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**UNIVERSITY OF NAIROBI**  
**FACULTY OF ARTS**  
**DEPARTMENT OF SOCIOLOGY AND SOCIAL**  
**WORK**

TOPIC

**HIV/AIDS LIFESKILLS CAPACITIES AMONG YOUNG**  
**PEOPLE IN DANDORA AREA**

**A MASTERS OF ARTS DEGREE PROJECT IN RURAL**  
**SOCIOLOGY AND COMMUNITY DEVELOPMENT**

**UNIVERSITY OF NAIROBI**  
**EAST AFRICANA COLLECTION**

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## DECLARATION

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

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I confirm that the work reported in this project was carried the candidate under my supervision.

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III  
**DEDICATION**

To my family with love and appreciation

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## LIST OF ABBREVIATIONS

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ARRM</b>	Aids Risk Reduction Model
<b>BCC</b>	Behavior Change Communication
<b>BSS</b>	Behavioral Sexual Surveillance
<b>CACCs</b>	Constituency AIDS Control Committee
<b>CBOs</b>	Community Based Organizations
<b>DHS</b>	Demographic Health Survey
<b>EFA</b>	Education for All
<b>ERS</b>	Economic Recovery Strategy
<b>FRESH</b>	Focus Resources of Effective School Health
<b>GoK</b>	Government of Kenya
<b>HIV</b>	Human Immunodeficiency Virus
<b>JAPR</b>	Joint AIDS Programme Review
<b>KDHS</b>	Kenya Demographic Health Survey
<b>KNASP</b>	National HIV/AIDS Strategic Plan
<b>MOH</b>	Ministry of Health
<b>MTCT</b>	Mother to Child Transmission
<b>NACC</b>	National AIDS Control Council
<b>NASCOP</b>	National AIDS and STD Control Programme
<b>NGOs</b>	Non-Governmental Organization
<b>STD/Is</b>	Sexually Transmitted Disease/Infections
<b>UNESCO</b>	United Nations
<b>UNGASS</b>	United Nations General Assembly
<b>UNAIDS</b>	United Nations
<b>UNICEF</b>	United Nations Children's Fund
<b>UNIFA</b>	United Nations
<b>USA</b>	United States of America
<b>VCT</b>	Voluntary Counseling Centers
<b>WHO</b>	World Health Organization



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## ABSTRACT

HIV/AIDS is the greatest challenge worldwide and most pressing public health problem. Many strategies have been employed to curb the spread of HIV/AIDS especially in Sub-Saharan countries where the epidemic has continued to kill many people including young people who have not been exempted and continue to be the worst hit despite being categorized as the widow of hope for both the current and future society. This study objectively focused on young people and sought to explore the HIV/AIDS life skills capacities among young people in Dandora area. The paper highlighted the various HIV/AIDS Life skills young people possessed in Dandora, the prevention techniques employed by the same and the consequent effect of these HIV/AIDS life skills capacities on sexual behavior necessary in HIV/AIDS prevention. The paper focused on a sample of 200 young people from Dandora area and employed both quantitative and qualitative techniques to gain data from respondents which were also analyzed both quantitatively and qualitatively. Findings revealed that 55.5% of the respondents were female while 44.5% were male. Most of this respondents did not possess necessary HIV/AIDS life skills for HIV/AIDS prevention as only 39% had critical thinking life skills, 43% creative and organizational skills, 62.5% had decision making skills, 54% goal setting and accomplishment skills, 50.5% capacity to sustain relationship/friendship and 42.5% problem solving and conflict resolution skills. 62% of the respondents were sexually active while 67.7% used a precaution in their sexual encounter although 44.5% only considered themselves at risk. There was a significant relationship between sex and HIV/AIDS life skills possessed by respondents which indicated that more male youths in Dandora area possessed the life skills than their female counterparts. There was no association between sexual activity and HIV/AIDS life skills as majority of respondents were sexually active. Majority of the respondents also possessed a fair knowledge and attitude towards HIV/AIDS issues although there study revealed a gap between the HIV/AIDS life skills possessed, sexual behavior and utilization of this knowledge and skills. Analysis of this finding will prove to be of value to institutions, organizations and governmental institutions that desire to create youth specific intervention programmes that have an impact on prevention of HIV infection among youths and the impact of the scourge in the society as whole.

# CHAPTER ONE

## 1.0 INTRODUCTION

### 1.1 BACKGROUND AND OVERVIEW

HIV/AIDS has had a drastic impact in the world more than any other disease or disaster on earth. At a global view, by 2007 more than 33.2 million adults and children were living with the HI virus while the number of new infections was recorded at 2.5 million with over 2.1 million deaths reported due to Aids. As of the same year, Sub-Saharan Africa has had and suffered the highest impact of the disease, 68% of the cases being from the region recording an estimated prevalence rate of 7.4% and more than 22.5 million people living with the virus. New infections as per the same year were estimated at 1.7 million, while 1.7 million died of AIDS as of 2007. An estimate of 6.9% of women and 2.2% of men in Sub-Saharan Africa living with Aids were aged 15-24 years as of end of 2006.<sup>1</sup>

In Kenya, since the first case of HIV/AIDS was reported in early 1984 more than 3 million people have succumbed to this annihilating scourge and millions others continue to reel under the effect of the pandemic. According to NACC report, Kenya is one of the countries which have shown reduction in HIV/AIDS prevalence as a result of the multifaceted approach that has brought change in risky behavior. As from the 2008 sentinel surveillance, HIV/AIDS prevalence in the country stands at an average of 8% an increase of more than 3% from 2006 and 5.1% in 1999. The report also estimates that more than one million people are HIV positive in the country, with more than 940,000 of this being in the 15-49 age bracket and 102,000 under age 14. The prevalence in urban areas stand at 8.3% compared to 4% in rural areas while the overall new cases of HIV infection were estimated at 60,000 as of 2006 (NACC, 2006, 2008).

HIV/AIDS prevention is the leading interventional approach, (apart from care and support) in the world with most organizations focusing on it due to the range of mitigating options it offers in combating HIV/AIDS. HIV/AIDS prevention provides

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<sup>1</sup> [www.unaids.org](http://www.unaids.org)

knowledge and skills that can limit the initial infection and spread of HIV/AIDS' multi-sectoral impact among individuals, families, communities and societies at large.

One of the available and most effective strategies in contemporary HIV/AIDS prevention among young people is the of life skills approach. Life skills approach has been used over the years in a wide spectrum of areas by both educationalist, social scientist and people in other professions both in governmental and non-governmental organizations as a model to promote information-based, skill-oriented and experiential competencies that are effective in dealing with adopting positive attitudes, behaviors and skills that are relevant in dealing with the challenges of life. International agencies including UNICEF, WHO for example have supported local programmes including Kenya to promote HIV/AIDS life skills programme as a HIV/AIDS reduction and avoidance model (WHO 1998, 1996, 1999). The global School Health Initiative and Health promoting Network have adopted life skills as priority strategy for school health in many parts of the Sub- Saharan Region. More specifically life skills model has been used in various prevention measures such prevention of drug abuse, teenage pregnancy, gender violence, HIV/AIDS and development of other coping skills necessary for adapting positively to challenges in life. In HIV/AIDS the life skills approach can provide youth specific prevention strategies which can enhanced knowledge and encourage the development of attitudes and skills to changing risky behaviors among youths and enabling them develop healthy behaviors and trends that that can limit the spread and impact of the epidemic. It gives a widow of hope as it helping them understand and analyze risk behaviors and know how to be able to deal with emerging with risk situations that may render them susceptible to HIV/AIDS.

## **1.2 PROBLEM STATEMENT**

As the impact of HIV/AIDS pandemic increases, more and more people are succumbing to the scourge not excluding young people. UNAIDS issued an updated epidemiology report in 2007 providing an overview of the state of the pandemic that indicated a change in numbers of those affected by the scourge. The revised estimate of people living with AIDS moved from 39.5million in 2006 to 33.2 million in

2007 globally, 68% of the cases being from sub-Saharan Africa.<sup>2</sup> In Kenya, the HIV/AIDS prevalence rate is at 5.1% as of 2006 down from 5.9 in 2005 and 10% in 1998. 55,000 people are newly infected as of 2006 while one million people are estimated to be HIV positive, 94% being within the 15-49 age brackets meaning that young people between ages 15-24 are still at a significant risk of contracting the virus. In Nairobi province, where more and more young people are being infected and affected by HIV/AIDS; the prevalence rate was at 11% as of 2003 and 8.3% in 2006 with more than 90,000 people living with the virus according to NACC report (2006). Despite the global and national reducing rates of the HIV prevalence at the local level the epidemic still remains a crisis with more and more people struggling under the impact of the scourge especially in poor communities. In Dandora area alone the mortality and prevalence rate are increasing and alarming. The prevalence rate for the whole population currently stands at 10% with the number of those dying from HIV/AIDS related ailments rising from an average of 36 per month in 1999, 48 in 2000 and currently estimated to be over 60 people per month. Consequently, these figures represent the youthful population as the population of Dandora is youthful in that 46% of the population is below 15 years, while 75% of the population falls below 30 years with only 3.4 above 65 years (Mutula, 2003).

This rising figures of HIV/AIDS of which the youth are a high risk group reveal the issues that the youths in this area grapple with as regards to awareness, education and other HIV/AIDS prevention strategies. This is because as they mature and become sexually active, more young people face serious health risks with too little factual information, too little guidance about sexual responsibility, few skills about how to protect themselves from adult coercion, and too little access to youth friendly health services. The strategy to be employed to tackle the effect of HIV/AIDS on the youth varies. This is because some young people are not yet sexually active. They need support and skills to postpone starting sex. Some suffer from sexual abuse and they need protection and care, particularly at this critical time when there is a threat of death from AIDS. Some start sex before marriage and change sexual partners several times

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<sup>2</sup> Data.org

before they marry. They need help to either abstain from sex or use condoms to prevent pregnancy and STIs.

Following the Millennium Summit of September 2000 which reaffirmed the International commitment to fighting HIV/AIDS, the UNGASS held a session on HIV/AIDS in June 2001 whose recommendation was to reduce HIV/AIDS prevalence among young men and women aged 15 to 24 in the most affected countries by 25% by 2005 and 25% globally by 2010. This included ensuring that at least 90% by 2005 and 95% by 2010 of young men and women aged 15-24 have access to information, education and youth specific HIV/AIDS education and services necessary to develop the life skills required reducing vulnerability to HIV infection. (UNGLASS 2001) Life skills approach henceforth has been adopted as holistic and fundamental building blocks to enable young people develop healthy competencies to avoid the risk of infection. Life skills capacities in HIV/AIDS prevention assist individuals to translate knowledge, attitudes and values into healthy behaviors that in the end run will reduce susceptibility to HIV/AIDS infection. Life skills capacities offer the information and skills that young people need to deal with these issues.

As a new approach and area of implementation, not much has been studied on the area especially within the sociological perspective of implications of life skills on HIV/AIDS through behavior change, modification and adaptation. Studies have mainly focused on drug abuse, reducing teenage pregnancy and building skill based curriculum in schools but very little has been not assessment of effect on HIV/AIDS reduction among young people.

This project is a quantitative exploratory study of the HIV/AIDS life skills capacities of young people in Dandora area. It was done to assess the various skills they possess, their understanding of HIV/AIDS and the measures they take in reducing and avoiding risk of HIV/AIDS contraction and the consequences of all these in behavior change that may lead to HIV/AIDS prevention. The main participants in the study included 200 young people between ages 15-24 living in Dandora area and 10 key informants. Data was collected from both secondary and primary sources and included both documentary

method, questionnaires administered to the main participants of the study, key informants interviews and focus group discussions. Data was also analyzed both qualitatively and quantitatively.

### **1.3 RESEARCH QUESTIONS**

1. What HIV/AIDS life skills capacities do young people possess?
2. In which ways do these young people acquire these HIV/AIDS life skills capacities?
3. What is the understanding of HIV/AIDS prevention techniques and what measures do these young people employ to avoid and reduce contraction of HIV/AIDS?
4. In which ways do possession HIV/AIDS life skills capacities lead to prevention of HIV contraction?

### **1.4 HYPOTHESIS**

1. There is a relationship between age and HIV/AIDS life skills competencies possessed by young people in Dandora area
2. There is a relationship between sex and HIV/AIDS life skills competencies possessed by young people in Dandora area
3. An association exists between HIV/AIDS life skills competencies possessed by young people in Dandora and sexual behavior.

### **1.5 PURPOSE OF STUDY**

The purpose of this research was to find out HIV/AIDS life skill capacities among young people in Dandora area

### **1.6 STUDY OBJECTIVES**

The broad objective of this research was to find out HIV/AIDS life skills capacities of young people in Dandora area. In so doing the study enabled us to understand whether life skills capacities have any impact in affecting behavior change among young people especially in prevention of contraction of HIV/AIDS. The specific objectives of the study were:-



- 1) To highlight the various HIV/AIDS life skills capacities that young people in Dandora area possess capable of preventing the contraction of HIV;
- 2) To describe the prevention techniques employed by the young people to reduce and avoid their risk of HIV/AIDS contraction;
- 3) To assess the consequent effect of these HIV/AIDS life skills capacities on proper sexual behavior necessary for HIV/AIDS prevention .

### **1.7 SIGNIFICANCE OF THE STUDY**

Young people have been well documented as a special needs group especially in HIV/AIDS life skills due to their risky sexual behavior and frequent lack of information and access to the services (Mcmauley and Salter, 1995). They are always often characterized by patterns of thinking in which immediate needs tend to take priority over long term implications, and initiation of behaviors that may be perpetuated over a life time (W.H.O, 1998).

Data from the National AIDS control programme show that peak ages of AIDS occur at 15-24 years. This is of great concern given the fact that 60% of the total population in Kenya is between these ages. Young people also form the fastest growing segment of the population in Kenya and it is for this reason that this study intends to focus on HIV/AIDS life skills in young people in order to explore and offer future remedies that can impact their lifestyle in this era of the AIDS pandemic.

This study will enable the government and development partners to provide direction in designing culturally, morally and scientifically acceptable HIV/AIDS life skills education programmes for the young people. It will also strengthen the capacity of teachers, parents, church leaders and communities in general to enable them lead and understand ways of approaching young people in relation to HIV/AIDS life skills education be good role models in raising this generation. It is with this motivation that this study has sought to underline, motivate and reinforce the urgency of mitigating the spread of HIV/AIDS among young people and the overall society by providing a life skills education framework that can be adopted in policy and programme development

for implementation of HIV/AIDS life skills education for youths and others in schools, colleges, churches, organizations and the general society.

### **1.8 SCOPE AND LIMITATION OF THE STUDY**

This research was limited to study of young people aged 15-24 years. This is because this age bracket present and is regarded as the most formative years of a person and it is during this phase that an individual establishes attitudes that are likely to determine their level of responsibility as regards to HIV/AIDS prevention. The study focused on 200 young people living in Dandora area and not of any other areas as a representative sample of the overall population of young people living in the area and also due to financial and time constraints. The research was also be limited to HIV/AIDS life skills capacities hence the outcome of the study cannot be generalized to other areas like drug abuse, gender violence etc.

### **1.9 DEFINITION OF CONCEPTS**

#### **Youths**

Youth is a development stage of a person between childhood and adulthood. They refer, in this paper, to age group 15 to 24 and may be used interchangeably with youthful, young people and adolescents.

#### **HIV**

Human Immunodeficiency Virus is a small infectious organism that reproduces within a person and damages the body's immune system or its natural ability to fight infections and eventually leads to AIDS.

#### **AIDS**

Acquired Immunodeficiency Syndrome is a condition characterized by an immune system that cannot fight infections leading to a group of signs and symptoms that occur together and characterize a particular illness. A person is said to have AIDS once their immune system is so damaged that they develop opportunistic infections, which take advantage of the weakened immune system, and eventually die from them.

### **Life Skills Capacities**

These are interpersonal and psychosocial competences that are important in developing attitudes, behaviors and values that are helpful in decision making, problem solving, creative thinking and adapting positively to one's environment. They are directed toward personal actions and action towards others, as well as actions to change the surrounding environment to make it conducive to health (UNICEF, 2005) They are the decision making, problem solving and conflict resolution, creative, relationship/friendship building, critical thinking goal setting and accomplishment skills that empowers a young person needs to avoid and reduce the risk of contracting HIV/AIDS infection by helping them make responsible choices.

### **Knowledge**

The term knowledge and information will be used interchangeably in this paper. Information is what is communicated about a particular fact or subject; something you receive or are told. Knowledge refers to the state or condition of understanding that fact or subject, and being able to apply it.

### **Attitude**

In this study, attitude encompasses the broad domain of social norms, ethics, morals rights, values culture, spirituality and religion, and feelings about self or others. Attitudes are what an individual holds as valuable beliefs and values and forms the opinions concerning different issues in life

### **Sexual Behavior**

Behavior is the action or reaction of an individual in this case a young person under specified circumstances. Sexual behavior is person's sexual practices that allow a person to express their feelings. Healthy sexual behavior are measured by the level in which an individual takes responsibility for their sexual health through activities such as abstinence, delay of sexual intercourse, and consistent and correct use of contraception and barrier methods.

# CHAPTER TWO

## 2.0 LITERATURE REVIEW

### 2.1 THE LIFE SKILLS APPROACH

#### 2.1.1 BACKGROUND OF LIFE SKILLS APPROACH

According to Boler and Aggleton, the idea of life skills has its roots in North America and European psychology. This is evident in the notion that it is possible to attempt to correct deficits that are connected with certain psychological disorders and perhaps more prominent in occupational psychology, where efforts were made to identify the qualities of successful leadership and where skills were perceived as necessary in realizing this archetype. This was mainly in the area of leadership and management training, but later other areas like media work training adopted the model. (2005)

In 1990's when it became apparent that many young people and adults were not going to change their sexual behavior merely because they were told they should, the international development community rallied around the idea of teaching life skills as part of HIV/AIDS education. Not only would this life skills allow young people to act upon their knowledge, it was also an apparent innocuous intervention which did not explicitly discuss sex and sexuality directly, thereby reducing the potential conflict from the sexually conservative factions which are prominent in many high prevalent countries. (Boler and Aggleton, 2005: 6)

#### 2.2 SOCIOLOGICAL PERSPECTIVE ON LIFE SKILLS APPROACH

Sociology focuses on human social interaction and rules and processes that bind and separate people not only as individuals but as members of association, groups and institutions. Sociology enables us to understand the structure and dynamics of society, and their intricate connections to patterns of human behavior and individual life changes. It examines the ways in which the forms of social structure groups, organizations, communities, social categories (such as class, sex, age, or race), and various social institutions (such as kinship, economic, political, or religious) affect human attitudes, actions, and opportunities.

According to Schaefer and Lamm (1995), sociology is the systematic study of social behavior and human groups. It focuses mainly on influence of social relationships upon people's attitudes and behavior and how societies are established. The discipline also explores how both individuals and collectivities construct, maintain, and alter social organization in various ways. Sociology asks about the sources and consequences of change in social arrangements and institutions, and about the satisfactions and difficulties of planning, accomplishing, and adapting to such change. Areas studied in examining social dynamics include: culture, values, socialization, cooperation, conflict, power, exchange, inequality, deviance, social control, violence, order and social change.

One major goal of sociology is to identify underlying, recurring patterns of and influences on social behavior and tries to provide explanation for such patterns. Sociology thus tries to solve social problems such as unemployment, HIV/AIDS, reasons for suicide as for Durkheim's theoretical work on suicide and many other areas. This is mainly to yield practical applications for human behavior, attitudes and organizations. (Shaefer and Lamm, 1995)

Life skills approach falls within applied sociology which has become a social phenomena in the recent past due to its implications on behavior, attitudes and their consequences on solving different social problems such as homelessness, HIV/AIDS, suicide and many other. The Life skills approach views acquisition of life skills holistically as a participatory and action-oriented process in the context of the environment. Humans are part of their environment and the environment is inextricably linked to human interaction. Life skills are designed to enhance efforts to positively develop or change behavior related to the well being and healthy functioning of the society.

As an applied sociology therefore, life skills play an important role in building social values that enable people to make responsible choices especially in HIV/AIDS issues. Hence in sociological terms life skills approach offers multifaceted approach to HIV/AIDS which is a global sociological problem to comprehensively help individuals

reduce and avoid HIV infection so that individuals can maintain and promote healthy lifestyles.

## **2.3 POLICY FRAMEWORKS ON HIV/AIDS AND LIFE SKILLS APPROACH**

### **2.3.1 HISTORICAL REVIEW OF POLICY RESPONSE TO HIV/AIDS**

Since 1984 when the first case of AIDS was identified in Kenya, the policy environment has gone through three broad phases. Each phase was unique in Kenya, but has reflected the experience of other countries which have had to confront the disease. During the first phase, from 1984 through 1987, there was a general sense that HIV/AIDS was not a serious problem for the country. AIDS was described in the press and by policy makers as a 'disease of westerners' especially gay men. Since similar risk groups presumably did not exist in Kenya, it was assumed that HIV would only spread within a small population.

In 1985, the government created a National AIDS Council (NAC). However, the NAC lacked authority and resources to develop awareness or prevention efforts. Two years passed before the NAC formally met. In 1987 NASCOP (originally the National AIDS control Programme) was established and the Kenyan Red Cross and Red Crescent Society on behalf of the Ministry of Health initiated an HIV/AIDS awareness campaign.

Early in 1987, the British army prohibited its soldiers from taking leave in Mombasa, citing the threat of HIV among the commercial sex workers in the city. Business, press and the government of Kenya responded swiftly. The minister of Health at the time said, "There is no scientific evidence that Mombasa and Malindi constitute a source of AIDS in Kenya" and added, "The ministry of Health is satisfied that the known facts about AIDS in Kenya show that there is no need for panic". The minister blamed the foreign press for distorting the issue and "creating panic", (Daily Nation, January 16, 1987). It was within this environment that a few NGOs and the NASCOP- with support from select international donors-began constructing the infrastructure to confront HIV/AIDS. Within limited resources an attempt was made to reach out to a public that was confused by incomplete information and inflammatory comments.

The second phase, 1988-1991 saw a somewhat more realistic appraisal of HIV/AIDS as a potentially harmful health issue, but there was still a wide spread belief that AIDS was no more serious than other diseases. Responsibility for managing the response remained with the MOH, which became increasingly assertive in raising warnings about the consequences of the disease in Kenya. Nevertheless, the public was not responding to HIV/AIDS by changing their personal behavior. In March of 1989, the 'Kenya Times' argued that people were not changing their behavior in response to the 'low key public education campaign conducted through the media'. Meanwhile, influential religious leaders spoke out against the use of condoms for disease prevention. While they admitted that AIDS had become a Kenyan problem, they also argued that condoms were a 'western solution' that did not fit Kenya's situation. Policy makers hesitated to discuss AIDS because of the potentially harmful impact that such discussions might have on tourism (Lorch, 1993). Efforts by the MOH to involve provincial and district level policy makers in HIV/AIDS awareness and prevention activities frequently were ignored. Government as a whole relied on the MOH to address the issue, and relied on public education as the means to control the epidemic-which, in fact was not seen as an epidemic at the time. The government did not release surveillance data and almost all resources for HIV/AIDS prevention continued to come through the international donor community.

The third phase, 1992-1995 marked another significant change in Kenya's policy environment. The government released its surveillance data and in April 1993 hosted the first National Conference on AIDS. The minister of Health declared that AIDS had become a national crisis. Socio-economic impact assessment was initiated by both the government and international donors (Forsythe et al, 1993). NASCOP assumed a stronger coordinating role, especially of the field activities of NGOs and religious groups.

The rising number of illnesses and deaths from AIDS across all population groups provoked pressure for clear policy direction from the government. The 1994-96 National Development plan (and individual district plans) included a chapter on the

economic impact of HIV/AIDS and set out general statements to guide future action. In 1994, work began on producing a parliamentary Sessional paper on AIDS that would address a broad range of policies. Also in 1994, the government signed an agreement with the World Bank for a loan for STD and HIV prevention and control programmes constituting a significant financial commitment.

Despite these important developments, there remains a strong undercurrent of skepticism or downright opposition to more aggressive positions on HIV/AIDS prevention, support and care. Many religious groups oppose efforts to introduce sex education into schools, despite the importance of this target audience and the clear need for concise information. Condom promotion exists at a programme level, but is opposed by some senior government policy makers and influential religious leaders. A variety of legal, ethical and cultural issues related to HIV/AIDS prevention and the well being of families affected by HIV/ AIDS remain to be actively debated and acted upon.

### **2.3.2 NATIONAL HIV/AIDS POLICY FRAMEWORKS**

The government and other non- governmental stakeholders in a bid to curb the high prevalence rate of HIV/AIDS which as at 2000 had reached a pick of 14% prevalence mandated National Aids Control Council (NACC) to develop a national multi-sectorial response to HIV/AIDS and to be the national coordinating authority to provide the required leadership in developing one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners and one agreed upon country level monitoring and evaluation system. This lead to the development of the Kenya National HIV/AIDS strategic plan (KNASP) 2005/06-2009/10 and the National HIV/AIDS Monitoring and Evaluation framework both geared to providing direction in the strategic planning, implementation and assessment of HIV/AIDS issues in Kenya. The government also recently established the Ministry of youth and Development which was specifically mandated to tackle youth issues in the country. The ministry has designed a policy framework with its one agenda of providing a youth specific guidance to the issue of HIV/AIDS. The following discussion highlights on this policy frameworks.



### 2.3.1 The National HIV/AIDS Strategic Plan (KNASP)

The Kenya National HIV/AIDS Strategic Plan (KNASP) 2005/06-2009/10 provides the action framework for HIV/AIDS and the context within which all stakeholders will develop their specific strategies, plans and budgets to make responses. This is in the concept of national ownership, multi-sectorality, mainstreaming, harmonization and coherence, which aim to increase the pace of the AIDS response and promote more effective use of resources by clarifying relevant roles and relationships. The main purpose of KNASP is among other things, to provide:-

- clear and agreed upon vision, goal and targets for the national response over the period 2005 to 2010;
- clearly identify priority areas and key strategies for intervention by all stakeholders including GoK, civil society, the private sector and development partners;
- provide a results framework - to be revised annually - which guides interventions across all sectors by identifying specific tangible results to be delivered in each priority area, and identifying lead agencies and strategic partners responsible for implementation;
- establish a clear process, linked to the annual Joint AIDS Programme Review (JAPR), for partners to jointly review, consult and coordinate key interventions;
- empower civil society and private sector stakeholders to engage effectively in the national response;
- estimate financing requirements and identify financing gaps, and enable efficient allocation of resources across the national response; and
- Operationalize the Government's commitment to fight HIV/AIDS set out in the Economic Recovery Strategy (ERS), and set priorities for Government HIV/AIDS spending in the annual budget cycle.

These purposes were governed by core principles in implementation of the strategies which included a focus on multi-sectoral approach, including the development of strategic partnerships and mainstreaming HIV/AIDS in all key sectors; targeting vulnerable groups, focus on gender and youth; maximum engagement of PLWHA in

the implementation of the strategy; evidence-based interventions; empowered, participatory approach; and support to regional and international initiatives.

Of specific interest to this paper, is the focus on youth and gender in which KNASP developed strategies targeting the youths that includes among other things developing a carefully targeted prevention message; youth friendly access to HIV and reproductive health information and other services; mobilizing the education system to provide comprehensive prevention and care for youth in school; improving girls' access to education and skills training, and protecting their rights; and building partnerships with youth-based organizations.

One aim of these strategies, according to NACC is to reduce the number of girls and boys having sex by age 15, and promote abstinence and/or consistent practice of safe sex among those who are most vulnerable and the general population. KNASP 2005/06-2009/10 supported the development of a national BCC (Behavior Change Communication) strategy and BCC coordination mechanism which provide an overall guidance to all partners implementing BCC programmes. The strategy helped to ensure messages are evidence-based and effectively targeted; and, very importantly, avoid counter-productive and stigmatizing campaigns. The national BCC strategy also reflect the potential impact on prevention messages of the increasing availability of HIV/AIDS treatment in Kenya

KNASP also included education as one of the important preventive approaches against HIV/AIDS. This will enable both school going and other young people to acquire necessary skills necessary for behavior change in HIV/AIDS prevention. Hence life skills education as a strategy was considered to be effective at promoting healthy behaviors and reducing the risk of infection (NACC, 2005).

#### **2.3.4 National HIV/AIDS Monitoring and Evaluation Framework**

The goal of the National HIV/AIDS Monitoring and Evaluation Framework was to guide collection, analysis, use, and dissemination of information that enables the tracking of progress made in response to HIV/AIDS and enhances informed decision-

making. The framework provides an environment for inclusion of new fresh ideas on monitoring and evaluation and improvement of indicators in line with efforts done by experts and organizations working on monitoring and evaluation of HIV/AIDS. The framework further articulated the linkages, reporting relationships, and indicators used to measure inputs, outputs, outcomes, and impact of national response to HIV/AIDS.

Some of the areas to monitored and evaluated which also focus on assessing life skills, behavior change and HIV/AIDS among young people include:-

- a) Demographic Health Survey (DHS) which is a population based survey conducted by Central Bureau of Statistics Kenya with technical assistance from NACC and NASCOP. Apart from behavioral indicators collected, blood samples are also taken from individuals interviewed for HIV testing with their consent;
- b) Behavioral Sexual Surveillance (BSS) carried out after every two years on selected HIV/AIDS high risk populations. The surveys are coordinated by NASCOP or NACC;
- c) Lot Quality Assurance Sampling applied by NACC for the purpose of estimating coverage at various implementation levels and determination of priority areas by CACCs that are potential areas for funding through Community Initiative Activities proposals;
- d) Incidence studies may be carried out through small studies to ascertain the direction of the epidemic by determination of new infections of HIV during specified periods;
- e) Demographic Surveillance Surveys which complement incidence surveys and elicit demographic and other impact of HIV/AIDS on communities. This will be done through commissioned studies by interested groups;
- f) Special surveys done by implementers as operations research and institutions with capacity for the purpose of addressing areas of interest in the implementation of HIV/AIDS programmes.

### 2.3.5 National Youth Policy and HIV/AIDS

The National Youth Policy Framework addresses urgent issues for youth while pointing out the need for the development of high-quality systems of promotion, prevention, early support and intervention for youth. The key principles that underlie the policy include the respect of cultural belief systems and ethical values without discrimination of gender, origin, age, political afflictions and social status; equal opportunities and distribution of programmes, services and resources; gender inclusiveness; good governance and mainstreaming youth issues both at macro and micro levels.

According to the National Youth Policy framework AIDS among the youth has become a worrying issue. It continues to add that research has shown that a large percentage of new HIV infection occurs among the youth. Those most affected are young women aged 25-29 and young men aged 30-34 years, yet this age group has the most productive people in the society. The framework also comments that the fact that many of the youth use pregnancy control drugs, which are available over the counter, makes them more vulnerable to HIV/AIDS and Sexually Transmitted Infections (STIs). This is because they concentrate on prevention of pregnancy and overlook the risk of getting infected. Hence the Youth Policy Framework (YPF) has proposed the following strategic policies in its bid to curb the spread HIV/AIDS among the youthful population:-

- i. Incorporate representatives of the youth in efforts to fight the spread of HIV/AIDS in order to take into account the youth dimension to HIV/AIDS and target this group effectively
- ii. Promote and support youth campaigns aimed at encouraging a change in sexual behavior and discouraging drug and substance abuse, and negative peer influence
- iii. Promote and establish home and community-based welfare programmes to help youth orphaned by HIV/AIDS
- iv. Establish guidance and counseling units managed by the youth in all schools and other learning institutions
- v. Establish affordable rehabilitation centers to help youth addicted to drugs

- vi. Promote and enhance affordable or free counseling programmes on health-related issues, especially peer to peer counseling in faith based and institutions
- vii. Encourage parents to take a lead role in teaching and counseling their children on responsible sexual behavior
- viii. Promote and support programmes on personal hygiene and physical fitness and mental health
- ix. Improve the technical and institutional capacity of youth organizations/Community Based Organizations (CBOs) to enable them to effectively advocate and promote health programmes for youth
- x. Promote partnerships between the Government, CSOs and the Private Sector to work with the youth
- xi. Improve access to Voluntary Counseling and Testing (VCT) services for all youth.
- xii. Enhance the youth's capacity in leadership and advocacy to enable them to manage youth health programmes
- xiii. Promote research in youth health areas and make the findings accessible.

## **2.4 HIV/AIDS IN KENYA**

### **2.4.1 Basics of HIV/AIDS**

Human Immuno-Deficiency Syndrome is a virus that is only acquired by humans and destroys the human body's natural ability to fight infections by attacking the immune system that is, the CD4 cells (T Helper cells) in the white blood cells which defend the body against viruses and bacteria. Once in the CD4 cells the virus is multiplied over a period of time lasting normally from 8-10 years, damaging the body's defense mechanism. This leads to easy susceptibility to various opportunistic infections that eventually leads to death. This state of AIDS may manifest differently to different individuals so as other people may die soon while others can stay for a decade.

The HI virus is transmitted through body fluids such as blood, wound discharge, semen, vaginal fluid and breast milk from a person who is HIV positive. The primary ways of transmission in Kenya include unsafe sex (80%) with others being blood transfusion and mother to child transmission. The main factors influencing rate of spread of

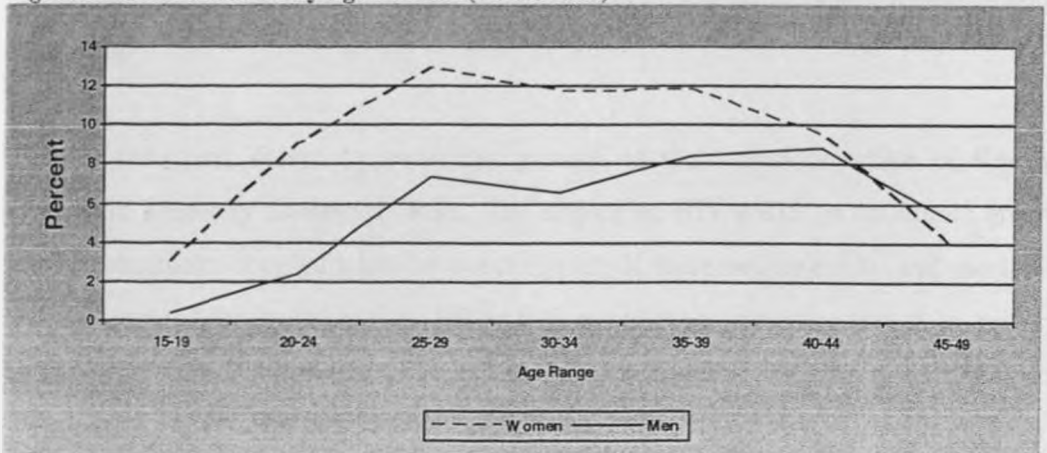
HIV/AIDS include slow pace in sexual beliefs and behavior, skewed cultural practices, general poverty with a lack of clear policy framework to guide intervention efforts. (WHO, 1999)

### 2.4.2 HIV Prevalence

According to NACC (2008) HIV/AIDS spread rapidly in Kenya during the 1990's reaching prevalence rates of 20-30% in some areas of the country. Prevalence subsequently declined in some sites in Kenya but remained stable in others. National prevalence declined significantly from a peak of about 10% to under 7% in 2004 and 5.1% in 2006. This trend is supported by data from national surveys which document changes in behavior toward fewer partners, less commercial sex, greater condom use and delayed age of first sexual encounter. NACC 2008 report also revealed that 6.7% of adults tested are infected with HI virus of NACC and sentinel surveillance data gives an adjusted prevalence of 5.1% nationally, 8.3% in urban areas and 4% in rural areas implying a total of 1 million adult Kenyans are infected with HIV, of whom about two thirds are women (6.7%). In addition there are estimated to be 100,000 children living with HIV.

The survey also revealed that gender difference is most pronounced among young people; in the 15-24 age range, female prevalence is nearly five times higher than male prevalence (see Figure 1). Prevalence rates also show significant regional and rural/urban variations, with average urban prevalence (10%) nearly twice that in rural areas (5-6%).

Figure 1: HIV Prevalence by Age and Sex (KDHS 2003)



### **2.4.3 HIV Infections and AIDS Deaths**

It is estimated that approximately 37,000 adults and 19,000 children became infected with HIV in Kenya in the year 2006. Prevalence data suggests that the majority of non-pediatric infections occur among youth; especially young women aged 15-24 years, and young men under 30 (NACC, 2008).

The rate of AIDS deaths has risen dramatically and it is estimated that there are about 85,000 AIDS deaths per year, a decline from 150,000 1998 due to antiretroviral drugs. This death rate, which exceeds the rate of new infection, tends to reduce overall prevalence as the epidemic in Kenya moves into the “death phase”(NACC, 2008). AIDS deaths in Kenya have a profound and increasing societal and economic impact. It is estimated that 1.7 million children under 18 are orphans, about half due to AIDS. As the cumulative total of AIDS deaths rises, the impact of these deaths on society will become increasingly severe. Already, life expectancy in Kenya has dropped from 60 years in 1993 to about 47 years in 2004 due to HIV/AIDS (NASCO, 2005).

### **2.4.4 The Socio-Economic Impact of HIV/AIDS**

According to NACC (2005), it is widely accepted that HIV/AIDS has major economic and social impact on individuals, families, communities and on society as a whole. In Kenya, as in other countries in sub-Saharan Africa, AIDS threatens personal and national well-being by negatively affecting health, lifespan, and productive capacity of the individual; and critically, by severely the accumulation of human capital, and its transfer between generations. Researches across much severely affected, low income, countries clearly indicate that HIV/AIDS is the most serious impediment to economic growth and development in such countries; there is no reason to expect Kenya to be an exception.

Poverty reduction, driven by economic growth, is the central objective of Kenya's Economic Recovery Strategy (ERS). The impact of HIV/AIDS on economic growth and development, coupled with the direct impact of increased mortality and morbidity on the lives of the poor, makes HIV/AIDS a uniquely corrosive threat to poverty reduction efforts. This impact has had major challenges in the society in that it has affected:-

- The productivity of the agriculture sector, upon which the majority of Kenyans rely for their livelihood. The sector has been undermined by negative impacts on the supply of labor, crop production, agricultural extension services, loss of knowledge and skills and at a personal level the trauma associated with death. Consequences include reduced household and community food security and decline in the nutritional and health status of smallholders and their families. Commercial agriculture, a major source of employment and foreign earnings, is detrimentally affected by increasing health costs as well as protracted morbidity and mortality of key workers.
- Educational services suffer as teachers are lost to AIDS and children drop out of school as parents die and household incomes fall. The health service loses trained staff and has to cope with the increasing burden of HIV-related infections.
- The direct cost and social problems associated with caring for increasing numbers of orphans, coupled with existing high poverty levels place severe burdens on family and societal structures.

In addition to these direct effects on production and social services, there is a growing realization that HIV/AIDS may undermine the long-term revenue base of the economy, and so reduce Government's capacity to provide the infrastructure and social services essential for long-term economic growth.

#### **2.4.5 HIV/AIDS Prevention**

Of all the issues surrounding HIV/AIDS pandemic, the most important is that HIV/AIDS is largely preventable. This means that HIV/AIDS education and prevention efforts are crucial in the fight against HIV/AIDS. This means that prevention of HIV infection, according to EFA Global report by UNESCO, must be approached by, on the one hand, by action to reduce individual risk, and on the other, to tackle the broader contextual, environmental and social factors that make people vulnerable. The reduction and avoidance of individual risk usually focuses upon the individual and his or her behavior. Empowerment, on the other hand, involves making changes in the



broader social, cultural, economic and political environment in which individuals live their lives. Both measures are essential for prevention success.

### ***Risk Reduction***

Good quality programmes of prevention education have beneficial effects. They result in the adoption of positive behaviors, including a delay of the age of first sex; an increase in the use of condoms among young people who are sexually active; a reduction in the number of sexual partners; a reduction in alcohol and drug use, and the risks associated with injecting drug use in particular. They have an effect on the environment, in particular by improving health, safety and security in educational settings and elsewhere within communities. Information is necessary but knowledge alone is not sufficient to protect young people against HIV/AIDS. What is needed is an interactive process of teaching and learning that helps young people acquire the knowledge, attitudes and skills to enable them to take greater responsibility for their own lives, resist negative pressures, minimize harmful behaviors and make healthy life choices.

A range of 'entry points' can be used for risk reduction work in and out of schools. These include work on gender, sexuality, pregnancy, violence, drug use, employment and broader social issues. However, the key elements of knowledge, attitudes and skills should be taught sequentially in ways that build upon one another. Education to prevent HIV/AIDS should always be coherent and gender sensitive and should not be spread thinly over a range of topics or subject areas. Health risk behaviors frequently have the same root causes. Based on research, the most successful programmes are those in which policy development, health promoting environments, skills-based health education and school health services are strategically combined. One widespread programming model is the Focusing Resources of Effective School Health (FRESH) programme jointly supported by UNESCO, UNICEF, WHO, the World Bank, and Education International.

Good quality risk reduction education relies on trained and skilled human capacity. They need to know that their interventions will be significant, and that they will be

supported in their efforts. This is especially true for HIV/AIDS where, despite clear scientific evidence to the contrary, the erroneous view continues to be expressed that HIV/AIDS education does not work, or that education about sexuality leads to increased sexual activity. Efforts to prevent HIV infection can be controversial, for educators as well as for the community. Political commitment at the highest level and most certainly from within ministries of health and education, is vital for success. Despite common misconceptions about HIV/AIDS education, community resistance should not be assumed. Community members, including parents and religious leaders, are often keen to be better informed and more involved.

### ***Risk Avoidance/ Vulnerability Reduction***

Vulnerability to HIV infection occurs when “people are limited in their abilities to make and effect free and informed decisions”. Vulnerability is determined by political factors such as the lack of will to respond effectively to the epidemic; economic factors such as poverty; education sector factors such as lack of good quality schooling; contextual factors such as dominant gender roles and expectations, violence and conflict, family breakdown or lack of ‘connectedness’ to family, school or community; and environmental factors such as absent or inadequate health and social services. Singly, or in combination, these factors render some groups systematically more vulnerable to HIV than others. These groups include children and young people living in extreme poverty; children and young people exploited sexually, economically or in other ways; children and young people discriminated against and marginalized on grounds of gender, ethnicity, sexuality and disability; young migrants and refugees; and young people who use drugs.

### ***Empowerment***

Education in and of itself can be a source of empowerment to prevention of HIV/AIDS as it increase literacy and general educational level, by enhancing a sense of connectedness and security, and by providing access to trusted adults. Young people with more education are more likely to use condoms than peers with less education, and are less likely to engage in casual sex, particularly in countries with severe epidemics. Schools can be outstanding places for promoting the rights of children and young

people. Unfortunately, they can also be places in which rights are compromised. Bullying, violence, harassment, gender and HIV/AIDS-related discrimination and sexual abuse must be recognized in schools, and appropriate steps taken to remedy them. Training and special measures, including the implementation of codes of practice, can be powerful tools for raising awareness and reducing discrimination in school environments. HIV/AIDS-related empowerment works best in an enabling environment, when it builds on strong foundations. These can include a legal infrastructure guaranteeing the provision of education and health services, together with policies and procedures guaranteeing human rights.

Addressing the root causes of vulnerability e.g., lack of political will, poverty, gender inequality — and breaking the silence around the epidemic has benefits for health and development, beyond HIV/AIDS itself. Multi-pronged and coordinated strategies are more effective in empowering youths than single ‘one-off’ approaches. Combining long-term efforts to reduce social exclusion (e.g. encouraging more girls to enter and stay in school); with more specific HIV/AIDS empowerment efforts can be mutually beneficial. The latter include building health policy around HIV/AIDS, building supportive environments, supporting community action, and establishing young person friendly health services. Many factors heightening vulnerability to HIV/AIDS among young people derive from the erosion of care and protection previously available from families and communities. By acting swiftly to provide needed services, countries and communities will reap benefits not only for HIV/AIDS-related empowerment, but also for a range of other health and development concerns. Good quality educational provision has been shown to empower young people against use of alcohol and drug use, unwanted pregnancies, violence and unemployment, as well as HIV/AIDS.

Hence empowerment which includes access to services relevant to young people, including treatment for sexually transmitted infections, sexual and reproductive health services, access to voluntary and confidential counseling and testing, HIV/AIDS treatment and care can be effective in HIV/AIDS prevention. It can also help communities to identify early warning signs of harmful drug use among youths and refer appropriately. Strong links with local health centers and other community

organizations can help young people link the knowledge and attitudes with actions to protect themselves.

## **2.5 YOUTH SOCIALIZATION AND TRANSMISSION OF SEXUAL INFORMATION**

According to Anigan (1981), with the breakdown of the traditional and family forum for socialization and the teaching of young people matters concerning sexuality, responsible adulthood and parenthood, the teenagers have been left to be socialized by other forces outside the family. In a study done in USA by Furstenberg (1971) where adolescents below the age of 18 were interviewed, it was found that nearly all the girls interviewed had acquired information on contraceptives and sexuality from casual conversation with friends, relatives and mass media. Other studies also found that most of the teenagers had learned most about sexuality from the media with parents, educators and health professionals contributing only minimally. This information was superficial, very sporadic and showed considerable ignorance about sexual matters. This ignorance and misinformation is explained by the fact that the parents, especially, who were presumed to be the right sources of information have failed to provide it and are also misinformed on the topic. According to Furstenberg (1971), there appears to be a "conspiracy of silence" between mothers and their daughters on matters concerning sexuality, pregnancy and how to prevent it.

According to Shifter (1982), about 40% of early puberty girls have never discussed any aspect of sexuality with their mothers and 96% of fathers never did so with their children. Shifter argues that this lack of communication between parents and their children could stem from the fact that the parents themselves may be ignorant and misinformed about their own sexuality and hence find it difficult to communicate effectively with their children.

Furstenberg (1971), further argues that parents carry a number of unexamined beliefs, attitudes and values from childhood into adulthood and continue to make adult decisions based on their childhood understandings of what they experienced and what was taught to them, without taking time to identify those assumptions and to examine

them in light of new information (Shifter, 1982). Parents could also find it difficult to talk about sexuality and may feel embarrassed talking to their children about it.

According to Shifter (1982), with the lack of forums for the transmission of proper values, the teenagers have been forced to make sense of conflicting messages and information they receive from the mass media, peers, schools, and other institutions. Many teenagers have thus engaged in sexual activities and other far-reaching social and sexual decisions without well considered values or accurate information.

## **2.6 YOUTH, VULNERABILITY AND HIV/AIDS**

There is evidence that face of HIV/AIDS is becoming younger and more feminine. The main reason based on the increasing HIV infection due to globalization, poverty, gender discrimination and lack of access to information and health services which increases their vulnerability. As the youths are isolated from mainstream society and with little knowledge and few life skills, they are at risk of acquiring HIV as a result of frequent unprotected casual sex and injecting drugs (WHO, 1990).

About one half of all human immunodeficiency virus (HIV) infections occur among young people under 24 years of age. Up to 60% of new infections in developing countries occur among 15-24 year-olds. In rural Tanzania, females aged 15-24 show the highest infection rate. The research also showed that young people are ill-informed about HIV/AIDS, symptoms, the need for treatment, and where to obtain treatment. Combined with many adolescents' fear of the medical system, these circumstances often result in avoidance and delays in seeking health care (Grosskurth et al 1995, 1995).

On the other hand, reproductive health services and health providers tend not to be youth friendly. Studies in Antigua, Senegal, & Thailand, among other settings, have found health facilities where adolescent clients are denied privacy and confidentiality, and in which the staff are often rude or moralizing (WHO, 1990).

Adolescents are also less able to turn down sex advances and less able to insist on adequate protection. Sometimes sexual activity involves abuse or coercion which in turn, is linked to young age at first intercourse and to make more than one sexual partner- both HIV risk factors. Conditions such as poverty, homelessness, political strife, and dislocation, which are increasingly common among young people in developing countries, are associated with sexual abuse or with sexual intercourse exchanged for money or support for basic needs thus young people are economically vulnerable to HIV infection (WHO, 1990).

Peer pressure is also a pivotal factor promoting misconceptions among youths that lead to their engagement in early, unsafe sexual practices. Prevalent arguments circulating among this age group include: sex is an expression of being in love; the sex drive cannot be controlled; sex is seen as an initiation rite into adulthood; and that sex is a test drive for sexual compatibility. Under such circumstances, abstinence or choosing not to have sex regularly, poses the social risk of being looked down upon by one's peers (Cates W & Mchpheeters, M, 1997).

### **2.6.1 Sexually Transmitted Diseases/ Infections**

Recent studies have indicated that the vulnerability of being infected with the HIV is higher in the presence of an STD. With reference to the young people, this casts a dim picture in that their rate of infection may increase rapidly if sexual activity remains at the same rate (WHO, 1990). Young people are vulnerable to STDS for both biological and behavioral reasons. Infact, worldwide the highest reported rates of STDS are found among young people aged 15-24. In the developed world, two-thirds of all reported STD infections occur among young people under the age of 25. In developing countries the proportion is even higher (Cates W & Mchpheeters, M, 1997).

Due to the biological, behavioral and cultural reasons, young people are at especially high risk of contracting STDS. Sizeable numbers of adolescents are sexually active. In some countries, sexual activity begins in early adolescence, either within or outside of marriage. Young age at first intercourse is a strong risk factor to STDS. For example research also shows that adolescents represent a large proportion of overall Chlamydia

infections worldwide – at least one third. In Haiti and Nigeria, this age group is reported to have the highest level of culture detectable Chlamydia. Prevalence levels can be high as one half of all sexually active young women (Cates W & Mcpheeters M, 1997). Their immature reproductive and immune systems make adolescents more vulnerable to infections by various STD agents which make them more susceptible to HIV infection (WHO, 1990).

### **2.6.2 Female Youth and HIV/AIDS**

According to NACC (2005), the female youth constitute 52% of total youth. Sexual activity among the youth begins quite early in their life. Over 44% of girls between 15-19 years old have had sexual intercourse. Sex at this age has adverse effects on health, besides other socio-economic consequences.

The factors that render girls more vulnerable to HIV/AIDS have both biological and social orientation. Research shows that, during unprotected sex, the risk of STDS and HIV infection is two to four times higher for women than men (Grosskurth et al 1995). Female youths also suffer more than their male counterparts from asymptomatic sexually transmitted infections (STIs), which often remain undiagnosed for long periods of time. This compounds the risk of contracting HIV through sores or lacerations in the underdeveloped lining of the vagina, in the event that unprotected sex occurs. As they progress, STIs cause sores in the reproductive organs that provide an entry point for HIV into the bloodstream during unprotected sex.

Entrenched gender biases often deprive girls of education; as a result, girls and women have much less knowledge of HIV/AIDS than men. Also, early marriage and gender violence increase the risk of HIV infection among them (Grosskurth et al 1995). For example, report by UNICEF *et al* (2002) points out that forced first sex which is mainly due to gender bias against girls, has been identified as one of the high risk factors for HIV infection among girls, coupled with the fact that their first sexual experience is often forced and coerced. And where forced or coerced to have sex, young girls are more vulnerable to HIV infection than older females. The genital tracts of the former

are underdeveloped and, therefore, more likely to permit entry of the virus should there be tearing or bruising of tissue during sex.

## 2.7 CONCEPTUALIZATION OF LIFE SKILLS

There are many different understanding of life skills, although none is universally accepted due to the diverse applicability of life skills as a model in all frameworks of life by different organizations and institutions.

Rychen and Salgnik in their publication *Selecting and defining key competencies* define life skills as “skills or abilities individuals need in order to achieve success in life, within the context of their socio-cultural milieu, through adaptation to, shaping of, and selection of environments”(2000). Life skills hence become fundamental building blocks to creatively adapt to new environment, shaping current environment by harnessing potentials within for achieving success in life.

Singh paper on *Understanding Life skills* commissioned for *EFA Global Monitoring Report* by UNESCO defines life skills as to mean a mix of knowledge, behavior, attitudes and values and designate the possession of some skills and know how to do something, to reach an aim. They include such skills as critical thinking, creativity, ability to organize, social skills and communication, adaptability, problem solving, ability to cooperate on a democratic basis. These skills are needed for actively shaping a peaceful future (2004:4).

UNICEF, on the other hand defines life skills as psychosocial and interpersonal skills that are generally considered important. It also defines the life skills-based approach as a behavior change or behavior development approach designed to address a balance of three areas: knowledge, attitude and skills (2003). Life skills are skills that are learned and are able to produce fundamental behavioral outcomes. They help to promote the well being and competence in young people and adults as they face the realities of life. Life skills then are “the abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of daily life” (WHO, 1996: 72).



### 2.7.1 MEASURING COMPETENCIES IN LIFE SKILLS

According to Boler and Aggleton (2005) it is desirable to assess the acquisition of life skills by measuring them as far as possible although it is obvious that not everything and not all life skills can be easily submitted to measurement, particularly as methodologies and tools are not available or adequately developed for the purpose.

They note that the only way to assess life skills is through appropriate proxies. Life skills can be assessed not only by adding up individual achievements measured by changes in behavior, but rather result from holistic indicators which take into account values such as: a) living together; b) respect and tolerance of differences and diversity; c) active participation in community, group, work and social life; d) living and working in dignity; e) making informed decisions. (Boler and Aggleton, 2005)

Life skills are not static skills, but evolve according to circumstances. Life skills depend also upon the family milieu and upon gender difference. The measurement of life skills should be able to take into account disparities in social background, gender and the labour market, as well as national and international cultural variations (Boler and Aggleton, 2005).

All life skills have a contextual relevance both within and across societies. It is important not to forget the context of life skills, because this is the main reason for the success of life skills learning. Life skills need to be adapted to the specific contexts of each country, each group or even each individual. Very often the generic and derivational definition will conflict with an inductive search of the same competencies in the real situation (Boler and Aggleton, 2005).

Various youth and health organizations and adolescent researchers have defined and categorized the key skills in different ways. Categorizations depend on the desired outcome, the disciplinary perspective of the program developer or research and the dominant theories underlying program design. The following are examples of life skills categories that focus on social competencies, violence prevention, and general health promotion as enlisted by WHO (1993)

- Skills related to social knowledge, perception, and emotional encoding and decoding, perspective taking, interpersonal reasoning, and interpersonal problem-solving.
- Cooperation, assertion, responsibility, empathy, and self-control social entry skills, conversational skills, conflict-resolution and problem-solving skills, and anger-control skills.
- Decision making/problem solving, creative thinking/critical thinking, communication /interpersonal relationships, self-awareness/ empathy, and coping with emotions/stress

In this paper life skills will be categorized and measured into three main skills/competencies: a) Social skills, b) emotional skills, c) cognitive skills. These skills are further sub-divided into specific skills as shown in the table below:-

**Table 1: Life skills Competencies**

Social Skills	Cognitive Skills	Emotional Skills
<ul style="list-style-type: none"> <li>▪ Communication skills</li> <li>▪ Negotiation skills</li> <li>▪ Interpersonal skills (for developing health relationships)</li> <li>▪ Cooperation skills</li> <li>▪ Empathy and perspective taking</li> </ul>	Decision making /problem solving skills <ul style="list-style-type: none"> <li>▪ Undertaking consequences of actions</li> <li>▪ Determining alternative solutions to problems</li> </ul> Critical thinking skills <ul style="list-style-type: none"> <li>▪ Analyzing peer and media influences</li> <li>▪ Analyzing one's perspectives of social norms and beliefs</li> <li>▪ Self evaluation and values clarification</li> </ul>	<ul style="list-style-type: none"> <li>▪ Managing stress</li> <li>▪ Managing feelings including anger</li> <li>▪ Skills for increasing internal locus of control (self-management and self monitoring)</li> </ul>

These three skill categories are not employed separately, but rather complement and reinforce each other. For example, a program aimed at promoting social competence in children would teach ways to communicate feelings (a social skill), to analyze different ways of handling social situations (a cognitive skill), and to manage their reactions to conflict (an emotional coping skill). The following section gives an overview of these categories of skills and explores the research that supports their use in various programmatic contexts.

## Social skills

The adolescent years represent a very challenging time as relationships with parents, peers and others become more complex. Effective social interactions are a critical factor for successful functioning in the home, school and work. One perspective on social skills, linking them directly to behavioral outcomes, is the social skills deficit model. This model hypothesizes that children who fail to develop the skills for interacting with others in a socially acceptable manner early in life are rejected by their peers and engage in unhealthy behaviors (violence, the abuse of alcohol and other drugs, etc.). One of the best predictors of chronic delinquent offending and violence among young people is antisocial behavior in childhood (Beyth-Marom, et al, 1989). Research has also indicated that about half of young people rejected by their peers do not have social deficits, but rather a high rate of aggressive behavior learnt at home. These young people tend to respond to their rejection by peers with aggression, initiating a cycle of aggressive behavior and peer aggression that escalates as the children get older (Beyth-Marom, et al, 1989). Young people with deficits in social skills may band together, thus reinforcing their isolation from their mainstream peers, as well as their unhealthy behaviors. Thus, the children who do not learn to share toys smile at peers, and take turns during play in preschool may find themselves involved in a peer group, defined by fighting and the abuse of alcohol and other drugs as young people. From a prevention and health promotion perspective, research supports the development of skills including communication, assertiveness, refusal, and negotiation (Mangrulkar et al, 2001).

Mangrulkar et al, 2001 note that in the area of preventing high-risk sexual behaviors, interventions have combined knowledge-based education with social skills training, including teaching negotiation skills and refusal skills, to produce changes in behavior of adolescents. Various research has found that problems associated with adolescent sexual activity (low contraception use, STDs, and teenage pregnancy) were related to deficits in communication skills, assertion skills and problem-solving skills. Hence social skills capacities focus (es) on increasing positive social skills with which to handle inevitable social disagreement and conflict. As (they) employ these skills, anger

is reduced through improved communication, and the consequences of uncontrolled anger are therefore reduced.

Perspective taking and empathy are two critical social skills. While research has supported the idea that children's social awareness begins from an egocentric perspective, it has also found that even young children have an awareness of others' feelings, and often respond to the distress of others' based on their level of empathic understanding. Young people are found to show increased skill in identifying and relating to another person's feelings if a real-life role model demonstrates empathy for a character in a distressful situation. This is also beneficial in high risk situations where empathy can be used to offer guidance in assessing situations by enabling the young people empathize with those already affected by the virus and put themselves in their position in the end run avoiding the risk of own infection (Mangrulkar et al, 2001; Beyth-Marom, et al, 1989).

### **Cognitive Skills**

Life skills approach combines both social skills and key cognitive skills: problem solving and decision-making. "Problem solving" is identified as a course of action that closes the gap between a present situation and a desired future one. This process requires that the decision maker be able to identify possible courses of action or solutions to a problem and to determine the best alternative solution (Mangrulkar et al 2001). According to Bandura's social learning theory, people who experience developmental difficulties are those who are less able to set appropriate goals and to generate ways of achieving those goals (Bandura, 1977). The work of Bandura reiterated the importance of problem solving and goal setting in healthy development. Young people need to "learn how, not just what to think earlier on" In some prevention research that idea is applied to skills that help adolescents to resist peer and media influences by learning how to think critically about messages from peers and the media (Botvin, et al, 1998).

Another crucial aspect of cognition is related to self-evaluation or being able to reflect on the value of one's actions and qualities to self and others, and is related to

expectancy or the degree to which one expects that one's efforts to shape life's outcomes actually determine the results. People who believe they are causally important in their own lives tend to "engage in more proactive, more constructive and healthier behaviors related with positive outcomes." Research found correlations between this kind of thinking and behaviors such as smoking cessation, contraceptive use among females and males, and academic achievement (Beyth-Marom, et al, 1989).

Social-cognitive models explore how cognition interacts with the family/peer context and existing beliefs/values to affect behavioral outcomes. The "habits of thought" model is one such social-cognitive model, mostly applied to modifying aggressive behaviors. Interventions address an individual's content of thought (by modifying beliefs that support violence), process of thought (by developing skills in social problem solving), and style of thought (by managing impulsive processing of thought) (Beyth-Marom, et al, 1989).

Finally, research has shown decision-making to be much more complicated than a simple rational process. Management of difficult choices, especially under stress, involved both cognitive thinking skills (identifying issues or problems, determining goals, generating alternative solutions, envisioning possible consequences) and emotional coping skills (calming oneself under stress, listening carefully and accurately, determining the best choice) (Beyth-Marom, et al, 1989; Mangrulkar et al, 2001).

### **Emotional Skills**

According to Mangrulkar et al 2001, skills for coping with emotions through learning self-management and controlling stress (often incorporating social problem solving skills) are critical in life skills. The bulk of the research in this area focuses specifically on anger reduction or conflict management, but social competency programs and substance abuse prevention programs also acknowledge their importance.

Cognitive-relaxation coping skills target emotional and physiological arousal, and focus on increasing skills for emotional control. Relaxation techniques are taught to help

young people calm down, so that they are better able to think about and deal effectively with frustration and provocation (Mangrulkar et al, 2001).

Managing anxiety is another important emotional coping skill. “Anxious young people tend to have distorted perceptions of the degree of threat present in certain situations, and lack the self-efficacy or effective coping skills to manage their internal distress” (Mangrulkar et al, 2001).

Emotional coping skills also include strengthening an internal locus of control, or a belief in personal control and responsibility for one’s life, and in a generalized expectation that one’s actions will be reinforced. Aspects of this include: learning to delay gratification of short-term rewards, to put forth personal efforts in the service of actualizing goals, and to seek help in times of distress.

### **2.7.2 LIFE SKILLS APPROACH AND BENEFITS IN HIV/AIDS PREVENTION**

Although innumerable life skills are necessary for different situations, ages and cultures it is suggested that there is a core set of skills at the heart of the skills-based initiative for the promotion of health and well-being of children and adolescents. According to UNICEF, life skills approach can be utilized in many content areas, issues and topics such as prevention of drug abuse, sexual violence, HIV/AIDS/STDs prevention, etc. The life skills approach empowers people to take positive actions to protect themselves and promote health and positive social change. The main objective of the life skills approach is generally to:-

- i) Gain abilities necessary to apply the conceptual thinking and reflection in concrete situations,
- ii) Gain capacities to be involved in effective interaction with the environment and provide an appropriate motivational attitudes,
- iii) Gain psychological prerequisites for successful performance such as problem solving capacities, self-confidence and skills for creative thinking (Singh, 2004:6)

Life skills approach are important since they are designed to facilitate the practice and reinforcement of psychosocial skills in a culturally and developmentally appropriate

way, it contributes to the promotion of personal and social development in prevention of health and social problems, and the protection of human rights (WHO, 1999:1). Life skills approach has a broader development and personal potential when the future is uncertain. They increase personal development and empowerment that people need to steer overall development in a sensible way.

Specifically, in response to the challenges of the negative impacts of HIV/AIDS the life skills approach has an essential role in reversing the very pandemic that threatens it. This is because life skills gives young people knowledge and the skills needed for healthy relationships, effective communication and responsible decision-making that will protect them and others from HIV infection and optimize their health (WHO, 1992). Hence young people, especially those between 15 and 24 years, offer a window of hope in stopping the spread of HIV/AIDS if they possess life skills competences. In the absence of a cure, the best way to deal with HIV/AIDS is through prevention by developing and/or changing behavior and values.

According to Gichuhi (1999), life skills aim to foster positive behaviors across the range of psycho-social skills (social, emotional and cognitive skills), and to change unacceptable behaviors learned early, which may translate into inappropriate and risky behavior at a later stage of life. Life skills are one way of helping young people to respond to situations requiring decisions which may affect their lives. Such skills are best learned through experiential activities which are learner centered and designed to help young people gain information, examine attitudes and practice skills. Therefore life skills education programmes promote positive health choices, taking informed decisions, practicing healthy behaviors and recognizing and avoiding risky situations and behaviors.

Life skills therefore help young people to deal effectively with the demands and challenges of everyday life and to respond to the difficulties encountered in everyday life. They help young people become socially and psychologically competent and to function confidently and competently with themselves, with other people and with the community.

One of the most important skills young people need in HIV/AIDS prevention is the ability to analyze situations, the behavior of individuals, and the consequences of their own actions, prior to engaging in those actions. This enables them to avoid certain situations and understand what risky behavior entails and how to manage or avoid risky situations (Gichuhi, 1999).

## **2.8 THEORETICAL FRAMEWORK**

### **2.8.1 RATIONAL CHOICE THEORY**

The concept and principles of rational choice theory place rational choice and action as significant in an individual behavior. According to George Ritzer, “the focus in rational choice theory is on actors. Actors are seen as being purposive, or as having intentionality. That is, actors have ends or goals towards which their actions are aimed. Actors are also seen as having references (or values, utilities)” (Ritzier, 1996). Hence in the rational choice orientation it is clear that the basic idea is that an individual acts towards the achievement of a goal which is shaped by the values and preferences. Ritzier continues to add that of importance is the fact that the actions are undertaken to achieve objectives that are consistent with an actor’s preference hierarchy. The theory also proposes that resources and opportunity costs determine the decision one makes. There are also two other ideas that are significant to rational choice theory according to the same author. The first is an aggregation mechanism, or the process by which separate individuals actions are combined to produce the social outcome. The second is the growing sense of importance of information in making rational choices (Ritzer 1996, 264). Hence the amount of information available has a profound effect on the actor’s choices.

Life skills have been conceptualized within a rationality framework for understanding human behavior. According to Boler and Aggleton (2005) life skills which mainly target young people propagate that young people think, act and learn the same way. This means that their risk perception determine their mode of behavior especially as regards to HIV/AIDS. The major assumptions propagated in life skills and life skills-based education as regards to theory of rational choice includes:-

- Individuals have rational choice over their actions



- Individuals have freedom to learn and act to become self-autonomous and self-empowered
- Individuals have agency over their actions
- Individuals have access to resources and power they need to change their lives.

Hence Rational choice theory propagate that individuals with life skills capacities (especially young people) have the rational control of their choices and actions as life skills empower them and give them the freedom to become self-autonomous and have agency over their lives. Life skills basically influences the risk perception of HIV/AIDS and enable individuals to overcome the complex web of political, socio-cultural and economic interactions surrounding HIV/AIDS; and gives them the power they need to choice behavior that will prevent them from being susceptible to HIV/AIDS.

## **2.8.2 RESILIENCE THEORY**

Resilience and risk theory attempts to explain why some people respond better to stress and adversity than others. Resilience theory argues that there are internal and external factors that protect against the social stressors or risks of poverty, anxiety, or abuse. If a an individual has strong protective factors, he or she can resist the unhealthy behaviors that often result from these stressors or risks. Internal protective factors include self-esteem and internal locus of control, while external factors are primarily social supports from family and community, such as positive role models or health services (Luthar and Zigler, 1991).

According to Bernard (1991), the characteristics that set resilient young people apart are social competence, problem solving skills, autonomy, and a sense of purpose. Although the social environments of these young people are marked by risk, they also have “protective qualities, including caring and supportive relationships, high expectations, and opportunities for youth participation, and involvement” (Meyer and Farrell, 1998, p. 472). An understanding of the relationship of the individual to the environment is the foundation of what is often called a comprehensive prevention approach. Such an approach employs strategies that maximize resilience and minimize

risk, involving not only the young person, but also the family and the community, as well as other service providers (often through case management or a “full-service” approach).

Resilience and risk theory provides an important part of a foundation for a life skills approach:

- Social-cognitive skills, social competence, and problem-solving skills serve as mediators for behaviors, both positive and negative. In other words, life skills programs designed to prevent specific problem behaviors (e.g., high-risk sexual activity, social rejection) or promote specific positive behaviors (e.g., healthy peer relationships, positive school adjustment) do not simply address the behaviors directly. Rather, they build the competencies or skills that are shown to mediate the behaviors.
- It is apparent that there is not a one-to-one relationship between risk factors and behavioral outcomes. “Recent findings in behavioral epidemiology indicate that mental health problems, social problems, and health-risk behaviors often co-occur as an organized pattern of adolescent risk behaviors” (Greenberg et al, 1999, p. 4). Programs that teach social and emotional skills had positive effects in multiple realms, such as decreasing aggression in boys, decreasing suspensions and expulsions, decreasing drug use and delinquency, increasing academic test scores, and increasing positive attachments to school and families (Hawkins et al, 1992). Thus, effective life skills programs address and have an impact on multiple behaviors.
- Many of the risk factors that threaten the health and well-being of young people (e.g., poverty, mental illness in family members, racial injustice) are out of the range of what most health promotion and prevention programs can do. Life skills programs address the mediating factors that research shows can be influenced to promote health and well-being.

### 2.8.3 BEHAVIORAL SCIENCE THEORY

Various theories in behavioral science have been used to understand behavior especially as regards to HIV/AIDS prevention. According to Ritzer, behavioral science

theory is concerned with the “relationship between the effects of an actor’s behavior on the environment and their impact on the actor’s later behavior. This relationship is basic of operant conditioning or the learning process by which behavior is modified by its consequence” (1996:263). Hence the environment in which the behavior exists is affected by the behavior and in turn acts back on various ways. This may have positive, negative or even neutral connotation and can affect the actor’s behavior later. Ritzer adds that “of great interest to behaviorist are rewards (or enforcers) and costs (or punishments). Rewards are defined by the ability to strengthen or reinforce behavior, while costs reduce the likelihood of behavior.” If the reaction has been rewarding to the actor, the same behavior is likely to be emitted in future in such situations. If the reaction has been painful or punishing, the behavior is less likely to occur in future (Ritzer 1996: 263).

This paper will focus on the various domains that have been used to explain behavior in HIV/AIDS as no one behavioral theoretical construct is able to explain the multiple challenges of HIV/AIDS. This domains incorporate concepts drawn from theories and perspectives adapted by both public health, social sciences and psychologists that have been used to understand behavior and will include: a) AIDS risk reduction, b) self-perception, c) Risk Appraisal, e) relationship and social influence, f) emotion and arousal, and g) environmental and structural factors.

### **AIDS Risk Reduction**

The AIDS Risk Reduction Model (ARRM), introduced in 1990, provides a framework for explaining and predicting the behavior change effects of individuals specifically in relationship to the sexual transmission of HIV/AIDS. A three stage model, the ARRM incorporates several variables from other behavior change theories, including the Health Belief Model “efficacy” theory, emotional influences, and interpersonal processes. The stages, as well as the hypothesized factors that influence the successful completion of each stage are as follows (Catania et al, 1990).

Stage1: Recognition and labeling of one's behavior as high risk. This is based on the knowledge of sexual activities associated with HIV transmission, belief that one is personally susceptible to contracting HIV and belief that HIV/AIDS is undesirable.

Stage 2: Making a commitment to reduce high-risk sexual contacts and to increase low-risk activities. The main assumptions in this stage include cost and benefit analysis of the risk, importance of sexual practice as seen by the individual and its potential risk, and knowledge of the health utility as well as social factors (group norms and social support), are believed to influence an individual's cost and benefit and self-efficacy beliefs.

Stage 3: Taking action. This stage is broken down into three phases: a) Information seeking; b) obtaining remedies and; c) enacting solutions. Depending on the individual, phases may occur concurrently or phases may be skipped. The main areas that are of importance in this stage are the place of social networks and problem-solving choices (self-help, informal and formal help); prior experiences with problems and solutions; level of self esteem; resource requirements of acquiring help; ability to communicate verbally with sexual partner; and sexual partner's beliefs and behaviors.

In addition to the stages and influences listed above, the author of the ARRM (Catania et al 1990) identified other internal and external factors that may motivate individual movement across stages. For instance, aversive states (e.g. high levels of distress over HIV/AIDS or alcohol and drug use that blunt emotional states) may facilitate or hinder the labeling of one's behavior. External motivators such as public education campaigns, an image of a person dying from AIDS, or informal support groups may also cause people to examine and potentially change their sexual activities.

### **Self- Perception**

This theory encompasses an individual's belief and attitudes about oneself such as ability and capacity to carry out actions necessary and sufficient to reduce one's risk. The domain is informed by variety psychological theories such as theory of planned action and socio-cognitive theory. The theory encompasses a variety of cognitive

processes that play a role in behavior and as said earlier relates to beliefs and attitudes about oneself similar to the risk –appraisal theory.

One of the widely used concepts in the theory is self-efficacy. According to Bandura 1994, “the primary aspect of self-efficacy is analogous to confidence a person has to perform that he or she can successfully perform a given behavior. He continues to add that self- efficacy reflects the extent to which a person is able to successfully perform a new desired behavior even under difficult circumstances.” Hence self- efficacy plays a pivotal role in explaining behavior that is relevant to HIV/AIDS.

Another aspect in self- perception domain is intention which is seen according to Dolcini et al, “as the direct precursor to a given behavior a cognitive and emotional state that poises an individual as ready for action.” He notes that intention is said to be composed of a combination of personal attitudes towards a behavior and perceived social norms for that behavior. Strong intentions involve commitment to carry out a behavior (2005). Hence increasing intentions such as to use condoms can be viewed as an important intermediary step in the step to the process of behavior change. There is a strong relationship between intention and HIV/AIDS-related behaviors as the specific behavior in this case is needs complex actions to be undertaken.

Bandura (1994) also brings out the concept of outcome in self perception which he refers to the “person’s perceptions about the ramifications of a particular behavior.” It is based upon weighing of the costs and benefits of performing a behavior. This case, positive outcomes of behavior are valued more than the negative outcomes are feared. This explains why an individual will engage in a certain behavior despite the perceived outcomes and in HIV transmission outcome expectancies may play an important role in the course of action an individual will undertake.

Self- standard/ self-identity are other areas that encompass a person’s perception. This is perception about the kind of person he/ she is. According to Bandura 1994, those perceptions are used to gauge the appropriateness of and the likelihood that one could perform a given behavior. Dolcini (2005) also adds that a variety of factors contribute

to a person's self-standards and include, but are not limited to family, cultural background, development stage and sexual orientation. Therefore according to Dolcini et al 2005 although we recognize that self-identity and self standards are influenced by social relationships, we locate them in the self- perception domain to reflect the cognitive, attitudinal quality of the constructs.

### **Relationships and Social Influences**

This domain addresses the interpersonal and social context of risk behaviors. The domain encompasses the influence of close intimate relationships as well as those from within one's sexual network. Dolcini et al 2005 comments that, although sexual behavior is private, the behaviors that place individuals at risk for HIV contraction are usually social. Forces outside the individual including partners, gender roles, power dynamics, cultural beliefs, and social norms impinge sexual activity (2005, 408).

The relationship and social influence perspective has been informed by various theories including theory of reasoned action, learning theories, gender and power theory, social-network theory and elements of Aids Risk Reduction domain also appear in this domain among others.

Dolcini et al 2005 summaries the Relationship and Social influence domain as encompassing the following propositions:-

- Interpersonal relationships influence individual choice
- Social influences determine the degree to which innovations and earlier adoptions of behavior change are deemed role models and as a result, influence subsequent adoption of behavior by the larger majority
- It also assumes that men and women are socialized to certain gender roles, in turn , affect intimate interactions
- Social support and networks act in determining , supporting or discouraging particular behaviors
- Group norms influence standards for personal behaviors. This means that norms encourage or discourage certain HIV risk behaviors, and the influence of important others on behavior is well documented. Among

young people for instance, peer group norms, peer group membership and friendships are consistently associated with sexual behavior.

- Interpersonal relationships exert profound influence on HIV-related behavior. Relationship history and the stage of a relationship influence the ability to discuss and to enact health-protective behavior. Hence issues related to communication, negotiation and comfort addressing sexual behavior is an explicit way to contribute to the likelihood that protective behavior will be enacted.

In summary the relationship and social influence domain focuses on the social nature of risk-taking behaviors. It covers a broad range of social factors ranging from intimate relationships to the social network, to cultural influences on relationships sexuality behavior that can be significant in HIV/AIDS prevention.

### **Risk appraisal**

This domain is drawn from a variety of health-protective behavior models and is an important construct in understanding risk perceptions and appraisal of individuals. The theory view perceived risk as a necessary precursor to behavior change. According to Dolcini et al (2004) “empirical work suggests that perceptions of risk are important in understanding HIV/AIDS behaviors. The relationship between perceived vulnerability and sexual practices may not be direct, however, in part because of the significant social and emotional aspects of sex. The main propositions appropriated by this domain as shown by both Dolcini et al (2004) and Catania et al (1990) include:-

- Risk perception have both cognitive and affective components, and a focus on one or the other of these aspects of self-assessment may lead to different conclusions/ behavior
- Knowledge about HIV transmission affects risk perception making accurate knowledge an important factor
- the specific aspects of risk that is being examined is also important as perception may be partner specific ( for example a main partner may not be viewed as risky in contrast a casual partner is seen as risky)

- Many people also underestimate their personal risk for HIV contraction while others overestimate their risk leading to a consequent psychological behavior of i.e. frequent HIV testing when no risk of behavior has occurred.

Risk appraisal domain hence includes a range of actions that influences an individual's awareness, perception and assessment of his/her personal risk of HIV contraction. This include factors such as stereotyped beliefs about who's at risk, misconceptions about how HIV/AIDS is spread, perceived susceptibility, perception of invulnerability, optimistic bias, geocentricism, defense coping, perceived risk, perceived severity and problem hierarchy.

These concepts according to Dolcini et al (2005) have a distinct effect on risk appraisal. Aspects such as optimal bias refer to the tendency to see others similar to you as a greater risk for a negative event, such as contracting HIV. Illusion of vulnerability, on the other hand, refers to a belief that one will not experience bad outcomes from risky activities. Problem hierarchy addresses the fact that individuals grapple with many issues in daily living and disease transmission may not be foremost on their minds. The possibility of HIV contraction seems remote to an individual who is struggling to find a job and hence these will affect risk appraisal.

### **Emotion and Arousal**

This domain is based on presumptions of rationality and tries to explain the emotional states that may affect risk-taking behavior directly or indirectly. It also addresses arousal, which is highly relevant to sexual behavior. According to Dolcini et al 2005 "risky sexual behaviors are more aptly characterized as drive based, physiologically motivated, and/or impulsive."

One important area stipulated in this model is affect. Catania et al (1990) notes that affect has many manifestations (e.g., fear, joy, anxiety, anger, excitement, and depression), and emotions can affect behavior in a variety of direct and indirect ways. For example, positive and negative mood can influence substance use or sensation seeking, and these may be indirectly related to HIV/STD risk behaviors. Long-standing



negative affective associations with sex, including shame, guilt, or anxiety, have been shown to result in lower levels of contraceptive use and negative reactions to communicating about sex. Positive affective experiences are also influential. In relationships with a strong emotional connection, it is difficult for individuals to view their partners as health threats. The positive feelings about the relationship may contribute to an inability to make accurate risk appraisals (e.g., “I couldn’t get an STD from her”) or may decrease intentions to negotiate condom use.

Emotional or affective experiences unique to the sexual encounter, particularly arousal, are also components of this domain. The desire for pleasure and gratification provides a strong motivation for sex. When individuals are concerned that protective actions will threaten sexual pleasure or comfort, they will be less likely to engage in them. Furthermore, arousal and the desire for sexual pleasure impose a sense of urgency that can distort judgment. In the face of this pressure, an individual’s capacity to evaluate a potentially risky situation and enact a new behavior may be sorely diminished. Acting to avoid potential risk involves confronting difficult issues, such as anxiety about personal health or trust in one’s partners, in the context of intimacy and arousal (Gold & Skinner, 1993; Dolcini et al, 2005).

Habits or internalized sexual scripts according to Dolcini et al (2005) is another component of this domain, and contribute to the regulation of sexual behaviors by influencing an individual’s experience of desire and sexual arousal. He continues to add that scripts influence the object of one’s sexual interest, what one does or does not do sexually, and the reasons one has sex. This aspect of sexuality is highly influenced by cultural and social factors, and individuals may be largely unaware of the sexual scripts they hold. Hence a focus on self-reflection can be useful in helping individuals identify behaviors they engage in that have been influenced by mood or arousal.

An understanding of emotions and arousal is hence important in explaining how emotions can undermine intentions to perform health protective behaviors. It emphasizes the interrelatedness of emotions and sex, and the need to be aware of the larger context in which behavior is occurring. (For example, when sexual risk behaviors

are coupled with addiction, as with injection drug use, the outcomes may be deactivating as the individual may be easily aroused and unable to control his/her emotions.) Hence emotions, in HIV/AIDS prevention, are likely to affect intentions to use condoms or self-efficacy to negotiate safer sex behavior with a new partner. The relationship with a sex partner will influence emotions and be influenced by them in turn.

### **Environmental and Structural Factors**

The environmental and structural domain highlights the fact that there are circumstances beyond the individual or social group that affect health and well-being. The historical emphasis on individual health behaviors has ignored the association between increased morbidity and mortality and social, structural, and physical factors in the environment, such as access to health care, unemployment, or minority status. This domain reflects the growing recognition that comprehensive approaches integrating psychological, organizational, and cultural issues as well as community planning and regulation are needed to adequately address health concerns. It specifically addresses the larger sociopolitical barriers and facilitators to health. These larger factors have been conceptualized as superstructural (e.g. homophobia, racism, sexism), structural (e.g. laws, policies), and environmental (e.g. living conditions, social pressures) conditions (Dolcini et al, 2005; Zimmerman & Rappaport, 1994). The model is also based on economic, social, and political models, such as community mobilization, empowerment, advocacy, and social action programs. It assumes that people assume control and mastery over their lives in the context of their social and political environment.

Empowerment encompasses prevention, as well as goals of community connectedness, self-development, improved quality of life, and social justice. As people work for societal change and improvement in their collective quality of life, they develop greater capacity to exert political pressure (Wallerstein & Freudenberg, 1998; Zimmerman & Rappaport, 1988). According to Wallerstein & Bernstein (1988), models based on empowerment paradigms have demonstrated that when these interventions enable

participants to take part in mobilizing and setting goals, efforts have been highly successful.

Similar to empowerment models, community mobilizing and organizing approaches emphasize strategies that develop advocacy skills and community ownership around a given issue. Community mobilization often involves phase-based activities, such as the development of community forums to address an issue or problem, creation of citizen action through the recruitment of community groups to implement a plan of action, and gaining the support of citizen action through media to raise awareness about the issue. Although historically similar in approach, empowerment models differ from community mobilizing and organizing strategies in that their emphasis is beyond winnable goals but also involve participatory processes to effect individual, group, and structural change.

Advocacy has also been widely used to address concepts included in the structural/environmental domain. Advocacy is defined as a set of skills used to create a shift in public opinion and mobilize the necessary resources and forces to support an issue, policy, or constituency and efforts to change community conditions related to health (Wallerstein & Bernstein, 1988). Media advocacy has become increasingly popular as a means of advancing initiatives. Evidence suggests that some of the most powerful effects on HIV risk behavior have come from legislative and regulatory changes. Several empirical contributions have demonstrated that the approaches described earlier have mobilized and empowered communities, in some cases resulting in broad-scale changes that have improved health conditions. Community mobilization and advocacy has had a significant impact on several HIV/STD-related areas, including needle-exchange and condom distribution programs. Media advocacy is frequently used as a strategy to influence policy and legislative changes, with varying success. There are some compelling examples of success reflected in the antismoking movements and seatbelt safety laws. However, despite the impressive body of evidence showing that needle-exchange programs work, multiple barriers continue to exist, and most jurisdictions do not have such programs in place (Friere, 1973).

The frameworks and models used to address the environmental and structural domain use varying strategies and approaches to facilitate community cohesion, empowerment, and change for improved quality of life. According to Wallestein and Bernstein, interventions that have utilized ecological models have been effective in addressing some of these issues as they focus attention on individual, social, and environmental actors. They continue to add, that it is important to note that in environmental and structural domain and its components, barriers influencing health conditions and quality of life are usually large, institutional determinants. For example, restrictions on the type and focus of intervention for which agencies receive funding may pose significant challenges for addressing factors falling under this domain. Furthermore, political action (e.g., advocacy, lobbying, enacting legislation) is often required to bring about meaningful change at this level. Current international work focused on breaking down structural barriers to HIV/AIDS care (e.g., making medication available in developing countries) is an excellent example of the complexity of this process and of the potentially wide-ranging impact when such programs are successful. Hence stem transmission on a larger scale, community and structural level programs are a critical complement to individual approaches. Although large-scale change comes about through processes that often take many years to be realized, they are likely to have a broad-based sustained impact (1998).

### **Summary of Behavioral Science Theory**

The behavioral theories play major role in understanding behavior and its relatedness to HIV/AIDS prevention. They also cover a broad range of influences and provide a framework for understanding the interrelatedness of individual, group, and structural factors affecting behavior. The domains are important in giving a theoretical framework for understanding in HIV/AIDS prevention and the role played by life skills in behavior change. Some of the main implications of behavioral theories in understanding the place of life skills in behavior change necessary for HIV/AIDS prevention include:

- Young people learn to behave through both instruction (i.e., how parents, teachers, and other authorities and role models tell them to behave) as well as observation (i.e., how they see adults and peers behaving). Their behavior

is reinforced, or modified, by the consequences of their actions and the responses of others to their behaviors.

- Self efficacy, which is a major component of behavioral science theory, is important to learning and maintaining behaviors, especially in the face of social pressure to behave differently. Thus, skills development not only becomes a question of outward behavior, but of internal qualities (such as self efficacy) that support those behaviors (Bandura, 1994).
- Young people's behavior (including risk behaviors) cannot be reduced to a single source, but is the product of complex interactions between people and their environment. Thus, young people with skills such as values clarification (to better understand one's own values and beliefs) and critical thinking (to clearly recognize and analyze the values of the social environment) can have more capacity to make proper judgment of risky situation and can easily adapt positive behavior that can reduce HIV contraction.
- Another implication is based on social influence domain which recognizes that young people will come under pressure to engage in risk behaviors, such onset of early multiple sexual involvement. Social pressures include "peer pressure, models of irresponsible sexual behavior learned from older people, and sexual involvement messages in the mass media that feature attractive sexual activities. Hence the socialization of an individual which determine the kind of life skills an individual may possess may reflect how an individual will react in risky situation.
- Environmental and structural factors also play a role in the level at which an individual is capable of utilizing skills. Empowerment, advocacy and community mobilization interventions, which give individuals life skills capacities, have a structural effect on HIV/AIDS prevention through behavior adaptation and change.

## **2.9 CONCEPTUAL FRAMEWORK**

The conceptual framework in this paper revolves around the relationship between life skills capacities and HIV/AIDS prevention. Life skills capacities have a consequent

effect on behavior adaptation and change necessary for HIV/AIDS prevention. Social and interpersonal skills, cognitive skills and emotional skills which form the main components of life skills capacities have effects on behavior adaptation, change and modification among youths that can be significant in avoiding, reducing the risk and empowering them consequently preventing the contraction and spread of HIV/AIDS. These life skills are learned by an individual within a specified environment where he/she is nurtured either actively or through socialization process. This means that the lack of this skills have the opposite effect of increasing the risk of HIV/AIDS infection. On the structural level the possession of life skills by an individual empower an individual to think and act rationally consequently affecting the choices they make.

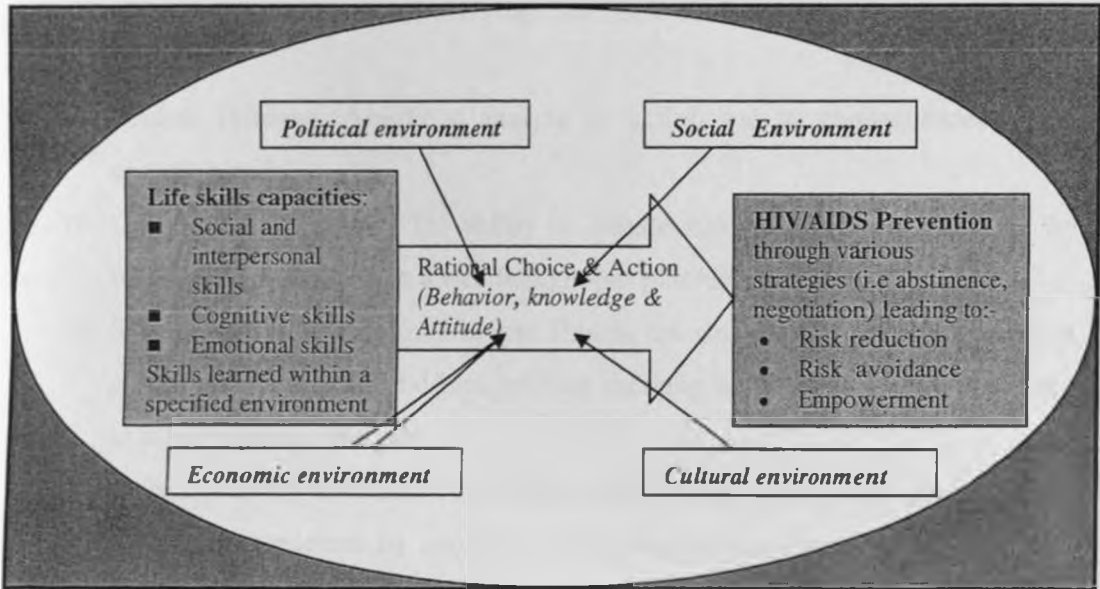
According to Visser (2005) life skills capacities include the development of various subsystems of the individual with the aim of facilitating change in the individual, often observed through behavioral processes. For example, by changing how an individual thinks feels or makes decisions, changes can also take place in the individual's behavior. Possession of life skills can contribute to an individual's capacity for adaptation and the development of new interactional patterns between the individual and his/her social context. Life skills capacities can therefore also impact on risk behavior related to HIV/AIDS, which is associated with various processes at the individual (such as self-esteem, awareness of personal risk), interpersonal (such as peer group norms, gender roles) and community and cultural levels

He continues to add that there is growing evidence that preventive life skills have a positive impact on the lives of children and adolescents. Specifically related to HIV/AIDS, it was found in meta-analyses of research results that possession of life skills contributed to some extent to change in risk behaviors. Individuals possessing life skills have increased levels of knowledge regarding HIV/AIDS, more assertiveness, more positive attitudes towards people with HIV and some indications of delayed sexual activity more condom use and fewer sexual partners (2005).

Hence with possession of these skills the individual is able to creatively think through the complex and cultural, economic and political factors/environment that contribute to

HIV/AIDS and make a rational choice of not putting themselves at risk of HIV/AIDS infection for their own benefit. This is as represented in the diagram below:-

**Figure 2: Conceptual Framework**



As shown above, despite the existing environment that one exists, possession of life skills can empower an individual to make the right choices and actions to avoid and reduce the risk of HIV/AIDS. Hence the life skills model becomes an important necessity in HIV/AIDS prevention.

### 2.9.1 Dependent variable

The dependent variable is HIV/AIDS prevention which is dependent on the life skills capacities possessed by young people in Dandora area. HIV/AIDS prevention includes such strategies as:-

- a) Risk Avoidance (including abstinence, reducing number of sexual partners, delay of sexual onset, knowing HIV Status and faithfulness to one partner)
- b) Risk reduction (including correct and consistent condom use and early detection of STIs)
- c) Empowerment (including having comprehensive knowledge, negotiation skills, refusal skills and mature decision making)

### 2.9.2 Independent variable

The independent variable is life skills capacities possessed by young people in Dandora area. Life skills capacities in this paper are those skills and competencies required for human development and adaptation of positive behavior that are fundamental in dealing effectively with the challenges of everyday life. Life skills capacities measured in this study included:

- a) **Critical Thinking:** Ability to analyze an action and its consequences before engaging in it
- b) **Creative skills:** This is the ability to handle risky situations responsibly by managing the situation in a well thought out plan/decision.
- c) **Sustaining relationship/friendships:** This is the ability to initiate and maintain proper relationships/friendships without crossing normal boundaries especially as regards sexual behavior
- d) **Problem solving and conflict resolution:** This is the ability to creatively handle HIV/AIDS pandemic by avoiding and managing risky context and resolving internal conflicts surrounding mode of behavior
- e) **Decision making:** This is the ability to manage a risky situation by making a responsible choice
- f) **Goal setting and Accomplishment:** This is the competency to set life targets that will enable a young person delay or abstain from sexual behavior
- g) **Refusal and Negotiation skills** are skills that enable an individual make an agreement with the others concerned in order to bargain or compromise on a situation that may be considered risky.



# CHAPTER THREE

## 3.0 METHODOLOGY

### 3.1 Research Design

The overall design was a quantitative exploratory study of HIV/AIDS life skills capacities among young people in Dandora area between ages 15-24 years. The above method was chosen due to the nature of this study which sought to measure characteristics, skill level, attitudes and beliefs and behavioral outcomes among young people between ages 15 to 24 years in Dandora area, Nairobi.

### 3.2 Site Selection and Description

This study was undertaken in Dandora area, a location in Embakasi Division. The Division is located on the 15km south east of Nairobi Central Business District and is both an administrative division and a constituency in Nairobi. Apart from Dandora location, the division comprises of 8 other locations namely Kariobangi South, Kayole, Mukuru Kwa Njenga, Njiiru, Ruai, Umoja and Embakasi. It occupies an area of 208 square kilometers and lies along latitude 1° 18' 0" South and 36° 55' 0" East. The division has a population of about 450,000 with the highest number of slums in Nairobi province.<sup>3</sup>

Dandora area is a slum and home to about 161,721 people with 34% of the population being young people in the 15-24 age brackets. The area is also occupied by Nairobi's dumpsite which is a significant feature in the area from which most of the populations especially the youth get their income (Mutula, 2003).

### 3.3 Sample Size

According to Moore (1991), sampling is necessary because of constraints in finance and time. He also notes that it has been proved from experience that handling a sample is more efficient than dealing with the total population. It is also assumed that by studying a sample, the characteristics of the sample will fully reflect those of the statistical population. This study focused on a sample size of 200 young people from

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<sup>3</sup> [http://wikipedia.org/wiki/Nairobi\\_Province](http://wikipedia.org/wiki/Nairobi_Province). [http://2007\\_Property.co.ke](http://2007_Property.co.ke).

Dandora community; the small sample was selected due to constraints of resources and time.

### **3.4 Sampling Procedure and Sample Characteristics**

Purposive sampling was used to select Dandora area, Nairobi as the site of study due to the increasing number of orphans and HIV/AIDS cases among youths in the area. Since Dandora area has many phases, three phases was randomly sampled to participate in the study. In order to select the respondents to be interviewed, Quota and snowballing sampling was employed. This entailed dividing the population into relevant strata for example age and sex. Then after fixing the proportion to be considered for each stratum, enumerators were given a quota of respondents to consider in each stratum and then identified respondents to participate through snowballing. (Singleton et al, 1988)

The sampling characteristics were defined by age, sex and geographical location. The sample for the quantitative inferential study included 200 youths between ages 18-24 and 10 key informants. 200 youths in the 15-24 year age category were administered a questionnaire from the area plus 10 key informants were interviewed. Only 20 respondents, 10 males and 10 females' youth respondents were purposively selected for the focus groups discussions. This number selected will ensure focus in the discussions and gaining of in depth information on the study area.

### **3.5 Data Collection Sources**

Both primary and secondary sources of data were be used to collect the required data in this study to ensure validity and reliability.

#### **3.5.1 Secondary Data**

Secondary data was collected using the documentary method of data collection. Documents are an important source of data in many areas of investigation. Vast amounts of information are held in documents, it provides a cost effective method of getting data which is permanent and available in a form that can be checked by others. Various reports on HIV/AIDS, books, periodicals, available records, bulletins and other

academic work in offices, internet and organizations dealing with HIV/AIDS issues were reviewed in order to source the required data from them.

### **3.5.2 Primary Data**

Primary data was collected using the following instruments and sources of data:-

### **3.6 Methods and Instruments**

**A standard questionnaire** as a data collection instrument was administered to the main participants of the research. The questionnaire comprised of both open and closed-ended questions. This questionnaire was administered to the respondents who to the youths aged 15-24 years in Dandora area. This helped to gain information from the sample population to meet the specific research objectives and questions of the study.

**Key informants** were purposively selected due to the fact that they were more conversant with the issues and social environment important to the researcher. These included people from different organizations, community leaders and others involved in youth specific HIV/AIDS intervention programmes. A discussion guide consisting of unstructured questions was used to gather information from them. The discussion guide consisted of key issues to facilitate a discussion.

**A focus group discussion** was also employed as a method of data collection where a focus group discussion guideline was used to facilitate a discussion and to capture the views of the young people. The focus group discussion was made up of 20 young people; 10 males and 10 females who were chosen purposively.

**Desk review** was used to collect secondary data from newspapers, magazines and other materials relating to HIV/AIDS and life skills.

**Table 2: Data Method and Instruments**

<b>DATA SOURCE</b>	<b>METHOD</b>	<b>TOOL</b>
1. Primary Data	a) Structured Interview	Questionnaire
	b) Focus Group Discussion	Focus group discussion guideline
	c) Key Informant Interview	Key informant guideline
Secondary data	Desk review	Magazines, newspapers, book and journal reviews

### **3.6.1 Unit of Analysis**

According to Singleton et al (1988) unit of analysis is what or who is to be described or analyzed. It is what the researcher seeks to explain or understand and can therefore be individuals, social roles, positions or even relationships. The unit of analysis in this study was HIV/AIDS life skills capacities among youths in Dandora area.

### **3.6.2 Unit of Observation**

Singleton et al (1988) comments that the units of observation are the objects, entity, or subjects from which data required for study will be obtained. In this study youths (between 15-24 age brackets) living in Dandora area were the main unit of observation.

## **3.7 DATA ANALYSIS PROCEDURES**

Data analysis was done both qualitatively and quantitatively in accordance to research objectives. As this is quantitative exploratory study, different data collection tools was used. Hence quantitative data collected was presented using both descriptive and inferential statistics. Descriptive statistics was used to measure the central tendency of data gained and summarize the data at hand to make them more intelligible, whereas inferential statistics was used to generalize sample data to the entire population. Qualitative data was analyzed through open coding then presented as statistical data in SPSS as quantitative together with quantitative data

# CHAPTER FOUR

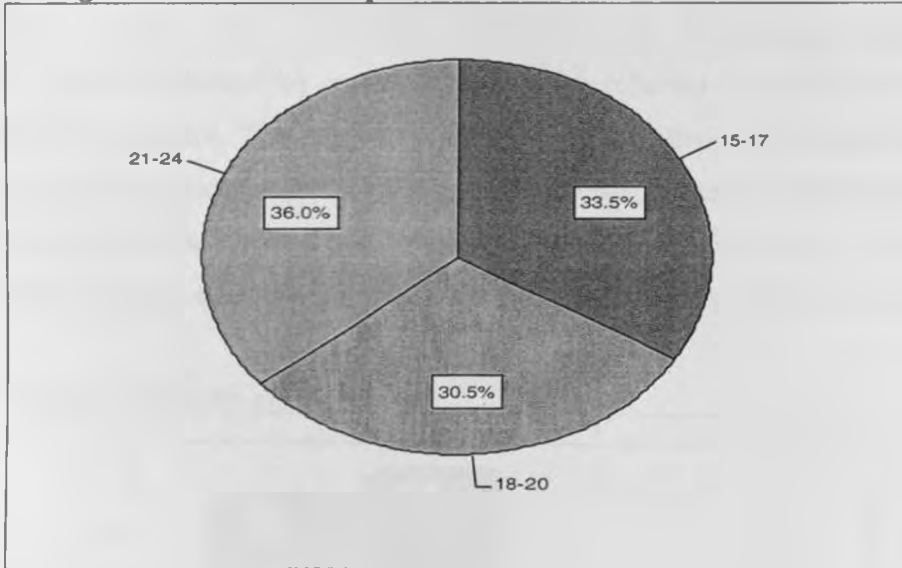
## 4.0 DATA PRESENTATION AND ANALYSIS

### 4.1 SOCIAL DEMOGRAPHIC CHARACTERISTICS OF YOUNG PEOPLE IN DANDORA AREA

#### 4.1.1 Age Distributions of Respondents

The study focused on 200 respondents from Dandora area. The study indicated an almost balance of age distribution among young people interviewed in Dandora as 36% were in 21-24 age bracket, 33.5% between the age of 15 to17 and the rest (30.5%) in the 18-20 age bracket. The age distribution of the young people is indicated in figure 4.

Figure 3: Age Distribution of Respondents



#### 4.1.2 Sex Distribution of respondents

Out of the 200 young people who participated in the study 55.5% were female while only 44.5% were male (See Table 3). This is a reflection of the national demographic characteristic where out of the 33.4 million people in the country, 51.5% are female while 48.5% are male (CBS, 2006).

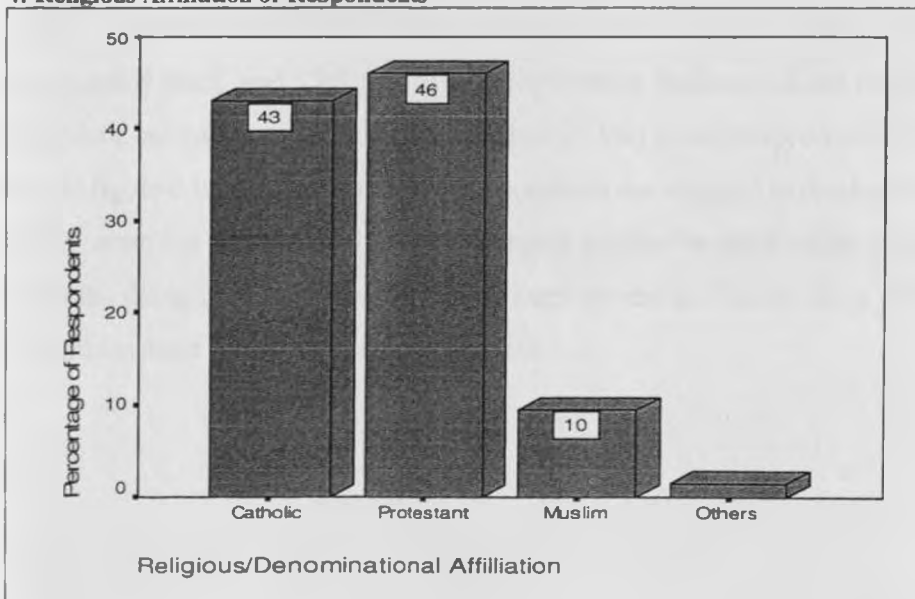
**Table 3 Sex Distribution of Respondents**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	89	44.5	44.5	44.5
	Female	111	55.5	55.5	100.0
	Total	200	100.0	100.0	

### 4.1.3 Religious/Denominational Affiliation of Respondents

According Schaefer and Lamm (1995) religion offers people meaning and purpose for their lives. It gives certain ultimate values and ends to hold in common. In Kenya 80% of the population is said to be people holding to the Christian faith as reflected in the study where majority of the participants were mainly from the Protestant background (46%). This was followed by catholic (43%) which reflected an almost equal to the protestant denomination. The two which were mainly Christian denominations had the majority of the respondents (83%). The rest of the respondents were Muslims (9.5%) and other religious background had 1.5% as illustrated in figure 6 below. This meant that many of the respondents were guided by Christian principles, values and norms.

**Figure 4: Religious Affiliation of Respondents**



#### 4.1.4 Education Level of Young People in Dandora Area

Assessment of the respondents interviewed showed that 43.5% had attained secondary education certificate, 33% primary certificate, 19.5% have a college certificate, 0.5% had attained a university degree and 1.5% and 2% respectively had no formal educational background or did not complete primary education respectively. This means that majority of the young people in Dandora have a basic educational background and a fairly high literacy level. As illustrated in table 4 a cumulative 63.5% of the young people in Dandora area had a secondary certificate (see table 4) which is a basic literacy level for any Kenyan person.

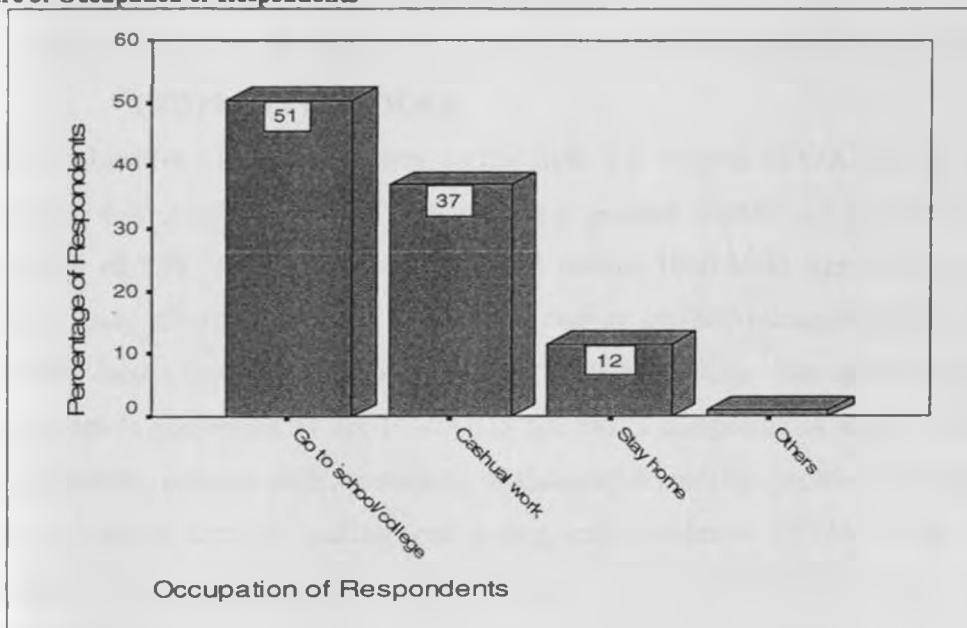
**Table 4 Highest level of Education**

		<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
1.	None	3	1.5	1.5	1.5
2.	Not completed Primary	4	2.0	2.0	3.5
3.	Primary	66	33.0	33.0	36.5
4.	Secondary	87	43.5	43.5	80.0
5.	College	39	19.5	19.5	99.5
6.	University Degree	1	0.5	0.5	100.0
	<b>Total</b>	<b>200</b>	<b>100.0</b>	<b>100.0</b>	

#### 4.1.5 Occupation of Young People in Dandora

Among the respondents 51% are students who go to school or college, 37% are involved in casual work, and 12% stay at home with their families and are not engaged in any source of income or education while the rest (1.5%) are employed in formal jobs. As shown in figure 6 below majority of the respondents are engaged in productive work as only 12% seem not to be actively participating in productive work while the rest are either students, doing casual work or in formal employment in Nairobi town which is a source of employment for many people in the area.

**Figure 5: Occupation of Respondents**



#### 4.1.6 Demographic Characteristics of Key informants Interviewed

7 key informants of mature age engaged in various occupations were interviewed to get their views on HIV/AIDS life skills issues among young people in Dandora area. Table 5 gives the detailed information of the social demographic characteristics of the key informants interviewed in this study.

**Table 5: Social Characteristics of Key Informants Interviewed**

	AGE	OCCUPATION	PLACE OF WORK
1.	33	Community Member	Jacaranda Youth AIDS and Change
2.	45	VCT Counselor	Samata Medical Services
3.	35	Assistant Manager	Karnskill College
4.	44	Headman	Chief's Office
5.	29	Teacher	Kinyango Secondary School
6.	45	Pastor	Life Line Ministries
7.	31	Manager	Dandora Football club



## **4.2 PRESENTATION OF STUDY FINDINGS**

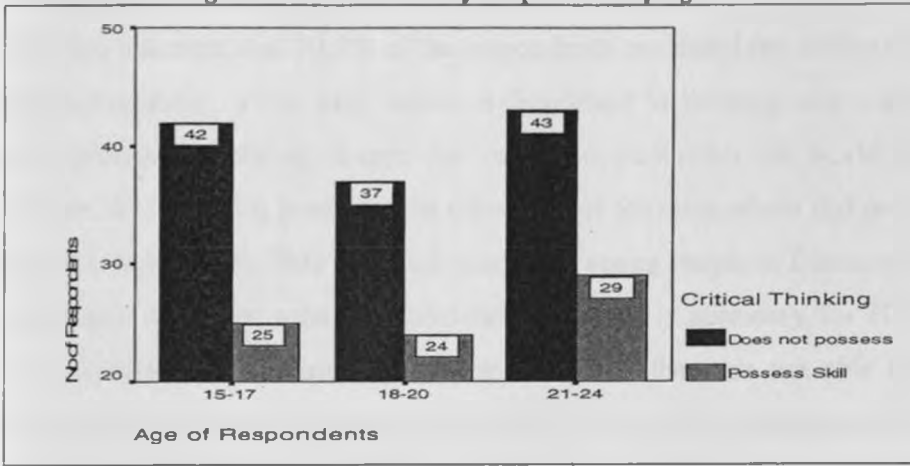
### **4.2.1 BASIC LIFE SKILLS COMPETENCIES POSSESSED BY YOUNG PEOPLE IN DANDORA**

The first objective of this study was to highlight the various HIV/AIDS life skills competencies that young people in Dandora area possess capable of preventing the contraction of HIV. As noted in the literature review HIV/AIDS life skills enables people to make informed decisions and develop coping and self-management skills that helps them lead a healthy and productive life (UNICEF, 2005). The study tested the young people's possession of six HIV/AIDS life skills competencies which included critical thinking, creative skills, sustaining relationship/friendship, problem solving and conflict resolution, decision making, goal setting/accomplishment HIV/AIDS life skills and refusal and negotiation skills. The findings of each HIV/AIDS life skills are discussed below.

#### **a) HIV/AIDS Critical Thinking Life Skill**

The first HIV/AIDS life skill that was assessed was critical thinking. The study measured whether the young people in Dandora had the capacity to think through a behavior and action before engaging in it by considering the resulting consequences of the behavior to HIV infection especially in resisting sexual pressure. The results showed that young people did not possess these HIV/AIDS life skills as only 39% of the total respondents indicating they possessed the competence while the rest 61% did not possess the life skill as illustrated in figure 9. The life skill was also not considered important as only 16% of the young people interviewed said it was an important HIV/AIDS life skill. This showed a non utilization of the Critical thinking HIV/AIDS life skills where it was reflected that lack of this life skills increased sexual activity among respondents as 62% of the respondents had engaged in sexual relation and were at risk of HIV infection. The young people participating in the focus group and key informant interview also identified that many of the young people engage in unprotected sex and use condoms inconsistently showing a lack of critical thinking as regards to consequences of this risky behavior to HIV/AIDS infection (see figure 7).

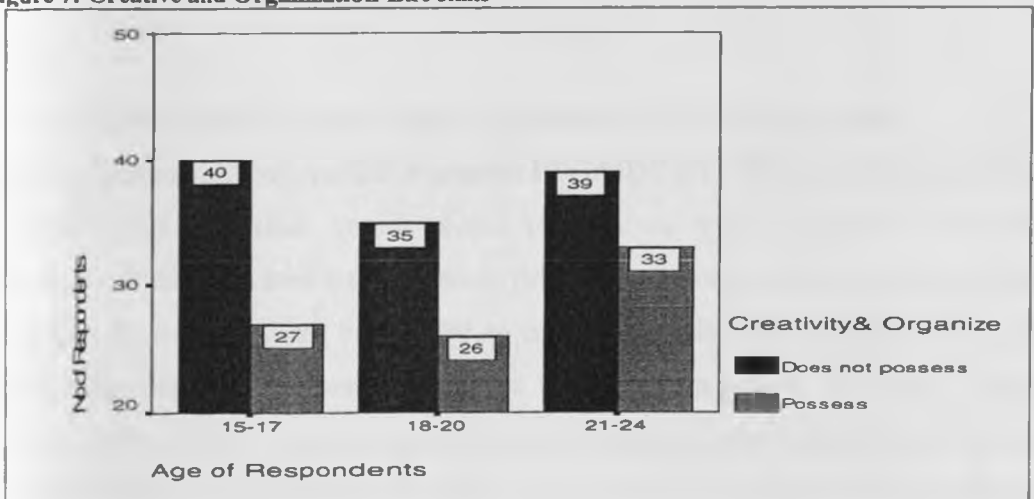
**Figure 6: Critical Thinking Life skills Possessed by Respondents by Age**



**b) HIV/AIDS Creative Life skills**

HIV/AIDS creative life skills were also assessed to ascertain the capacity of the young people in Dandora to creatively handle HIV/AIDS risk situations. From the study 16.5% of the young people interviewed did not consider this HIV/AIDS competency important in handling HIV/AIDS risky situation. It was further portrayed that out of the 200 respondents interviewed only 43% possessed the ability for creativity while 57% did not have this ability as indicated in Figure 8. The lack of this HIV/AIDS competency reflected the young people's disability to handle sexual pressure which from the study showed that more than half of these young people in Dandora were sexual active (62%) and could easily contract HIV.

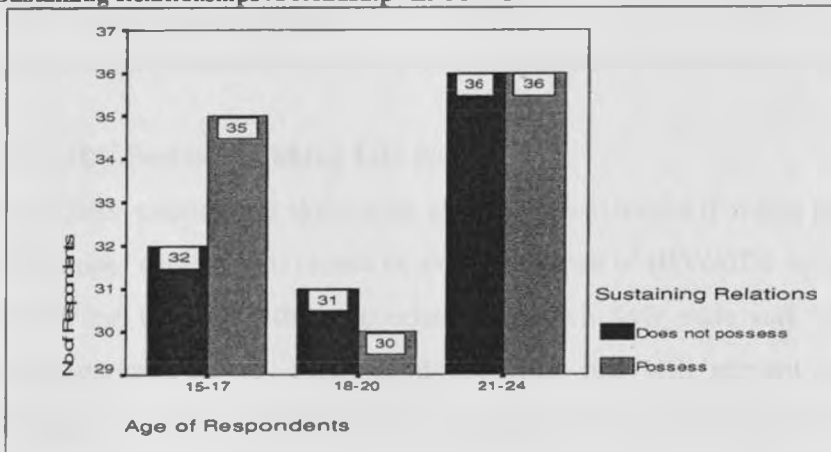
**Figure 7: Creative and Organization Life skills**



### c) Sustaining Relationships and Friendships Life skills

The study also indicated that 50.5% of the respondents possessed the ability to sustain relationships/friendship, a life skill which is important in building and maintaining positive relationship/friendship despite the various opportunities the world offers to young people. 49.5% which is almost the other half of the respondents did not possess this life skill (see figure 9). This indicated that some young people in Dandora area are able to maintain consistent relationship/friendship which is necessary for HIV/AIDS prevention especially as it relates to faithfulness while others are not able to do so. Faithfulness was also tested to through the length in which the young people kept and maintained a relationship. Majority (54%) said they had maintained a girlfriend/boyfriend for more than one year as compared to 12.5% who said they kept them for only one year, 6% for three to six months and only 4% for a week.

Figure 8: Sustaining Relationships /Friendships Life skills

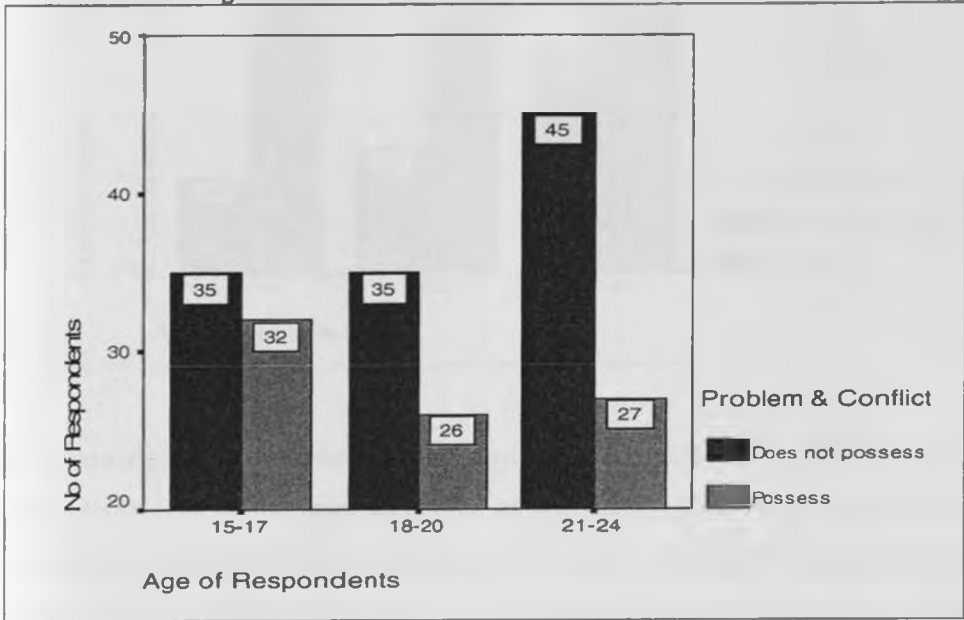


### d) Problem Solving and Conflict Resolution HIV/AIDS Life skills

The problem solving and conflict resolution HIV/AIDS life skill was assessed to course or action and resolutions young people in Dandora make to prevent HIV/AIDS infection. Study indicated that less young people were able to choose a positive course of action to reduce by not being able to handle the HIV/AIDS pandemic as a life threatening situation that needed attention to reduce chances of infection. This is because only 42.5% of young people in Dandora area possessed problem solving and conflict resolution life skills as reflected in figure 10 below and only 8% considered as an important life skill, the lowest rating among the five life skills measured in this

research (refusal and negotiation life skills was not measured in the order of importance).

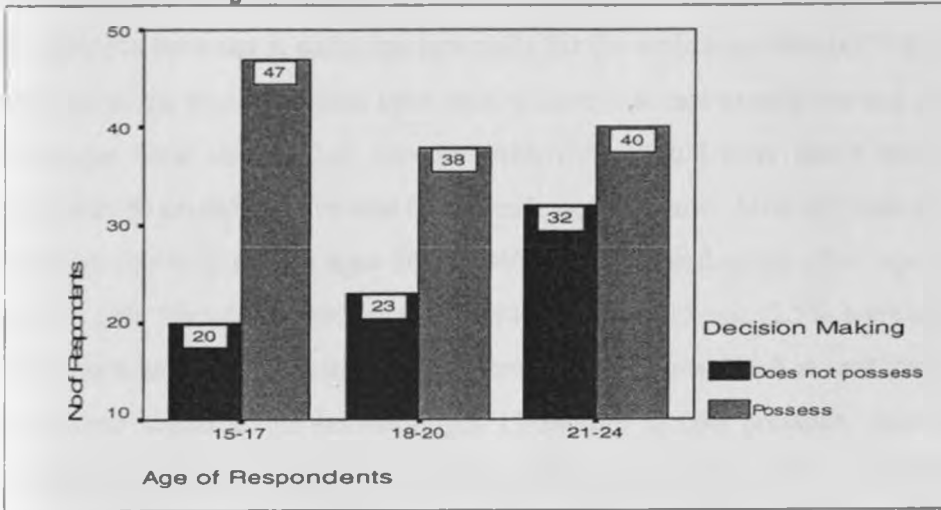
**Figure 9: Problem Solving and Conflict Resolution Life Skills**



**e) HIV/AIDS Decision Making Life Skills**

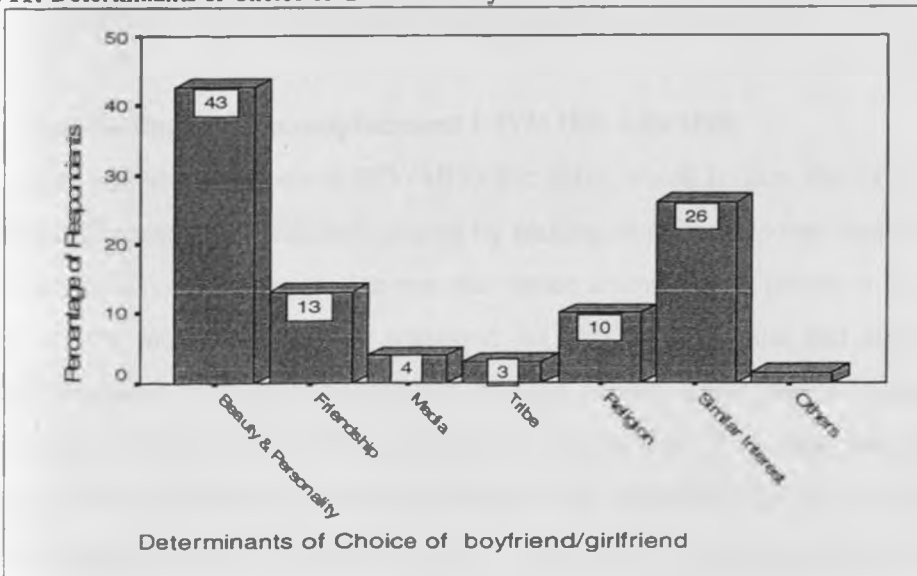
HIV/AIDS decision making life skills were measured to ascertain if young people were able to make proper decisions to reduce or avoid their risk of HIV/AIDS infection. The study revealed that 62.5% of the respondents of which 44% male and 56% female possessed the competence to make good decisions that will prevent them from HIV/AIDS infection while only 37.5% did not possess the life skills (see figure 11) Decision making HIV/AIDS life skills was the highest possessed life skills as compared to the other HIV/AIDS life skills measured in this study and was regarded as the most important 32% of the young people. This is because decision making is an important life skill that everyone grows into due to the demand in its utilization and the fact that everyone is required to possess the life skill at whatever level of interaction in society.

**Figure 10: Decision Making Life Skills**



Decision making among respondents as regards to HIV/AIDS issues was also measured in relation to various factors such as choice of girlfriend, choice of sexual activity, age at first sexual activity and decision making in forced sex. Most of the respondents made the decision to have a girlfriend/boyfriend (68%) and only 32% did not, a choice they made mainly due to the beauty and personality of their girlfriend/boyfriend (43%), similar interest (26%), religion (10%), media (4%), tribe 3% and other reasons such as financial status and family background (1.5%) as shown in the figure 12 below.

**Figure 11: Determinants of Choice of Girlfriend/Boyfriend**



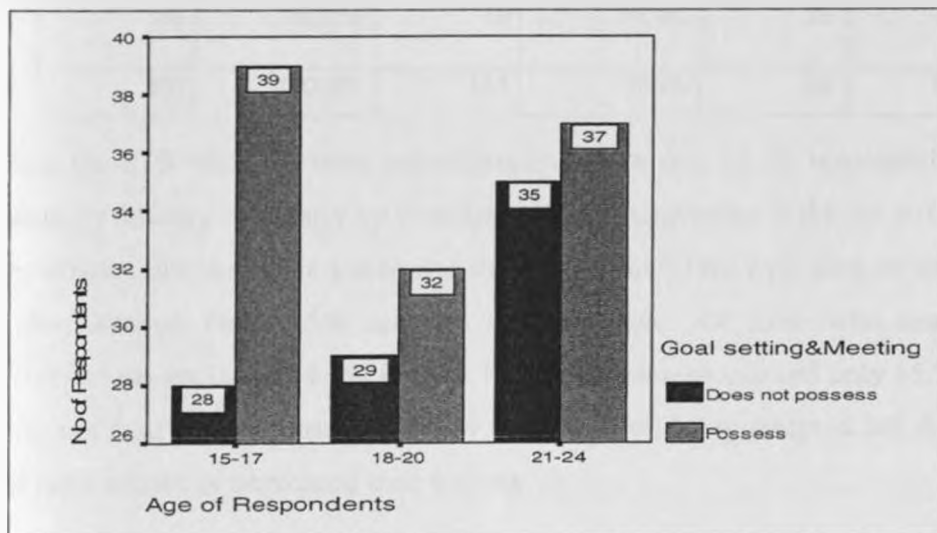
Decision making as regards to sexual behavior revealed that 62% of the respondents made a choice to have sex at early age especially for the male respondents (73%) which could be due to the social pressure upon men to have a sexual experience and also due to their upper hand in a sexual situation which could have made more male respondents to be sexually active than their female counterparts. Most of those who had sex made the choice at mainly ages 16-20 (34%) as compared to the other ages which showed that only 5% had sex before age 10, 14% aged 10-15 and 12.5% were ages 21-24. This is in relation to the national and international figures which reveal that young people become sexually active between ages 15-24 due to peer pressure, mass media which give conflicting messages that render young people vulnerable to HIV/AIDS infection (Cates and McPhetteers, 1997). As said earlier, this is also the age of highest HIV/AIDS infection as these combined issues [including lack of decision making life skills] lead to infection among young people between ages 15-24 according to Grooskurth et al (1995). Further realization of the study shows that the highest number of those who become sexually active made the choice in agreement with their partners (54%) ruling out the chances of coercion by the other partner although the focus group pointed out that the decision in first sexual encounter was the partner's choice who had the upper hand. This is true especially for young people as first exposure to sexual behavior at this tender age could lead to continuation in the same as Ritzer points out that to psychologists enforcers to before play a crucial role in strengthening or reinforcing a behavior. If the action has been rewarding to the actor, the same behavior is likely to be emitted in future in such situations (Ritzer 1996).

#### **f) Goal Setting and Accomplishment HIV/AIDS Life skills**

Goal setting and accomplishment HIV/AIDS life skills which reflects the capacity for an individual to manage difficult choices by making or delaying some decisions that are relevant to HIV/AIDS prevention was also tested among young people in Dandora. Majority of the respondents (54%) possessed the ability to set goal and accomplish them as compared to those who did not possess (46%). There was a relationship between this skill and sex of the respondents as more male 57% than female 47% youths in Dandora possessed goal setting and accomplishment life skills a competence which was important also in decision making. Setting goals was seen as important in

determining age at first sex of which as shown earlier most young people have engaged in sexual activity at an early age mainly between ages 16 to 20. This means the young people still need to these HIV/AIDS life skill to delay first sexual onset a problem which could be tackled by setting goals in life both for the current and future which could reduce their chances of HIV/AIDS infection.

**Figure 12: Goal Setting and Accomplishment Life skills**



### **g) Refusal and Negotiation Skills**

The study also examined the negotiation and refusal skills among respondents to assess their level of empowerment. This was to examine the ability of the young person's to bargain make a decision not engage in sexual activity when asked/forces by a friend/stranger. 67% of the respondents said they had been asked or forced to have sex by a friend/stranger while 33% said they had not been asked. Of those who had been asked/ forced, 46.6% were male while 59.4% were female. Those who had not been asked 46.4% were female while 53.6% were male as shown in Table 15.

**Table 6: Respondents Asked/Forced to Participate in Sex by Someone when they did not want**

ASKED/FORCED TO PARTICIPATE IN SEX BY SOMEONE						
		Yes(Asked/Forced			No (Asked/Forced)	
Sex		Sex			Sex	
	Frequency	Percentage (%)	Frequency	Percentage (%)	Frequency	Percentage (%)
Male	40	40.0%	54	40.6%	30	53.6%
Female	60	60.0%	79	59.4%	26	46.4%
Total	200	100.0%	144	100%	56	100.0%

Of those the 67% who had been asked/forced to have sex, 95.5% responded to the invitation by refusing reverently by considering the consequences of the act and giving the explanation that they were young and wanted to wait till the right time or other ran from the situation. Only 4.5% accepted the invitation. Of those who responded negatively to the invitation 84.5% felt that was their best response and only 15.5% felt that was not their best response. Especially those who said they accepted felt that they should have refused or negotiated their way out.

In a situation where the respondents were forced to have sex, the respondents stated their reaction would be to go to hospital for check-up (36.4%), talk to family about what happened (28.7%), keep it to themselves and try to solve it on their own (23.1%) or inform authorities in the area about what happened especially the chiefs, church leaders and teachers (11.8%). This was also mentioned in the focus groups although the participants in the focus group said they would mainly tell their closet friend or a favorable sibling with confidentiality of the matter not proceeding to other authorities or going to hospital. This is as shown in figure 19 below.

The high level of refusal and negotiation skills identified in this study indicated that young people are empowered on the issues of forced sex and are willing to share information with authorities so that the risk of infection would be reduced although this was not the same feeling in the focus group which the participants felt most young people would not disclose information when raped an indication of stigma associated with rape.



#### 4.2.2 Association between Age and Life Skills Competencies

The study tested the HIV/AIDS life skills against the age of respondents. The test was to find out if there was a relationship between age and HIV/AIDS life skills possessed by young people in Dandora. The study findings showed that there was no relationship between age and all the HIV/AIDS life competencies.

First and foremost the study showed no relationship between the age of young people in Dandora and critical thinking HIV/AIDS life skills competency. The study revealed that out of the 61% young people who did not possess critical thinking HIV/AIDS life skills, 21% were within the 15-17 age bracket, 18.5% within the 18-20 age bracket and 21.5% within the 21-24 age bracket. Of those who possessed 12.5% were aged 15-17, 14.5% within 18-20 age bracket and 14.5% aged 21-24. The tests of association between age and HIV/AIDS critical thinking life skills showed no relationship between the variable at chi-square 0.333, DF 2(5.99) <0.05 and probability of 0.936. This meant that possession or non-possession of HIV/AIDS critical thinking life skills was not determined by the age of the respondents as degrees of freedom within the age variables showed no significant difference of critical thinking HIV/AIDS life skills within the three age groups.

Creative HIV/AIDS life skills were also assessed against the age of the young people in Dandora. The study showed no significant level of association between the ages of the respondents and the creative HIV/AIDS life skills at chi-square 0.439, DF=2(5.99) <0.05 and P.803 as out of the 42.5% of young people who possessed the skills 13.5% were between 15-17 years, 13% between 18-20 years and 16.5% of the respondents between 21-24 years. Those who did not possess 20% were aged 15-17, 17.5% also 18-20 and 19.5% 21-24 and indication of no significant difference between the ages of those who possessed or did not possess.

There was no significant relationship between capacity to sustain relationships/friendship HIV/AIDS life skills and age ( $\chi^2 = 0.131$ , DF=2(5.99) <0.05, P0.937). This is indicated in the cross tabulation where out of the 62.5% of young people in Dandora who possessed this HIV/AIDS life skills 17.5% were aged 15-17,

15.5% were within the 18-20 age bracket and 18% within the 21-24 age bracket. Of the 50.5% those who did not possess 16% were within the 15-17 age bracket, 15.5% within 18-20 and 18 within 21-24 age bracket. This showed that the capacity of young people to sustain relationship or friendship was not determined by their ages but by other factors.

Only 42.5% showed they possessed problem solving and conflict resolution HIV/AIDS ability while the rest (57.5%) did not possess the life skills. Frequency count indicated that 32 of the respondents who possessed this life skills were within the age 15-17, 26 between ages 18-20 and 27 between ages 21-24. Of those who did not possess 35, 35, and 45 were aged 17-18 and 18-20 and 21-24 respectively. There was no significant relationship between possession of problem solving and conflict resolution life skills and age of respondents ( $\chi^2 = 1.496$ ,  $DF=2(5.99) < 0.05$ ,  $P 0.473$ ).

62.5% possessed decision making HIV/AIDS life skills while only 37.5% did not possess the life skills. The 62.5% who possessed this life skills; that is a count of 125 of the respondents interviewed, 47 were within the 15-17 age bracket, 38 within 18-20 age bracket and 40 within 21-24 age bracket as shown in figure 13 Their was no significant relationship between possession of decision making HIV/AIDS life skill and age of the respondents ( $\chi^2 = 3.155$ ,  $df=2(5.99) < 0.05$ ,  $P.206$ ).

54% of the respondents interviewed possessed goal setting and accomplishment life skills while 46% did not possess the life skill. Those who possessed 39 were within the 15-17 age bracket, 32 within the 18-20 age bracket and 37 within the 21-24 age bracket shown in figure 14 below. There was no significant relationship between possession of goal setting and accomplishment HIV/AIDS life skills and age ( $\chi^2 = 0.734$ ,  $DF=2(5.99) < 0.05$  and  $P.693$ ).

Hence the summary of the frequency count of the relationship between the ages of the young people and the various HIV/AIDS life skills is as illustrated in table below.

**Table 7: Cross Tabulation of Age and Various HIV/AIDS Life Skills Competencies**

HIV/AIDS Life Skills Competencies		Age			Total
		15-17	18-20	21-24	
<b>Critical Thinking HIV/AIDS life skills</b>					
Does not Possess	Frequency	42	37	43	122
Possess	Percentage	21.0%	18.5%	21.5%	61.0%
Does not Possess	Frequency	25	24	29	78
Possess	Percentage	12.5%	12.0%	14.5%	39.0%
<b>Creative HIV/AIDS Life skills</b>					
Does not Possess	Frequency	40	35	39	114
Possess	Percentage	20.0%	17.5%	19.5%	57.0%
Does not Possess	Frequency	27	26	33	86
Possess	Percentage	13.5%	13.0%	16.5%	43.0%
<b>Sustaining Relationship/Friendship HIV/AIDS Life Skills</b>					
Does not Possess	Frequency	32	31	36	99
Possess	Percentage	16.0%	15.5%	18.0%	49.5%
Does not Possess	Frequency	35	30	36	101
Possess	Percentage	17.5%	15.0%	18.0%	50.5%
<b>Problem Solving and Conflict Resolution HIV/AIDS Life Skills</b>					
Does not Possess	Frequency	35	35	45	115
Possess	Percentage	17.5%	17.5%	22.5%	57.5%
Does not Possess	Frequency	32	26	27	85
Possess	Percentage	16.0%	13.0%	13.5%	42.5%
<b>Decision Making HIV/AIDS Life Skills</b>					
Does not Possess	Frequency	20	23	32	75
Possess	Percentage	10.0%	11.5%	16.0%	37.5%
Does not Possess	Frequency	47	38	40	125
Possess	Percentage	23.5%	19.0%	20.0%	62.5%
<b>Goal Setting HIV/AIDS Life Skills</b>					
Does not Possess	Frequency	28	29	35	92
Possess	Percentage	14.0%	14.5%	17.5%	46.0%
Does not Possess	Frequency	39	32	37	108
Possess	Percentage	19.5%	16.0%	18.5%	54.0%

### 4.2.3 Association between Sex and Life Skills Competencies

The study sought to find out whether there was relationship between sex and the various HIV/AIDS life skills competencies. The study revealed a significant relationship between the various factors and sex in which more males possessed the HIV/AIDS life skills than their female counterparts.

The first life skill that was assessed was critical thinking HIV/AIDS life skills. By sex, 60.3% male and 39.7% female possessed critical HIV/AIDS life skills while 34.4% male and 65.6% female did not possess critical life skills. The study showed a significant relationship between sex and possession of critical life skills at  $\chi^2=12.854$ ,  $DF=1(3.84) >0.05$  and Probability of 0.000 in which 60.3% of male possessed more life skills than female (39.7%) as shown in the cross tabulation table 8 below.

**Table 8: Cross Tabulation of Sex and Possession of Critical Thinking Life Skills Competencies**

			The life skills competencies Respondents Possess		Total
			Does not possess	Possess	
Sex	Male	Frequency	42	47	89
		Percentage	34.4%	60.3%	44.5%
	Female	Frequency	80	31	111
		Percentage	65.6%	39.7%	55.5%
Total		Frequency	122	78	200
		Percentage	100.0%	100.0%	100.0%

There was a relationship between sex and creative HIV/AIDS skills which from the cross tabulation below pointed that more male possessed the skills than females at chi-square 4.936,  $DF=1(3.84) >0.05$  and  $P.206$ . This meant that sex of the young people in Dandora consequently affected the creative HIV/AIDS life skills (see table 9).

**Table 9 Cross tabulation of Sex and Creative and organizational life skills**

			Creative and Organizational life skills		Total
			Does not possess	Possess	
Sex	Male	Frequency	43	46	89
		Percentage	37.7%	53.5%	44.5%
	Female	Frequency	71	40	111
		Percentage	62.3%	46.5%	55.5%
Total		Frequency	114	86	200

The study also showed an association between sex and possession of sustaining relationship/friendship life skills at  $\chi^2 = 0.342$ ,  $DF=2(3.84) < 0.05$  and  $P=0.559$  where 42% of male and 54.4% female did not possess the sustaining relationship/friendship HIV/AIDS life skills while 46.5% and 53.5% said they possessed the life skills as shown in table 10.

**Table 10 Cross Tabulation of Sex and Sustaining Relationship/Friendship Life Skills**

			Sustaining Relationship/Friendship Life Skills		Total
			Does not possess	Possess	
Sex	Male	Frequency	43	46	89
		Percentage	37.7%	53.5%	44.5%
	Female	Frequency	71	40	111
		Percentage	62.3%	46.5%	55.5%
Total		Frequency	114	86	200

Against sex, 34.4% male and 62.6% female did not possess problem solving and conflict resolution life skills while 54.1% male and 45.9% female said they possessed the HIV/AIDS life skills. There was a relationship between sex and possession of life skills at chi-square 5.537,  $DF 1(3.84) < 0.05$  and probability of 0.019 which leaned towards less female (45.9%) than male (54.1%) possessing problem solving and conflict resolution life skills as shown in the cross tabulation table 11 below.

**Table 11: Cross tabulation of Sex and Possession of Problem Solving Life Skills**

			Problem Solving Life Skills		Total
			Does not possess	Possess	
Sex	Male	Frequency	43	46	89
		Percentage	37.4%	54.1%	44.5%
	Female	Frequency	72	39	111
		Percentage	62.6%	45.9%	55.5%
Total		Frequency	115	85	200
		Percentage	100.0%	100.0%	100.0%

These showed abilities resulting to more male (54.1%) than female (45.9%) possessing the HIV/AIDS life skills as reflected in figure 12.

**Table 12: Cross tabulation of Sex and Possession of Decision Making Life Skills**

			Decision Making		Total
			Does not possess	Possess	
Sex	Male	Frequency	34	55	89
		Percentage	45.3%	44.0%	44.5%
	Female	Frequency	41	70	111
		Percentage	54.7%	56.0%	55.5%
Total		Frequency	75	125	200
		Percentage	100.0%	100.0%	100.0%

The study showed that 34.8% male and 65.2% female did not possess goal setting and accomplishing life skills while 52.8% male and 47.2% female said they possessed goal setting and accomplishment life skills. There was a relationship between sex and possession of goal setting and accomplishing life skills at  $\chi^2=6.514$ ,  $DF=2(5.99) >0.05$  and  $P.011$ ).

**Table 13: Cross Tabulation of Sex and Possession of Goal Setting and Accomplishment Life Skills**

			Goal Setting and Accomplishing Life Skills		Total
			Does not possess	Possess	
<b>Sex</b>	Male	Frequency	32	57	89
		Percentage	34.8%	52.8%	44.5%
	Female	Frequency	60	51	111
		Percentage	65.2%	47.2%	55.5%
<b>Total</b>		Frequency	92	108	200
		Percentage	100.0%	100.0%	100.0%

The finding above which indicated a significant relationship between sex of the young people and the various HIV/AIDS life skills competencies where more males than females had a higher level of HIV/AIDS was also reflected in the literature review. There is a gender bias towards females where more females than male are deprived of education and access to information. According to UNICEF et al (2002) female youths are at risk of contracting the HIV/AIDS because they lack the knowledge on HIV/AIDS and skills to handle HIV/AIDS situations.

#### **4.2.4 HIV/AIDS PREVENTION TECHNIQUES EMPLOYED BY YOUNG PEOPLE IN DANDORA**

The second objective of this study was to describe the prevention techniques employed by young people in preventing HIV/AIDS. As said in the literature review HIV/AIDS prevention is paramount in the fight against HIV/AIDS amongst the other HIV/AIDS intervention strategies. This means as EFA Global report (2005) pointed out prevention of HIV infection must be approached by action to reduce and avoid individual risk and empowerment which involves the interaction of broader environmental factors. This study examined these three levels of prevention where the respondents' knowledge, attitude, behavior and actions were tested.

First, the study sought to find out the level of understanding among young people in Dandora of HIV/AIDS. From the qualitative data gained, the young people had a fair understanding of HIV/AIDS. This included the understanding that HIV/AIDS is an Immunodeficiency disease acquired from other people and leads to AIDS; HIV/AIDS is

a sexually transmitted disease; a blood disease; a killer disease and lastly a hormonal disease. All this were basic understanding of HIV/AIDS although most of the respondents focused on the fact that HIV/AIDS is sexually transmitted, an understanding which did not include the other aspects of transmission. More than half of the young people (67.5 %) said they had come in contact with a HIV/AIDS person while 32.5% had not come in contact with any. Of those who said they had come in contact with a HIV positive person, 22.5% made the conclusion they were positive based on their health condition, 27.5% were told by the HIV positive person themselves, 15% learnt of their status from neighbors and family members while 4% learnt from other avenues i.e. from the VCT or they themselves were positive. This finding indicated that the young people were familiar with HIV/AIDS transmission, effects and consequences on the individual.

The respondents also had a fair knowledge on HIV/AIDS prevention techniques. As noted from the research 77% talked about HIV/AIDS issues which were also the main prevention techniques they employed to reduce their risk of preventing HIV/AIDS infection. This included abstinence which was listed by 50.5% as the most common prevention technique, delay of sexual onset (16.5%), being faithful to one partner(37%), 31% said avoiding sharp object like syringes, needles, sharing of circumcision objects and razor blades, 43% of respondents stated use of a protection (condoms) during sexual activity, 9.5% said avoiding blood contact especially during transfusion, 5% said avoiding deep kissing while 10.5% listed visiting a voluntary counseling centre as a way of reducing and avoiding risk of contraction of HIV/AIDS. This also came up in the focus group discussion and deep kissing reinforced as the silent risky behavior that many are engaged to avoid contracting the virus but expose themselves to the virus unknowingly. This figures are almost consistent although differ in percentage with the UNAIDS 2008 progress report on the global AIDS epidemic that indicated that among 15- to 24-year olds living in low- and middle-income countries, only 24 per cent have comprehensive correct knowledge of HIV, which means they can correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), reject the two most common local misconceptions about HIV transmission and



know that a healthy-looking person can have HIV. This figure is far short of the UNGASS target of 95 per cent by 2010. Moreover, only 9 of the countries reporting survey data collected between 2000–2006 have reached at least 50 per cent coverage of comprehensive correct knowledge of HIV among young men or women aged 15–24. (2008)

Some of the young people felt they were not at risk of contracting HIV infection (44.5%) while 53.5% felt they were not at risk of infection although 62% who said they have had sex with one or more of their partners. Those who were sexually active, 67.7% said they used a precaution which was use of a condom while 32.3% said they did not use any precaution. Of those who used the precaution or condom 80.6% also felt it reduced their risk of contracting the virus while 19.4% said it did not reduce their risk of contracting the virus. Condom was considered the main precaution used by young people in Dandora as revealed by the focus group as it reduces chances of contracting the virus and helped girls not to become pregnant. The others mentioned was use of pills although this was not common among young people. This is as shown in the table 14.

**Table 14: Distribution of Sexually Active, Use of Precaution and Perception to Contraction of HIV/AIDS**

	Had sex with girlfriend/boyfriend		Use of Precaution		Use of Precaution and Perception of Risk of contracting HIV/AIDS	
	Frequency	Percentage (%)	Frequency	Percentage (%)	Frequency	Percentage (%)
Yes	124	62.0%	84	67.7%	100	80.6%
No	76	38.0%	40	32.3%	24	19.4%
Total	200	100.0%	124	100.0%	124	100.0%

Majority of the youths have also had an HIV test (54%) which showed that many young people wanted to know their status so that they can plan and make better decisions for their future although 46% had not done an HIV test due to the fears associated with test which has also been identified in the rest of the society. NACC report showed that

many people [including young people] have not gone for the rest due to the fear of dyeing faster from stress of knowing their status (2004).

The study also tested the young people's stand on various HIV/AIDS issues. This was to examine the level of empowerment among the young people by testing their knowledge and attitude towards various HIV/AIDS issues. One area the study sought to assess was the whether a person needed to know and reveal their HIV/AIDS status to their partners. Findings revealed that 38% of the respondents strongly agreed that they needed to know the HIV status of their sexual partners before engaging in sex, 14.5% disagreed 8.5% were neutral on the matter, 15% agreed while 24% strongly disagreed that one needed to reveal their HIV/AIDS status before engaging in sexual activity.

This was further stretched to examine whether one needed to know all the status of their sexual partners/boyfriend/girlfriend and 22% of the respondents strongly disagreed that they needed not know the status of their partners, 22% disagreed, 20% were neutral, 8% agreed while 28% strongly agreed that they always know the status of all their sexual partners. This indicated a gap between the desire to know the partners status and the fact that they really know the status of their partners/girlfriend/boyfriend. This gap could be due to the fact personal status is a confidential issue which does not need to be shared hence the rare occurrence that one would know the status of their partners.

In relation to the above statement, 21.5% strongly disagreed that they can get HIV/AIDS from any of their partners no matter how long they have known them, 9% disagreed, 9% were neutral, 17% agreed while 43.5% strongly agreed to the above statement. Assessment can be made that many of the young people in Dandora were familiar with the effect of HIV/AIDS and the need to use preventive measures as also minority felt that that partners relating sexually needed to decide the kind of precaution to use together and not independently. A minority of the young people (7.5%) strongly disagreed that partners need to decide use of condoms together, 2.5% were in disagreement, 11.5% where neutral, 28.5% agreed while 50% strongly agreed that partners relating sexually need to decide the kind of precaution to use together. The high agreement to the need for partners to decide to use condom together is also a

reflection of behavior among respondents where it was noted earlier than 67% of the sexually active young people used condom as a preferred mode precaution and also the agreement that the use of precaution reduced their risk of contracting the HIV (80.6%). Those who disagreed or strongly disagreed with the statement could have based the myths which were listed in the focus group that condom is not 100% effective, it reduces sexual pleasure and the stigma associated with purchase of condoms in the community.

Assessment on the attitude of young people towards the attitude of partners to choose their sexual partners and not to reveal their status to their sexual partners revealed many young people were not in agreement with this information. This is because 37.5% in strongly disagreement, 17% disagreed, 13.5% were neutral, 13.5% agreed while 18.5% strongly agreed that not revealing and choosing your partners was important. This indicate a fairly balanced level of awareness among the respondents as also the overall stand in the society is that matters revolving an individual should held with confidentiality and people whether positive or negative need to choose their sexual partners without discrimination.

From the study 38% strongly disagreed with the stand that their was no problem in having sex with before marriage, 14.5% disagreed, 15.5% were neutral, 11% agreed and 21% strongly agreed with this stand. The strong disagreement to this statement indicated a popular notion that young people already were sexually active (62% of respondents) and this statement was a challenge to their sexual behavior which was contradiction to their attitude. 73.5% felt that HIV/AIDS was an issue of both the young and the old and should be addressed at all level.

Awareness level of the risk of HIV/AIDS transmission and its effect on all ages and levels of society was also high. This is indicative of the fact that 59% strongly disagreed that HIV/AIDS is a disease of older people and not the young, 13.5% disagreed, 9.5% were neutral on the statement, 4.5% agreed while 13.5% strongly agreed with the fact that HIV/AIDS is an issue that transcend age and all ages should be involved in reducing its magnitude in the society. The summary of the frequency and

percentage of young people's views and feeling concerning these different HIV/AIDS issues is shown in the Table 16.

**Table 15: Respondents Views and Feeling on Various HIV/AIDS Issues**

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a. Need to know HIV status of Sexual Partners	Frequency	76	29	17	30	48
	Percentage (%)	38.0%	14.5%	8.5%	15.0%	24.0%
d. I always know the HIV status of all my partners (Boyfriend/girlfriend)	Frequency	44	44	40	16	56
	Percentage (%)	22.0%	22.0%	20.0%	8.0%	28.0%
c. I can get HIV/AIDS from any of partners no matter how long I have known them	Frequency	43	18	18	34	87
	Percentage (%)	21.5%	9.0%	9.0%	17.0%	43.5%
d. Partners(Boyfriend/girlfriend relating need to know the kind of precaution to use together	Frequency	15	5	23	57	100
	Percentage (%)	7.5%	2.5%	11.5%	28.5%	50.0%
e. Using a Condom as a Precaution during sex does not reduce the risk of contracting HIV/AIDS	Frequency	41	42	32	44	41
	Percentage (%)	20.5%	21.0%	16.0%	22.0%	20.5%
f. People should be given the right to choose their sexual partners and not reveal their HIV status during sexual intercourse	Frequency	75	34	27	27	37
	Percentage (%)	37.5%	17.0%	13.5%	13.5%	18.5%
g. Their is no problem in having sex before marriage	Frequency	76	29	31	22	42
	Percentage (%)	38.0%	14.5%	15.5%	11.0%	21.0%
h. HIV/AIDS is an issue of older people not young people	Frequency	118	27	19	9	27
	Percentage (%)	59.0%	13.5%	9.5%	4.5%	13.5%

#### **4.2.5 CONSEQUENCES OF LIFE SKILLS CAPACITY ON SEXUAL BEHAVIOUR NECESSARY IN HIV/AIDS PREVENTION**

The third objective of this study was to assess the consequent effect of these HIV/AIDS life skills capacities on sexual behavior necessary in HIV/AIDS prevention. This was to assess whether the young people in Dandora considered the effect of their behavior as a risk to HIV/AIDS infection. Life skills are important because they give an individual the ability to analyze situations, the behavior of individuals and consequences of their own actions, prior to engaging in those actions. They also enable the individual to avoid certain situations by helping them understand risky behavior and how to manage or avoid risky situations (UNICEF 2005). As stated in the conceptual framework, the possession of HIV/AIDS life skills can enable an individual to creatively think through the complex existing situations and environment and make a rational choice to not put themselves in risky situations that contribute to HIV/AIDS infection.

As noted earlier most young people did not possess the various life skills pointed out in this study. Also it was noted that more than half of the respondents (62%) were sexually active. A Study in Kenya showed that perception of risk and high knowledge about HIV/AIDS does not necessarily translate to behavior change. Even in the face of existing perception and knowledge of self-risk, risk taking behavior (multiple partners, sex with high risk partners, no condom use, healthy-looking person does not have HIV/AIDS, etc), is still high (Ruto, 2001). This is also the case in this study where despite the fair knowledge on HIV/AIDS prevention many young people are still sexually active.

The young people who said they were sexually active, 73% were male while 52.3% were female. By age 38.8% were within the 15-17 age bracket, 65.6% within 18-20 age bracket, and 79.2% within the 21-24 age bracket. This is a further indication that most young people did not have the life skills necessary to affect their behavior for HIV/AIDS prevention. Due to the lack of life skills their high sexual activity increased their level to contract the HIV/AIDS virus. The key informants also noted that many young people continue to be infected due to the high level of sexual activity among them. This is because HIV/AIDS spread has persistently increased over time as more

young people continue contracting the virus especially with the introduction of ARVs which has made people become more promiscuous.

All the key informants pointed out the youth are the worst hit by the HIV/AIDS pandemic in Dandora area. This is because most of them do not have information on HIV/AIDS issues and other sexually transmitted diseases. They are also idle and easily succumb to HIV infection especially for girls who fall prey to prostitution. Poverty, drug abuse has also contributed to the high infection rate among young people in the area. Most of their strategies which include campaigns, voluntary counseling and testing, increasing young people's participation in productive activities have not bore fruit because do not abstain but chose to engage in sexual activity. There was also a tendency of inconsistency to use of condoms among those who use as they only use them the first time with the partner and after that they don't use as they seem to trust their partners in following sexual encounters with the same partner. This increases chances of infection as not many young people are faithful to one partner. According to UNICEF many young people in the age group 15–24 engage in unsafe behavior. Condom use during higher-risk sex is increasing but still very low, ranging from 31 per cent among young women in sub-Saharan Africa, for example, to 59 per cent among young men in South Asia. Condom promotion and use has been less successful in high prevalence countries of sub-Saharan Africa, where most HIV transmission occurs during long-term relationships in which condoms are seldom used (2007).

#### **4.2.6 Association between HIV/AIDS Life Skills Competencies and Sexual Behavior**

The study also tested the hypothesis that life skills capacities have an effect on sexual behavior of young people in Dandora area. This was to ascertain whether young people considered their risk of infection by using the various competencies they possessed to prevent themselves from contracting HIV/AIDS infection.

A look into the relationship between HIV/AIDS life skills and sexual behavior among young people and revealed no association between sexual behavior and HIV/AIDS life skills competencies. Critical thinking HIV/AIDS life skills was tested at chi-square

3.072, 2(0.599<0.05 degrees of freedom and probability of 0.038 and there was no relationship between this two variables. Sustaining relationship/friendship and sexual activity were tested at chi-square  $\chi^2=1.264$ , DF=2(0.599<0.05 and probability of 0.532 and there was also no relationship between the two variables. Problem solving was also tested at chi-square 0.734, DF=2(0.599<0.05 and P.181 and there was also no relationship between the two variables. Decision making and sexual activity ( $\chi^2=3.414$ , DF=2(0.599<0.05 P.190) had also no association. Goal setting and accomplishment was also tested against sexual activity chi-square  $\chi^2= 1.443$ , DF=2(0.599<0.05 P.482 and there was no association between the two variables.

The lack of association between this variables indicate that the sexual behavior of respondents was not due to the life skills individuals possessed but by other factors such as the social, economic, or political environment this young people existed in. This means that despite the high level of sexual activity among respondents, it was not necessarily due to the possession problem solving, decision making, capacity to sustain relationships/friendships and goal setting/accomplishment HIV/AIDS life skills but due to other factors.

However creative and organization HIV/AIDS showed a significant relationship at  $\chi^2= 6.535$ , DF=2(0.599>0.05 P.215. The cross tabulation leaned towards the fact that more young people who did not possess the life skills were sexually active. This could be because as indicated in the conceptual framework, [these young people] are unable to creatively think through complex situations that contribute to HIV/AIDS and make rational choice not to engage in sexual behavior. Hence the high chances that lack of creativity among respondents has lead to the high sexual activity consequently affecting the other life skills competencies and leading to the high infection rate among young people. This could also be an indication of a lack of proper utilization of HIV/AIDS prevention techniques they listed in this study. The association between sexual behavior and the various HIV/AIDS life skills is as shown in the table 13.

**Table 16: Association between Sexual Behavior and Life Skills Competencies**

Variable	Life Skills Competencies			Significance
	Does not Possess	Possess	Totals	
<b>Sexual Activity</b>	<b>Critical Thinking life skills</b>			
Yes	80 (65.6%)	43(55.1%)	123	$\chi^2 = 3.072, df=2(0.599<0.05, P.038$
No	41 (33.6%)	35(44.9%)	76	
	<b>Creativity and organizational life skills</b>			
Yes	78 (68.4%)	45(52.3%)	123	$\chi^2 = 6.535, df=2(0.599>0.05$ P.215***
No	32(30.7%)	41(47.7%)	76	
	<b>Sustaining relationship and friendship life skills</b>			
Yes	63(63.4%)	60(59.4%)	123	$\chi^2 = 1.264, df=2(0.599<0.05 P.532$
No	36 (36.4%)	40 (39.6%)	76	
	<b>Problem solving and conflict resolution skills</b>			
Yes	76(66.1%)	47 (55.3)	123	$\chi^2 = 0.734, df=2(0.599<0.05 P.181$
No	38 (33%)	38 (44.7%)	76	
	<b>Decision making life skill</b>			
Yes	50 (66.7%)	73(54%)	123	$\chi^2 = 3.414, df=2(0.599<0.05 P.190$
No	24(32%)	52(41.6%)	76	
	<b>Goal setting and accomplishment life skills</b>			
Yes	58(63%)	65 (60.2%)	123	$\chi^2 = 1.443, df=2(0.599<0.05 P.482$
No	33(35.9)	43 (39.8%)	76	

\*\*\*Significant Association



# CHAPTER FIVE

## 5.0 SUMMARY , CONCLUSIONS, AND RECOMMENDATIONS

### 5.1 SUMMARY

200 respondents were interviewed in this study which was 100% turnout and 7 key informants unlike the expected 10 due to time constraints and lack of resources. By age their was an almost balance among young people interviewed as 36% were ages 21-24, 33.5% between the age of 15-17 and the rest (30.5%) in the 18-20 age bracket. This indicated an almost balance in the ages of respondents in the study. There were more female (55.5%) than male (44.5%) respondents in the study with the majority affiliated to protestant (46%) and catholic (43%) religions. Also majority had attained a secondary education certificate (43.5%) and were involved in productive activities, 51% mainly going to school/college and 37% engaged in casual work in the community. This removes the assumption that most young people are idle as only 12% of the respondents stated that they stay at home.

The study indicated that majority of the respondents did not possess most of the HIV/AIDS life skills indicated in this study indicating the high risk of HIV/AIDS infection although most indicated that decision making (32%) was the most important life skill, followed by creative an organizational life skills (16.5%), then critical thinking (11%), 10.1% considered sustaining relationship/friendship while 8% problem solving/conflict resolution the rest being goal setting and accomplishment. The study was also a significant relationship between the life skills measured in this study including critical thinking, creativity and organizational life skills, decision making, problem solving/conflict resolution, sustaining relationship/friendship and goal setting and accomplishment and sex of the young people indicating that more female lacked life skills than their male counterpart indicating this susceptibility to HIV/AIDS infection although the study showed that more male (73.7%) than female (52.3%) were sexually active. Despite this there was no relationship between the life skills measured and the age of the young people.

HIV/AIDS prevention techniques were also examined in this paper. The study revealed that most of the young people in Dandora had a fair knowledge on HIV/AIDS although this knowledge mainly relied on sexual behavior. The young people in this paper interviewed saw HIV/AIDS as immunodeficiency disease mainly transmitted through sexual behavior. This information which was basic and true although there is need for it to be expanded to knowledge on other areas transmissions such as blood contact and mother to child transmissions.

The respondents also had a fair knowledge on HIV/AIDS prevention techniques. 77% talked about HIV/AIDS issues with their partners/girlfriend/boyfriend mainly focusing on faithfulness, abstinence, precautions to avoid infection, ways of transmission and effect of the disease incase of infection. From the personal interview and focus group they also listed prevention techniques they employed as including the abstinence, prevention of blood contact, delay of sexual onset, use of a condom and Voluntary counseling and testing. Although it was noted from the focus group and key informants that despite the high rate of sexual activity among young people most of the young people did not use condoms consistently as many used it at first encounter with a sexual partner and tended to relax at the consequent encounters with increased familiarity with the specific sexual partner. The young people on the other hand felt they were not at risk of contracting HIV infection (44.5%) while 53.5% felt the were not at risk of infection.

The study also tested the young people's stand on various HIV/AIDS issues. The stands taken by young people indicated a fair level of empowerment among respondents portrayed by their attitudes towards certain behavior, desire to avoid and reduce their risk of infection. Examination of the key informants interviews indicate that many young people are infected due to lack of social amenities and economic activity which render them idle and succumb to HIV infection. Hence a multifaceted approach needs to be employed to reduce and avoid risk of infection among young people in Dandora area.

## 5.2 CONCLUSIONS

In conclusion, study revealed that the sexual behavior of many young people in Dandora leads to high infection rate in the community. More and younger people in the area continue to grapple with the disease due to their sexual behavior which has been contributed due to their economic status, lack of social amenities and myths held by many people in the community concerning HIV/AIDS.

Further there is a gap between sexual behavior and possession of life skills; that is a gap between knowledge and practice. As the study indicated many young people had a fair knowledge on HIV/AIDS issues but this knowledge was not able to lead to prevention from engaging in sexual activity as the study showed more than half of the young people were sexually activity. This gap is the lack of HIV/AIDS life skills among the young people which due to its absence, many young people were not able to critically and creatively think through behavior before they engaged in it, make concrete decisions based on the consequences of such actions especially with the high rate of HIV/AIDS infection.

Many of the young people in Dandora do not possess necessary life skills to reduce HIV/AIDS avoidance and reduction despite having a fair know how on the various prevention techniques they could employ. They did not possess HIV/AIDS life skills which could be effective in delay of onset of sexual intercourse and among experienced youths in increasing the consistency of use of condoms at all sexual encounters and decreasing the number of sexual partners.

Hence sexual behaviors which have been learnt over time needs to be unlearnt through reinforcement of positive behavior that would reduce and avoid the risk of infection among young people in Dandora area. This is because possession of life skills is the best form of empowerment that can be employed among people to reduce the spread of HIV/AIDS within this age category. The young people can therefore be empowered especially in prevention if they are helped to find a source of income to keep them bus and awareness on HIV/AIDS prevention is raised.

### 5.3 RECOMMENDATION

The summary and conclusions lead us to make recommendations both to policy makers, institutions and organizations working with young people. It has become profound from this paper that there is gap between possession of life skills, sexual behavior and HIV/AIDS prevention among young people.

- Both governmental and non-governmental organizations to strengthen their efforts on youth specific intervention programmes that can enhance life skills and reduce infection among young people both nationally and locally.
- More campaigns and awareness on the HIV/AIDS related issues that young people grapple need to be implemented to increase knowledge among young people of HIV/AIDS prevention
- This means that life skills curriculum should continue to be employed and reinforced in formal and informal schools so that more young people will adopt positive behavior necessary for HIV/AIDS prevention.
- Further more specific intervention strategies such as encouraging young people to attend VCT, enhancement of family and communal values need to be employed to encourage young people in positive behaviors that would reduce HIV/AIDS infection.
- The government and non-governmental organizations need to also reach out to young people through facilitating accessibility to necessary resources that will help young people in participating in gainful economic activity that will keep them busy and reduce idleness, an issue that has come up as a major contributor to HIV infection.
- Lastly, more research need to be done to determine how this intervention strategies can be employed to increase young people participation in making their own future HIV/AIDS free and prosperous where the intervention strategies are acceptable among this age group and have consequent effect on increasing HIV/AIDS life skills and reducing HIV/AIDS infection among young people in Dandora, Kenya and the world at large.

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## 7.0 APPENDIXES

### QUESTIONNAIRE:

#### HIV/AIDS LIFESKILLS CAPACITIES AMONG YOUNG PEOPLE IN DANDORA AREA

My name is Brenda Erukei, a Postgraduate student at the UON. I am doing a research to assess the life skills capacities for young people in HIV/AIDS prevention. The information you provide will be handled with confidentiality.

DIVISION \_\_\_\_\_

DATE: \_\_\_\_\_

PHASE: \_\_\_\_\_

QUESTIONNAIRE NO: \_\_\_\_\_

#### SECTION A: PERSONAL INFORMATION

1. AGE: (Tick the age bracket to which you belong)

(15-17)

(18-20)

(21-24)

2. SEX:

Male

Female

3. What is your religion/denomination?

1). Catholic

2). Protestant

3). Muslim

4). Others (please specify) \_\_\_\_\_

4. What is the highest level of education that you have attained?

1). Did not go to school

2). Did not complete primary

3). Primary school certificate

4). Secondary school certificate

5). Obtained college certificate/ Diploma

6). University degree

5. How do you spend your day?

1). I go to school/college	<input type="checkbox"/>
2). I do casual work	<input type="checkbox"/>
3). I stay at home	<input type="checkbox"/>
4). Others(specify) _____	

**SECTION B: BASIC LIFE SKILLS COMPETENCIES (Tick appropriately)**

6.	Which of the abilities below do you possess? (Tick those applying to you)	✓
a)	I am able to think critically about an issue	
b)	I am creative and organized in the way I present things to other people	
c)	I am able to sustain friendships and relationships with people	
d)	I am able to resolve conflicts and problems in my life	
e)	I am able to make good decisions concerning my life	
f)	I am able to make and accomplish goals I make in life	

7. Which of the above abilities and skills do you consider most important to you?

- a) Thinking critically about issues
- b) Being creative and organized in the way you present things
- c) Keeping and sustaining friendships and relationships
- d) Resolving conflicts and problems
- e) Making good decisions concerning your life
- f) Making and accomplishing goals

8. How did you acquire these abilities and skills?

- i. I learnt from friends
- ii. I learnt from my family
- iii. I learnt from my own experience with people
- iv. I learnt in school
- v. Others (please specify) \_\_\_\_\_

9. Do you have a girlfriend or boyfriend?

- Yes
- No

10. What influences or what would influence your choice of the girlfriend or boyfriend you want? (Tick those applying to you)

- a) Beauty and personality
- b) Friends
- c) What I see in Media
- d) Tribe
- e) Religion
- f) Similar Interests
- g) Others (please specify) \_\_\_\_\_

11. How long do you keep a girlfriend/boyfriend?

- a) Less than a week
- b) Less than a month
- c) Months
- d) One year
- e) More than one year
- f) Others (please specify) \_\_\_\_\_

12. Once you become someone's boyfriend or girlfriend what do you expect from them?

- a) Your friendship
- b) Gifts
- c) Sex
- d) Faithfulness and commitment
- e) Others \_\_\_\_\_

13. What are you required to offer them?

\_\_\_\_\_

\_\_\_\_\_

### SECTION C: HIV/AIDS AND LIFE SKILLS COMPETENCIES

14. What do you understand by HIV/AIDS?

\_\_\_\_\_

15. Do you know of any HIV/AIDS person in your community?

Yes

No

16. How did you know they were HIV+

a) From neighbors

b) I saw they looked sick and concluded they were positive

c) They told me themselves

d) Others( please specify) \_\_\_\_\_

17. a) Do you consider yourself at risk of contracting HIV virus?

Yes

No

b) If no. why? \_\_\_\_\_

18. Do you talk about HIV/AIDS with your girlfriend/boyfriend?

Yes

No

19. What do you mainly focus on during these discussions?

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20. Have you ever had sex with any of your partners (girlfriends/boyfriends)?

Yes

No

21. At what age did you first have sex?

a. Less than 10 years

b. 10-15 years

c. 16-20 years

d. 21 to 24

e. I have not had any

22. Was having sex at that time your choice or your partner's (girlfriend/boyfriends) choice?

a) It was my choice

b) It was my partner's choice

c) Both of us made the choice

23.	How many sexual partners have you had? a) One <input type="checkbox"/> b) Two <input type="checkbox"/> c) Three <input type="checkbox"/> d) Four <input type="checkbox"/> e) Others specify _____
24. a)	During the time you had sexual intercourse did you use any precautions to avoid pregnancy or contracting HIV/AIDS or Sexual transmitted diseases? Yes <input type="checkbox"/> No <input type="checkbox"/>
b)	If yes, what did you use? _____
c)	If you used one, do you think the kind of precautions you used reduced your risk of contracting HIV/AIDS? Yes <input type="checkbox"/> No <input type="checkbox"/>

25. What other ways can someone use to avoid and reduce their risk of contracting HIV infection? (list at least three)

- i. \_\_\_\_\_
- ii. \_\_\_\_\_
- iii. \_\_\_\_\_
- iv. \_\_\_\_\_
- v. \_\_\_\_\_

26. Are there times when someone had asked you to have sex with them and you did not want?

Yes

No

27. How did you respond to the invitation to have sex with them?

\_\_\_\_\_

a) Was that the best response?

Yes

No

b) If no, what would be the best response in such a situation?

---

c) In case you are forced into a sexual intercourse, how would you react?

i. I would talk to my parents about it

ii. I would go to hospital and get treatment

iii. I will keep it to myself and try to solve it

iv. I will tell other people around me i.e. teachers, chief about it

v. Others (please specify) \_\_\_\_\_

d) Please tick the number that best describe your feeling concerning HIV/AIDS prevention. The numbers represent the following responses:

(1=strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=strongly Agree)

a)	I need not to know and reveal my HIV status to any of my sexual partners (girlfriend/boyfriend)	⊗1	2	⊗3	4	5☺
b)	I always know the status of all the partners (girlfriend/boyfriend) I relate with	⊗1	2	⊗3	4	5☺
c)	I can get HIV/AIDS from any of my sexual partners no matter how long I have known them	⊗1	2	⊗3	4	5☺
d)	Partners (boyfriend/girlfriend) relating sexually need to decide the kind of precautions to use together	⊗1	2	⊗3	4	5☺
e)	Using a condom as a precaution during sex does not reduce the risk of contracting HIV/AIDS	⊗1	2	⊗3	4	5☺
f)	People should be given a right to choose their sexual partners and not to reveal their status during sexual intercourse	⊗1	2	⊗3	4	5☺
g)	There is no problem in having sex before marriage	⊗1	2	⊗3	4	5☺
h)	HIV/AIDS is an issue of older people and it should not bother young people	⊗1	2	⊗3	4	5☺

28. a) Have you ever gone for an HIV test?

Yes

No

b) If yes, what were your reasons?

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c) If no, what are your reasons?

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## FOCUS GROUP DISCUSSION GUIDELINE:

### HIV/AIDS LIFESKILLS CAPACITIES AMONG YOUTHS IN DANDORA AREA

I am Brenda Etukei, a Postgraduate student at the UON. I would like you to discuss the following questions in your groups. Feel free to discuss and say anything in the questions asked. I promise I will keep all the information you discuss confidential.

- 1) What are the basic skills one needs to be able to relate to anyone?
- 2) How do young people gain these skills
- 3) Can young people abstain from sex?
- 4) At what age do most young people in Dandora become sexually active?
- 5) When a young person first has sex, is it normally their choice?
- 6) When do you say that a person is ready to become sexually active in Dandora?
- 7) What do young people believe here concerning HIV/AIDS?
- 8) Do many young people here believe they can become HIV Positive?
- 9) Have you heard or seen any young person who is HIV Positive in this community and how did they look like?
- 10) What do young people consider to be risky behavior as regards to HIV/AIDS?
- 11) What precautions do young people here use in preventing themselves from contracting HIV/AIDS?
- 12) What is the attitude of young people concerning HIV/AIDS in this community?
- 13) Do young people discuss matters of sex and HIV/AIDS in this community?
- 14) When a young person decides to have sex with a partner, do they base it on feelings or their principles?
- 15) To whom do young people mostly discuss sexual matters in the community?
- 16) Who would help a young person decide whom to be in a sexual relationship with?
- 17) When this person gets a sexual partner (girlfriend/boyfriend) would they inform anyone, if so who would it be?

18) What sexually healthy behavior can a young person adopt to reduce their chances of contracting HIV/AIDS?

Thank You

### **INTERVIEW GUIDE: KEY INFORMANT INTERVIEW**

#### **HIV/AIDS LIFESKILLS CAPACITIES AMONG YOUNG PEOPLE IN DANDORA AREA**

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I am Brenda Etukey a Postgraduate student at the University of Nairobi. I am doing a study on HIV/AIDS life skills among young people in Dandora area and would like to interview you on the said topic.

- 1) Name\_\_\_\_\_
- 2) Age\_\_\_\_\_
- 3) Occupation\_\_\_\_\_
- 4) Place of work\_\_\_\_\_
- 5) How did you start involving yourself in HIV/AIDS issues?
- 6) From your experience, how do you view the HIV/AIDS pandemic?
- 7) Do you think young people have been left out?
- 8) What are the specific issues what young people grapple as regards to HIV/AIDS?
- 9) What kind of intervention strategies do you offer to this young people?
- 10) From your experience do you consider these strategies appropriate in tackling the issue of HIV/AIDS among these young people?
- 11) How can we empower young people in the area of preventing HIV/AIDS?
- 12) What is your understanding of HIV/AIDS life skills?
- 13) What are the life skills that young people possess that have been beneficial in preventing HIV/AIDS?
- 14) What life skills do you consider lacking in most young people?
- 15) How much have you and your organization been able to do to improve these life skills among young people?
- 16) What else can be done to reduce the spread of HIV/AIDS among young people?

Thank You!