epidemic. Population Develop Review.
7. Central Bureau of statistics Ministry of planning. 2002. Statistical Abstract. . Nairobi. Government printer
8. Family Health International/AIDSCAP.1996. AIDS in Kenya: Socio-economic impact and policy implications. Family Health International, USA.
9. Family Health International/UNAIDS. 2001. Effective prevention strategies in low prevalence settings. Family Health International, USA.
10. Government of the United Kingdom. April 2001. Department for International Development, Health and Population Department, "HIV/AIDS in Kenya - How Political Commitment Can Make a Difference," Stories from the Field Series (London: Government of the United Kingdom,).
11. Lori Bollinger, John Stover, and David Nalo.1999. "The Economic Impact of AIDS in Kenya," (Washington, DC: Futures Group International)
12. Mary Grace Alwano-Edyegu and Elizabeth Marum.1999. "Knowledge is Power: Voluntary HIV Counselling and Testing in Uganda," UNAIDS Best Practice Series (Geneva: UNAIDS).
13. Ministry of Health / Nascop. 2001. "Background, Projections, Impact, Interventions and

Policy on Aids in Kenya" (Sixth Edition). . Nairobi.Government printer

14. National AIDS and STDs Control Programme (NASCOP), (1999). *AIDS in Kenya: Background, Projections, Impact and Interventions*, 5th ed. (Nairobi: Ministry of Health,).
15. Nzioka, Charles. 2000. "The impact of HIV/Aids on the University of Nairobi." Paper Prepared for ADEA Working Group on Higher Education.
16. Obudho, R.A. 1995. "STDs, HIV/Aids and Urbanization Process in Kenya." African Journal of Health sciences. Vol. 2. No 1.
17. Pathfinder International, Africa Regional Office. 1999. Adolescent Reproductive Health in Africa: Paths into the Next Century. Nairobi, Kenya: The Office,
18. Peter Abell, "Sociological Theory and Rational Choice Theory," Chapter 8 of Turner and James Coleman, *Foundations of Social Theory*, p. 292-299 and 220-228.
19. Population Reference Bureau [and] Population Services International. 2000. Social Marketing for Adolescent Sexual Health: Results of Operations Research Projects in Botswana, Cameroon, Guinea, and South Africa. Washington, DC: The Bureau,.
20. Rosen JE, Conly SR., 1998. Africa's Population Challenge: Accelerating Progress in Reproductive Health. [Country Study Series, no. 4] Washington, DC: Population Action International.
21. Stephen Buckley, 1997. "Wife Inheritance Spurs AIDS Rise in Kenya," *The Washington Post*,
22. Susan Hunter and John Williamson, 2000. *Children on the Brink 2000*, (Washington, DC: U.S. Agency for International Development).
23. Tony Johnston, 2000. *The Adolescent AIDS Epidemic in Kenya: A Briefing Book,* rev. ed. (Nairobi: Population Communication Africa).
24. U.N. Joint Progamme on HIV/AIDS (UNAIDS), 2000. *Report on the Global HIV/AIDS Epidemic: June 2000,* (Geneva: United Nations).
25. UNAIDS and UNICEF, 1999. *Children Orphaned by AIDS: Front-line Responses from Eastern and Southern Africa* (New York: United Nations).
26. UNAIDS. 1999. Listen, Learn, Live! World AIDS Campaign with Children and Young People: Facts and Figures. Geneva: UNAIDS.
27. UNAIDS/WHO.2003. "Aids Epidemic Update, December 2003."

28. UNICEF Eastern and Southern Africa Regional Office, "The Silent Emergency".
29. World Bank, 2000. *Exploring the Implications of the HIV/AIDS Epidemic for Educational Planning in Selected African Countries: The Demographic Question* (Washington, DC: The World Bank).
30. World Health Organization (WHO) and UNICEF, 1994. *Action for Children Affected by AIDS: Programme Profiles and Lessons Learned* (Geneva: United Nations).

ANNEX
QUESTIONNAIRE

Good morning/afternoon. My name is Douglas Waswa and I am a Master of Arts student in Medical Sociology at the University of Nairobi. Currently, I am conducting a study on Sexual Behavior among University of Nairobi Students in the Era of HIV/Aids. This is in partial fulfillment for the award of the Masters degree.

You have been selected at random to participate in this study. I would like to talk to you about your day-to-day life at the University and how you interact with your colleagues and the outside community. I assure you that your responses and opinions will remain confidential and will be used for the purposes of this study only.

Would you like to participate in this study?
Yes.....1 (continue)
No.....2 (End interview)

SECTION 1: SOCIODEMOGRAPHIC CHARACTERISTICS

First I would like to ask you questions about yourself.

1.	Sex of respondent.	Male..... 1 Female..... 2
2.	In what month and year were you born?	**Month** **Year** ☐☐ ☐☐☐☐
3.	How old were you at your last birthday?	☐☐
4.	What is your current marital status?	Single (Never Married) 1 Cohabiting 2 Married 3 Widowed 4 Divored/Separated 5

5.	What is your year of study?	First Year …….. Second Year…… Third Year…….. Fourth Year…… Fifth Year…….. Sixth year…….. Other……	1 2 3 4 5 6 7
6.	Did you grow up mainly in an urban or rural area?	Rural…… Urban……	1 2
7.	What is your religion/denomination?	Catholic…… Muslim…… Protestant…… African traditional……... **Other (Specify)**_____	1 2 3 4 5
SECTION 2: KNOWLEDGE, ATTITUDES AND PERCEPTIONS ON HIV/AIDS.			
8.	Have you ever heard of HIV/AIDS?	Yes…… No……	1 2
9.	Name some of the ways that HIV is passed from one person to another.	Sexual Intercourse Mother to Child transmission Blood Transfusion Sharing of needles and sharp objects Other (Specify)……	1 2 3 4 5
10.	How HIV is **<u>mainly</u>** transmitted from one person to the other?	Sexual Intercourse Mother to Child transmission Blood Transfusion Sharing of needles and sharp objects Other (Specify)……	1 2 3 4 5

11.	How can a person protect him/herself from contracting HIV?	Abstinence 1 Being faithful 2 Use of condoms 3 Avoid sharing of sharp objects 4 Other (Specify)..... 5
12.	Who is at risk of contracting HIV?	Anyone 1 Those with Many sexual partners 2 Other (Specify)..... 3
13.	In terms of your own risk of getting HIV/Aids, would you say that you are at...?	No risk 1 Little risk 2 Moderate risk 3 High risk 4 Don't know 5
14.	Have you ever had an HIV test?	Yes 1 No 2
15.	Have you had an HIV test in the last 3 months?	Yes 1 No 2
16.	Can a healthy looking person have HIV/AIDS?	Yes 1 No 2 Don't know 3
17.	Do you have a close relative or friend who is infected or has died of HIV/Aids?	Yes 1 No 2 Don't know 3
SECTION 3: SEXUAL HISTORY, BEHAVIOUR AND EXPOSURE TO HIV/AIDS.		
18.	How old were you when you first had sexual intercourse?	Age in years ☐☐

19.	How many different people have you had sex with in the last 3 months?	☐☐
20.	When was the last time you had sex?	Within the last one week 1 Within the last 3 months 2 More than 3 months 3
21.	The last time you had sex had you taken any alcohol?	Yes 1 No 2 Never taken alcohol 3
22.	The last time you had sex had you taken any drugs?	Yes 1 No 2 Never used drugs 3
23.	Have you ever been forced to have sex against your will?	Yes 1 No 2
24.	Do you think your sexual partner has other sexual partners apart from you?	Yes 1 No 2 No Sexual Partner 3
25.	Do you think your sexual partner has had sex with other partners in the last three months?	Yes 1 No 2 No Partner 3
26.	Sometimes it happens that people have sex in exchange for money or other favors, have you ever paid or received money in exchange for sex?	Yes 1 No 2
27.	Do you think University of Nairobi students have sexual partners who are non-students?	Yes 1 No 2 Don't know 3
28.	Do you think that your sexual partner has another sexual partner who is a non-student?	Yes 1 No 2 Don't know 3
29.	Have you ever had sex with a non-student in the period you have been a student here?	Yes 1 No 2
30.	Have you ever suffered from a sexually Transmitted infection?	Yes 1 No 2
31.	Have you ever used a condom?	Yes 1 No 2

32.	How many times have you used a condom in the last 3 months, would you say all the time, sometimes or never?	Always 1 Sometimes 2 Never 3
33.	The last time you had sex, did you use a condom?	Yes 1 No 2 N/A 3
34.	How do you mostly spend your leisure time?	_____ _____ _____ _____
35.	Who do you mostly spend your time with at the University?	
36.	Why do you think students engage in sexual intercourse?	Their right as youth 1 Peer pressure 2 To prove sexuality 3 Pleasure 4 To show love 5 Financial gain 6 Too much free time 7 Moral decay 8 Other..... 9
37.	Do think it is the University students' right to engage in sex as youths?	Yes 1 No 2
38.	Do you think a law should be created to control entry of people of opposite sex into university students' rooms?	Yes 1 No 2
39.	How often do you visit night clubs?	At least once in a week 1 Once in every Fortnight 2 Once per month 3 Once per semester 4 Never visits night clubs 5

Key Informant Interview guide

SECTION 1: General Information

1. Indicate sex and age of respondent.
2. What is your designation at the University?
3. What is your highest level of education?
4. How long have been working at this University?

SECTION 2: Behaviour and Experience with HIV/Aids

1. What do students at this University do to have fun?
2. What kinds of sexual activity/relationships exist at this University?
3. Which kind of sexual activities among students are most risky?
4. Is there any category of students that appears to be at higher risk for HIV infection?
5. Why do you think students engage in sex? Probe among themselves and outsiders.
6. Is there commercial sex at the University? Who are the commercial sex workers and who are they having sex with?
7. **If they are**, why do you think students are engaging in commercial sex work?
8. Do students engage in drug use? What about alcohol abuse?
9. How big of an issue is Aids at this University?
10. What is your view on how students take the problem of HIV/Aids? (Probe: whether they see Aids as a serious or a slight problem).
11. Are there HIV testing facilities at this University?
12. Do students make use of these testing facilities? If not why?
13. Are you aware of any students who are affected or infected with HIV?
14. How are students infected with HIV treated by others at this University?
15. What do you think should be done to reduce the rate of infection or HIV prevalence among the student community at this University?