UNIVERSITY OF NAIROBI

School of Journalism

M.A. COMMUNICATION STUDIES

TITLE:

FACTORS INFLUENCING HIV/AIDS PREVENTION CAMPAIGNS-:

A STUDY OF MEN WORKING IN THE INFORMAL SECTOR IN NAIROBI

BY

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A research project submitted to the School of Journalism of the University of Nairobi in partial fulfillment of the requirements for the award of the Degree of Master of Arts in Communication Studies.

AUGUST, 2005

DECLARATION

I do hereby declare that the work presented in this report is my original work and has not been submitted in part or other form for a degree in any other university.

Signed: ..... Date: November 23, 2005

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APPROVAL

This project report has been submitted with my approval as University supervisor

Signature: ..... Date: 28/11/05

Mr. Kamau Mubuu

LIST OF ACRONYMS/ABBREVIATIONS

HIV/AIDS	-	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
WWW	-	World Wide Web
NGOs	-	Non-governmental Organizations
UNICEF	-	United Nations Children's Education Fund
MMAAK	-	Movement of Men Against AIDS in Kenya
WHO	-	World Health Organization
NASCOP	-	National Aids and STD Control Programme
PATH	-	Program for Appropriate Technology in Health
UNO	-	United Nations Organization
UNDP	-	United Nations Development Programme
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
AIDS	-	Acquired Immune Deficiency Syndrome
JHU	-	John Hopkins University
NACC	-	National AIDS Control Council
VCT	-	Voluntary Counseling and Testing Centres
ABC	-	Abstinence, Being faithful and Condom use
HBM	-	The Health Belief Model
HEM	-	Hierarchy of Effect Methods
S-M-C-R Model	-	Source, Message, Channel and Receiver
IEC	-	Information, Education and Communication
STD	-	Sexually Transmitted Diseases
CSWs	-	Commercial Sex Workers
Four Ps	-	Product, Price, Place and Promotion

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DEDICATION

To all people who have been affected and infected by HIV/AIDS. Some of whom may have lost their lives sooner than expected, while others may still be holding on to dear life, but could be weak, lonely, depressed and deserted by the loved ones.

ABSTRACT

HIV/AIDS has caused more death and suffering in the world than any other scourge known in history. In Kenya, as a result of HIV/AIDS, there are many orphaned children languishing in poverty, and are often disinherited by their immediate and extended families. The life expectancy of Kenyans has been considerably reduced by the impact of HIV/AIDS from 55 to 45 years.

Despite the miseries caused by the scourge and in spite of the abundant information on prevention of HIV/AIDS many people have not adopted positive sexual behaviour. Thus in order to find lasting solutions to the problem, this study sought to examine Communication and other related factors that could be influencing sexual behaviour among men. Given that the media has over the years taken a leading role in HIV/AIDS Prevention Campaigns, the study sought to establish the extent to which Mass Communication has impacted on behaviour change. Other related factors that fundamentally affect man such as Socio-Economic and demographic factors were also investigated, in order to ascertain whether they affect behaviour change.

Communication factors that were found to be influencing HIV/Prevention Campaigns were summed up in the S-M-C-R model as: Source, Message, channel, receiver and the effects of communication whereby it was established that the main source of information on HIV/Preventive Campaigns is the radio. However most respondents preferred discussing HIV preventive messages with peers/friends through interpersonal communication than through the radio.

The study sought to unearth how age and other demographic factors influenced behaviour change and established that men aged between 15 and 45 years were very active sexually and that majority of them used condoms although not regularly. Their failure to use condoms as prescribed was interpreted as failure of HIV/preventive campaigns to produce desired results. Hence the justification to identify and establish factors hindering adoption of safe sex as prescribed.

Culture was found to be deeply rooted in the lives of many respondents, hence a factor of great influence to behaviour change. Some of the men admitted that they practiced polygamy; some confirmed that they consented to wife-inheritance and more still majority confirmed that they had unprotected multiple sexual relationships because according to their cultural beliefs it was proof of manhood.

The significance of the study is that, it aims at empowering men with HIV preventive messages in order to involve them in the fight against HIV/AIDS. This is based on the recognition that in Africa, as elsewhere in the world, man enjoys a privileged social position in that they are leaders in the home and society; hence if enlisted in the fight against HIVAIDS they would use the leadership role and change the course of the epidemic. This is because men are the decision-makers in the families and on sexual matters. They are the ones who decide mostly who to have sex with, when and how hence, if targeted with effective messages men are better placed than women to bring a turn around in the course of HIV/AIDS epidemic. Yet the common practice by the NGOs has been mostly to target the women who barely make sexual decisions. Therefore this study sought to target men in order to establish Communication, Socio-economic and demographic factors that have been hindering them from adopting positive sexual behaviour, with a view removing the barriers. After thorough investigations this study established that:

There are a number of communication barriers encountered by men when seeking information on safe sex. In this study 79% of the respondents pointed to lack of open communication and misinformation as some of the communication barriers. It was confirmed that radio has been very instrumental in creating awareness. In this regard KBC has more listenership than the other radio channels. It was established further that most of the preventive messages were received through the radio. However, it was confirmed that over-reliance on radio communication/messages as a means of attaining change in sexual behaviour was in itself a communication barrier. This was revealed through focused group discussions and key informant interviews who pointed out that interpersonal communication among peers and colleagues at work place was a more preferred medium of communication than radio, thus more effective for behaviour change campaigns.

The study established that the men are the ones who make decisions on sexual matters that is where, how and when to have sex and with who, and in concurrence with the above view, 52% of the respondents confirmed that men are the decision makers on sexual matters in the family.

Some social barriers were also found to be discouraging positive sexual behaviour. In this regard, the study focused on wife inheritance, polygamy, and Christian values while others like circumcision, witchcraft, and evil spirits were clumped together under other traditional practices. The respondents who practiced the above traditions were classified as follows: wife inheritance 2%, polygamy 10%,

other traditional practices 63% and Christian values 26%. It was also confirmed that 22% of the respondents do not use condoms because it is against their religious teachings.

Among the low-income groups it was established that low income is one of the hindrances to adoption of safe sex methods. In this regard it was revealed that 54% of the respondents earned less than Ksh.5,000/= per month. As a result they could not afford adequate housing for their families and therefore were forced to live separately from their wives (who are left in the rural homes). This scenario creates a conducive environment for extra-marital relationships as the man ends up acquiring girlfriends in the city; as confirmed by key informant and focused group discussions.

The study established further that low income accounts for irregular use of condoms by majority of the respondents. This was summed up from focused group discussion: "if we cannot adequately afford the basic necessities, such as food, shelter and clothing, how would we budget for purchasing of condoms on a monthly basis?" It was confirmed that the quality of the condoms was another important factor that contributed to adaptability or non-adaptability. From the study 67% of the respondents preferred the Trust condom citing that it was of high quality compared to the rest. The free GoK condoms were the most unpopular, and poor quality was cited as the reason for its unpopularity. The study confirmed that condom use would be the most preferred preventive method if quality is improved.

This study was conducted through a field survey in Nairobi among men working in the informal sector in Kenyatta market area and its environs. The main tools of data collection were structured questionnaires, focused group discussions and Key Informant Interviews conducted among 320 men identified through random selection.

In view of the above findings, the challenge for HIV/AIDS preventive campaigners is to design effective messages and to encourage interpersonal communication among peers and friends as it was confirmed to be more effective than radio communication. To this effect, 52.2% of the respondents indicated that they would prefer to discuss sexual matters with their peers/friends compared to only 20.2% who preferred to discuss with their wives/partners.

A major recommendation given was the need for further studies to establish whether men in the informal sector are HIV/Risk-groups. It was established that the respondents are vulnerable to HIV Infections because 64.1% of them admitted having multiple sexual relationships and a good number also admitted engaging in unprotected/careless sex. It was also confirmed that 59.9% of the

respondents do not know their HIV status and had no intention of knowing, as they feared that the results could confirm them to be HIV-positive following their carefree life styles. The above conclusions are alluding to the fact that men in the informal sector could be HIV Risk-groups. Therefore, there is urgent need to establish whether they are HIV Risk-groups so that the campaigners would target them with appropriate messages.

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CHAPTER ONE

1.0 INTRODUCTION

The status of HIV/AIDS epidemic in Kenya is characterized by the high rate of HIV infections and a growing number of illnesses and deaths among Kenyans.
Due to the high death toll caused by HIV/AIDS, the Kenya Government declared AIDS a National disaster in 1999. Currently HIV infections are placed at over 2.5 million people in Kenya and over 700 people die daily from HIV/AIDS placing the AIDS pandemic as the biggest threat to social, economic and development in Kenya.

However, despite the enormous amount of information on HIV prevention there seems to be a big communication gap in the programs aimed at changing man's behavior because such programs, as few as they are, tend not to challenge the contextual determinants of man's behavior. The focus on changing man's behavior must extend beyond the availability and use of condoms and the attention paid to the roles and responsibilities of men and women rather than focusing only on women. Therefore, for campaigns to be effective they should include all the different social roles, and norms that affect the sexual behavior of both men and women. There are also Socio-economic and demographic preventive factors that must be addressed in order to have effective campaigns.

1.1 BACKGROUND OF THE STUDY

Since 1984 when the first case of AIDS was identified in Kenya, it has gone through three phases as follows:[1] The first phase1984-1987: There was a general belief that HIV/AIDS was not a serious problem in the country. During this period AIDS was described in the press as a disease of 'Westerners' especially 'gay men' (Steven Forsythe & Bill Rau (1996-p.3) As such ordinary Kenyans did not see AIDS as an immediate danger to them. However, the press sensationalized AIDS and the *Standard Newspaper* report headlines referred to AIDS as the 'killer Disease in Kenya' and a 'Horror sex disease in Kakamega (Steven Forsyth & Bill Rau (1996), p.3.

[1] Steven Forsythe & Bill Rau (1996) Ed. AIDS in Kenya, United States Agency for international Development, Published by Family Health International USA p. 3

As a result of awareness campaigns mounted by the press, the dangers posed by AIDS became so real that in 1987 the British prohibited their soldiers from taking leave in Mombasa citing the threat of HIV among the Commercial Sex Workers.

The second phase 1988-1991 saw a somewhat realistic appraisal of HIV/AIDS as a potential harmful health issue. In 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' (Steven Forsyth & Bill Rau-1996, p.4). However, the influential religious leaders spoke out against the use of condoms for disease prevention. While they admitted that AIDS had become a national problem, they argued that condoms were western solution that did not fit in the Kenyan situation.

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 for Health declared that AIDS had become a National crisis (Africa Confidential, Vol., 34, No. 11, May 1993).[2] From that period to date HIV/AIDS has steadily spread throughout the country causing devastative effects to many families. Therefore, in an attempt to contain the situation in Kenya today there are many NGOs but most of these organizations target women, orphans, widows and commercial sex workers, in a very specific way because their objectives and mission is exclusively to assist women, widows, and orphans who are affected and infected by HIV/AIDS. Some of these organizations cater for breast-feeding mothers by equipping them with information for preventing mother-to-child transmission. Some of these organizations promote female Reproductive Health by providing women with HIV preventive information. One such organization is the Policy Project based in Nairobi, which among other activities, caters for women's family planning needs, and their Reproductive Health. Women have benefited a lot from such organizations but few of such organizations are targeting men. However, if men are not empowered with enough preventive information, they would undermine the women's efforts in preventing HIV/AIDS. This is because in heterosexual situation, which is the commonest way of spreading HIV infections in Africa, it takes two to get AIDS; as such both sexes should be targeted with prevention information, with equal emphasis. Therefore, it is time to start targeting men by seeing them not as some sort of a problem but as partners in the fight against HIV/AIDS. The over emphasis

on women's programs is based on the belief that wherever there are social problems women and children suffer most and more so in Africa where a woman's position is secondary to the man's position both in public domain and in the home[3].

1.2 PREAMBLE

Due to low involvement of men in the fight against HIV/AIDS, most men in Kenya have not been empowered with adequate information on HIV/AIDS prevention. Most of the information they have has been accessed through the Media (print and electronic media). However since most of the people in developing countries are illiterate or semi-illiterate they often opt for radio messages, which are brief and rapid leading to lack of adequate information.

This inadequacy of information on HIV-prevention coupled with the fact that the African sexual behavior is deeply rooted in their traditions, in order to convince the men to change their social behaviors that hinder the progress in the fight against HIV/AIDS, effective communication methods must be identified through a study so that would attain positive behavior change among men could be attained.

In most Kenyan communities, gender determines how and what men and women should know about sexual matters and their attitudes towards sex. These gender ideals are part of a child's socialization process, which determines their knowledge and attitudes towards sex. These ideals and expectations based on gender roles should be investigated in order to address the prevailing gender inequalities in making sexual decisions.

For example, the campaign on condom use aired on TV or radio assumes an equal distribution of power in sexual relationships. Yet in Africa and in many parts of the world sexual decisions are often made by men; and women are not supposed to know much about sex and are not allowed to discuss sex with their partners. Hence, the woman may have the intention and the will to adopt condom use, but the actual adoption requires the active cooperation of the male

[2] Africa Confidential Kenya: "Haggling for Aid for AIDS", Volume 34 No. 11, May 1993
[3] Interview with Mr. Charles Kaduwa programmes Officer, WOFAK, May 2004.

partner. Therefore, considering men's leadership roles in both public and private domains would make them better placed in spearheading the fight against HIV/AIDS.[4]

The male migrant workers, who are subject of this study, are urban laborers from rural areas. They characteristically leave their families in the rural areas and move to the cities to look for jobs to do in order to earn a living. Due to the fact that they are often separated from their families for long periods and while living in the city, they may visit commercial sex workers or they may have temporary 'unofficial wives', this behaviour could place them as a 'risk group'. Occasionally when they return to their rural villages, where they will have sexual relationships with their wives as well. Such loose sexual behaviors could lead to HIV infections.

1.3 STATEMENT OF THE PROBLEM

In Kenya today, HIV/AIDS is killing people at an alarming rate. According to the Kenya Government statistics, AIDS deaths are at the rate of 700 people per day. Although men are strategically placed in the society, as leaders both nationally and at family levels, they have not been targeted enough, with effective HIV/AIDS preventive messages to encourage them to change their sexual behavior. As a result most of them have not adopted safe sex methods, such as regular condom use, being faithful or adopting abstinence where appropriate. Instead they still equate condom use to eating 'a sweet with its wrapper'. This blatant rejection of condoms use by most men must be seen as a communication problem.

On the other hand, the fear of HIV infection has prompted some men to believe in the 'virgin myth' and they seek out the uninfected young girls and even babies, for ritual cleansing which they mistakenly believe will free them from HIV infection. The end result is a deadly tragedy whereby a trend is developing in Kenya, where babies are being defiled and young girls being raped. Recently through Nation Television, the Chief Administrator of Nairobi Women's Hospital, Hurlingham revealed that the Hospital is receiving approximately ten defilement and rape cases daily.

[4] UNFPA (1999) Source: Google, Partners for Change Enlisting Men in HIV/AIDS Prevention, p. 2

In view of the above problem, infected men continue to expose themselves to re-infections and to infect others. Currently in Kenya, the level of awareness of HIV/AIDS is placed at 90 percent, yet less than 40 per cent of the general populations have made deliberate efforts to change their behaviour[6]. The disparity between the level of awareness and the rate of behavioral change is too wide that there appears to be a problem. Therefore, the big question to be addressed by this study is why is it that people are largely aware of the dangers of HIV/AIDS but have not changed their sexual behaviors to avert the problem.

In many Kenyan communities, men have tended to be socialized to adopt risk-taking behavior, regarded to be inline with 'manhood expectations', which all men are supposed to achieve in order to avoid losing masculinity. The risk-taking behavior tends to increase men's chances of contracting HIV infections, because it includes having many sex partners, and in some communities it involves having many wives, thereby condoning polygamy.

To drive the above point home according to Udoto, in the *East African Standard*, 2001: p. 11, most African men believe that 'fear' of anything whatever it is, even fear of death should not predominate a 'real' man's actions 'lest' he be referred to as a lesser man. The article cites the case of the Luo community where there is a common saying that 'an authentic bull dies chewing the grass'. Which if literally translated means that, a real man should not sacrifice his sexual desires even at the risk of contracting AIDS because just as a 'bull' dies with grass in his mouth, a 'real' man is expected to get sexual pleasures regardless of the risks involved.

This study is set to answer the question: 'how can communication be made more effective and more receptive to the men, in order to make them adopt safe sex methods through regular condom use, abstinence, or through being faithful to one partner?' The main communication problem appears to be embroiled in the fact that, most messages directed at behavioral change, tends to be mass mediated and usually based on individualistic approach to change, without taking into account the Socio-economic context within which these relationships take place. For instance, the advertisements for social marketing of condoms, and other safe sex methods are based on individual decisions. Yet in most Kenyan communities, an individual is subsidiary to the society and most important decisions that affect an individual are based on the needs of the

[6] WOFAK Newsletter, August 2003 issue "Enhancing behaviour change" By Christine Oyaro and Hilda Achieng (p.7)

society as a whole. The fact that most HIV preventive messages seem to have been designed to address the individual needs vis-à-vis the needs of the society, is an omission that may have lead to rejection of safe sex methods. It appears that the communicators did not understand that in Africa, an individual is viewed as a product of the society and priorities of the society take prominence over his priorities. Also the over-emphasis on radio messages has been counter-productive because radio messages are non-interactive hence, presenting one-sided communication, which has proved to be ineffective in attaining behaviour change.

Demographic factors such as education and age, influence behaviour change adoption among the less educated men and women, in that the viral cause of disease is not understood instead among such people it is believed that most deadly diseases are caused by either a curse or witchcraft or both. For effective target campaigns it is important to identify and establish the age bracket of the most sexually active men and to establish whether they use condoms as prescribed. However, the study confirmed that in-effective communication methods, low Socio-economic status and demographic factors could be posing major problems to adoption of positive sexual behaviour among men.

Therefore in order to effectively address the obstacles that hinder man from adopting positive sexual behaviour, the study sought to identify and establish effective communication methods; Socio-economic and demographic factors that would yield desired results in HIV prevention campaigns.

[7] Udoto Paul, The East African Standard (2001) P. 11

1.4 OBJECTIVES

The objective of the study is to investigate Socio-economic and demographic factors influencing HIV/AIDS preventive campaigns among men working in the informal sector.

In order to achieve the above general objective this study will specifically:

(i) Identify and establish communication factors influencing the adoption of positive sexual behavior among men.

(ii) Identify and establish socio-economic factors influencing the adoption of positive sexual behaviour; and

(iii) Identify and establish demographic factors influencing the adoption of positive sexual behaviour.

1.4.1 QUESTIONS TO GUIDE THE STUDY

In order to achieve the study objectives, questions were formulated to guide the study as follows:

(i) Identify and examine communication factors that influence sexual behaviour change among men?

(ii) What are the Socio-economic factors that influence positive sexual behaviour?

(iii) What are the demographic factors that influence men's adoption of positive sexual behaviour?

1.5 SIGNIFICANCE OF THE STUDY

HIV/AIDS has claimed 7.3 million men in the world since the start of the epidemic (UNAIDS Report 1999). This deadly toll combined with the unmet sexual reproductive health needs of men and boys are enough to justify the study. Added to this is the fact that men are involved in the decision making of almost every case of sexually transmitted HIV infection. The dominant role is clear for husbands who have multiple partners yet refuse to use condom during sexual intercourse with their wives, and for older men (sugar daddies) who have sex with younger girls who lack power to protect themselves. The male dominant role in sexual matters is not being

challenged and hence propelling the spread of HIV/AIDS. Therefore, something has to be done to stop this trend and now is the time.

In an article on Health authored by Wangari Mathaai, the 2004 Nobel Prize winner and an Assistant Minister for Environment, she asserted that there is a lot of misinformation circulating about Aids which is also fuelling its spread especially among the uninformed rural populations of Kenya (East *African Standard*, Tuesday October 12,2004 page 13). Due to misinformation some people claim that if an infected man has sex with a virgin then he would be cured. As a result young girls have been made vulnerable to sexual abuse and infection. The 'virgin myth' should be viewed as a communication problem, in that most men appear not to be aware of how HIV infection is contracted. To this Mathaai emphasizes that the information bearers must inculcate the spirit of moral responsibility and moral values to guide the people.

In an article by Albert Kasambeli, quoting the United Nations department of Social affaires, he said that Aids will have devastating consequences in the Sub-Saharan Africa in the near future in virtually every sector of the society (*People Daily*, Tuesday October 12, 2004 page 3). According to the UN Report cited above Kasambeli sounded further warning that 'without effective vaccine or cure or better programs to prevent the spread of the HIV/AIDS epidemic, which has already killed 20 million people in the Sub-Saharan Africa since its out break in the 1980s will cause up to 100 million deaths in Sub-Saharan Africa by the year 2025.

The Government of Kenya is currently addressing HIV/AIDS prevention but most of the programmes are not effective in attaining positive sexual behaviour. For instance, the campaigns on condom use have not received a positive reception. This is because the campaign is based on individual decision making as opposed to society/community involvement in the decision, which would be much more acceptable in Kenyan communities because individuals are subservient to the community.

Therefore, this study is significant in that it identifies the obstacles to behaviour change so that preventive campaigns would be directed to the obstacles with appropriate messages aimed at eliminating the barriers to behaviour change. The government would use the study findings in the implementation of HIV prevention programmes, and in policy formulation.

Finally, according to WHO Report, 2003 women in many Kenyan societies may remain ignorant of the facts of sexuality and HIV/AIDS because they are not "supposed" to be sexually "all knowing'. Men on the other hand may remain ignorant about sex because they are supposed to be sexually "all knowing" so they become shy to inquire about sex lest they be seen "as lesser men". This is why it is important to enlist men in the fight against HIV/AIDS in order to empower them and make them more responsive to safe sex.

A change in men's sexual behaviour can influence the course of the HIV/AIDS epidemic in a focus that cannot be underestimated. It is important to note that men's behaviour plays more critical role in the transmission of HIV/AIDS than women's, but public attitudes including the media tend to blame women. However with positive approach men could be made to accept to take a leading role in the fight against HIV/AIDS. Hence time is ripe to start seeing men as part of the solution.

Since Kenya is one of the most hit countries with HIV/AIDS scourge, if effective preventive measures are not urgently put in place, the impact of the disease will be of unimaginable magnitude. Currently, AIDS is threatening capabilities of health care systems, jeopardizing the education of children as they are orphaned at tender age. This coupled with food insecurity due to death of able-bodied people, weakens the economy and development as experienced workers die at the height of their economic productivity.

At the world leaders UN Summit in 2000, Kasambeli, in his article cited above, confirmed that HIV/AIDS was the most important population concern, especially in the Sub-Saharan Africa where the virus is preventing the achievements of the Millennium Development Goals. The report stresses that efforts to prevent new infections and provision of treatment for the infected HIV/AIDS population are essential, and as a result:

(i) This study is very significant because its main aim is to reduce the impact of this devastating disease by identifying and establishing Socio-economic and demographic factors that are negatively influencing HIV prevention campaigns, thus creating an enabling environment for eliminating the obstacles to behaviour change.

(ii) Based on the findings of this study, appropriate recommendations would be made that would be useful to the Government policy makers, planners and interventionists, hence

would facilitate the removal of obstacles that hinder men from adopting positive sexual behaviour.

1.6 STUDY ASSUMPTIONS

The study assumed that the respondents were fully informed about HIV prevention, but due to inefficiency of communication on HIV preventive messages; coupled with negative cultural practices men were inhibited from adopting positive sexual behaviour. It was assumed further that the respondents' low Socio-economic status; demographic factors such as level of income, age and education all impacted negatively on their adoption of positive sexual behaviour.

1.7 STUDY HYPOTHESES

It was hypothesized that there would be no significant relationship between communication factors; Socio- economic and demographic factors and behavior change. By implication it was presumed that most men in the informal sector have not adopted positive sexual behavior despite the fact that they are fully aware and informed of the consequences and the dangers of the disease.

In view of the above the study is set to test the following hypotheses:

(i) The first hypothesis is "there is no significant relationship between communication factors and sexual behaviour change".

(ii) The second hypothesis is "there is no significant relationship between Socio-economic; demographic factors and sexual behaviour change".

1.8 OPERATIONAL DEFINITIONS

Operational definition means describing the variables in their measurable form and the method of obtaining the measurement for each. It is important that each of the variables be operationally defined to assure that the data will be gathered and analyzed consistently.

1.8.1 Perceptions and attitudes:

They could be positive or negative perception, which refers to a process by which an individual gains an insight (understanding) of what is happening and forms an opinion about it. This would mean that the way respondents viewed adoption of new sexual methods as a way of improving their reproductive health and avoiding contraction of HIV/AIDS infection as possible indicators.

In most studies two distinct indicators would be probable, namely positive and negative indicators. In this study there is a possibility that some respondents are already making some deliberate efforts to avoid HIV infection while others are repulsive to change.

1.8.2 Positive indicators for Behavior change are as follows:

Adoption of condoms, abstinence, and or being faithful to one sex partner. If the respondents indicate that they use condoms regularly or that they practice restricted sexual relationships, for example, being faithful to one woman (wife). This would be regarded as a positive indicator and it is measurable.

The second positive indicator for behavior change is taking a deliberate step to establish their HIV status by visiting VCT. Those who have established their HIV status with a valid certificate from the VCT center will be measured and they are likely to adopt safe sex methods.

Open discussions about the dangers of HIV infection with spouse is a positive indicator

Involvement in community groups for HIV/AIDS campaigns aimed at empowering people (men) leads to a positive sexual behavior.

Rejecting traditional practices that may lead to HIV infection, for instance, wife inheritance, polygamy, having multiple sexual partners (as a sign of manhood) is a sign of the positive direction.

1.8.3 Negative indicators for Behavior change are as follows:

Non-adoption of condoms even when an individual is engaging in risky sexual behaviors, conducive to HIV infection, for instance, having many sexual partners.

Rejection of visiting VCT (knowing HIV status) even though there may be signs that one could be a victim due to careless life style or due to his deteriorating health yet one does not make a positive move to establish HIV status.

Lack of free communication or openness to one's spouse on HIV prevention when one indicates that he does not engage in open discussions with wife regarding sexual matters.

Lack of interest in community HIV/AIDS groups aimed at providing information about HIV prevention. This is indicated by failure of the respondent to take part in HIV prevention social groups in church.

Practicing negative cultural practices such as wife inheritance, polygamy and careless sex for proving of muscularity (manhood).

1.8.4 Communication

It is one of the most important variables that is subject to this study. The dictionary definition of the word communication is the art of transmitting information, ideas, attitudes and feelings from one person to another. It also refers to something communicated such as a message, letter or telephone call. When a message is directed to one or more of the person's senses for instance, sight, sound, touch, taste, or smell; this is known as non-verbal communication. On the other hand, when messages are directed from one individual to another this type of communication is known as interpersonal communication.

However, the contemporary world is too complex that interpersonal communication may not be adequate in spreading information to all parts of the world as such it has been complemented by mass communication. This type of communication is done through electronic devices such as the radio, TV, Internet, newspapers, magazines, etc, that are capable of distributing similar messages to millions of people throughout the world in a matter of seconds or minutes. In addition to this satellites have made it possible to provide live coverage of news or events in any part of the world. As a result of the efficient world information systems defying distances, by providing messages in any part of the world in a matter of seconds or minutes, has turned the world into a global village.

This study is based on the assumption that the targeted population has been exposed to HIV-preventive messages through interpersonal communication and mass mediated messages. As such the respondents are in a position to give views about the most effective communication channel, in convincing men to change their sexual behavior. This study is also set to establish whether the flow of information is originating from the media then passed over to the rest of the people who may choose to adopt it or not depending on their social status as posited by Rogers in his theory of Diffusion of Innovation. For this study, the source of information is measurable by considering the responses. The issue here is; does the information originate from the mass media or from the interpersonal sources? The indicator here is measurement of direct response from respondents on where they get HIV-preventive information.

1.8.5 Sources of Information on Behavior Change

The respondents will indicate all their possible sources of information. They will rank them in order of the most effective, effective, fairly effective. In this regard apart from the media, the respondents also indicate the alternative sources of information (any social networks e.g. opinion leaders and their characteristics. This point will determine the most favorable source of information is it the media or the opinion leaders? This will be especially of much interest to us with regards to effectiveness of the theory of diffusion of innovation among the illiterate and semi- illiterate people.

1.8.6 Behavioral Change

Behavior refers to the way somebody functions in a particular situation and it may be bad or good. Change means to make or to become different or to alter or to transform something, may it be a person or an object. In this study, the main interest is to establish whether the respondents' behavior is changing from unsafe sex to safe sexual methods. This would be measured by assessing how the respondents responds to the practices that hinder positive behaviour, these factors may be social, cultural, spiritual, or economic practices.

Prior to the outbreak of the HIV epidemic men used to engage in unprotected sexual relationship, because all STDs were curable. However with the advent of HIV/AIDS there is an urgent need to change the behaviour of unprotected casual sex by adopting, responsible and safe sex methods, which would protect one from HIV infections. Therefore, any response indicating that they are making deliberate efforts to avoid contracting HIV infection through adoption of safe sex methods, such as abstinence, being faithful to one partner, and condoms use (ABC) would be classified as behavior change, in measurable terms.

Accepting to visit VCT to establish HIV-status is also a positive move toward a positive sexual behaviour and is measurable.

1.8.7 Spirituality Factor

Religious beliefs are handled separately from cultural beliefs because this study assumes that they influence behavior change differently. This assumption is based on the fact that different denominations or cults have different rules; as such they may influence people who belong to similar ethnic culture differently. For instance, polygamy is accepted in many African communities, but a good number of people in Africa do not prescribe to polygamy due to their religious convictions, hence proving that religious convictions can conflict a cultural practice. The same applies to family planning methods whereby, some churches are opposed to it and this has influenced some of their followers to reject family planning. The Catholic Church is a good example here. The use of condoms as a safe sex method is also strongly opposed by the Catholic Church; as such it is one of the objectives of this study to establish whether religious beliefs hinder adoption of safe sex methods. Establishing the denominations of the respondents and linking it to their responses will measure this.

For those whose actions will be determined by their religious convictions, their spirituality will then be regarded as a negative indicator. This study is also committed to establish the extent to which religious beliefs are hindering people from adopting positive sexual behaviors in the face of HIV prevalence.

Although these domains mentioned above are interrelated, they may have different impact on preventive health behaviors. That is why in this study, they will be tested each one of them on their own in order to measure the extent of they impact on behavior change. The framework adopted in this study recognizes that the individual is a product of a particular social context or society. Therefore, for HIV-preventive messages to have a meaningful effect, intervention programs should begin with targeting the society or individuals in the society. Thus individuals should continue to be targeted but only in the context of their interaction with the society for instance, how is behavior change affected by an individual's interaction with culture, religion, economic status, etc.

1.8.8 Socio-Economic and Demographic Factors

This refers to social, economic and demographic factors such as cultural values affecting individuals in a particular way, what the society expects individuals to do, level of income and how it affects individual roles in the society, level of education, individual's age and population. These factors may contribute negatively or positively towards behavioral change. This study is set to establish whether Socio-economic and demographic factors affect behavioral change and the details of its impact are elaborated below. It will be established whether susceptibility to infection is connected to age – in other words which age group is more prone to HIV infection and why.

Under social factors, spirituality is considered separately from other social matters because it regarded to have influence that is not consistence to known cultural values in a given society in this regard the study seeks to establish how spirituality per se affects sexual behaviour. The study will determine how respondents from different religions adoptive to behaviour change.

1.8.9 The Level of Education of the Respondents

This point will determine whether there is a significant relationship between the level of education and adoption and non-adoption of innovation.

1.9.0 Cultural Practices

Culture is a way of life, and the sum total of the inherited ideas, customs, beliefs, art, values and knowledge that constitutes the shared basis of social action. Culture is also defined as a total range of activities and ideas of a group of people with shared traditions, which are, transmitted and reinforced by members of a group. It also refers to a social organization of a particular country or group of people. For purposes of this study, operational indicators under cultural practices could be unique or negative cultural characteristics that may promote or hinder prevention of HIV/AIDS infections such as wife inheritance, polygamy, casual sexual relationships etc. Therefore, the extent to which culture is affecting behavior change either positively or negatively is measurable.

In this case, positive indicators refers to rejection of negative cultural practices which promotes the spread of HIV infections, for instance, practicing polygamy, practicing wife inheritance and having many sexual partners as a show of manhood. In traditional communities open discussions between men and women was not allowed as women were considered to be inferior to men. Hence status of women in relation to men in the society was disadvantaged because women were not allowed to have decision-making powers with regards to many matters in the community, including sexual matters. In this study, the response with regards to gender relations will be measured in terms of their influence on the sexual negotiations and decision-making. The issue here is to measure whether the respondents are in favor of discussing safe sex methods with their spouses.

1.9.1 Benefits of Adopting the Innovation

Diffusion of innovation would take a positive trend if the benefits of the new innovation were demonstratively more than non-adoption. The realization of the benefits is a direct response from the respondents based on their experiences. If the innovation is complicated and not easy to apply then the benefits will be limited because the complicated nature will be an obstacle for adoption. Also if the innovation is not in tune with the accepted traditional practices within a community, this too may hinder adoption.

1.9.2 The Mode of Adoption

The study is to establish whether those who have adopted condom use are regular in their approach or do they use condoms irregularly and if so, why. This point will determine the obstacle that prevents complete circle of adoption of safe sex (by regularly and predictably leading a positive sexual behavior).

CHAPTER TWO

2.0 LITERATURE REVIEW AND THEORETICAL FRAMEWORK

This chapter focuses on information sourced from behaviour change scholars, some of who are pioneers on HIV prevention theories/behaviour change models. These theories have been tried tested and proven to be effective in attaining positive behaviour change. Information in this chapter is sourced from Secondary data through library books and Internet journals.

A study conducted by Awusabo-Asare, posits that at the initial stages of the HIV/AIDS epidemic, governments and organizations provided information on AIDS with the hope that the individuals would modify their behaviors positively in the light of available information on HIV/AIDS, (University of Cape Coast Ghana-1999 p.235-240). During this period the operating philosophy was that the people should not die out of ignorance since it was assumed that as soon as they were informed of the dangers of HIV/AIDS they would adopt safe sexual behaviour. However, this was not to be. Inherent in the approach was the acceptance of the diffusion model.

According to the diffusion this model, a person or a small group of people, innovators who in theory account for about 2.5 per cent of the population always introduce new ideas or ways of life. With time the innovation (new ideas) spreads throughout the population first among the most receptive group, the early adopters who account for 13.5 per cent of the population, followed by the early majority and finally it brings the total of the adopters to 50 per cent of the population. The late majority accounts for 34 per cent of the total population. If that group also adopts the innovation it would bring the total to 84 per cent in this case the spread is considerable to have reached the saturation point. The last group comprises of 16 per cent of those individuals who resist change in the face of all the available evidence. They are referred to as laggards. Thus there is the group that is always expected to resist change. Thus Resistance to change implies that the individuals or the groups is aware of the existing situation that needs to be changed, accept that there should be change, have necessary skills but are unwilling to effect change.

The study by Awusabo–Asare points out that in the area of sexual behavioral change relating to HIV/AIDS, barriers to change involve cultural dimensions and economic factors. Secondly, a number of IEC strategies aimed at behavior change in sub-Saharan Africa have been impersonal, modeled on some of the successful experiences from more developed countries which have a large reading public. Yet people in the Sub-Saharan Africa are more listeners than readers; the majority especially the females are illiterates. Thirdly, political commitment is important for behavioral change as demonstrated in the case of Uganda but this is not the case in a number of Sub –Saharan African countries, where some of which are still at the denial stage. In this case Awusabo-Asare is of the opinion that in many African communities the best approach to HIV prevention is perhaps to address the "still-existing" barriers to change rather than resistance to change. In this regard he concurs with this study because the study objectives are grounded on identifying and establishing factors than hinder men from adopting positive sexual behaviour.

The community concept has been used in targeting the general public; there has not been any attempt to define the community. Awusabo-Asare has posited two broad categories of community namely: the vertical community and the horizontal community. The former refers to the groups of people within a common interest that they defend such as the homosexual community and religious and ethnic based groups. The horizontal community on the other hand refers to the group of people within a geographically defined area. Their binding factor is that they occupy a definable space in relation to other areas. They may or may not have a common interest beyond those associated with proximity. Historically the horizontal community has been the focus of public health programs since outbreaks of epidemics have occurred in geographical areas.

However, available evidence suggests that vertical communities, with their shared identities have been able to develop programs that have changed behavior. Some of the homosexual communities in Australia and USA have been able to achieve behavioral changes, which have stopped the spread of HIV/AIDS among their members.

In Sub-Saharan Africa the concept of community according to Awusabo-Asare as used in interventions is less clear. A number of intervention programs described as community based have targeted high-risk groups such as sex workers, their clients, and long distance truck drivers. In most cases these individuals do not have the shared identity that characterizes vertical

communities and programs designed, as such do not involve the horizontal community within which the people live. As a result programs have been sporadic and not diffused into the general population. Hence the next generation of programs in the Sub-Saharan Africa should recognize the differences of communities and the dynamics involved.

In an article by Kerry Cullian quoted by Awusabo-Asare he asks " How do you get people to change their sexual behavior so that they are not at risk of getting HIV/AIDS? He says certainly not by giving them the right information and assuming that they will modify what they do. He emphasizes that changing people's sexual behavior is crucial in preventing HIV infection but it is a complicated process involving how an individual relates to his entire environment including Socio-economic and political. Thus programmes that do not consider the above factors are not likely to produce positive results.

However, according to Heidi Van Rooyen, a psychologist stationed in a VCT in Kwa Zulu Natal Midland South Africa, many South African behavior change interventions are not based on theory and seem to assume that people will change if given the 'right information'. However, she warns that theory is very important because it attempts to identify and understand what caused behavior but warned that many behavior change theorists were not developed to address AIDS. As a result a number of theories focused on interpersonal relationships, the intimate one-on-one relationships without taking into account the institutions and communities in which these relationships are taking place. In this case Van Rooyen points out that the only possible way forward lies in addressing the cultures and the contexts in which relationships take place.

In a conference paper presented by Akuno, he points out that many interventionists have been of the opinion that the communities have been responding well to messages, however, he poses: do communities ever change behavior? He goes further to point out that it is the individuals who change not the communities. This is because the knowledge does translate into attitude change and consequently practice of behavior. Therefore, there is need to bridge the Knowledge, Attitude and Practice gap. Akuno asserts that the worksite strategy targeting men strongly recognizes that the indoctrinations and social norms put men at the top of decision making in the family. In this view he concurs with the UNAIDS report of 1999 cited above, by indicating that men often initiate sex, by determining whether sex takes place, where, with

whom, and how. In this regard men are usually the custodians of the social constitution on what is moral, sexual cleansing and a myriad of such privileged positions.

Aggleton, on the other hand asserts that appropriate and effective communication is central to the success intervention to reduce the risk of HIV infection. In his review he examines the contexts in which communication occurs as well as the contribution of communication theory, social marketing theory, and structural intervention theory to intervention development.

Darrow 1997 (pp 88-94) in his review of prevention of sexually transmitted diseases he emphasizes the importance of incorporating applied research, social marketing, and principles of behavior change into STD prevention. He asserted that Information and education programs were provided at the beginning of the 20th century to warn the public about the dangers of venereal infections and to support medical model of case identification and case management under care of qualified medical practitioners. According to Darrow the public Health approach offered advice about chemical chemotherapeutics and barrier prophylaxis but avoided the issue of social prophylaxis. With the failure of antimicrobial agents to eradicate syphilis in the 1960s, rapid increase of viral sexually transmitted diseases (STD) and resistance strains of gonorrhea in the 1970s and the discovery of AIDS in the 1980s, alternatives to the traditional public Health approach were sought and supported. Three major innovations have been introduced to STD prevention as a result namely, social marketing, community involvement, and behavior change programs.

In the UNFPA report of 1999 efforts to include men and boys in sexual and reproductive health policies and programs have intensified world wide in response to HIV/AIDS epidemic. Condoms have long been promoted as protection from unwanted pregnancies and sexually transmitted diseases, but with the outbreak of HIV/AIDS epidemic the focus on condoms has been on the HIV prevention campaigns in many countries of the world. However, to involve men in the fight against HIV/AIDS effectively there is need to go beyond the condom use. The attention for the imbalance of power between men and women should be addressed. This will begin by questioning widely held beliefs about masculinity that contributes to the situations of risk and makes it easier for the HIV to spread untamed.

Hence today the challenge is not only to involve men in life saving programs and services but also to engage them as partners and better yet as leaders in overcoming HIV/AIDS[11] (UNFPA, 1999).

According to the above-cited UNFPA Report, reasons why men should be focused on are[12]:

- Because enlisting men to prevent HIV infection is the surest way to change the course of the epidemic. Men are involved in almost every case of transmission and almost always have the power to protect themselves and their partners;
- Because risk taking behavior increase men's chances of contracting and transmitting HIV;
- Because men's involvement is needed to empower women to protect themselves from HIV infection;
- Because promoting the use of condom are among the best ways to improve men's sexual and reproductive health, but has not received adequate attention;
- Because men and women benefit from open communication that can help build equal and safe sexual relationships;
- Because men have much to offer as fathers, husbands, brothers, sons and friends and needs to take a greater role in caring for family members with AIDS

Men are at risk because when they fail to protect themselves they also placed their partners at the risk of contracting HIV/AIDS. Young men are at risk more than older ones. In all parts of the world men tend to have more sex partners than women thereby increasing their own and their partners risks to HIV infection[13].

2.1 ATTITUDES THAT INCREASE RISK OF HIV INFECTION

Risky situations involving sexual and drug taking behavior in men are supported by cultural beliefs and expectations about "manhood. For about two thirds of world's men life expectance is lower than women. The main cause for death for young men is traffic accidents and violence,

[11] UNFPA (1999) Source: Google, partners for change: Enlisting men in HIV/AIDS Prevention p. 3

[12] Ibid UNFPA (1999) P. 3-4

which are both related to versions of manhood, which encourage taking risks or using violence to resolve conflicts.

Men are expected to be strong and caring to provide food and shelter and to fight to defend themselves and their families. In most African communities virility is defined by frequent penetration with young men pressured into sex by the needs to prove themselves (UNFPA, 1999 p.3). Often physical needs for sex are accepted as is paying for sex. The attitudes and practices that support situations of risks are impediment to safer sex. These obstacles may include ideas of masculinity, unfounded myths, and common misinterpretations of situations as follows[14]: -

- Beliefs that men are invincible and not liable to become infected that is real men ("Total" men) don't get sick this may prevent them from seeking information;
- They visit commercial sex workers often believing that going without sex is bad for health;
- Condoms use is discouraged by concerns that condoms break easily, are clumsy reduce sexual pleasure equated to "eating a sweet with its cover".

2.2 MEN'S ATTITUDES AND BEHAVIOUR PUT WOMEN AT RISK

Women and girls are at special risk of HIV due to physical and social reasons. This is due to the fact that they often have less control over when, where and whether sex takes place. Hence this has resulted in women contracting HIV at a faster rate than men, throughout the world. Women are exposed to increased risk of infections because men are more likely to have more sex partners consecutive and concurrent while women are more likely to be faithful to men[16]. Women are denied opportunities to protect themselves when the men refuse to use condoms.

In view of the above scenario, HIV passes more easily from men to women than vice versa and also more easily to young women than older ones. Social and physical factors such as violence

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[13] Elizabeth N. Ngugi, Esthetics and Health; Merits and Demerits of the female condom, MEDICOM Volume l, 15, No. 1. January – February, 2000 p. 15-16

[14] Elizabeth N. Ngugi, Esthetics and Health; Merits and Demerits of the female condom, MEDICOM Vol. 15, No. 1. January – February, 2000 p. 15-16

[16] UNFPA, (1999) Source: Google, Partners For change; Enlisting Men in HIV/AIDS Prevention, p.3

fuel the epidemic. All are complicated by the inequality between men and women. Women are probably more susceptible than men to infection from HIV in any given heterosexual encounter due to biological factors – the greater area of mucous membrane exposed during sex in women than in men, also the greater quantities of fluids transferred from men to women, the higher viral content of male sexual fluids and the micro tears that occur in the vaginal tissue.

According to Dowsett Gary, researchers in South Africa concluded that male violence has enormous consequences for the nation's struggle to stop the spread of HIV/AIDS. Their comprehensive study surveyed more than 37,000 young men. In this study one in four admitted having had forced sex without a woman's consent by the age of 18. Many thought "Jack rolling" was cool and manly. Eight out of 10 young men claimed women were responsible for sexual violence inflicted on them. Three in 10 thought that women who were raped asked for it[17].

In Kenya, little is known about men's changing roles within the household or the changing relations between genders from men's point of view. As a result men's problems, struggles and anxieties about changing rights and obligations of fatherhood are not dealt with. That is why men have not fully accepted to change their sexual behavior. As a result of this negative attitude, Programs have not been formed to meet men's needs. It has also been recognized that men lead extremely diverse lives rich/poor, powerful/marginalized, abusive/abused, some are faithful to one partner others are not they have occasional relationships with women or fellow men. Hence these complexities call for a wide range of responses. Welcoming men to talk about their concerns and to use clinics and services is part of change. Such strategies include the following:

- Working with men to reach other men increasing the number of male health providers and educators;

- Meeting contraceptive needs and going beyond contraception to address concerns such as sexually transmitted diseases and Voluntary Counseling and Testing (VCT) (To know one's HIV status);

[17] Dowsett Gary, Some Considerations on Sexuality and Gender in the Context of AIDS, Academic Premier, 106@ Columbia edu. Vol. II Issue 22 p. 21 November 2003

- Making sure that men can obtain high quality condoms at low cost and learn how to use them correctly;

- Asking men what they need in order to enable them adopt to new chances fully.

Effective communication can help overcome stigma, shame and misinformation that makes HIV to thrive despite enormous efforts to prevent it. In this regard it is important to improve communication between men and women on issues and the understanding of their joint responsibilities so that men and women are equal partners in public and private life

IEC projects are very effective in inspiring change and they have been used in many HIV/AIDS Programmes a Thailand study showed that most men have their first experience of sexual intercourse with commercial sex workers at age 17 and HIV is in youth of 17-25 years old. The projects developed partner's leaflets and handouts etc. Then more than 8000 youth leaders disseminated materials and encouraged the youth to use condoms and contraceptives. The above peer education project proved to be very effective in influencing and encountering adoption of condom use.

According to Mulenga Acting Zambian Minister for Health, men are largely responsible for spreading of HIV infections. He said this when officiating at the International Candlelight Service to commemorate people who have died of AIDS, at the Cathedral Holly Cross in Lusaka. Mulenga said that in Zambia, more women than men aged between 16 and 49 years get infected with HIV, and one in every six Zambian was HIV positive. As a result of this devastating impact on health he posed that HIV is the greatest challenge in human history and he went further to state that:

> *"If it takes two to get infected, and with the fact that more women than men get infected, then men are responsible for spreading the virus, if the statistical facts are factual".*

In a study by the University of Witwatersrand's Reproductive Health Research Unit (RHRU), commissioned by Love Life the findings were that among the 10% who were HIV positive 77% were women, and nearly one in four women aged between 20-24 is HIV positive compared to 14 men of the same age.

The survey involved a national representative sample of 11,904 people aged 15 and 24. More than 80% of young men said they really wanted to have sex for the first time whereas only 30% of women reported the same. This study asserted that young South African women were being coerced by their partners into sex to the extent that renders girls more vulnerable to infection with HIV than men.

2.3 GENDER DIVISIONS OF HIV/AIDS

There seems to be clear evidence that men's behaviour play a more critical role in the transmission of HIV than women's, but public attitudes including those of the media tend to blame women. Sex workers and women in general are often seen as the source of the disease. When a man learns that his wife is HIV positive, it can be easier for him to blame her for bringing the disease in the family than recognize that it is far more likely to have been its own behavior.

According to Foreman (UNESCO, 2000 pp 15-38), it is men's domination of women's sexual lives as in violence against women and in customs as the belief that sex with a virgin girl will cure an older man of AIDS that lies at the heart of the epidemic.

2.4 SOCIAL STEREOTYPES ENCOURAGING NEGATIVE BEHAVIOUR

The love life survey cited above, found that on average women were having sex with men four years older than them hence making it difficult for them to refuse unwanted sex or negotiate condom use. The study found that 6% of all sexually active youth had been physically forced to have sex. Women are being forced to have sex by their boyfriends and it is not being regarded as rape: "many young men and women see this as perfectly normal". There was need to tackle this misconception and challenge young men's sense of entitlement by finding ways of making them change their sexual behavior.

In an article in the East African Standard by Udoto, titled *Kenyan Men and HIV/AIDS-Where Men play Roulette with AIDS,* (2001, p11) he quoted a traditional Kenyan proverb: "An authentic bull

dies chewing the grass …" It matters little that the grass could be poisonous, inedible, or even too young". He states further that for Kenyan urbanites they are treated to offensive stickers in public vehicles and pubs as follows: -

"A girl is like a maize cob to be chewed" Another declares that a woman is like a bus; you miss one you get another. But a man is like a train you miss one and it is gone"[18]

These messages could sound entertaining but they clearly show men's attitude towards sex and their subsequent role in the HIV/AIDS spread. Hence the HIV/AIDS fight has the challenge to change the harmful concepts of masculinity and contents of long held beliefs and attitudes that must be discouraged as part of the efforts to slow down the spread of HIV/AIDS.

Udoto's theme takes heavily from the London based Panos publication: AIDS and MEN: Titled Taking Risks or Taking Responsibility. This book recognizes that it is fallacious to place the responsibility for protection against AIDS on women yet it is largely men's behavior that propels the epidemic. Therefore, the challenge is to encourage men to value sexual responsibility and restraint rather than excuses, we will have gone along way towards reducing the risks of transmitting HIV.

Communication between men and women is at the heart of this positive change on sexual behavior. However, communication can only be effective, if and when the educators are able to convince men to take the lead in the fight against HIV/AIDS. That is why male involvement and empowerment in the fight against HIV/AIDS is a must if the course of the disease is to change.

In a study by Nganzi Stella, Nyanzi Barbara Kalima Bessie pool Robert (2003) whose aim is to examine the sexual behaviour of a highly qualitative and quantitative data were elicited from 212 motorbike taxi men locally called Bodaboda men from two study sites in Masaka, Uganda. Selection criteria was availability and willingness to participate in the study[19].

[18] Paul Udoto's Publication in the *East African Standard*. 'AIDS and Men: Taking Risks or Taking Responsibility. P. 7, 2001.

[19] Ngazi Stella, Nyanzi Barbara, Kalima Bessie, Pool Robert (2003) Mobility sexual Networks and Exchange Among Boda Boda men in South West Uganda. Source: Academic Premier (Culture Health &Sexuality, May 2004 Volume 6 Issue 3, p16)

Research techniques employed were questionnaires and focused group discussions, in depth interviews and case studies. Findings indicate that Bodaboda men are a highly mobile group who engage in frequent seasonal rural-migration. Consequently, the Bodaboda men have a wide network of both serial or concurrent multiple partnerships which they have with adults, youths, widows, students, sugar mummies bar maids, commercial sex workers, etc. money plays an important role in access to sexual partner. Since Bodaboda men have regular access to cash they have a higher bargaining power for sex[20].

Access to money is also commonly cited in the case of fishermen along Lake Victoria facilitating soliciting for sex from women fish traders, for survival. When women go to the beach to buy fish it becomes so difficult to get fish since the fishermen will only sell or give fish to the women in exchange of sex. As a result it is an open secret that among the fishermen along Lake Victoria around Rusinga, Kaksingiri, Gwassi, women fish traders are given fish in exchange of sex. The Nation TV in January, 2004 gave good feature coverage of this phenomenon as women traders themselves gave confessions during the interviews and admitted that they have been victims of such sexual horrors at the hands of men. This is a clear indication that most men have not adopted positive sexual behaviour and subsequently their behavior towards sex as evidenced by the behaviour of soliciting for sex in exchange to fish. Along the Kenyan beaches there is a common slogan: 'Fish for sex' or 'sex for fish'. NGOs and the Government are tying to discourage such bad sexual behaviors but with little success.

2.5 AIDS INFORMATION AND EDUCATION

In order to inform and educate the general population in Kenya about HIV infection and control, print and electronic media have been used both formally and informally as part of Government progamme[21] (Elizabeth N. Ngugi & Francis A. Plummer, 1988 p. 567). According to Ngugi and Plummer, in Kenya the mass media began creating awareness to the general population in the late 1980s with newspaper captions that contributed to increasing awareness. Examples shown on Table 1 are adopted from Ngugi and Plummer from their article cited above:

[20] Ibid

[21] Elizabeth N. Ngugi & Francis A. Plummer Health Outreach and Control of HIV Infection in Kenya, Journal of Acquired Immune Deficiency Syndromes, Vol. I No. 6, 1988 p. 566-568

Table 2. 1: Selected Headlines from Kenyan Newspapers Concerning AIDS

November 16, 1985	"Three AIDS Death in Kenya"
March 3, 1986	"Researchers call for Big AIDS Campaign"
April 4, 1986	"Campaign launched to Help Fight AIDS"
April 14, 1986	"Keep AIDS at Bay, Stick to Safe Sex"

The above quoted messages on Table 2.1 above were repeated in the electronic media. In December 1987, a survey was conducted to find out what Kenyans know about AIDS: How it is transmitted, how to avoid getting infected and the communication channels that best reached the people. The study population was randomly selected from 21 districts out of 42 districts in Kenya. The method of data collection was questionnaires. Seven thousand five hundred and eighty people of different sex were randomly chosen to participate in the study. Out of the above respondents 3,498 were urban and 3,664 were rural residents.

The outcome yielded important information that is useful to AIDS education strategies. For example Table 2.2 below shows how people heard about AIDS. According to findings illustrated in table 2.2 the media is the leading provider of information followed by interpersonal communication passed through word of mouth. This mode of communication is quite common in Africa especially among the illiterate people (E. Ngugi and P. F. Plummer 1988 p. 567).

According to Ngugi et al, information about AIDS from one person to the other is one of the single most important modes of communication (56%) radio (58%) and newspapers (42%).

Table 2.2: How Kenyans have learned about AIDS: Males and Females

Mode of Information on AIDS	**Yes**	%
Radio	4373	57.6
People (friends, teachers etc)	4241	55.8
Newspapers	3193	42.0
Posters	1854	24.4
Television	554	7.3

Source:

Table adopted from E. Ngugi and Plummer (1988 pp 567)

According to the above study the woman had low exposure to all modes compared to men. This may be due to different accessibility levels and level of interaction.

In an article "Enhancing Behaviour change" Oyaro and Achieng (2003 pp 7) have cautioned that behaviour change communication has been mistakenly focused on community education through posters, brochures, pamphlets and tapes, but this approach has not achieved the desired effects. This has resulted in giving too much information on the disease and little information on behaviour change, hence the need to draw a balance on messages that focus on behaviour change. Strategies that will make behavior change take root are as follows (Oyaro and Achieng 2003 p. 7): -

- Promotion of VCT services at strategic locations such as health care delivery points;
- Promotion, demonstration and distribution of user friendly and culturally accepted information, communication and education material;
- Encouraging individuals living with HIV infection to talk of their experiences in public forums and to their families in order to demystify the infection and give it a human face.

In another study by Ngugi et al it is pointed out that one of the most important aspects of control of sexually transmitted diseases is the understanding of sexual behaviour. Yet given that most people in Africa consider discussing sex as a taboo, for example the Kikuyu (Ngugi 2001: Reaching Clients of Commercial Sex Workers, Male Sexual Behavior in Kenya – unpublished)[22]. This secrecy about sexual matters makes it very difficult for researchers to get to the roots of male sexual behavior.

Therefore, in an attempt to unearth the male sexual behavior the study set out to establish preferred sexual behaviors of men and to facilitate facts that would be useful for positive intervention.

[22] Ngugi, E. N. Njeru, E.K. Plummer F.A. Moses, S. Karanja M, University of Nairobi , Kenya University of Manitoba, Canada, Ministry of Health Machakos General Hospital, Reaching Clients of Commercial Sex Workers, male sexual behaviour in Kenya unpublished research carried out in Machakos and Thika Towns. (2001).

A cross sectional survey of all possible male clients of commercial sex workers was done from urban male population in Thika and Machakos towns. A knowledge, Attitude and Practice (KAP) survey was administered by trained interviewers with health background. Focus group discussions were also employed, to probe sensitive issues related to sex/sexuality and health seeking behavior. Most of the respondents were found in bars, self- employed (jua kali) touts, and public transport drivers and businessmen.

In the study eighty five per cent of the respondents said they had heard about condoms and when asked what condoms were used for 91% mentioned prevention of STD/AIDS, 28.6% mentioned prevention of pregnancy while 0.7% said they did not know. According to Ngugi's study it was reaffirmed, that the high level of knowledge (awareness) was not comparable to preventive behavior because a large number of 42.0% of the men respondents said they have never used a condom. Of those who may have used condoms, however, among those who used condoms, majority of them said they obtained condoms from the clinics. However, those who had never used condoms when asked why, they said it was because they did not know how to use them. Equally important to note is that the above study revealed that AIDS information was mostly from Mass Media (91%). The second important source is from friends and neighbours (Ngugi et al, 2001)[23]. It is therefore, important to note that the failure of men to use the condoms is mainly due to a communication problem. This is in the fact that they say they do not know how to use the condoms which in effect means that they have not been made to know how to use the condoms. Also they may have not been made to understand the usefulness of condoms so they have not taken it seriously. If communication were successful then the men would have surely taken advantage of condom use in order to avoid contracting HIV/AIDS. As evidenced from the study, the majority of the people get preventive information from the media. Yet as we know the media is only effective in creating awareness and not in effecting behavior change. According to this study and other studies awareness has been achieved up to 99 per cent but those making deliberate effort to change their behavior positively are only 25 per cent. This may point to the effect that the communication channels that are effective for behavior change have not been exhausted enough. Hence the gap between awareness and behavior change. Therefore, the main aim of this study is to narrow the gap between awareness and positive behavior change. By identifying the obstacles that prevent men from adopting positive

[23] E. N. Ngugi Reaching Clients of Commercial Sex Workers, Male Sexual behaviour in Kenya Research carried out in Thika and Machakos Towns (2001)

behavior and also identifying the most effective communication channel that would be used in effecting behavior change.

The above study further revealed that 18% of respondents said they always need to have sex with someone else other than with their wives and they did not give reasons why and this is an area that needs research. The wives need to take note and seek information on how to satisfy their husbands [24].

In view of the fact that information on AIDS is mostly received through the mass media and through friends or neighbors, this could perhaps explain the lack of success in achieving sexual behavior change among men. This is because mass media is only good at creating awareness and not in effecting behaviour change. Effective communication that would lead to behavior change has to be done through counseling, focus group discussions, where the communicator and the target group will first establish trust and confidence in one another before getting into convincing someone to change their behavior about such a sensitive subject such as sexual behavior. For example in Africa rituals that involve sex are part of the daily lives of the community members. These rituals were considered to be essential for maintaining order in the society.[25]

Since women lack negotiation skills for safer sex practices, coupled with the absence of women controlled methods for STD/HIV prevention and control aggravate the situation. Male domination in sexual matters and their reluctance to use male condoms with wives, girlfriends and commercial sex workers is an added reason why men should be enlisted in the fight against HIV/AIDS. This is in the light of the fact that the female condom has some set back which are inherent in the fact that it is complicated to use and so expensive that an average Kenyan woman cannot afford it.

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[24] E. N. Ngugi et al, Ibid

[25] Oyugi B. O. Mutemi R. M. Aoko M. Mboya T.O. Socio-Cultural Determinants of Sex Behaviour: A case study of Mwingi and Homa Bay Districts, Kenya. *University of Nairobi, + National AUIDS Control Program, **Ministry of Planning, ***Results of a Pilot Study

[26] Elizabeth Ngugi, Special Review Articles: Esthetics and Health Merits and Demerits of the Female Condom, MEDICOM Vol. 15 No. 1 January – February 2000 p. 15-17

Female condom is an important option for prevention and control of STD/HIV/AIDS. The challenge is to make the female condoms available, affordable and accessible.[26]

According to E. Ngugi if properly used "female condom is believed to be as good as or better than male condom at preventing STD/HIV infections because it is stronger and covers a slightly larger area. However, it is slightly more effective than the male condom in preventing pregnancy[27]. There are demerits of female condoms, for example, in some cultures self-fondling of private parts is discouraged or even considered as taboo, yet the female condom requires the user to insert it. Also the woman find the actual insertion technique difficult to master. However, with training the skill is acquired. Since men do decision making in sexual matters, if men are not fully empowered about HIV/AIDS prevention they might not appreciate the female initiative to use condoms. Hence reject it and stop woman from using it.

2.6 SOCIO-CULTURAL AND SOCIO-ECONOMIC ENVIRONMENTS

Studies already done on AIDS in Kenya seemed to have ignored the socio cultural background of the Kenyan societies. Ayayo and Muganzi assert (1993:5)[28] in their article on sexual practices and the risk of the spread of HIV/AIDS in Kenya. They reveal that the transmission of the African AIDS is slightly different from the Euro-American AIDS. They pose a question: why should the African AIDS be spread almost exclusively through heterosexual intercourse? The answer to this question may include the fact that in Africa there is still a number of heterosexual partners as a result of many types of marriages, for example, polygamy, widow inheritance) (practiced among many communities in Kenya). According to Ayayo and Muganzi, this grave situation is made worse by the fact that many Kenyans are moving away from the rigid traditional authorities and rules of conduct, which used to surround sex and reproductive matters, as a result creating a free socio-sexual freedom.

Ayayo and Muganzi further reveal that among the Maasai community of Kenya there is a socio-sexual freedom within the same age set. This is likely to suggest that AIDS could spread easily

[27] Ibid, p. 15-17

among members of the same age-set because they share the same partners (Ayayo and Muganzi: 1999:6). In the same article they have indicated that studies in West Africa reveal, that a significant number of women including schoolgirls engage in sexual relationships in order to earn some income, a practice that is also happening in Kenya, whereby ordinary women other than the elite adopt sexual behavior outside their marriage to meet specific needs. In view of the above prevailing social relationships, sex seems to be so free that neither the tradition nor religious norms can control it adequately (Ayayo and Muganzi: 1993 p. 5). They assert that the prevalent sexual activity among the youth is due to lack of parental authority over them. Elders in many Kenyan societies assert that night dances, which are frequented by the youth in the rural areas and in urban areas, provide ample opportunity for meeting and for gratifying sexual feelings. This is made worse by the freedom that not all courtship should lead to marriage but they relate sexually making it possible for contracting and spreading HIV.

Ayayo and Muganzi reveals further that in some Kenyan communities young men do not to marry girls who are still virgin because they want proof of fertility. One such society is the Akamba of Kenya. In this community boys and girls must have had some sexual experience before marriage. Ayayo and Muganzi assert that almost all the traditions and norms that governed sexual relations have been ignored almost completely. In this assertion they concur with Ger, in her publication: AIDS Hope or Disaster (the East African Standard, 1999:45). Ger states that: "information gap is contributing to the spread of STDs and AIDS in schools because in the African society it was the responsibility of an aunt or an uncle to explain to a girl or a boy respectively what adolescence entails". [29] She states further that due to breakdown of kinship ties, mothers are forced to assume this role, which they are not performing well; coupled with the fact that sexuality is not discussed with ease like any other subject compounds the problem even further. Mulindi (2004) too made this assertion during an interview with him on this study.[30] He affirmed further that in Africa discussing sex openly is regarded as a taboo. As a result sexual matters are discussed rarely and when absolutely necessary and even during such circumstances, it is talked about with guilt, fear, and anxiety. Ger (1999:46) points out that as a result majority of the youth get information concerning their sexuality from peers, media,

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[28] A.B.C.Ayayo and Muganzi, (1993), The Sexual Practices and the risk of the spread of HIV/AIDS in Kenya, PSRI University of Nairobi p.5

[29] Caroline Ger Onyango, (1999) AIDS Hope or Despair East African Standard, Nairobi, Kenya p.45

[30] Interview with Dr. Sobbie Mulindi Vice Chairman National Aids Council and Senior Lecturer University of Nairobi, College of Health Sciences may, 2004

teachers, house helps, and religious groups.[31] Consequently several girls and boys have fallen victims of the information gap leading to early sexual debuts, which correlates with involvement with multiple sex partners.

2.7 HIGHLY MOBILE POPULATION CONTRIBUTES TO THE SPREAD OF AIDS IN KENYA

In most Kenyan communities, men are expected to provide all the basic necessities to their families. In order to meet this demand men move from rural areas to towns in order to secure employment or business opportunities. In the process of fending for family or personal needs they develop sexual networks or linkages that could lead them into contracting HIV infections. Border towns like Busia are good example of possible impacts of mobility on the spread of HIV infections. According to Lukalo in a study published by UNESCO in 2000 pages 51-61) the border towns tend to be cosmopolitan with a mixture of people interacting on different levels many of whom are only there temporarily.[32]

There tends to be more money in circulation, which encourages an active social life as is evidenced from the loud music that spills out of the numerous bars, lodges and hotels in Busia town. Along the main street it seems that every other shop is a bar and a lodging and patrons are seen as early as 10.00 a.m. Movement between rural and urban homes even within a restricted area like Busia District is now frequent and may explain the rapid increase in HIV infections. Mobility associated with migration is usually temporary, people leave their villages hoping to find seasonal or temporary work but always hope to return home. Despite moving to towns migrants tends to keep in touch with their families and friends at home (in the rural areas) ensuring regular contracts especially during weekends and holidays and an infected individual may spread HIV/AIDS to others at both ends of the chain[33].

Mobility linked to urbanization has long been recognized as a factor in the spread of AIDS in Kenya, but little has been done to understand the enormity of it, the vulnerability it creates and its impact on the lives of the people.

[31] Ger Onyango, Ibid p. 46
[32] Ibid, Rose Lukalo, "Highly Mobile Population Contributes to the spread of AIDS in Kenya" p.51-61
[33] Ibid Rose Lukalo, P.51-61

In 1960 only 7 per cent of Kenyans lived in the urban centers but this figure has risen to 28% of Kenya's 29 million people and is largely as a result economic factor (UNFPA, Report 1998).

The capital city of Nairobi for example has experienced rapid growth. The population of Nairobi is now estimated at over 3 million with a growth of 6% more than half of Nairobi population lives in slums. The urbanization in Kenya is attributed to rural-urban migration. The young school leavers who are in search of employment and other opportunities in urban centers are the most dominant immigrants. It is in the slums where most of those who migrate to urban areas end up living.

One of the giant slums in the heart of Nairobi is Kibera, consisting of 13 villages. Kibera, is a home to an estimated 850,000 people who have a lot in common with most poor communities world-wide, have had the social and economic systems on which members of the community depend for their survival, but have been challenged and stretched to capacity by AIDS.

According to Anne Owiti, Coordinator of a community based program for AIDS orphans and their families in Kibera slums (UNESCO, 2000), says that it is important to understand that relationships in the slums are borne out of needs and practices. For example, a man working as a night watchman in a city might enter into a relationship with a woman simply to ensure that he has someone to provide security for his house while he is away (UNESCO, 2000)[34]. In exchange the woman gets food, shelter and a measure of protection. It is also common for men living in such arrangements in the urban centers to leave their wives in the rural areas.

The fact that slums are inherently unhealthy places with lack of access to running water and stinking open sewers, no electricity, no roads, overcrowding. These factors make it difficult for those planning AIDS interventions to reach populations living in the slums.
The result is that, Kibera which is said to be the largest slum in Sub-Saharan Africa, has a high incidence of HIV/AIDS estimated at 25 per cent and is still growing even higher.

Attitudes towards sex have definitely changed. Ochola-Ayayo (1998) conducted a study on sexual practices and risk of the spread of HIV/AIDS and found that three quarters of

interviewees in urban areas no longer believe in cultural values that restricted sex before and outside marriage. This is strong evidence that social, cultural and economic changes have taken place with rapid urbanization.

With an average population growth of 2.6 per cent the population of Kenya is expected to reach 50.2 million by the year 2025. Revised projections released recently, however, suggest that the AIDS epidemic could stabilize the population at 32 million in 12 years time, at which point the population growth will have slowed down to 0.6 per cent because of HIV/AIDS (Lukalo UNESCO, 2000)[35]. According to the UNESCO Report cited above towns with the highest recorded incidence of HIV/AIDS include Nakuru, Kisumu and Nairobi at 20-30 per cent followed by Mombasa, Kakamega, Thika with the prevalence of 10-20%. With exception of Thika these towns are also major truck stops on the highway.

Boomtowns have grown around the truck stops with many sex workers to whom the truck drivers may turn to for sexual relationship while away from their spouses.

2.8 MOBILITY AND GENDER

An interesting aspect of the mobile population in Kenya is the distinct gender breakdown. More men than women tend to migrate to cities like Nairobi and other urban centers where they can find work, leaving wives behind in the rural areas.

Similarly the truck drivers too leave their wives behind. The result is the breakdown of social norms especially those governing sexuality and results in increase vulnerability to risky sexual behavior and HIV/AIDS.

To date, efforts in Kenya to control the spread of HIV/AIDS have concentrated on health education and awareness creation about the disease based on knowledge that it tends to spread faster among people who engage on risky behavior. Almost the whole population in Kenya has been reached with information on AIDS and studies have shown that knowledge about the disease is widespread. However, this has not encouraged people to change their behavior.

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[34] Ibid Rose Lukalo. P53

Mulindi says that "Despite having information at hand, people continue to put themselves at risk on a daily basis" UNESCO (2000)[36]. He says further "Since the inception of the National AIDS Control Program in the late 1980s, there has been a presumptive belief that traditional health education about HIV/AIDS would be sufficient to introduce widespread behavior change.

There are clearly more powerful factors that continue to influence the choices that people make, even if faced by life-threatening situations as those posed by the risk of being infected with HIV/AIDS.

Human mobility has contributed both positively and negatively to the creation of Kenya, as it exists today. The increasing movement of individuals and large populations of people within and outside the country is part of the structure of modern Kenya and the process cannot be stopped.

2.9 KENYA'S STRATEGIC GEOGRAPHICAL POSITION RESOURCES AND FACILITIES CONDUCIVE TO MOBILITY

The strategic geographical position of the country with access to natural harbors, its natural resources, its position as an economic center for trade in the Eastern Africa regions, its reputation as the leading tourist destination in Eastern Africa region, has all contributed to its attraction to many international visitors (tourists). Also Kenya's excellent conference facilities have turned it into a host of many conferences and workshops. There is over concentration of industries, companies and other potential sources employment. Consequently, local population tends to migrate to the cities or urban areas in search of employments, business opportunities. Hence millions of people are on the move around Kenya each year.

Efforts to stop the spread of HIV/AIDS must begin by recognizing this high mobility of people as a point of intervention and focus specifically on reaching people on the move with programs that address their real vulnerabilities. This must not be done in a piece meal manner as has been the case in the past where certain groups as CSWs are targeted as high risk while others like tourists are ignored in the assumption that they have been catered for elsewhere.

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[35] Ibid Rose Lukalo (UNESCO, 2000) p. 54

HIV/AIDS interventions must look at the issue of mobility with greater thoroughness beginning with research to scientifically design the common conditions that encourage exposure to HIV/AIDS and thus influence the impact of HIV/AIDS in Kenya.

2.10 REDUCING HIV TRANSMISSION IN DEVELOPING COUNTRIES

In developing countries socio-economic factors foster behavior such as unprotected sex with multiple partners that facilitate HIV transmission[37]. (Nagelkerke et al 2001 p. 224). Dealing with socio-economic issues may take decades or longer. Therefore, researchers have to come up with effective interventions that can improve health and put HIV infections at bay.

Nagelkerke et al came up with three intervention criteria for containing HIV/AIDS prevalence. In the first criteria it is important to note that transmission in developing countries is largely by heterosexual intercourse, yet how sexual behavior drives the transmission is often misunderstood.[38]

In any given population the most number of sex partners is heterogeneous. This according to Nagelkerke has prompted the concept of high frequency transmitter core groups of individuals who have multiple partners and are key in maintaining HIV epidemics. Therefore, "ensuring condom use by one core group member with 100 sex partners per year is more than one 100 times as efficient as ensuring condom use by someone with one partner."[39] This is qualified as the number of individuals that an intervention needs to affect to prevent one infection, that is the intervention efficiency ratio.[40]

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[36] Ibid (UNESCO, 2000) p. 60
[37] P. Jha, N.J.D. NagelKerke, E.N. Ngugi, J.V.R. Prasada Rao, B. Will bond, S. Moses, F.A. Plummer, Reducing HIV Transmission in Developing counties Policy Forum: Public health Vol. 292 Science www.sciencemag.org April 13, 2001 p. 224
[38] N.J.D. NagelKerke, E.N. Ngugi, J.V.R. Prasada Rao, B. Will bond, S. Moses, F.A. Plummer, Reducing HIV Transmission in Developing countries Policy Forum: Public health Vol. 292 Science www.sciencemag.org April 13, 2001 p. 224
[39] Nagelkerke et al p. 224
[40] Nagelkerke et al p. 224

The second criterion is amenability to change, which Nagelkerke et al relates to the feasibility of success of the intervention in accessible populations. For instance, it is practical to make sexual contacts safer than to avert such contacts[41]. Similarly it is more feasible to ensure condom use during casual sex than with steady partners.

The third criteria are cost-effectiveness. Since most interventions are long-term assessment of cost effectiveness of particular measures is very crucial.

Peer mediated education programs among female sex workers are perhaps the ones with the highest impact in preventing HIV infections in developing countries. Peer mediated education programs generally reduce the stigmatization associated with the sex trade. Although high-risk men are not as readily identified as high-risk women, they may be accessed for intervention through their work place. However, according to Nagelkerke et al, there are many more clients than there are female sex workers and they have far fewer sex partners reducing the intervention efficiency ratio (Nagelkerke et al 2001 p. 224).

Several interventions have potential in preventing HIV infection. One of them Voluntary Counseling and Testing Centers (VCTs) is very popular but its sustained effect on behavior change remains to be seen. In deed in Kenya today there are many VCTs and the government is committed to the program and it is encouraging people through concerted efforts to visit VCTs and the response has been fair.

Although female condoms or vaginal microbicides may become effective alternatives to male condoms in preventing HIV transmission, the female condom use is limited and evidence for efficacy is lacking. The cost element is also prohibiting because female condoms are very expensive and out of reach of many women.

Mass media information increases knowledge of HIV and is thought to create environment permissive for prevention interventions. However, in industrialized countries there is little evidence for direct effect on behavior and there are few studies on effect of mass media campaigns in developing countries. Nagelkerke et al have come up with five recommendations for controlling the spread of the epidemic as follows: -

[41] Nagelkerke et al p. 224

i. HIV control programs need to incorporate the most effective evidence based interventions and should focus on high-risk groups as a first priority.

ii. The Government and donors should set aside substantial funding on high impact interventions.

iii. Money should be spent better. Out of the 60 World Bank HIV/AIDS projects before 1992 only 48% were spent on condom promotion, 57% supported STD treatment and 38% was spent on AIDS treatment.

iv. Expanded research agenda should include studies on effectiveness of male circumcision and vaginal microbicides.

v. There is need to enhance monitoring of key interventions. Countries need to collect reliable surveillance data, map transmission hot spots, estimate coverage for key interventions and evaluate the impact of interventions on HIV transmission.

HIV/AIDS Communications must be culturally appropriate although when certain dominant cultural and traditional norms and values favor the conditions for the spread of HIV/AIDS, communications practitioners may need to challenge them. But there is a danger that when outside influence and money back these challenges local communities often reject what they consider a cultural assault, regardless of how reasonable the outcome or how honorable the intentions of the outsiders. Therefore, positive health behaviors are more likely to be attained and sustained when the people within a cultural setting are involved in a contextual transformation process. More so the people to be involved in the process of change are the ones whose cultural source of power is threatened most and in this regard men's source of power is threatened most hence if their involvement is attained then positive change will occur. I say that man's source of power is threatened through endangering HIV/AIDS as this gives both men and women equal say over sex issues. Whereas in a cultural society all decision-making lies with the man as the undisputed head of the family and the household. For HIV/AIDS war to succeed, men's power over decisions making in such issues as family and sex issues must be challenged but has to be done tactfully without pursuing them to rebellious attitude. Inequalities between men and women both directly contribute to the spread of HIV/AIDS. Strategically women must be at the center of the response to HIV and AIDS, tactically men must be involved to address both AIDS and gender inequalities.

2.11 THEORIES AND MODELS USED IN HIV/AIDS PREVENTION: SOCIAL THEORIES AND MODELS

According to UNAIDS Report of (1999, P.8) over emphasis on individual behavioral change with a focus on the cognitive level has undermined the overall research capacity to understand the complexity of HIV Transmission and control. Focusing only on the individual psychological process ignores the interactive relationship of behavior in its social, cultural, and economic dimension thereby missing the possibility to fully understand crucial determinants of behavior. In the UNAIDS Report cited above, it is pointed out that in many cases, motivations for sex are complicated, unclear, and may not be thought through in advance.

Social norms, religious beliefs and gender power relations infuse meaning into behavior enabling positive or negative changes. The main difference between individual and social models is that the latter aim at changes at the community level. Sociological theorists asserts that society is broken up into smaller sub cultures and it is the members of one's immediate surroundings, the peer group that someone most identifies with that has most significant influence over an individual's behavior. According to this perspective effective preventive efforts especially in vulnerable communities that do not have societal support will depend on developments of strategies that can enlist community mobilization to modify the norms of this peer network to support positive changes.

Commonly used communications theories and models have been reviewed by researchers and practitioners and found to be limited in their applicability to HIV/AIDS prevention, care, and support (UNAIDS a Penn State Project 1999). This is due to the fact that many of these theories and models focus primarily on individual behavior, and make little or no allowance for the role of the social and environmental context of disease prevention interventions. The assumptions (such as individualism as opposed to collectivism) on which these theories and models are based on, is foreign to Africans[1].

[1] UNAIDS Penn State Project Communication Framework for HIV/AIDS, UNAIDS INFORMATION center, 1999 p. 18

In the African context, role of the family, group and the community play a greater role in decision making than individuals. Yet theories and models based on individualism continue to dominate communication strategies for HIV/AIDS prevention and care.

The models of behavior change most often used to guide health communications programs are the same ones used to inform promotion programs. These theories and models include Health Belief Model, the theory of reasoned Action, Social Learning and Cognitive Theories. The AIDS Risk Reduction Model has the following components: Stages of Change, Hierarchy of effects, Social marketing and Diffusion of Innovation theory[2].

2.11.1 THE HEALTH BELIEF MODEL (HBM)

This model was developed in the 1950s to predict individual response to use of screening and other preventive health services. This theory posits that health behavior is a function of individual's socio-demographic characteristics, knowledge, and attitudes as follows:

(i) Perceived vulnerability to a particular disease (ii) Perceived seriousness of the disease, for instance, 'how hard would my life be if I got AIDS?' (iii) Beliefs in the effectiveness of the newly adopted behavior (IV) witnessing death of an AIDS victim. (v) Perceived benefits of preventive action (VI) barriers to taking a positive action.

2.11.2 THEORY OF REASONED ACTION

Fishbein and Ajzen advanced the theory of Reasoned Action in the mid-1960s. It is based on the assumptions that human beings are usually quite rational and make systematic use of the information availed to them. This theory is similar to the Health Belief Model but it adds the constructs of behavioral intentions as a determinant of health behavior. It focuses on the role of personal intention in determining whether the behavior will occur. According to this theory a person's intentions is a function of two basic determinants: I) attitude (towards the behavior) and ii) subjective norms i.e. social influence. In this case normative beliefs play an important role in the theory and generally focus on what an individual believes other people would expect him to do especially influential people.

2.11.3 SOCIAL LEARNING AND COGNITIVE THEORIES

The social Learning and cognitive theories are based on the assumption that individual behavior is as a result of interaction with people and or environment whereby motivation plays an important role in what is learned and retained. According to Bandura (1977) central tenets of the social cognitive theory are: self-efficacy and belief in expected out comes.

2.11.4 THE AIDS RISK REDUCTION MODEL

This Model is based on the belief that one has to label behaviour as risky for one to start a change to the next and sustainability of change. Cantania et al developed this model in 1990. It identifies three stages involved in reducing risk for HIV transmission as follows: i) behavior labeling ii) commitment to change: and iii) taking action.

2.11.5 STAGES OF CHANGE MODEL

This model is based on the conception that individual behaviour change goes through a process involving a series of five interrelated stages namely; (i) Pre-contemplation stage whereby an individual has not considered using condoms. (ii) Contemplation period whereby the individual is contemplating using condoms (iii) Action stage where by an individual is considering using condoms (iv) the individual is using condoms consistently for a period less than six months) (vi) using condoms consistently for a period more than six months consistently. This is the maintenance period. (vi). Finally the relapse period during which an individual is slipping –up with the condom use.

2.11.6 HIERACHY OF EFFECTS MODELS

This focuses on individual behavior change in a linear fashion, which begins with exposure to information and assumes that knowledge attitudes trial and adoption of the censored behavior will necessarily follow.

[2] Ibid.

2.12 DIFFUSION OF INNOVATION THEORY

The Diffusion of Innovation theory focuses on the communication process through which new idea or products become known and used in a target population. Diffusion of Innovation is one of the major theoretical frameworks of this study. The interpretative models of diffusion (by Wejnert Barbra –2002) provides a conceptual array of variables defined in diffusion research into three major components as follows:

i) The characteristics of the innovation itself within which two sets of variables are defined concerning public versus private consequences and benefits versus cost of adoption

ii) The characteristics of the innovators that influence the probability if adoption of an innovation. Within this component six sets of variables concern societal entity of innovators. For instance, familiarity with innovations, status in the society, socio-economic characteristics, position in social networks, personal qualities and benefits of the new idea

iii) The characteristics of the environment via structural characteristics of the modern world. This latter characteristic involves four sets of variables: a) societal culture
b) Political conditions c) geographical settings d) global uniformity.

The theory of Diffusion of Innovation is grounded on the work of Rogers and Shoemaker. The crucial elements of this theory are: i) the innovation ii) which is communicated through certain channels iii) over time iv) among the members of the social system.

There are four elements of communication theory that can be related to the theory of the Diffusion of Innovation as proposed by Aristotle's model of communication consisting of the speaker, the speech, and the listener. Lasswel's communication as dealing with: **'who says what, through what channel of communication, to whom, with what result'** as formed the main basis of the **S-M-C-R** model which consists of: **Source, message, Channel, Receiver and the effects of the communication**. The receivers are members of a social system, the channels are means by which innovation spreads, the message is the origin of the innovation i.e. an inventor who is the change agent or opinion leader, finally the effects and the overt behavior

for instance adoption or rejection of the behavior. All innovations should not be assumed as equivalent units of analysis. This is because others take relatively shorter time to reach their complete adoption while others take decades to reach complete adoption. This is because there are several factors that contribute to their different rate of adoption. These factors are as follows:

(i) Relative advantage, which refers to the degree to which the innovation is perceived as better than the idea that it supersedes. The degree of relative advantage may be measured in economic terms but often-social prestige factors, convenience and satisfaction are also important components. It does not matter whether the innovation has a great deal of objective advantage, what matters are whether the individual perceives the innovation as advantageous. Hence the greater the relative advantage of an innovation the more rapid would be its rate of adoption. If we take condom adoption for instance, it is objectively very advantageous yet its adoption has been relatively low. Could it be that the relative advantage of the condom use is not great? This is one of the issues that this study is set to find out. What is the objective advantages viz a viz the social and prestige advantages that out ways the objective advantages? If this mystery is brought to light then the obstacles to complete condom adoption could be dealt with.

(ii) The second issue is compatibility, which refers to the degree to which an innovation is perceived as being consistent with the existing values, past experiences and needs of the receivers. According to this theory an idea that is not consistent with the prevalent values and norms of the social system will not be adopted as rapidly as an idea which is compatible.

(iii) Complexity is also a very important factor in adoption of innovation. It refers to the degree to which the innovation is perceived as difficult to understand and use. Members of the social system readily understand some innovations. Others are complicated and not easily understood and hence they take long to be adopted.

(iv) Triability refers to the degree to which an innovation may be experimented with on a limited basis. New ideas which can be tried on installment plan will generally be adopted more quickly than the innovations which are not divisible Innovation that is triable represents less risks to the individual who is considering trying it.

(v) Observability; this refers to the degree to which the results of innovation are visible on others. Hence the easier it is for an individual to see the results of an innovation the more likely it is for him to adopt it.

(vi) Finally, the time factor is an important consideration in the process of diffusion of innovation and it involves the following: decision making process of which an individual passes from first knowledge of the innovation through to its adoption or rejection. It includes the relative earliness or lateness to which an individual adopts an innovation when compared with the other members of the society has made the theory to come up with five adopter categories as follows: In the first category there are the venturesome or the innovators. This group leads the rest of the society in adoption of innovations. They control quite substantial amount of resources, which makes them eager to adopt new ideas or innovations. The second group is the early adopters. This group has the greatest degree of opinion leadership than any other group. Potential adopters look for early adopters for advice and information about the innovation. The early adopters are considered by many as the man to check with before using a new idea. This adopter category is generally sought by the agents to be a local missionary for spreading the diffusion process. They serve as role models for many other members of the social system. His peers respect the early adopter. This Category known as the early majority, adopts the idea just before the average member of the social system. They interact with their peers more frequently but they do not have leadership roles. The late majority usually view adoption as an economic necessity and the answer to increasing economic pressures. They approach innovation with a careful and a skeptical air and they do not adopt until most of the people within the social group will have done so.

Finally the laggards are the last to adopt an innovation. They posses no opinion leadership they are traditional in their outlook towards life. Their point of reference is the past. Decisions are always made in terms of what has happened. This individual interacts primarily with people who are of traditional values. When the laggards finally adopt an innovation it may have been superseded by another or a more recent idea, which the innovators are already using.

In view of the above this study aims to establish how the individual perceives the innovations that have been introduced to bring sexual behavioral change for HIV/AIDS prevention. Could

it be that due to the failure of the interventionists to follow the theory strictly that sexual behavioral change has been so elusive? Perhaps the interventionists have not demonstrated to the people the full benefits of the innovation? Or the communicators have no credibility? The study is set to unearth all these mysteries.

2.13 CONDOM PROMOTION AND SOCIAL MARKETING

It has been proven many times that correct use of condoms is an effective method of preventing HIV transmission. Yet there are many research studies that have identified obstacles to their use in many researches throughout the world including inaccessibility and lack of partner communication among other factors.

At the initial stages of HIV prevention programs included condom promotion and free distribution as part of a comprehensive HIV prevention package. Free distribution was essentially aimed at introducing condoms where they were not available previously although this method was successful in introducing condom use to the larger population lack of sustainability and reliability of free condoms distribution programs commanded the introduction of condom social marketing strategies aimed at certain population.

The aim of social marketing is to remove the barriers to condom use by using commercial – marketing techniques such as advertisement and packaging to make the products available, affordable and attractive to all people. Social marketing techniques highlight the importance of adapting the campaign to suit the needs of the users and always asking the consumer about his point of view and needs.

Results of these programs have shown dramatic increases in condom sales in Cote d'Ivoire, Uganda and Malaysia. After a 3-year peer led condom promotion among sex workers in Bangui, India found that condom use rates rose from 3% to 81%[3].

[3] UNAIDS (1999) Sexual Behavioural Change for HIV: Where has theories taken us? P.

Social marketing is an approach to promoting the acceptability of social ideas through the mass media. Social marketing's well known "four Ps" (product, price, place and promotion) have been applied to HIV/AIDS prevention in condom.

2.14 KNOWLEDGE GAP THEORY

In generation of knowledge to society scholars went further to stratify the society into two different classes as follows: higher socio-economic status and lower socio-economic class. Tichnor et al and O'neal theorized that the people who are in the higher socio-economic bracket would have more information than those in the lower socio-economic bracket. Therefore each time people are exposed to information those in the higher socio-economic status will get more in formation than those in the lower economic status hence the creation of a knowledge gap. The reason why those in higher economic status will get more information is that they have high income and as such they have the means with which to control instruments of information. In addition to this they are educated and they can understand almost all the languages of communication through the media. They also have information processing skills, and in most cases are computer literate and can operate the radio and the TV well. Those in the higher Socio-economic status also own instruments of information storage (computers, newspapers, journals, magazines, televisions with satellite dish making it easier to access many channels) and they have many contacts with the change agents. Therefore this theory posits that the more knowledge is generated, the wider the knowledge gap between the upper and the lower Socio-economic groups since those in the lower socio-economic status can not cope well with the rapid speed at which the new information is generated; while those in the higher socio-economic status would continue to get more and more information.

However, there are several assumptions in this theory because even if one may belong to a higher economic status it does not automatically mean that he would have interest in the generation of information. This theory does not take into account the cultural instincts, which dictates to us what to know and what to block ourselves from because it assumes that people will absorb all they see or hear. In this regard the theory also ignores the theory of selective perception, which affirms that people will watch what they want to watch and they will listen to what they want in a very selective way.

However, in application knowledge gap theory is useful and can be used to give information to people commensurate to their level of knowledge and exposure. In this sense this theory would be very effective in targeting people with appropriate information.

CHAPTER THREE

3.0 METHODOLOGY

3.1 SIZES AND LOCATION OF THE STUDY AREA

Kenyatta Market area is in Nairobi and it is situated approximately 3 kilometers from the city center. The area is surrounded with various residential estates namely: Ngumo-Nera, Ngumo-Phase 1, Golf Course Phase-1, Golf Course-Phase 2, Highview Phase-1, Highview-Phase 2, Magiwa, Sunview and Muchai Drive – homes. The area is neighbouring one the biggest informal settlement in sub-Saharan Africa, the Kibera Slums, which is a very overcrowded area. The Kibera Slums provide the labour force required in Kenyatta Market and the surrounding residential areas.

Kenyatta Market is a City Council market and within its surroundings there are several temporary shops commonly referred to as 'kiosks'. There are also modern high-rise buildings within the area housing offices and apartments for middle class people working in the formal sector. All the facilities mentioned above show that this place is a very busy commercial center, which has attracted quite a big population of people with fairly good buying power.

The area is very strategically placed, close to Kibera slum, which provides ready and cheap accommodation for the workers in the informal sector. Consequently, Kenyatta market area is very attractive to a cross-section of workers in the informal sector and almost all the different categories are found there. The targeted population in this study comprises of 1280 men working in the informal sector as listed in table 3.1. They will constitute the sampling frame from which a representative sample will be drawn.

Table 3.1 Types of Informal Businesses in the Kenyatta Area and the Number of Workers

Data types and sources required that a pilot survey be conducted. The pilot survey was used to identify the informal businesses within Kenyatta Market and the surrounding areas and the results were as follows:

Name of Business	Nature of Business	Number of workers	Location
Giwa Engraved	Engravings	2	Muchai Drive
Kisumu Furniture	Furniture	5	Muchai Drive
Grocery Kiosks(14)	Selling groceries	14	Muchai Drive
Taxis	Taxi Drivers	5	Muchai Drive
Bicycle Repairer	Bicycle repairers	2	Muchai Drive
Newspapers	Vendors	6	Muchai Drive
Grocery kiosks	selling groceries	9	Golf Course Phase 1
Security	Security guards	20	Golf Course Phase 1
Kenyatta Jua Kali garage	Vehicle repairers	200	Kenyatta Market
Jua kali garage	vehicle repairers	80	Near Galexon (Kenyatta Mkt)
Jua kali garage	vehicle repairers	50	Next to IDH (Kenyatta Mkt)
Jua kali garage	vehicle repairers	20	On Mbagathi Road
Petrol station garage	vehicle repairers	10	Kobil station Mbagathi Rd.
Mbaruk Road Furniture	Carpentry	30	Kenyatta market
Chicken shades	Chicken sellers	8	Kenyatta Market
Charcoal	Charcoal dealers	8	Kenyatta Market
Kiosks	Groceries	10	Sunview Estate
Hawkers	Selling all sorts of things	50	Kenyatta market
Bicycles	Repairers	2	Golf Course P.1
Kiosks	Selling groceries	10	Ngumo Nera
Charcoal	Selling charcoal	2	Ngumo Nera
Zazani Furniture	Carpentry	8	Ngumo Nera
Ngato Nono Furniture	Carpentry	8	Ngumo Nera
Kiosks	Selling groceries	32	Golf Course P.2
Cyber Cafes	Air time	4	Golf Course P.2
Kiosks	Groceries	20	Highview
Fod stalls & Alcohol	Kenyatta Mkt	50	Kenyatta Market
Drivers	Bus drivers & Matatu Drivers	50	Bus Terminus
Bicycle	Repairers	4	Highview
Cobbler	Shoe repairers	2	Ngumo P.1
Suppliers	Bread suppliers	20	Ngumo p.1
Taxis	Transport	15	Kenyatta market
Taxi	Transport	25	Golf Com Centre
Lorry Drivers	Transport	4	Golf Com. Centre
Drivers	Hoarse drivers	50	City mortuary
Butcheries	Selling meat	32	Kenyatta market
Technicians	Electronics repairers	15	Kenyatta market
Cobblers & shoe shine	Shoe repairer & shoe shine	14	Kenyatta market
Car wash	Washing cars	15	Kenyatta market
Car wash	Washing cars	20	Mbangathi road (next to Kobil Petrol Station)
Temporary shelter	Selling shoes	130	Kenyatta market
Cleaners	Toilet cleaners	4	Kenyatta market
Temporary shelter	Green grocers	130	Kenyatta market
Alcohol kiosks	Selling alcohol	60	Kenyatta market
TOTAL		**1280**	

NB: This estimated population excluded the men working in the formal sector employments within Kenyatta Market Area

3.1.1 Informal Sector:

The informal sector refers to the sector of employment that is not officially recognized by the government. The services rendered are not standardized and do not conform to the laid down rules and requirements. Hence the consumers/clients receive such services at their own risk. However, due to the fact that the sector provides essential services at a much lower cost than the formal sector, they are very popular with the majority of Kenyans who cannot afford to pay for similar services in formal sectors. As a result the informal sector has expanded all over Kenya, especially in major towns and cities, providing job opportunities for the many would-be unemployed Kenyans.

3.2 METHODS OF DATA COLLECTION

Data was collected through a field survey conducted within Kenyatta Market and its environs. In order to identify the respondents a pilot survey was conducted and 1280 men working in the informal sector were identified as illustrated in table 3.1. A sample of 320 of them was selected through random selection.

The tools for data collection were: structured questionnaires, Focused Group Discussions and Key Informants interviews. The three methods were used because each of them had a complementary and unique role in contributing to accuracy of findings.

The structured questionnaires were used because they are easy to cover a large sample size within a minimum of time and cost. Also since sexual matters are private, most people are shy to discuss them openly, however, through questionnaire method respondents can remain anonymous and can give very candid responses.

Although focused group discussions are a new way of doing research they are very effective in behaviour studies. Another advantage of focused group discussions is that they comprise small groups of homogenous individuals (with the same age, same life-cycle, and social/economic status) and as such they discuss freely without feeling shy. Hence important information would be obtained.

The key informants were chosen from among those who had worked in the informal sector for a considerably long time because they were informed about factors influencing adoption of positive sexual behaviour among men. Most of their ideas concurred with those from questionnaires and focused group discussions.

Another advantage of key informant interview is that it all owes great flexibility in the questioning process, and the greater the flexibility the less structured the interview hence allows the free flow of questions and answers in a natural sequence. It also gives the researcher greater control over the interviewing situation.

Therefore, in order to obtain better results five (5) focused groups were randomly selected from the ten focused groups. Key informants on the other hand were 15, similarly randomly selected from 30 who were also randomly identified from the sampling frame.

These three research methods were used for triangulation purposes so that each method of data collection served as a censor for the other thereby ensuring guarantee for accuracy of findings.

3.3 SAMPLING PROCEDURE

The procedure used in this project is stratified sampling. This sampling procedure was used because it is the most suitable sampling method in a situation where the population is composed of distinct groups because it would be possible to divide the population into strata. Stratified method allows for random sampling from each group in the proportions that each group bears in the population a whole. The total population in this study was 1280 people and a sample of 320 people, which is 25% of the population, was selected through random sampling.

The sampling frame is on table 3.1. In order to come up with a representative set different trades were stratified into five (5) categories. The first category is the carpenters, which includes people who deal in woodwork, furniture, cushions, roofing and all sorts of woodwork mostly for domestic and small enterprise. The second category are the motor vehicle mechanics and technicians for instance, vehicle mechanics, panel beaters, vehicle wiring, car-identity makers, bicycle repairers, radio, TV and fridge technicians and other domestic electrical appliances.

The third category was food, beverages and alcohol vendors. This category includes bar attendants, kiosk traders, and food and beverage traders. This category also includes alcohol vendors who sell beer; spirits and some even sell illicit drinks such as 'kumi kumi'. After working hours food and alcohol 'kiosks' are often filled to capacity with both men and women who are often in a relaxed and leisurely mood, which in return would appear to be very conducive to careless sex since they often over-drink and get intoxicated. This category also includes butchers who sell roasted meat which is known as 'nyama choma' and is a delicacy to many Kenyans and more so to alcohol drinkers. Green grocers are also included in this group. They form a big majority as they sell fresh fruits and vegetables, which are popular to most Kenyans.

The fourth category comprised of transport and public telephone operators. This includes taxi drivers, town bus drivers, hearse drivers, lorry drivers, pickup drivers, public phone and cyber café operators. These drivers provide transport in the city and its environs but they are stationed at Kenyatta Market. They work long hours and make enough money for survival and after work they frequent the bars in this area for relaxation because these bars have lots of drinks and bar women whose entertainment and such people appreciate service.

The fifth category comprised of the hawkers. These are traders engaged in all sorts of mobile businesses. They trade in second-hand clothes for children and adults; they sell jackets, coats, sweaters, shoes, utensils and vehicle parts. They are very popular as they sell quality clothes at affordable prices. They walk long distances in search of customers; however, the group captured in this study mostly frequent the Kenyatta Market area and its environs since majority of their customers are in this area. This category also includes chicken sellers, charcoal traders, cobblers and shoeshine men, and the car-wash men.

In order to arrive at the sample of 320 people in proportion to the number of people in different strata the groups of respondents were stratified further into the following groups:

Table 3.2: **The Sampling Frame Consisting of Informal Businesses in Kenyatta Market Area**

Trade	Name of Workshop	Place	Size of Population
Carpenters	Giwa Engraved	Mucai Drive	2
	Kisumu Furniture	Mucai Drive	5
	Mbaruk Road Furniture	Mbaruk Road	30
	Zazani Furniture	Mucai Drive	8
	Ngato Nono Furniture	Ngumo Estate	8
			TOTAL = 53
Mechanics and Technicians	Bicycle repairers	Mbaruk Road	2
	Kenyatta Jua Kali Garage	Kenyatta Market	200
	Jua Kali Garage	Nxt to Galexon Hotel	80
	Jua Kali Garage	Next to IDH gate	50
	Jual Kali Garage off Mbagathi Road	Next to City Mortuary	20
	Bicycle repairer	Golf Course Ph. I	2
	Bicycle repairer	Highview Estate	4
	Petrol Attendants and Mechanics	Shell BP, Mbagathi Road	10
	Car-identity makers	Kenyatta Market	1
	Technicians	Kenyatta Market	15
			TOTAL = 384
Food, Beverages and Alcoholic Drinks	Bread suppliers	Ngumo Estate	20
	Alcohol traders	Golf Course Ph. I	9
	Security Guards	Golf Course Ph. I	20
	Kiosk traders	Sunview Estate	10
	Green grocers	Mucai Drive	14
	Kiosk traders	Ngumo Estate	10
	Kiosk traders	Golf Course Ph. II	32
	Kiosk traders	Highview Estate	20
	Green grocers	Mbagathi Road	130
	Alcohol traders	Mbagathi Road	60
	Food and Alcohol traders	Kenyatta City Council Market	50
	Butchers	Kenyatta Market	32
			TOTAL – 407
Transport and Public Telephone Operators	Taxi drivers	Mucai Road	5
	Taxi drivers	Kenyatta Market	15
	Taxi drivers	Golf Course Community Centre	25
	Lorry drivers	"	4
	Cyber café	Golf Course Ph. II	4
	Cyber café	Fairlane, Golf Course	4
	Cyber café	Comm. Centre	20
	Hearse drivers	City Mortuary	50
	Town Bus and Matatu drivers	Highview Bus Terminus	50

			TOTAL = 177
Hawkers	Newspaper vendors	Mucai drive	6
	Chicken traders	Kenyatta Market	8
	Charcoal dealers	Kenyatta Market	8
	Hawkers selling all sorts of merchandise clothes, vehicle parts, utensils, etc)	These traders sell in the entire Kenyatta Market, its environs	50
	Charcoal traders	Ngumo Nera Estate	2
	Shoe repairer	Ngumo Estate	2
	Cobblers and shoe shiners	Kenyatta Market	14
	Car-wash	Kenyatta Market	15
	Temporary sheds for selling shoes	Mbagathi Road, Golf Course Community Centre, Kenyatta Market parking lot	130
	Toilet cleaners	Kenyatta Market	4
			TOTAL = 259

The above stratified groups were sampled as follows in proportion to their population through the formula: f=n/Nx xi.

Table 3.3 Stratified Groups

Strata	Total Population	Sample Size
Carpenters	53	13
Mechanics and Technicians	384	96
Food, Beverage and Alcohol Traders	407	102
Transport and Public Telephone Operators	177	44
Hawkers, Mobile Traders and Temporary Shelter Traders	259	65
TOTAL	1280	TOTAL = 320

3.4 DATA ANALYSIS

3.4.1 Variables of the Study

Dependent Variables

Dependent variable is adoption of safe sex method which is referred to as Condom-use, having one wife, being faithful, abstinence and visit to VCT (for establishing of HIV-status and for counseling on positive behaviour). Thus adoption was conceptualized in both practice and

attitude. The study established whether the respondents used condoms and also whether they were negative or positive towards other safe sex methods.

Independent Variables

The independent variables were factors that would influence the decision to adopt or not to adopt safe sex methods. These factors are generalized into problems encountered with information on safe sex methods, economic factors, socio-demographic factors and cultural practices concomitant with the adoption of safe sex methods.

3.4.2 Data Analysis

Data analysis was done using both quantitative and qualitative approaches. This approach was appropriate because it adds the scope to a study thus ensuring that biases inherent in one approach are countered by the other approach (Green et al: 1989). The Statistical Package for Social Sciences (SPSS) was used to conduct the analysis through cross-tabulations that enabled chi-square tests of the hypothesis to be tested and determined.

For the questionnaires data was coded by assigning numbers to available categories. Then the questionnaire responses to various questions were categorized according to the objectives of the study. Then frequencies were determined through cross-tabulation and percentages determined. Cross-tabulations were done to identify any relationship if any between chosen variables linked to the objectives. Then major findings were noted. Finally, the research identified relationships between the independent variables and dependent variables and appropriate explanations and interpretations of the study were drawn.

This study relied heavily on secondary and primary data collection techniques so as to reveal the distribution patterns in the study. Graphical representation and tabulation of the sample data was used in the analysis process.

Measures of association such as cross tabulation through chi-square shall be employed to measure variations and associations, where the need shall arise. Where significant tests shall be required, the significant level shall be at $\alpha = 0.05$ (95% confidence level). However, focused group discussion data and key informant interview data shall be subjected to qualitative analysis.

The chi-square will be very useful in this study for data analysis because it is suitable in evaluating whether the difference between observed and a set of theoretical assumptions is satisfactorily significant. The chi-square works by testing a distribution actually observed in the field against some other distribution determined by the null hypothesis. The formula for chi-square is $X^2 = \sum (O-E)^2/E$

O = Observed frequency

E = Expected frequency

n - 1 = the degree of freedom

n = the number of the fraction

In other words the chi-square is a measure of aggregate difference between observed and expected frequency under the null hypothesis such that when the P value is greater or equal to 0.05 the less likely it is that the null hypothesis (H_o) is correct. That is if the chi-square value is greater than the critical value at a given significant level then H_o is rejected.

3.5.3 LIMITATIONS OF THE STUDY

Major limitation of this study is lack of enough time to enable the researcher to conduct the study thoroughly. Another limiting factor is limited funds that are necessary for any field survey to be carried out efficiently. There is also a technical limitation with regards to the fact that many Kenyans consider open discussions on sexual matters as a taboo. Hence most people tend to avoid open and truthful discussions on sexual matters and they tend to with hold useful information that would assist researchers. As a result when they are forced by circumstances to discuss sexual matters with researchers, they tend to give misleading information.

In order to bridge this limitation the study will use a combination of data collection techniques such as structured questionnaires, focused group discussions and key informant interviews in order to counter check the information collected through the questionnaires.

Another limitation is that the targeted group did not have a sampling frame so the researcher had to conduct a pilot study in order to establish the sample frame of the study in order to determine the sample to be used in the study.

Not all the sampled respondents took part in the study, therefore, out of the sampled 320 we had between 290 and 280 and out of the above figures some of the respondents chose not to respond to some questions in the structured questionnaires. However, the study still went on smoothly and analysis carried out successfully.

CHAPTER FOUR

4.0 DISCUSSIONS AND INTERPRETATION OF FINDINGS

4.1 INTRODUCTION

This chapter is devoted to the presentation and analyses of the research findings. The findings from each of the three research objectives are summarized in tables, pie charts and graphs in order to facilitate interpretation.

The first objective of the study was to identify and establish communication factors influencing adoption of positive sexual behaviour. The study established that ineffective communication methods such as over emphasis on individualistic approach to change in condom use campaigns, lack of open communication and over emphasis on radio messages were hindering adoption of positive behaviour among men.

The second objective was to identify and establish socio-economic factors influencing adoption of positive sexual behaviour. It was established that some negative cultural practices, such as polygamy, wife inheritance and engaging in multiple sexual relationships (to prove manhood) were undermining adoption of positive sexual behaviour.

The third objective was to identify and establish demographic factors influencing adoption of positive sexual behaviour. The study established that age and education influenced behaviour. For instance men aged between 15 and 45 were found to be the most sexually active and had the highest percentage of condom use. However, it was established that they did not use condoms regularly, because they could not afford to buy condoms regularly since their income level is less than 1(one) USD a day.

4.2 DESCRIPRITION OF FINDINGS BY OBJECTIVES

OBJECTIVE ONE:
COMMUNICATION FACTORS INFLUENCING THE ADOPTION OF POSITIVE SEXUAL BEHAVIOUR AMONG MEN.

Table 4.1 Problems encountered when seeking information on safe sex

The Problem	Frequency	Percentage
Lack of communication	115	54
False information on AIDS	54	25
Had no problem	45	21
TOTAL	**214**	**100**

The findings indicate that there are a number of communication barriers that are encountered by men as they seek information on safe sex. Lack of open communication and false information about AIDS are all dealing with the problem of communication and account for 79% of all the cases in the study. During focused group discussions and key informant interviews, lack of open communication was also singled out as the major obstacle to free flow of information on safe sex, among men.

Table 4.2 Summary results of men embarrassed by open sexual discussions

Respondent	Frequency
Yes	52
No	225
TOTAL	**277**

Further, during the focused discussions the respondents revealed that culturally it is a taboo to discuss sexual matters openly. This finding concurred with the Studies by Ngugi (2000), which indicate that discussing sexual matters among the traditional Kikuyu community was regarded as a taboo. However, the results from a sample size of 277 indicate that the majority of the

respondents (81%) would not be embarrassed by open discussions of sexual matters. The summary of the results is shown in table 4.2.

Table 4.3 Men's preference during sexual discussions

Preference	Frequency	Percentage
Anybody	32	12.2
Friends/Peers	137	52.2
Family Members	27	10.4
VCT Counselors/Doctors	9	3.4
Wife/Partner	53	20.2
Church Groups	1	0.4
Nobody	2	0.8
Elders	1	0.4
TOTAL	**262**	**100**

Findings in Table 4.3 indicate that most men prefer to discuss sexual matters with their friends or peers, because most of them were not free to discuss sexual matters openly with their spouses.

That 52.2% of them would prefer to discuss sexual matters with their friends/peers compared to only 20.2% who preferred to discuss with their wives/partners. Generally the findings above underline the role of interpersonal communication in the dissemination of messages on safe sex and HIV/AIDS.

Social norms, religious beliefs and gender power relations infuse meaning into behaviour thereby enabling positive or negative changes. The sociological theories asserts that society is broken into smaller sub-cultures and it is the members of one's immediate surroundings, the peer group, that one most identifies with, that has most significant influence over an individual's behaviour. According to this perspective and in line with the above findings, effective preventive efforts in vulnerable communities must identify the peer network in order to support positive changes. That failure to do this would undermine the effectiveness of communication. In this regard it is paramount to note that effective communication methods must take into account the social environment within which communication is taking place.

Table 4.4 **Preference of radio channels among men**

The Radio	Frequency	Percentage
1. Kiss 100 FM	45	17
2. Kameme FM	25	9.6
3. Radio Africa	2	0.8
4. K.B.C.	81	31
5. Waumini FM	6	2
6. Nation FM	21	8.1
7. Citizen FM	27	10.4
8. Ramogi FM	26	10
9. Inooro FM	3	1.6
10. Metro FM	9	3.5
11. Biblia Husema	3	1.2
12. Capital FM	3	1.2
13. BBC	2	0.8
14. Pwani FM	2	0.8
15. Family Hope	2	0.8
16. Classic	3	1.2
TOTAL	**260**	**100**

The findings in table 4.4 reveal the radio stations that were preferred by the respondents. From the study finding above KBC radio is the most frequented channel by men in the sample survey. Kiss 100 FM, Citizen and Ramogi follow with 17% and 10 % respectively, of the men sampled frequenting radio stations. The findings demonstrate the effectiveness of the radio in creating awareness among men, on the dangers of unprotected sex.

From the study findings over reliance on radio as a means of attaining change in sexual behaviour is a communication barrier in itself. It was confirmed through focused group discussions and key informant interviews that for behaviour change to take place, interpersonal communication is more effective and even more preferred by the respondents who overwhelmingly confirmed that they preferred to discuss sexual matters with peers/friends.

Table 4.5 Presenting preventive messages that the Respondents learnt through the media.

No.	Message	Frequency	Percentage
1.	Je, una yako?	6	2.2
2.	Use condoms	163	60.3
3.	New standard condoms for extra pleasure	2	0.7
4.	HIV program/campaign	6	2.2
5.	Maisha iko sawa na trust	11	4.1
6.	Abstain	23	8.5
7.	AIDS kills	21	7.8
8.	Be faithful	20	7.5
9.	No to sex workers	1	0.4
10.	Ukimwi na jamii	3	1.1
11.	Visit VCT	9	3.3
12.	Prevent STD/HIV and have a better life…	1	0.4
13.	Too young to have sex	4	1.5
Total		**270**	**100**

From the above findings it confirms that a lot of preventive messages are received through the radio, thereby confirming that the radio has been responsible for the high awareness level of HIV prevention. This finding concurs with the assumption of the study, which states that the respondents are fully aware of HIV prevention methods but there were some factors that were hindering them from adopting positive sexual behaviour. However, table 4.6 revealed that there are alternative sources of information on HIV-prevention, which should be strengthened in order to get good results on behaviour change.

Table 4.6 Alternatives sources of information identified by men

Source	Frequency	Percentage
Friend/Peers	145	49.3
Colleague	67	22.8
Relative	25	8.5
All above	32	10.9
Wife	25	8.5
TOTAL	**294**	**100**

The research findings point to the need to reinforce interpersonal communication among peers/friends. This is because discussions of sexual matters are still handled discretely in many Kenyan communities. For one to change their sexual behaviours then one to one communication is the choice of the majority of the respondents as seen in the earlier findings and for the communication to be effective it must be both penetrating and convincing. This pre-supposes confidence building which can only be attained through interpersonal communication among peers. Yet generally in many Kenyan communities, due to over-emphasis on unsuitable channels of communication, sex matters are discussed rarely and when absolutely necessary. Mulindi (2004) concurs that when sexual discussions take place they are often undermined by guilt, fear and anxiety leading to withholding of vital information.

This explains the shyness to discuss sexual matters with spouses because in many Kenyan communities women were not supposed to know much about sex if they profess to have much knowledge about sex they are perceived to have low morals. Thus the slow adoption of safe sex methods could partly be attributed to lack of effective communication methods. To this effect some preventive messages are regarded as inconsistent with the commonly held social values hence not easily adopted. Thus the findings of the study render credence to the views of the diffusion theorists. According to diffusion theory an idea that is not consistent with the prevalent values and norms of the social system will not be adopted as rapidly as an idea, which is compatible. In the African context, role of the family, group and the community play a greater role in decision making than individuals. Hence theories and models based on individualism have to be complemented with theories that recognize the role of the community in individual behaviour and decisions, for them to succeed.

Table 4.7: Summary of results of why men do not use condoms

Response	Frequency	Percentage
Expensive	15	10.9
Don't like condoms	123	89.1
TOTAL	**146**	**100**

A point in case is condom use campaigns which emphasize on individual decision, the packaging of the message lays emphasis on individual's role to make sexual decisions with no regard to the

societal values, such as discreteness to discussions regarding sexual matters. Focused group discussions revealed that the advertisements of the condoms were sometimes embarrassing as they were aired in the families comfort in the sitting room when watching television or listing to radio without due regard to the composition of its audiences (young, old, in-laws parents etc). Perhaps this could be the reason why most men have not fully adopted condom use. To this effect the study confirms that 89.1% of men do not like condoms and that if they had a better preventive method in place, they would not use them.

In many Kenyan communities discussing sexual matters in public without taking age into account is regarded as offensive. This could be the reason why most respondents preferred to discuss sexual matters with peers/friends through international communication because age is taken into account in such a conversation and the discreteness and privacy is also guaranteed, and as a result one feels more free to discuss and to reflect on the messages as opposed to preventive messages through the radio which are rather public.

Table 4.8: A summary of men's visits to VCT

Visited VCT	Frequency	Percent
Yes	113	40.1
No	169	59.9
Total	**282**	**100.0**

Most respondents indicated that they did not want to visit the VCTs for fear of testing HIV positive. This fear is a true testimony to the fact the campaigners must be using ineffective preventive communication methods. As a result most people have not understood the real benefits of establishing their HIV status as illustrated in the table above.

The research findings point to high awareness of HIV/AIDS messages. At least each of the men sampled had a favourite radio station. The role of radio messages in disseminating preventive measures is also significant: 60% of the men sampled indicated they heard of the use of condoms as a preventive measure through the radio. Further, the research findings reveal that 87% of men seek alternative sources of information. Friends, colleagues and wives were

considered reliable sources by majority of men in the study. See tables 4.3, 4.6 and 4.10 for the summary results. In a nutshell, the findings confirm that mass communication and interpersonal communication are serious complements to each other, and that the dominance of men in sexual matters at the family level implies that they have a significant role in HIV prevention.

4.3 THE SOCIO-ECONOMIC FACTORS INFLUENCING THE ADOPTION OF SAFE SEX METHODS

OBJECTIVE TWO

4.3.1. SOCIAL FACTORS

This objective was aimed at identifying the socio-economic factors that influence the adoption of positive sexual behaviour either negatively or positively. Social factors referred to here were cultural and religious practices that could fundamentally influence an individual's sexual behaviour.

Community as a concept is applied in this study to refer to people living in the same geographical area but could be totally different in their outlook towards life. The respondents are urbanites that come to the city to look for opportunities. Thus they are of diverse cultural backgrounds and thus influenced by different social values. During the focused group discussions it was confirmed that the respondents from communities where traditional circumcision for boys is practiced declared openly that they would not stop the practice despite the dangers associated with it. The dangers here are related to possibilities of contracting HIV infections through unhygienic methods of circumcision by the traditional circumciser. They pointed out that it is expensive to go to hospitals for circumcision and that circumcision in hospitals would erode its ritual meaning and related cultural values. It was also established that belief in witchcraft or curses undermines effort to contain the spread of HIV infection. From focused group discussions it was intimated that since the commencement of HIV prevention campaigns and revelation of the dangers of wife inheritance, the practice continues to thrive privately and in secrecy and that those engaged in such practices are embarrassed to speak out openly for fear of being stigmatised.

Table 4.9: The prevalence of negative traditional practices among the respondents

The Practice	Frequency	Percent
Wife inheritance	4	1.5
Polygamy	26	9.9
Other traditional practices	166	63.1
Christian values	67	25.5
Totals	**263**	**100.0**

Key informants intimated that a good number of people still believe that diseases and especially a severe one that kills such as AIDS, is caused by witchcraft or a curse from the unappeased ancestors. To such people viral cause of disease is foreign and as such containing the spread of the disease is being undermined. Some respondents conceded that they are pushed into wife inheritance and other multiple sexual relationships by these repugnant traditions, since they do not know the difference between a curse and an actual disease. The research findings indicate 63.1% of the men sampled were pressured into these repugnant traditional practices. This is a high percentage pointing to cultural influence on behaviour change that cannot be attributed to chance, definitely a strong influence.

These findings concur with confirmation obtained from focused group discussions and key informant interviews which revealed that traditional ceremonies performed during funerals and circumcisions leads to night dances which are frequented by many young people and provide ample opportunity for meeting and for gratifying sexual feelings. According to Ayayo and Muganzi (1993) this situation is made worse by the fact that in many Kenyan communities today not all courtship should lead to marriage so they freely relate sexually making it possible for contracting and spreading HIV infection.

Table 4.10: Summary of men showing those with multiple sexual partners

Sexual Partners	Frequency	Percentage
2	59	64.1
3	18	19.6
4	11	12.0
5	4	4.3
Totals	**92**	**100.0**

The results above points to the fact that 64.1% of the respondents have multiple sexual relationship thus concurring with the UNFPA Report (1999), which indicates that in most African communities many young men are pressured into multiple-sexual relationships in order to prove their man hood hence placing them at the risk of contracting HIV-infection. This finding is confirmed further by findings in table 4.11 whereby 38.7% of respondents confirmed that they have multiple sexual relationships because it is normal for men to do so. When asked to justify why they had to condone lose sexual morals, most respondents explained that seductive dressing by women was the cause of their loose morals. This view was strongly supported by focused group discussions and key informant interviews.

From the findings it was confirmed that living separately from spouses does present a situation conducive to multiple sexual relationships. In this regard 31.2% of the respondents confirmed that they had multiple sexual partners because the spouse is in the countryside.

Table 4.11 Summary of excuses for multiple sex partners by the respondents

Excuse	Frequency	Percentage
1. Wife is in the countryside	29	31.2
2. Normal for men	36	38.7
3. Influenced by peers	19	20.4
4. Family background	6	6.5
5. I protect myself	1	1.1
6. Prospecting for a partner	1	1.1
7. Divorced	1	1.1
TOTAL	**93**	**100**

Polygamy is another traditional practice that is common among many Kenyan communities and it hinders men from positive sexual behaviour. Although it is practised in all communities the practice has now taken a different shape of acquiring mistresses. Research findings indicate that only 10% of the men sampled rejected polygamy. The findings point to the prevalence of extra-marital relationships out of the 93 sampled respondents; 100 had extra marital affairs. (See table 4.11).

4.3.2. ECONOMIC FACTORS

Table 4.12: Summary results of men living with their wives in Nairobi

Respondent	Frequency	Percent
Living with wife	100	61.7
Living alone	60	37.0
Both	2	1.2
Totals	**162**	**100.0**

Due to economic reasons 37% of the respondents do not live with their wives in Nairobi while 61% of the men sampled lived with their wives in Nairobi.

Table 4.13: Summary results of the respondents and their preferred condoms

Preferred Condom	Frequency	Percentage
1. Trust	98	66.7
2. Sure	25	17.0
3. G.O.K.	7	4.8
4. Roughrider	6	4.1
5. New std. Condoms	5	3.4
6. Preventor	3	2.0
7. Happiness	1	0.7
8. Durex	1	0.7
9. Salama	1	0.7
TOTAL	**147**	**100**

The study revealed Trust condoms as the most popular among men because they felt that its quality was god and the cost of ten Kenya shillings per set of three, they find it occasionally affordable. Although the Government of Kenya was providing condoms the study confirmed that the GoK condoms were not popular even though they are free. Key informant interviews revealed that most men perceive the GoK condoms as of low quality, smaller than expected and prone to tearing. The summary findings of the respondents to various types of condoms are summarized in table 4.13.

It is significant to note that when directly asked if they prefer condom use for prevention, the majority of the respondents gave contradicting responses; other said they prefer condoms for prevention while some said they did not to use condom as a preventive measure. From focused

group discussion there were some answers, the respondents argued were too personal to reveal and hence kept their positions to themselves. But on the overall condom use received a positive response.

Summary of findings below confirms that despite the positive reception to condom use there is still a good number of men who reject condom use just because they are indifferent, while others do not use condoms because they cannot afford given their low income status (table 4.14).

Besides the social factors the study reveals that due to economic obstacles over 41% of the respondents cannot avail the use of condoms regularly as a preventive measure because they cannot afford to buy condoms (see the table below). This finding concurs with the UNAIDS Report (1999) which asserts that most people in the developing countries are poverty stricken and are living on less than 1 (one) USD per day, hence any HIV preventive measure/method which has financial implications is not feasible. From the findings 58.3% confirmed that they can afford to buy condoms while 41.3% confirmed that they cannot afford to buy. Given that the free GoK condoms are of very low quality leading to their being rejected by most men the only option left is that most of them have opted not to use condoms, and from focused group discussions even the 58.3% who have pointed out that they can buy regularly, do not use them as prescribed hence they are exposed to the dangers of HIV infection.

Table 4.14: Summary results of the affordability of condoms on regular basis

Respondent	Frequency	Percentage
Can buy regularly	142	58.3
Cannot buy regularly	100	41.3
TOTAL	**242**	**100**

Table 4.15: Summary results of monthly income of respondents

Monthly Income	Frequency	Percentage
> 3000	54	15
3000 – 5000	126	47.5
6000 – 10000	85	32.1
11000 – 20000	33	12.5
21000 – 30000	4	1.5
TOTAL	**265**	**100**

The low-income level among the respondents was established as one of the economic hindrances to safe sex methods. The study finding in table 4.15 indicates that 54% of the respondents earned less than five thousand Kenya shillings per month. They cannot afford adequate housing for their families in their places of work in the city. As a result of low income and poor housing, 37% of the respondents indicated they were forced to work and live away from their spouses. During group discussions poverty was identified as a major factor undermining safe sex methods. The respondents revealed that their wives live in the countryside because of the high cost of living in the city. While a number of excuses were offered for multiple partners in sex, it is significant to note that 31% of the respondents attributed it to living far from their wives (table 4.16 below).

Low income was singled out as the reason for irregular use of condoms. Indeed from the group discussions it emerged that the respondents understood affordability of condoms to mean buying condoms occasionally, perhaps once or twice a month. "If we cannot adequately afford the basic necessities, such as food, shelter and clothing, how could we afford condoms regularly on a monthly basis", they wondered. Majority conceded to buying condoms only with commercial sex workers. However, most of them do not use condoms with their regular girlfriends. At least 10% of the respondents quoted the prices of the condoms as inhibiting.

Table 4.16: Summary results of the decision makers on sexual matters in the family

Decision on Sex	Frequency	Percentage
The man	111	46
Both	132	54
Totals	**243**	**100**

From the findings the men are the decision makers on sexual matters in the family. This is confirmed by the fact that 46% of them are the sole and overall decision makers in the family while 54% conceded that they make decisions jointly with their wives/spouses. Hence the findings confirm that men are involved in all decision making on matters regarding sex. The finding concurs with the UNAIDS Report (1999) which states that men in every sexual decision men are involved hence enlisting them in the fight against HIV/AIDS could lead to a turn a round of the fight against HIV/AIDS.

Table 4.17: Role of the church in dissemination of information

Information on HIV	Frequency	Percent
Provides	253	92.3
Does not Provide	21	7.7
Total	**274**	**100**

Religious values were indicated to aid the rejection of harmful traditions and 92.3% confirms that the church provides HIV-preventive information. This is a high percentage that cannot be attributed to chance. Christian values were offered as explanations to departure from practices such as wife inheritance. As a social factor, spirituality was revealed in the FGD as cutting across all the communities, irrespective of their cultural backgrounds. The Church, it was revealed, was playing a significant role in the dissemination of information on HIV prevention. Moreover, the findings indicate that contrary to religious teachings 78% of the respondents use condoms as a preventive measure against HIV/AIDS.

Culture plays a central role in lives of many people in most communities in Kenya. The findings above confirm that wife inheritance, polygamy, other cultural practices (such as witchcraft, circumcision and others) influence the adoption of positive sexual behaviour in a negative way. It is important to note that 63% of the respondents are engaged in negative traditional practices that undermine adoption of positive sexual behaviour, such as belief in witchcraft as the cause of disease hence conflicting with the viral cause of HIV. They also confirmed that they support and take part in the traditional circumcision conducted by the traditional circumciser. This is in spite of the fact that campaigners were encouraging people to adopt modern circumcision methods performed by qualified doctors.

However, it is important to note that 22% of the respondents do not use condoms because it is against their religious teachings, but most of the respondents revealed that they participate in church support groups aimed at HIV prevention.

4.4 DEMOGRAPHIC FACTORS HINDERING MEN FROM ADOPTING SAFE METHODS

OBJECTIVE THREE

The study investigated the extent to which demographic factors were hindering adoption of safe sex methods. One of the demographic variables considered was age. The age of the respondents ranged from 15 to over 55 years. The respondents were then divided into six age groups. The preferred safe methods for sex for each group were measured and the results summarized in the tables below.

It is significant to note that when directly asked if they prefer condom use for prevention, the majority of the respondents gave contradicting responses; others said they prefer condoms for prevention while some said they did not like the use of condom as a preventable measure. From focused group discussion there were some answers, the respondents argued were too personal to reveal and hence kept their position to themselves. But on the overall condom use received a positive response. Summary of findings below confirms that despite the positive reception to condom use there is still a good number of men who reject condom use just because they are indifferent, while others do not use condoms because they cannot afford given their low income status. Besides the social factors, the study reveals that due to economic obstacles over 41% of the respondents cannot avail the use of condoms as a preventive measure.

Table 4.18: The preferred safe sex methods in the 15-23 age group

Safe Sex Method	Frequency	Percentage
1. Faithfulness	34	25.2
2. Condom	50	37.0
3. Abstain	51	37.8
TOTAL	**135**	**100**

Table 4.19: 26-35 age group

Safe Sex	Frequency	Percentage
1. Faithfulness	43	44.8
2. Condom	38	39.6
3. Abstain	15	15.6
TOTAL	**96**	**100**

Table 4.20: 36-45 age group

Safe Sex Method	Frequency	Percentage
1. Being faithful	12	46.1
2. Condom	10	38.5
3. Abstain	4	15.4
TOTAL	**26**	**100**

Table 4.21: 45-55 age group

Safe Sex Method	Frequency	Percentage
1. Being faithful	6	50
2. Condom	3	30
3. Abstain	1	10
TOTAL	**26**	**100**

Table 4.22: Age group of over 55 years

Safe Sex Method	Frequency	Percentage
1. Condom	1	100
2. Being faithful	0	0
3. Abstain	0	0
TOTAL	**1**	**100**

The findings above also indicate that there is a positive relationship between age and preference of safe sex methods among men. The research findings revealed that men between 15 and 45 years are the most vulnerable to HIV infection because they were the most sexually active but the research findings indicate that more than 37% in each of these age groups use condoms. This should not be viewed as a small percentage given that the respondents were responding to three different methods. This in effect means that those that prescribe to condom use are not few in percentage. Therefore through age segmentation target campaigns by age could be effective in reinforcing this positive trend in the adoption of safe sex methods among this particular age group.

The findings concur with Nagelkerke's second intervention criteria, which posit that amenability to change is more practical to make sexual contacts safer than to avert such contacts. Similarly, it is more feasible to introduce and ensure condom use during casual sex than to insist on convincing people to be faithful to one partner or abstinence for the unmarried. The finding

confirm that the respondents viewed condom use as beneficial and protective against HIV infection hence pointing to further concurrence with the theory of Diffusion of Innovation, which states that an innovation is adopted if seen as beneficial.

Secondly the study investigated the influence of education as a demographic factor. Findings revealed that only 36.7% of the respondents had completed primary education and 47% of them had secondary education. From key informant interviews it emerged that most of them were not fluent in English and Kiswahili and had difficulty filling the questionnaire as a result most of them had to be assisted with the questionnaire. The key informant interviews further indicate most of the respondents had never read newspaper articles on HIV/AIDS prevention. Being semi-illiterate they are unable to access scientific or medical journals, let alone the internet.

In this regard the finding is consistent with the Knowledge Gap theory which states that at any given time when people are exposed to information, those in higher socio-economic status will get more information than those in the lower socio-economic status. This is because those in the higher economic status have the means with which to control instruments of information, for instance, access to Internet, television, scientific magazines and newspapers. They also have information processing skills. Informants revealed that most of the information the respondents had was from radio, friends or hearsay from people they meet. During focused group discussions it was clear that most of the respondents did not have any knowledge about the scientific issues surrounding the uncertainty in having a breakthrough in the treatment of HIV/AIDS.

While most of the respondents conceded that many of their colleagues have died of the scourge, they attributed it to witchcraft from colleagues, family members or clan members. Others attributed HIV/AIDS deaths to a curse occasioned by the upsetting of the ancestors through violation of some traditional values. They do not want to go beyond their traditional worldview on the causes of diseases and deaths. To them the scientific explanations are rather abstract and clouded with suspicion. Thus most of the men in the informal sector remain reluctant to the scientific explanation.

The finding thus point to a knowledge gap among men working in the informal sector. However, the findings from focused group discussion revealed that some of the respondents do

not use protective sex even when they engaged in casual sex. Grilled on the issue they kept changing the story thus indicating that they had reservations on revealing the truth. Thus the actual sexual behaviour by most of them was secretly safeguarded but through the three methods of data collection for instance questionnaires, focused group discussions and key informant interviews, we were able to come up with the findings such as indicated above. The findings, in a nutshell, urge for an urgent need for research on the various demographic and socio-economic factors among men in order to determine further the factors that are contributing to the slow flow of information on sexual diseases and HIV/AIDS prevention.

4.5 HYPOTHESES TESTING AND FINDINGS

The study has two hypotheses as follows: the first one: "There is no significant relationship between communication and sexual behavior change"; and the second one: "There is no significant relationship between Socio-demographic factors, economic factors, and sexual behaviour change".

Therefore, in order to establish whether there is a statistically significant relationship/association between the variables under study a statistical test was done. The Chi-Square test of significance was chosen as the most appropriate measure of association for the study.

The following communication variables were cross tabulated with sexual behaviour change variables: Communication variables were as follows: (i) Radio listnership, (ii) Preferred communication methods (iii) Problems encountered with information on safe sex methods
(iv) The decision making concerning sexual issues in the family; and (v) Problems encountered while looking for information on prevention of HIV/AIDS. Behaviour change variables were as follows: (i) Condom use (ii) the number of wives the respondents had (iii) VCT visit
(iv) Abstinence and (v) Being faithful to one partner.

i) **The Statistical Tests on Communication Sectors versus Behaviour Change**

Table 4.23: Representing Communication Problems and Condom Use

PROBLEMS ENCOUNTERED WITH INFORMATION ON SAFE SEX METHODS	CONDOM USE		
	YES	NO	TOTAL
• Lack of clarity of information given	57 52%	28 49%	85 51%
• Misinformation due to lack of competence by campaigners	39 36%	20 35%	59 36%
• Lack of openness when discussing sex issues	13 12%	9 16%	22 13%
TOTAL	**109** **100%**	**57** **100%**	**166** **100%**

$\chi^2 = 0.500$, $P = 0.779$

The results above confirm that there is no statistically significant association between problems encountered with information on safe sex methods and condom use.

Table 4.24: Representing Communication Problems and the Number of Wives

PROBLEMS ENCOUNTERED WITH INFORMATION ON SAFE SEX METHODS	NUMBER OF WIVES RESPONDENTS HAVE		
	ONE	TWO AND ABOVE	TOTAL
• Lack of clarity of information given	43 50%	5 33.3%	48 48%
• Misinformation due to lack of competence by campaigners	32 38%	5 33.3%	37 37%
• Lack of openness	10 12%	5 33.3%	15 15%
TOTAL	**85** **100%**	**15** **99.9%**	**100** **100%**

$\chi^2 = 4.809$, $p = 0.090$

The test results indicate that there is no statistically significant association between problems encountered with information on safe sex methods and the number of wives that one has.

Table 4.25 is representing problems encountered with information on safe sex methods and cross-tabulated with VCT visit.

Table 4.25

PROBLEMS ENCOUNTERED WITH INFORMATION ON SAFE SEX METHODS	***VCT Visit***		
	Yes	**NO**	**Total**
• Lack of clarity of information	42 67%	46 40%	88 49.0%
• Misinformation due to lack of competence by campaigners	14 22%	52 45%	66 37.0%
• Lack of openness when discussing sex issues	7 11%	17 15%	24 14.0%
TOTAL	**63** **100%**	**115** **100%**	**178** 100%

$\chi^2 = 12.066$, P = 0.002

The results above indicate that there is a statistically signification association between problems encountered with information on safe sex and VCT visits. 67% of the respondents who visited the VCT also viewed information on safe sex as lacking clarity. Therefore, it is logical that they sought further clarifications at the VCT. However, 52% of the respondents did not visit the VCT but they confirmed that they encountered problems of misinformation with regards to HIV preventive messages. Focused Group discussions concurred with the above findings that some HIV Preventive information was misleading. For instance, a good number of the respondents were of the view that they could not contract HIV Virus even if they had sex without condoms so long as they were not bruised during sexual intercourse thus, HIV Virus according to such uninformed campaigners could only be contracted if there was blood contact, which according to them could only occur if there were bruises during sexual intercourse. This misinformation was a commonly held belief among the respondents as confirmed through key informant interviews. Little do they know that some of these bruises are so tiny that they cannot be easily noticed neither can they be prevented.

Problems encountered when looking for information on safe sex cross-tabulated with condom use and the Chi-square test was done; the results were as follows:

Table 4.26

PROBLEMS ENCOUNTERED WHEN LOOKING FOR INFORMATION ON SAFE SEX METHODS	***CONDOM USE***		
	Yes	**NO**	**TOTAL**
• People are not free to discuss sex.	53 53.0%	36 59.0%	89 55.3%
• False information about AIDS.	40 40.0%	11 18.0%	51 31.7%
• Lack of adequate information.	7 7.0%	14 23.0%	21 13.0%
TOTAL	**100** **100%**	**61** **100%**	**161** **100%**

$\chi^2 = 113.410$, $P = 0.001$

The results indicate that there is a statistically significant relationship between problems encountered while looking for information on safe sex and condom use. This finding concurs with the UNFPA report (1999) which states that men have not been empowered enough with HIV preventive messages and as such time was ripe to enlist men in HIV/AIDS prevention campaigns. The percentage of those who do not use condoms was found to be 59.0%. This could be attributed to lack of free discussions leading to lack of empowerment of men on HIV/AIDS prevention. Focused group discussions and key informant interviews, confirmed that tangible information on HIV/AIDS prevention was not readily available to men. As a result men often viewed safe sex methods with skepticism. This coupled with the fact that most of the information received was through the radio, which is less interactive channel of communication; attaining sexual behaviour change among men has been too slow.

The Chi-square tests done on Radio listenership, cross-tabulated with behaviour change variables such as VCT visit, condom use and the number of wives one had; all indicated no statistical association. Illustrations are on the tables below.

Table 4.27: Representing Radio Listenership and Condom Use

Radio Listenership		Condom Use		
		Yes	**No**	**Total**
If Yes do you listen regularly?	Yes	125 87%	100 89.3%	225 87.%
	No	19 13%	12 10.7%	31 12.1%
		144 **100%**	**112** **100%**	**256** **100%**

$\chi^2 = 0.364$, P = 0.546

The results on table 4.27 indicate no statistically significant relationship between radio listenership and condom use.

Table 4.28: Representing Radio Listenership and the Safe Sex Methods Practiced by Respondents

Radio Listenership		How are you protecting yourself from HIV Infections?			
		(A) Abstinence	**(B) Being faithful to spouse**	**(C) Condom use**	**Total**
If yes do you listen regularly	Yes	51 89.5%	133 87.5%	52 92.9%	236 89%
	No	6 10.5%	19 12.5%	4 7.1%	29 11%
Total		**57** **100%**	**152** **100%**	**56** **100%**	**265** **100%**

$\chi^2 = 1.218$, P = 0.544

There is no association between Radio listenership and safe sex methods practiced by the respondents. However, it is important to note that among those who listen to radio regularly 87.5% are protecting themselves from HIV infections by being faithful to spouse, while 92.9% protect themselves through condom use and 89.5% practice abstinence. Hence this area needs to be studied further to establish whether there are other factors, contributing to the high use of

safe sex methods among the regular radio listeners. The results confirm that condom use is a leading safe sex method with 92.9%. This finding concurs with the UNFPA (1999) report, which emphasizes that is more practical to make sex safer than to avert the behaviour.

A table representing those who make decisions concerning sexual matters in the family cross tabulated with the number of spouses (wives) and a statistical test done. For results see the table 4.29.

Table 4.29

Who makes decisions concerning sexual matters in your family?	**How many wives do you have?**		
	One	**Two and Above**	**Total**
You as the man	50 42.4%	12 48.0%	62 43.4%
Both of you have a say	68 57.6%	13 52.0%	81 56.6%
Total	**118 100%**	**25 100%**	**143 100%**

$\chi^2 = 0.266$, $P = 0.606$

There is no statistically significant relationship between decision making on sexual issues in the family and the number of spouses.

Table 4.30: A table showing relationship between decision making on sexual issues and condom use

Who makes decisions concerning sexual matters in your family?	**Condom Use**		
	Yes	**No**	**Total**
You as the man	50 40.7%	57 54.8%	107 47.1%
Both of you have a say	73 59.3%	47 45.2%	120 52.9%
Total	**123 100%**	**104 100%**	**227 100%**

$\chi^2 = 4.533$, $P = 0.033$

The results of the test indicate a statistically significant relationship between decision making on sexual issues and condom use. From the results, it is clear that among spouses who have equal say on sexual issues, there is high percentage of condom use at 59.3% while among men who make sexual decisions alone "as men" have a high percentage of lack of condom use at 54.8%.

Table 4.31: Relationship Decision Makers on Sexual Issues in the Family and VCT Visit

Who makes decisions covering sexual matters in your family	Ever Visited VCT Centre		
	Yes	No	Total
You as the man	37 38.9%	78 53.4%	115 47.7%
Both of you have a say	58 61.1%	68 46.6%	126 52.3%
Total	**95** **100%**	**146** **100%**	**241** **100%**

$\chi^2 = 4.835$, P = 0.028

Statistically Significant Relationship

Decision-making concerning sexual matters in a family was also cross-tabulated with VCT visit and tested and the results confirmed that there is a statistical association as per the table 4.34 below. It is important to note that in families where both husband and wife make decisions on sexual issues, the VCT visits are at 61.1%. However, in families where men are the overall decision-makers the percentage of those who have not visited VCT is 53.4%.

Table 4.32: A table representing the people whom the respondents felt free to discuss with cross-tabulated with condom use

Whom would you feel free to discuss HIV/AIDS with	Condom Use		
	Yes	No	Total
Anybody	16 12%	17 16%	33 14%
Friends/peers	70 52%	55 52%	125 52%
Family Members	44 32%	29 28%	73 30%
VCT/Counselors	6 4%	4 4%	10 40%
TOTAL	**136** **100%**	**105** **100%**	**241** **100%**

$\chi^2 = 1.347$, P = 0.718

The results of the test indicate no statistically significant relationship between those preferred one for discussions on HIV/AIDS prevention and condom use. However, it should be noted that those who preferred to discuss safe sexual methods with peers/friends have the highest percentage condom use at 52% while those who preferred to discuss with family members were 32% and only 4% chose to visit VCT counselors for discussion on safe sex methods. The above findings are suggestive of strong peer influence on sexual behaviour.

Table 4.33: Representing those who the Respondents felt free to discuss with the VCT Visits

Whom would you feel free to discuss HIV/AIDS with	Have you ever visited VCT		
	Yes	No	Total
Anybody	18 17%	16 10%	34 13%
Friends/peers	44 43%	91 58%	135 52%
Family Members	37 36%	44 28%	81 31%
VCT/Counselors	4 4%	6 4%	10 4%
TOTAL	**103** **100%**	**157** **100%**	**260** **100%**

$\chi^2 = 6.553$, $P = 0.088$

No statistically significant Relationship was found between the person one feels free to discuss with and VCT Visit. However, it should be noted that through Focused Group discussions and key information interviews the majority of those who did not visit the VCTs confessed that they feared to know the results because if they happen to be HIV positive, they would be completely depressed beyond repair.

The statistical test results above confirm that there is significant relationship between some communication variables and some behavior change variables as follows:

1. There is a statistically significant relationship between Problems encountered with information on safe sex and VCT visit as confirmed by the test illustrated on table 4.25;

2. There is statistically significant relationship between problems encountered when looking for information on safe sex methods and condom use (table 4.26);
3. There is statistically significant relationship between those who make decisions concerning sexual issues in the family and condom use as illustrated on table 4.30;
4. There is statistically significant relationship between those who make decisions concerning sexual issues in the family and VCT visit (table 4.31).

Therefore, in view of the above statistical associations, the null hypotheses (Ho); "there is no significant relationship between communication and sexual behaviour change" is rejected.

The second hypothesis: "there is no significant relationship between Socio-demographic factors, economic factors and sexual behaviour change" was also tested. The behaviour change variables, similar to those used in the first hypothesis, were cross-tabulated with the relevant variables representing social factors for instance, the number of wives, one's denomination; demographic factors such as age, level of education, marital status, and finally the economic factors such as income.

(ii) Socio-Demographic Factors versus Behaviour Change Variables

Table 4.34: Representing education levels and visits to VCT

	Ever visited VCT?		
Education Level	**Yes**	**No**	**Total**
Primary	31 28%	71 42%	102 37%
Secondary	61 54%	70 42%	131 47%
College	20 18%	26 16%	46 16%
TOTAL	**112** **100%**	**167** **100%**	**279** **100%**

$\chi^2 = 6.497$, P = 0.039

The results above confirm that there is a statistical association between education and visit to VCT. Those with secondary level are leading in VCT visit with 54%. This could be explained by the fact that those who are educated usually open up to new ideas and are therefore, able to understand the dangers of disease hence they try to avoid contracting diseases.

Table 4.35: Representing Relationship between Education and Condom Use

Education Level	Condom Use		
	Yes	**No**	**Total**
Primary	63 43%	31 28%	94 36%
Secondary	5 39%	67 59%	124 48%
College	27 18%	15 13%	42 16%
TOTAL	**147** **100%**	**113** **100%**	**260** **100%**

$\chi^2 = 10.868$, P = 0.004

The results above confirm statistically significant relationship between education and condom use. It should be noted that 59% of secondary school graduates are leading in high percentage of rejection of condom use. However, from focused group discussions it was confirmed that most of the respondents were high school dropouts at form one level. Therefore, there is no much difference in the education level between primary level and secondary level among the respondents. However, the rejection of condoms by high percentage of the high school drop-out needs to be investigated further. A point to be noted here is that those who consented to condom use among primary level was 43%, secondary level was 39% and college level was 18%. The results confirm that the respondents had below average condom-use.

Table 4.36: Representing Marital Status versus Condom Use

Marital Status	Condom Use		
	Yes	**No**	**Total**
Married	64 44%	64 58%	128 49.8%
Single	76 51%	44 40%	120 46.7%
Divorced/Widowed	7 5%	2 2%	9 3.5%
TOTAL	**147** **100%**	**110** **100%**	**257** **100%**

$\chi^2 = 6.111$, P = 0.047

The results above indicate statistically significant relationship between marital status and condom use. More singles use condoms than the married this could be attributed to the fact that the singles tend to have more sex partners hence they use condoms much more than the married ones, because of the uncertainty in their relationships.

From the above findings 51% of the singles use condoms while 44% of the married people use condoms; this could account for those who have left their wives in the countryside and could be having extra-marital affairs hence they resort to condom-use.

Table 4.37: Representing Income and Visit to VCT

INCOME	Ever Visited VCT		
	Yes	No	Total
Less than 3,000	11 10%	6 4%	17 6.5%
Between 3,000 – 5,000	43 40%	82 52%	125 47.5%
Between 6,000 – 10,000	33 30%	51 33%	84 32.0%
Between 11,000 – 20,000	18 17%	15 10%	33 12.5%
Between 21,000 – 30,000	3 3%	1 0.6%	4 1.5%
TOTAL	**108 100%**	**155 100%**	**263 100%**

$\chi^2 = 10.711$, $P = 0.030$

The above test result confirms that there is a statistical association between income and VCT visit.

The findings reveal that 89% of the 155 sampled respondents who earn between Ksh.3,000 and 10,000 have not visited the VCT. Although there is a statistical association between income and VCT visit, it should be noted that from focused group discussions, five (5) out of the fifteen (15) groups confirmed that most respondents did not go to VCT for Testing of HIV-status, because they feared that incase they were positive they would not know how to manage their lives

thereafter. Others indicated that they could not afford the cost of HIV-status testing at the VCT centres.

Table 4.38: Representation of the Relationship between Denomination and Condom Use

Denomination	Condom Use		
	Yes	**No**	**Total**
Catholic	74 50%	28 26%	102 39.8%
Protestant	73 50%	81 74%	154 60.2%
Total	**147** **100%**	**109** **100%**	**256** **100%**

$\chi^2 = 15.870$, P = 0.000

There is statistically significant relationship between Denomination and condom use. Among the Catholics 26% do not use condoms while among the Protestants 74% do not use condoms. There has been a long and protracted debate between the Catholic Church and the Government on condom use as a protective measure against HIV/AIDS. During focused group discussions it came out clearly that all the Christian Churches do not prescribe to condom use for prevention of HIV. Instead most churches viewed condom use negatively as prompting promiscuity/prostitution. Hence this standpoint may be attributed to the 74% of the Protestants who confirmed that they do not use condoms.

Religion was classified on its own as it was assumed that it affects people in a different way from culture because people from different cultures may follow religious traditions and abandon their tribal culture.

Table 4.39: Representing Denomination and how many Wives the Respondents have

Denomination		How Many Wives do you Have?		
		One	**Two and Above**	**Total**
What is your denomination	Protestant	48 38.4%	11 40.6%	59 38.8%
	Catholic	77 61.6%	16 59.4%	93 61.2%
Total		**127** **100%**	**27** **100%**	**152** **100%**

$\chi^2 = 0.51$, $P = 0.821$

There was no statistically significant relationship.

Table 4.40

THE POSITION OF THE CHURCH ON CONDOM USE		Do You Avoid Condom Use because your Church is against it?		
		Yes	**No**	**Total**
Does your Church support Condom Use?	Yes	5 9.4%	38 20.2%	43 17.8%
	No	48 90.6%	15 79.8%	198 82.2%
Total		**53** **100%**	**188** **100%**	**241** **100%**

$\chi^2 = 3.277$, $P = 0.070$

In contrast to the statistical association between denomination and condom use, as seen earlier, it should be noted that there was no statistical association between religious denomination and the number of wives the respondents had; and also no association with condom use.

Table 4.41: A Table Representing Condom Use and Cross Tabulated and the Number of Partners

CONDOM USE		Do you have more than one sex Partner		
		Yes	**No**	**Total**
Do you use condoms when you engage in extra marital sex?	Yes	53 64.6%	58 45.3%	111 52.9%
	No	29 35.4%	70 54.7%	99 47.1%
Total		**82** **100%**	**128** **100%**	**210** **100%**

$\chi^2 = 3.277$, $P = 0.070$

The results above indicate that there was no statistically significant relationship between condom use and the number of partners that one had.

The findings confirm that 34.5% of men in the informal sector do not use condoms even when involved in extra marital sex. 64.6% confirmed that they have multiple sex partners but they use condoms for protection. However, from focused group discussions, most of the respondents intimated that they do not use condoms regularly. Therefore, it should be noted that they apply the rule (condom use) selectively and rarely, hence, the need for further studies to establish whether men in the informal sector are HIV risk group or not.

The following socio-demographic factors, economic factors, cultural practices and sexual behaviour confirmed significant relationship when the statistical test was applied as follows:

(i) That there is statistically significant relationship between Education level and VCT visit (tale 4.34).

(ii) That there is statistically significant relationship between Education level and condom use; (table 4.35).

(iii) That there is statistically significant relationship between marital status and condom use. (table 4.36).

(iv) That there is statistically significant relationship between income and VCT visit (table 4.37)

(v) That there is statistically significant relationship between Denomination and condom use (table 4.38).

In view of the above statistical tests results, which clearly indicate that there is some statistical significant relationship between some socio-demographic factors, some economic factors and sexual behaviour change, the null hypothesis: "there is no significant relationship between socio-demographic factor, economic factors, and sexual behaviour change", is therefore, rejected.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATIONS

This chapter outlines a summarized version of major findings of the research and gives appropriate conclusions and recommendations.

5.1 SUMMARY OF FINDINGS

Findings arising from the study and in line with the objectives of the research were noted as follows: -

That there are communication barriers, socio-economic and demographic factors that continue to undermine the adoption of positive sexual behaviour among men working in the informal sector. One such finding points to lack of open communication on sexual matters. As a result 54% respondents alluded to the above sentiments, while 25% confirmed that most people give false information about safe sex methods. The above findings confirm that preventive messages have inherent communication problems that need to be addressed in order to make them more effective. Through focused group discussions it was confirmed that there was a lot of misinformation to the effect that condoms were laced with HIV virus and that they were prone to breakage during use. As a result among some respondents condoms were perceived as a danger.

The above communication barrier could be dispelled through vigorous preventive campaigns through engagement of trained communicators who would use effective communication methods. It is recommended that in order for people to discuss sexual matters openly they should be divided into groups comprising of peers and friends where they would be free to air their views. If this is done regularly, shyness would be reduced or completely eliminated. In this regard, peer groups would be most effective as the study found that most people prefer to discuss safe sex methods only with their age mates. To this effect 52.2% of the respondents indicated that they were freer to discuss safe sex methods with peers/friends while only 20.2% preferred to discuss such matters with their wives. This finding is paramount in that through friends/peers, interventionists could create an avenue through which information would

penetrate the people belonging to different age brackets, thereby offering a possible breakthrough in eliminating the communication barriers that are hampering the free flow of information. It is therefore recommended that messages for HIV prevention campaigns should be designed according to the needs of different age groups in order to make them effective.

Further findings established that 46% of the men are the decision makers on sexual matters within the family while 54% of the men indicated that they allow their wives to take part in making decisions on sexual matters as shown on table 4.2. This finding concur with findings from focused group discussions and key informant interviews which indicate that in almost all Kenyan communities men are the ones who make decisions on family matters including sexual matters. This confirmation is important because it reveals that men play a very important role in decision making hence they are well placed to give leadership on HIV/AIDS prevention campaigns since naturally they are leaders in the home and at various levels in the society hence they could change the course of the HIV/AIDS epidemic. This finding concurs with the views expressed by Wangari Maathai, Nobel Peace Prize Laureate, during her interview with CNN reporter – Jonathan Mann – soon after receiving the Nobel Peace Prize (December 2004). Maathai stated that men are in a better position to protect women from contracting AIDS because preventive methods favour them and they have a privileged social position whereby they make decisions on how, where and with whom to have sex (KBC TV, December 2004). Therefore, programmes aimed at HIV prevention, should begin to target men, much more aggressively than has been the case. In view of the above, and as a result of their undisputed leadership position in the family, if men are empowered with effective HIV prevention skills and messages, they could easily introduce safe sex methods to their spouses.

The study confirmed that KBC is the most favourite radio channel on HIV/AIDS information and awareness creation. That out of the 16 radio channels, KBC radio was found to be the most favourite with 31% listenership, followed by KISS 100 FM (17%) Citizen FM (10%) Ramogi FM (10%), Kameme FM (10%). The findings also indicated that age and social factors play important roles in the choice of radio channels through focused group discussions and key informant interviews. It was confirmed that the younger people between 15-35 years mostly prefer KISS 100 FM. It was confirmed further that KISS FM, KBC Ramogi FM and Kameme FM were good at airing good music and interesting programmes that meet the needs and expectations of the young.

The study confirmed that ethnic FMs have more listenership from members of the particular ethnic communities because programmes are conducted in the vernaculars, which are only understood by people from a particular community. A good example here is Kameme FM where almost all listeners are from the Kikuyu community because almost all the programmes are conducted in the Kikuyu language; Ramogi FM was found to have an exclusive Luo listenership also for similar reasons. However, KBC, KISS 100 FM and Radio Citizen FM had listeners from various communities because most of their programmes are conducted in English and Kiswahili languages which are spoken by a cross-section of people in Kenya.

The above findings would be of great interest to donors sponsoring HIV prevention campaigns and programmes as the findings reveal the most popular radio channels making it easier for interventionists to choose the channels for their intended target groups.

Related to the above, were findings from focused group discussions and key informant interviews which confirm that most people prefer interactive programmes. In this regard the study recommends that radio programmes on HIV information and prevention should be interactive in order to enable the audiences to take part fully in the debates.

Due to high illiteracy rate in Kenya, donors and the Government should introduce many ethnic based FM stations to cater for as many ethnic communities as possible so that language should not be a barrier to adoption of positive sexual behaviour. As confirmed by the study ethnic FMs have high listenership among members of the particular ethnic community and they are now spearheading HIV prevention campaigns in ethnic languages hence language as a barrier to preventive messages will soon be a thing of the past if all ethnic committees are covered by ethnic FMs.

To support that radio is a powerful channel of communicaton the study confirmed that 93% of the respondents have radio ownership with 88% listenership. This finding was further confirmed by the respondents' HIV/AIDS awareness level of 95% which is suggestive of the fact that radio is a very powerful communication channel that should be used in HIV prevention campaigns. The only challenge is that the radio programmes have to be improved by making it interactive in order to make it more effective in effecting behaviour change.

The study established that apart from the radio channel, interpersonal communication with peers and friends is the most favoured method of communication for discussing sex issues. This finding concurs with views from focused group discussions and key informant interviews which points out that one to one conversation and small group discussions often lead to more open discussions, hence would be an effective channel for HIV prevention campaigns.

Arising from the findings is the fact that 43% of the respondents do not use condoms even when they are engaged in extra marital sex, while 57% use condoms whenever they are engaged in extra marital affairs. However, this finding should be taken cautiously, with the understanding that most respondents confirmed through focused group discussions and key informant interviews, that they do not use condoms regularly. In this regard some respondents intimated that they use condoms selectively depending on whether the sex partners allows him to do so, that is, if the woman does not want the man to wear the condoms, the man would in most cases comply with her needs.

However, most respondents intimated that they use condoms regularly when engaging in sex with commercial sex workers and strangers but once the relationship becomes steady and he becomes familiar with the woman, he would stop the condom use, and instead engage in unprotected sex. Therefore, familiarity with a sex partner leads to unprotected sex. The study confirmed that the practice of engaging in unprotected sex, based on familiarity, is common but very dangerous and could lead to HIV infections.

The above findings and the practice of engaging in unprotected sex among men in the informal sector is pointing to the fact that men in the informal sector could be HIV "risk group", thus they should be declared as such so that the campaigns could target them with appropriate messages.

Therefore, the challenge for the interventionists is to introduce programmes that would lead to sustainable and regular condom use among men in the informal sector. In this regard people need to be informed that 100% condom use is the only effective preventive method. It is recommended therefore, that for any love relationship that one needs to be consistent with the first safety move is to visit the VCT for testing of HIV status for both partners.

From focused group discussions and key informant interviews, it was confirmed that most respondents did not know their HIV status and were not willing to do so for fear of testing HIV positive. Although the structured questionnaires revealed that 40% of the respondents had established their status through VCT while 59.9% had not, from focused group discussions and key informant interviews the number who had established their status was much smaller than 10%. In view of the above, more campaigns are required to popularize VCTs than has been done. Given that most respondents are residents of Kibera slums where there are a number of NGOs engaged in HIV prevention campaigns, with several VCT centers established there, yet a big percentage do not know their HIV status and are not willing to visit VCTs, there is an urgent need to step up campaigns using effective communication methods to achieve this end.

The study established that the Trust Condoms are the favourite for most respondents at 68% user rate, while the GoK free condoms which have flooded hotels' toilets and bars had the lowest user rate of 4.8%. Focused group discussions confirmed further that the GoK free condoms are of low quality and are too small and sometimes burst when in use. As a result most respondents do not use them. However, the Trust Condoms were highly rated as affordable and of good quality. This finding is very important in that it would send a message to the Government on the need to give good quality free condoms in order to achieve desired objectives. The above confirmation would also send a message to the manufacturers to improve the quality of condoms because good quality would encourage people to buy and to use them since condom-use was rated as among the best HIV preventive methods within the age-group of 15 – 23 years as shown in table 4.18. The reason why they prefer condoms to other methods is that one's safety is guaranteed because if used as prescribed the condoms appear to be 100% preventive.

In view of the above, the challenges for the interventionists and communication experts is to design good messages that would make people more receptive to condom use because from the findings of the study it has been confirmed that most people are willing to use condoms, what is lacking is effective communication that would remove all the barriers to complete condom adoption.

The study established that traditional practices lead to the spread of HIV infection as indicated at table 4.9. Through focused group discussions it was confirmed that the respondents were

adamant to abandon certain traditional practices even though such practices could lead to HIV infection. Focused group discussions and key informant interviews confirmed that some practices could not be abandoned due to the cultural value attached to such practices. Hence they were so secretive about such practices and they even gave misleading and conflicting information. This was particularly so about wife inheritance because many respondents from the communities where it is practiced indicated that they do not practice it while through key informant interviews it was intimated that they practice it in secrecy. Another cultural practice is circumcision which is a danger or prone to HIV infection if conducted by the traditional circumciser. Here the respondents insisted that the practice has to be carried out by the traditional circumciser and whether this could lead to HIV infection or not, they would stop the practice.

Due to economic reasons 37% of the respondents do not live with their wives in Nairobi, but 61% live with them in Nairobi however, findings from focused group discussions revealed that most of the respondents' wives only pay occasional visits to their husbands in the city and return to upcountry because they are permanent residents in the rural areas as the men cannot afford to pay for adequate accommodation for their families in the city of Nairobi. This concurs with Wangari Maathai's view that the majority of the poor people in Kenya are living on less than one US dollar a day. As a result it is not possible for most men working in the informal sector to afford the high cost of house rent in the city to enable them to accommodate their families. Instead the wife and children are left to live in the rural homes.

From the findings the average income of the respondents was less than one US dollar a day. Through focused group discussions, it was established that most of them did not have regular income. This is because they get their little income from Kenyan tax payers of average income, who are also overstretched with high taxation by the government and high inflation rate which has characterized of the Kenyan economy for many decades. As a result of the above factors men working in the informal sector, have to contend with meager income.

5.2 CONCLUSION OF FINDINGS FROM THE STATISTICAL TESTS

The findings of the Hypotheses tests confirm that there is statistically significant relationship between problems encountered with information on safe sex cross-tabulated with VCT visit. It

should be noted that there was high percentage of VCT visits among those who encountered problems with information on HIV/AIDS prevention. This could suggest that the VCTs need to be much more equipped than otherwise, with more information on HIV/AIDS prevention than counseling per se.

The research findings also confirmed that there is statistically significant relationship between socio-demographic factors and behaviour change. Hence given that the population under study is an urban population, the above findings could be used for age segmentation for target campaigns among men working in the informal sector.

It was also confirmed that families where husband and wife have equal decision making power on sexual issues, there was high percentage of condom use among men placed at 59.3% while families where men were the overall decision makers on sexual issues there was a high percentage of rejection of condoms at 54.8%. This is a very important finding which campaigners could use to encourage men to allow their wives to have a joint decision making power on sexual matters.

Findings from focused group discussions confirm that religious forums presented opportunity for accessing HIV/AIDS information. Although there is no statistical association between the position of Church and condom adoption, a big percentage of 79.8% do not use condoms but confirmed that the Church had nothing to do with their decision. However, from another sampled group 90.6% respondents confirmed that they do not use condoms because the Church does not support it. This is a big percentage that requires further investigation because if the Church is so influential, even though the statistical tests confirmed that there was no significant statistical relationship between denomination and condom use there could be other factors causing such a big percentage of respondents to reject condom use hence the need for further studies.

The study confirmed that the null hypotheses (H_o) "there is no significant relationship between communication and sexual behaviour change" cannot be adopted because test results confirm that there were statistically significant relationships between some variables of communication such as problems encountered with information cross-tabulated with VCT visits and also when

cross-tabulated with condom-use. There is also significant relationship between decision making concerning sexual matters and condom-use; and between decision-making on sexual matters and VCT visit all point to the fact that the null hypothesis cannot be adopted.

The second null hypothesis: "there is no significant relationship between socio-demographic, economic factors and sexual behaviour change" also cannot be adopted because there is significant relationships between some socio-demographic and some economic variables and some behaviour change variables as indicated in the findings as follows: education level and VCT visit; between education level and condom-use; between marital status and condom-use; between income and VCT visit; and between denomination (religion) and condom-use. All the above significant relationships point to the fat that the second null hypothesis is rejected.

The above test results are important because they point to areas where campaign emphasis is required. For instance who encountered problems with information to HIV/AIDS prevention had a high percentage of rejecting VCT visits – 45% who did not visit VCT pointed to lack of competence of communication and 40% of those who did not visit VCT pointed to lack of clarity of information on safe sex methods; and this is logical because the communication has not been effective hence the response to VCT visit has been poor. Also the tests revealed that those who encountered problems when looking for information on safe sex had a high percentage of condom rejection placed at 59.0%.

It is very important to note that families where men are the overall decision makers on sexual matters there is a very high condom rejection rate at 54.8%, while families where decisions are made by both men and wives there is a high condom-use rate of 59.3%. The statistical test also confirmed that there is a significant relationship between decision making on sexual matters and condom-use. The tests established further that rejection of VCT visit is high among men who make sole decisions on sexual matters; this was placed at 53.4% while those who allow their spouses to make joint decision with them on sexual matters had the high VCT visit rate at 61.1%. The statistical test confirm that there is a significant relationship between decision making on sexual matters and VCT visits.

The test on marital status was cross-tabulated with condom-use confirm a significant relationship also confirmed that the high percentage of those who use condoms are the single. This finding is important in that the campaigners should know whom to target most, that is the singles, but this is not to suggest that others do not use condoms. The study established that 44% of the married use condoms.

Income level was found to have a significant relationship with VCT visit. Those earning between Ksh.3,000-5,000 have a high rejection rate of VCT visit placed at 56% citing that they could not afford the cost of visits. This finding can be used by Government planners for the Government to sponsor VCT visits in order to cut the cost barriers. Other respondents cited that they did not like to visit the VCTs for fear of testing HIV-positive. This barrier could be tied to the cost element. In that the respondents have no access to trained counselors who would use effective communication methods to convince them to visit VCT because they cannot afford the cost of counseling.

5.3 RECOMMENDATIONS FOR FURTHER RESEARCH

Little research has been done in the area of sexual behaviour change among men. This study has ventured into unearthing the obstacles that inhibit the adoption of positive sexual behaviour among men. Ineffective communication strategies, demographic factors and socio-economic factors have been found to be at the center of all the problems prohibiting behaviour change. However, further studies needs to be done to test the relationship between the source, message channel and the effects of the communication on behaviour change. This should be done in the light of the fact that this study has established that there are preferred sources, messages and channels whose impact should be monitored scientifically through experimental and control groups.

Further study needs to be done to establish the rate of HIV infection among the men working in the informal sector and to determine whether they are a risk group or not. The findings established that these groups of people are vulnerable to HIV infection since a good number of them had multiple sex partners yet most of them do not use safe sex methods even when

engaged in careless sex thus alluding to the fact that they could be classified as HIV-risk group. Therefore, since men in the informal sector are a major labour force of our economy, they are the backbone of the economy and a lot needs to be done in the area of HIV prevention amongst them hence it is important to study them further and determine the extent and rate of HIV infection among them in order to determine whether they are HIV risk-group or not, so that they can be targeted as such by the campaigners with appropriate messages.

Findings points to the fact that most of the respondents feel more free to discuss safe sex mattes and HIV prevention matters with friends, colleagues and peers. As a result a study should be conducted to measure the extent to which peer led campaigns are effective among men in the informal sector. If this is found to be effective it could bring a turn-around in the spread of the epidemic.

From focused group discussions, it was established that when men are drunk, they do not use safe sex methods. However, revelations from key informant interviews and from focused group discussions confirmed that a good number of the respondents consume alcohol regularly. Hence, a study should be conducted to establish the extent to which alcohol interferes with adoption of safe sex methods, in order to come up with effective recommendations on solutions to the problem.

The statistical association between religious denominations and condom adoption also calls for further study. This is because there has been long and protracted debates on condom use between the Church and the circular organizations. Hence the need to establish whether the Church's position against condom use is an obstacle to positive sexual behaviour.

Through Focused group discussions, key informant interviews and structured questionnaires it was confirmed that most men preferred to discuss sexual issues with peers/friends to this effect 52.2% of the respondents concurred. This strong peer dominance to communication on sexual matters should be studied further by incorporating other factors that this study did not consider, such as the influence of age-sets on sexual behaviour. Since this study concentrated on an urban population consisting of people from diverse cultural ones, the cultural impact on behaviour did not come out distinctly. Hence the need for further investigations among people living in the rural areas in a culturally homogeneous setting is inevitable.

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APPENDIX I

Figure 4.1 **A pie chart showing the percentage distribution of communication barriers among men**

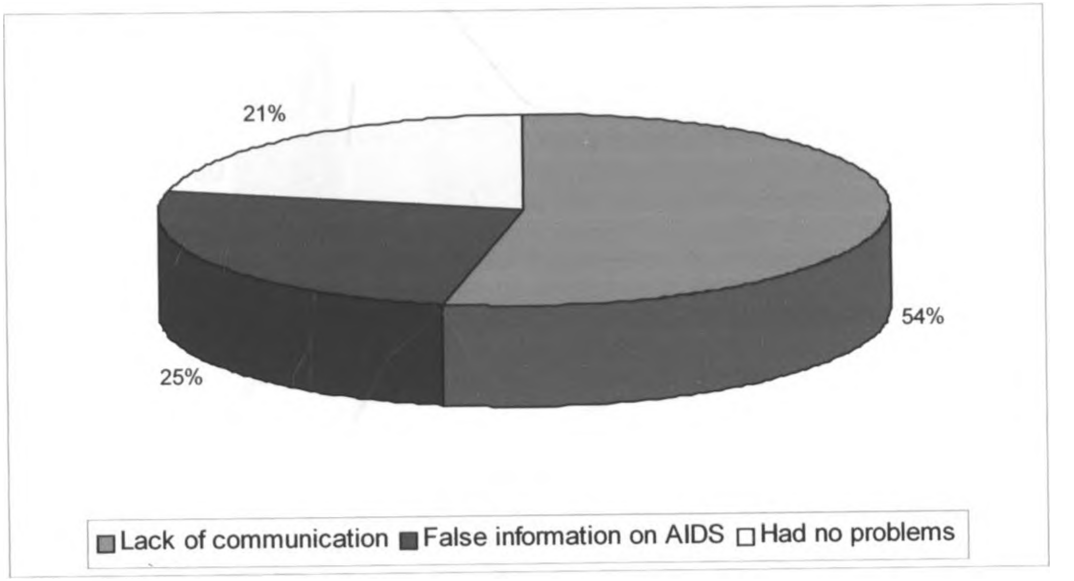


Figure 4.2 **Pie chart showing responses on open sexual discussions.**

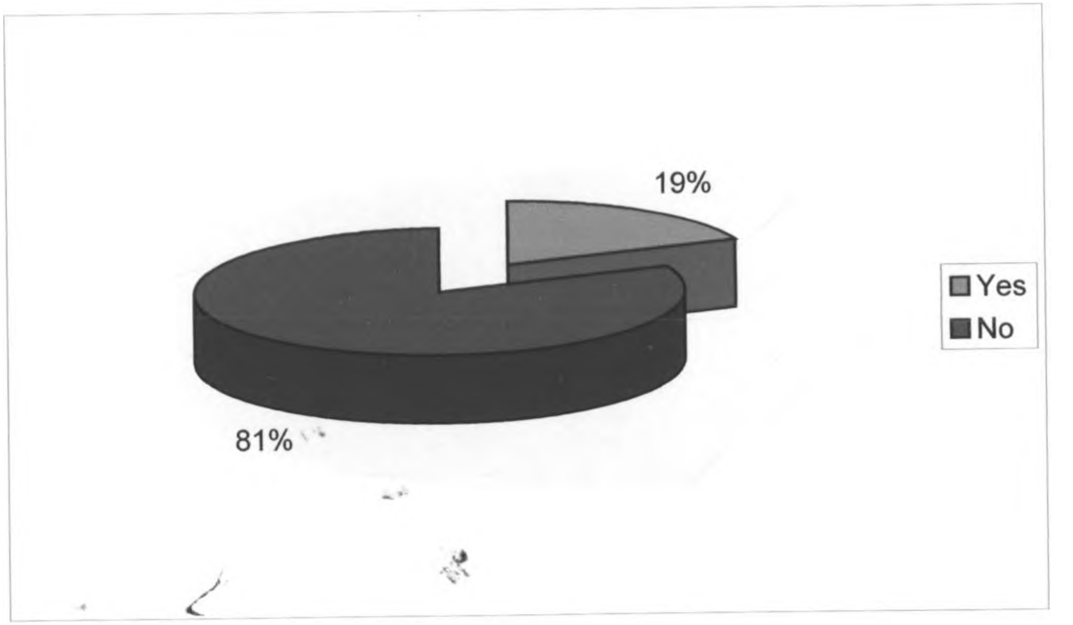


Figure 4.3 **A bar graph showing source of information identified by men.**

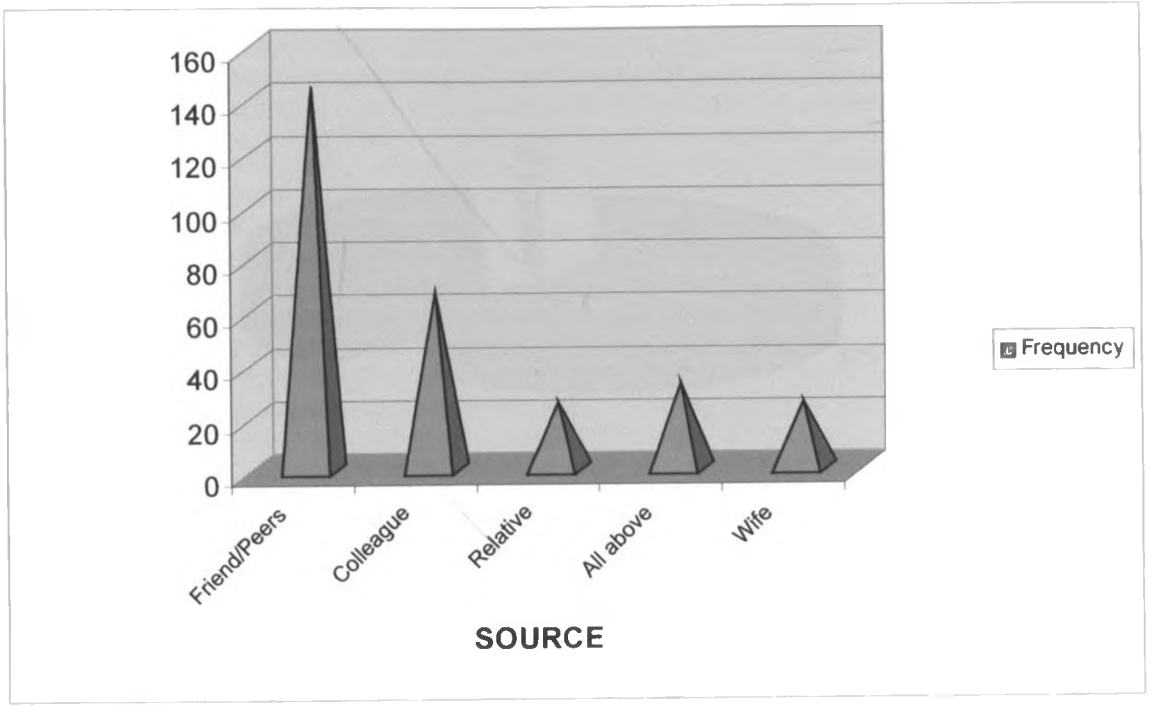


Figure 4.4 **A pie chart showing the decision makers on sexual matters in the family.**

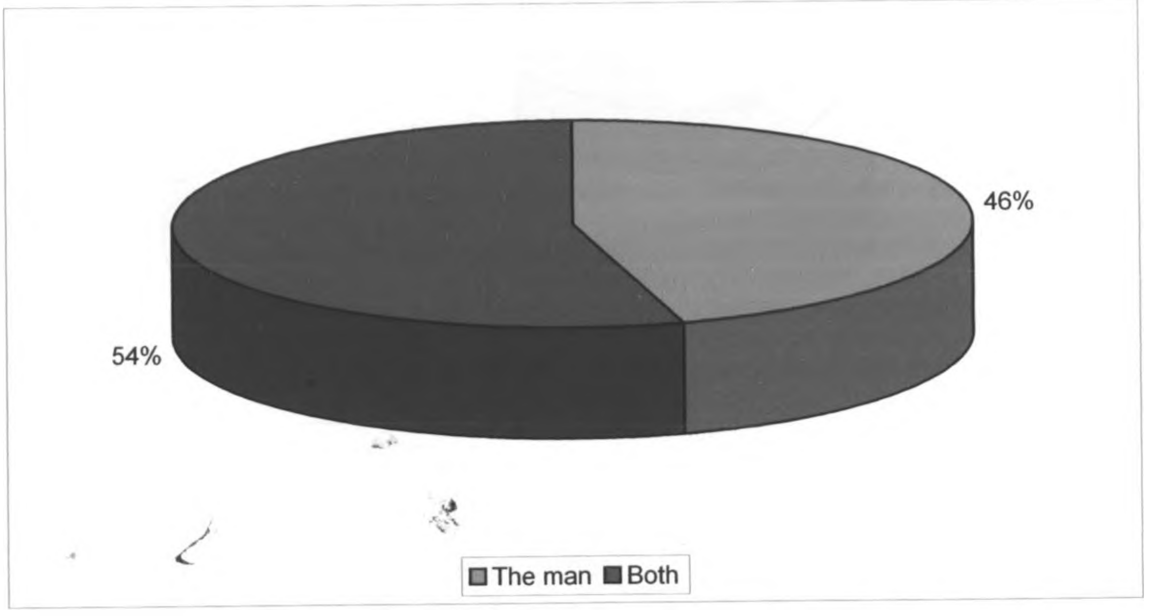


Figure 4.5: A pie chart showing distribution of men living with their wives

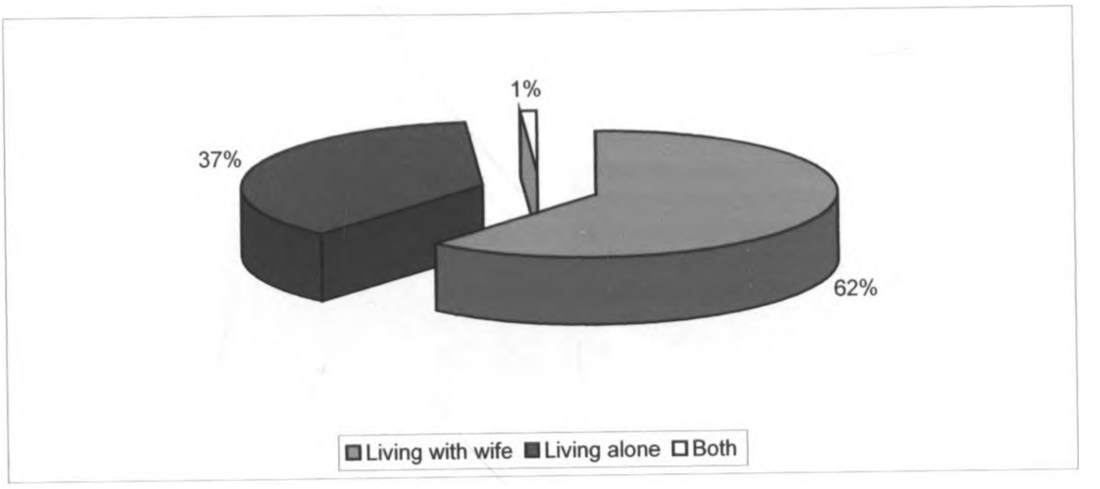


Figure 4.6: A pie chart showing distribution of sexual partners among men

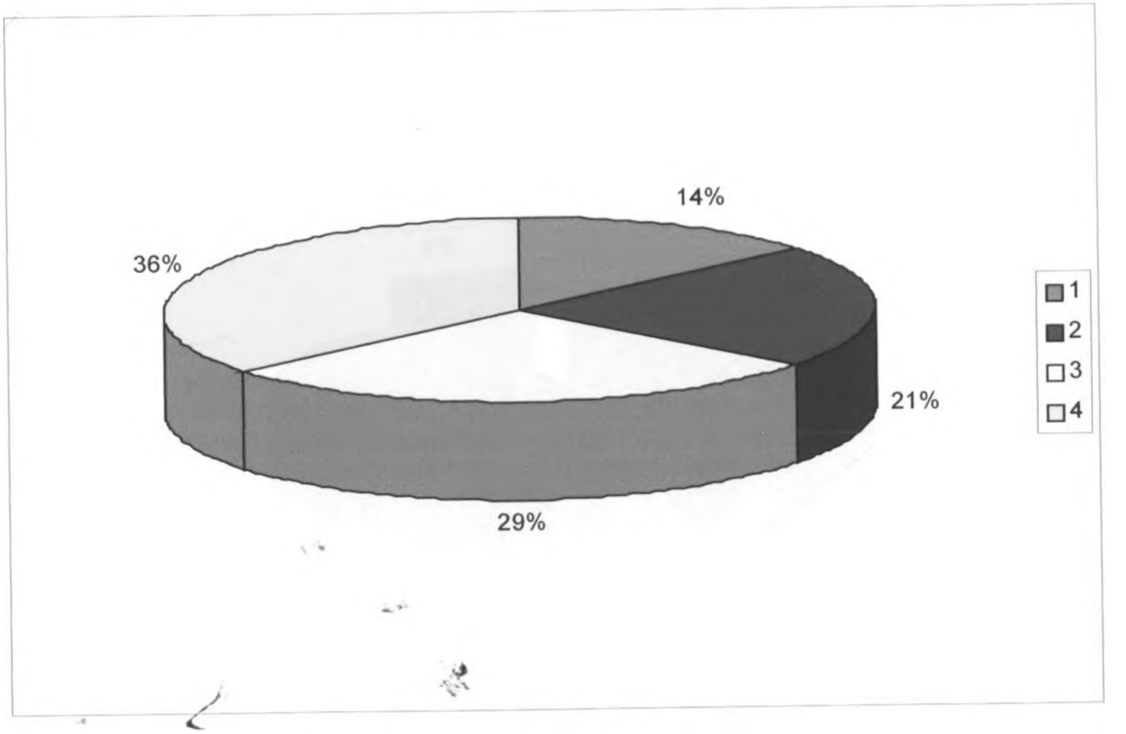


Figure 4.7: A pie chart showing distribution of visits to VCTs

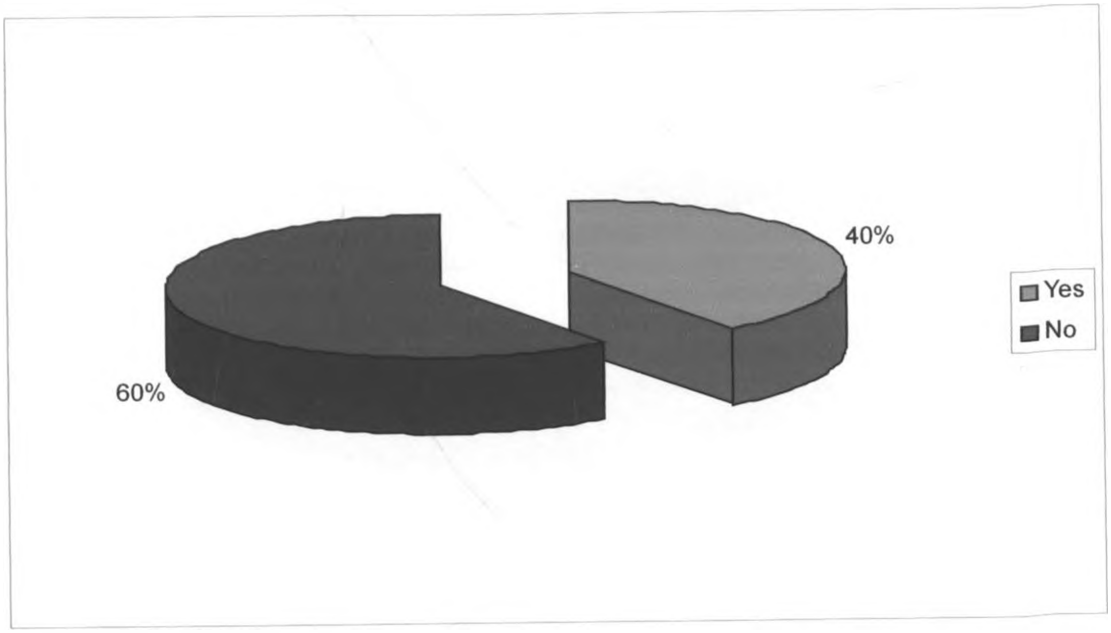


Figure 4.8: A pie chart showing the role of the church in dissemination of information

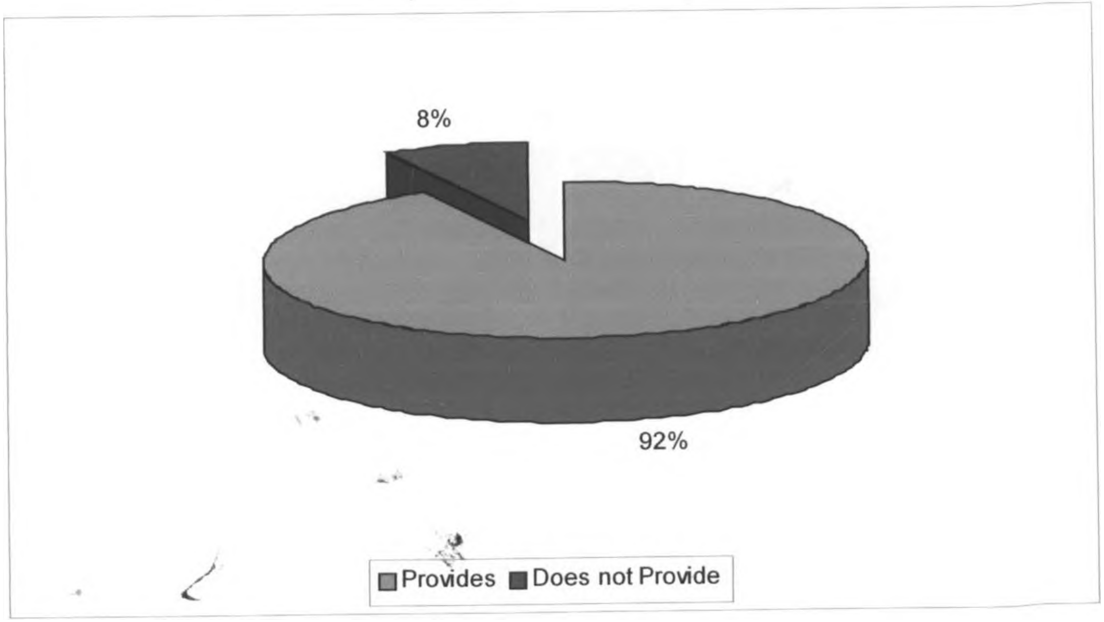


Figure 4.9: The prevalence of traditional practices among respondents

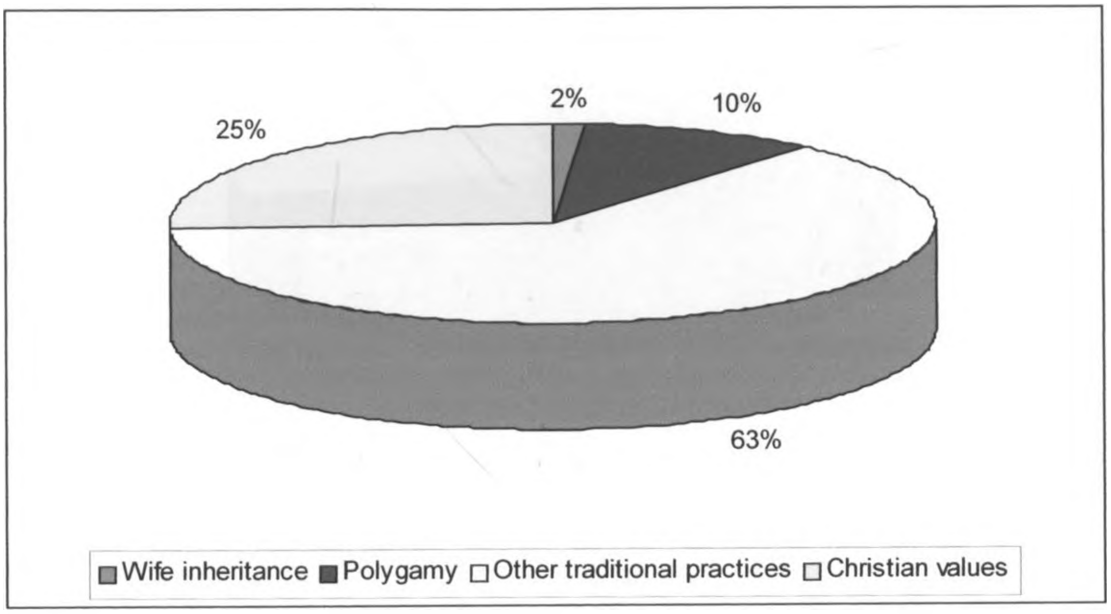


Figure 4.10: A pie chart showing distribution of monthly income among respondents

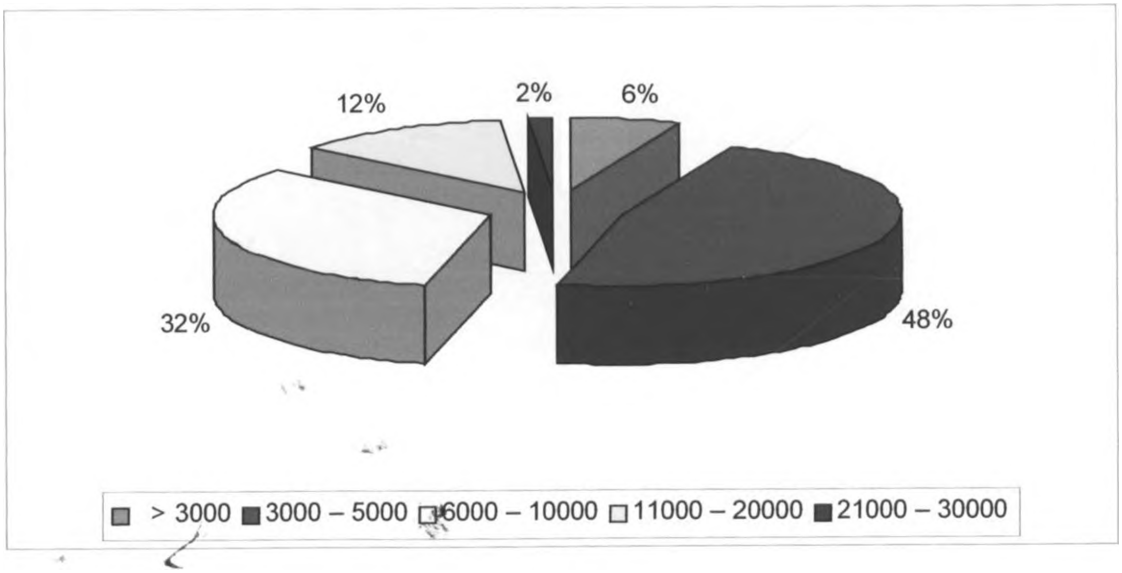


Figure 4.11: A pie chart showing excuses for multiple sex partners by respondents

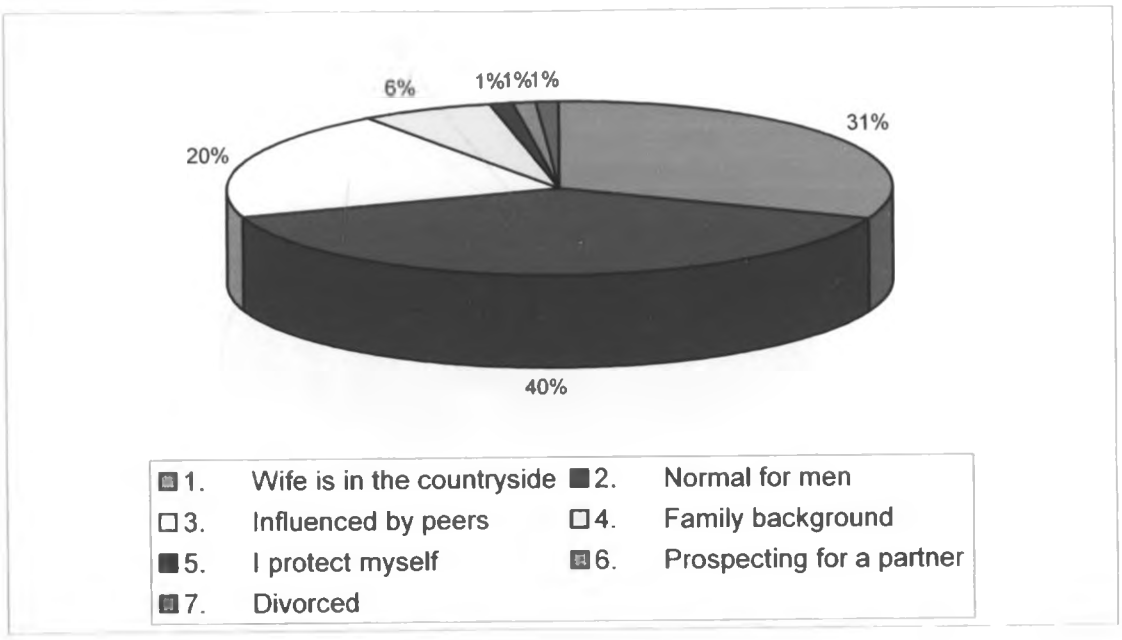


Figure 4.12: A pie chart showing the preference of condoms among men

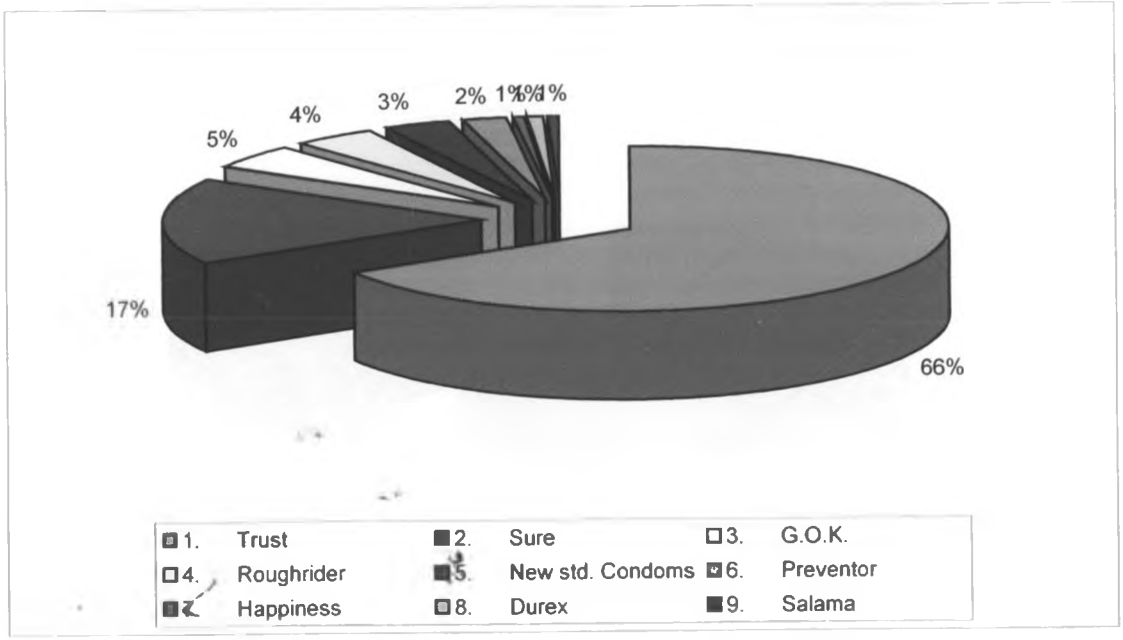


Figure 4.13: A pie chart showing the preference of condoms among men

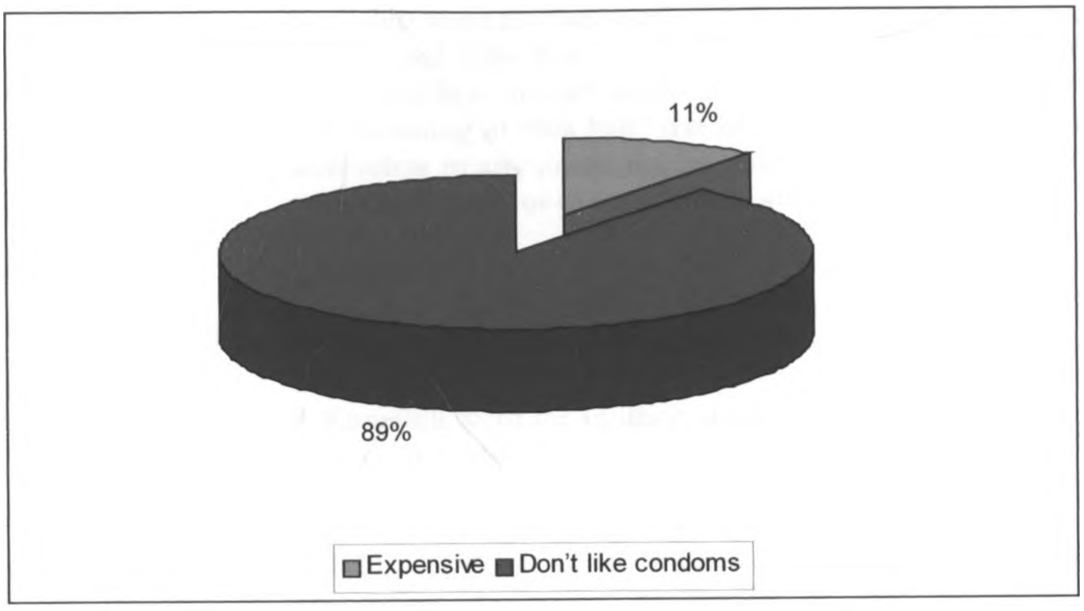
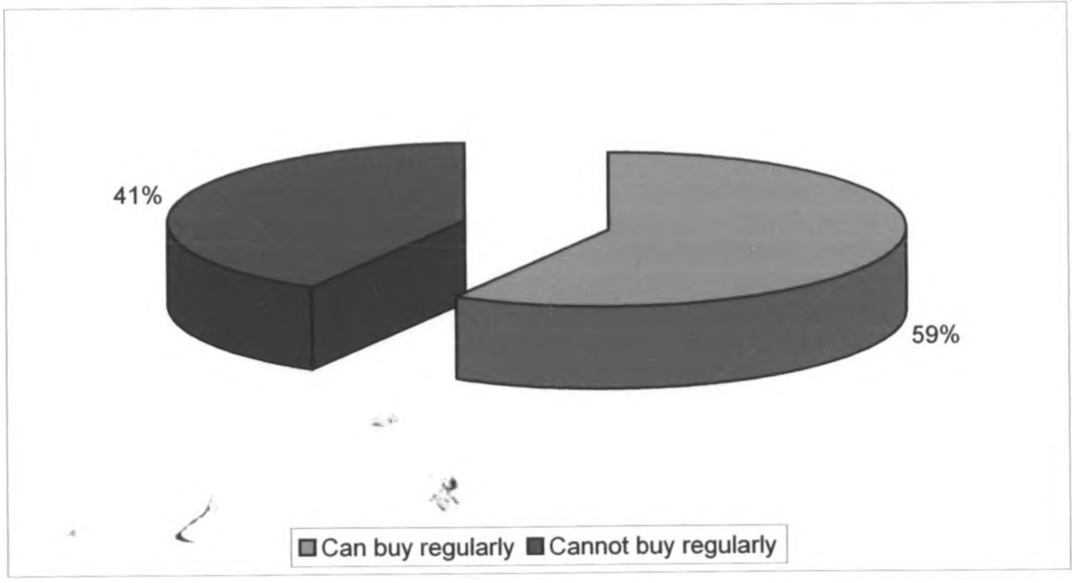


Figure 4.14: A pie chart showing distribution of affordability of condoms among men



4.15 - Translation of commonly used Kiswahili slangs.

FGDs - Focus Group Discussions

"Jua-kali" - Kiswahili word for "hot sun" but the word is locally used to refer to informal jobs that are often carried out in the open grounds where workers are hit by the hot sun hence the name "jua kali". The meaning of "jua kali" has been modified over the years and it now refers to any job in the informal sector, whether carried out in the open ground or in a temporary shed.

"Kiosks" - Kiswahili word for small shops built of temporary structures. Such shops are usually illegal structures and are which are prone to demolition by the City Council authorities

"Kumi kumi" - A Kiswahili word for an illicit alcoholic drink which is very popular among the low-income people in Nairobi, Kiambu, Thika and Machakos. Its name is driven from a Kiswahili word 'kumi' which mean ten (10) because each glass of "kumi kumi" is sold at Ksh.10/=. "Kumi kumi" is often mixed with formaline (methanol) and other dangerous chemicals in order to have a faster intoxicating effect on the consumers but as a result, the consumers have ended up either dying or losing eyesight.

"Nyama choma" - A Kiswahili word for roasted meat.

4.16 Questionnaire for Key Informants

Below is a letter of appeal to the respondents to offer information:

This project is designed to establish whether poor communication impacts negatively to behavior change among men.

This is a study of men in the informal sector in Kenyatta market and its surrounding estates. It is an academic project towards partial fulfillment of the requirement for the Degree of Masters of Arts in Communication Studies, University of Nairobi. Therefore, in order to enable me to complete this project successfully, I wish to request you kindly to offer your time to fill out the attached questionnaire.

Please give truthful and accurate answers as much as possible because accurate and truthful response could reveal facts that may save life or lives.

Thank you for your patience and understanding.

SAMPLE QUESTIONNAIRRE USED FOR DATA COLLECTION:

Please tick your choices of answers and give truthful and <u>accurate explanations where necessary</u>.

1. Please state your name---------- (Optional)

2. Sex?
   a. Male ☐
   b. Female ☐

3. What is your marital status?
   a. Married ☐
   b. Single ☐
   c. Widower ☐
   d. Divorced ☐

4. How old are you?
   a. 15-25 years ☐
   b. 26-35 years ☐
   c. 36-45 years ☐
   d. 46-55 years ☐
   e. Over 55 years

5. How many wives do you have?
   a. One ☐
   b. Two ☐
   c. Three ☐
   d. Four ☐

6. What is your denomination?
   a. Catholic ☐
   b. Protestant ☐
   c. Other, specify ----------

7. Do you go to church regularly?
   a. Strictly regularly ☐
   b. Moderately regularly ☐
   c. Occasionally ☐
   d. Rarely ☐

8. What is your education level of?
   (i) (a) Primary ☐
   (b) Secondary ☐
   (c) College ☐
   (d) Other, specify----------
   (ii) How many languages do you speak? State them here in order of proficiency

a. Very well..... ☐ state
b. Well..... ☐ state
c. Moderately..... ☐ state
d. Poor..... ☐ state

9. i) What work do you do to earn a living?
   a. Mechanic ☐
   b. Carpentry ☐
   c. Car wash ☐
   d. Electrician ☐
   e. Shoe repairer ☐
   f. Other specify----------
   ii) Where are you stationed to work? ----------
   iii) Are you trained in the work (trade) that you do?
      a. Yes ☐
      b. No ☐

10. i) How much monthly income do you earn from your work?
   a. Between kshs. 3,000-5,000
   b. Between kshs 6,000-10,000
   c. Between kshs. 11,000-20,000
   d. Between kshs 21,000-30,000
   e. Other, specify----------
   ii) Where do you live in Nairobi? ----------
   iii) What is your monthly expenditure on the following?
      a. Rent---------- (State amount paid)
      b. Water and electricity---------- (State amount paid)
      c. Food and general family up keep ---------- (State amount spent)

11. i) When did you first come to Nairobi?
   State the year----------
   ii) What prompted you to come to Nairobi?
      a. To find a job ☐
      b. To visit a relative ☐
      c. Other, specify ----------

12. If you are married, is your wife living with you in Nairobi?
   i) a. Yes ☐
      b. No ☐
   ii) If not, state why she is not living with you ----------
   iii) Where is your rural home? ---------- (State the district and the province)
   iv) What tribe do you belong to?
      a. Kikuyu ☐
      b. Luo ☐
      c. Kamba ☐
      d. Luhyia ☐
      e. Kalenjin ☐
      f. Other, specify----------

13. Do you own a radio?

i) a. Yes ☐
b. No ☐

ii) If yes, do you listen to it regularly?

a. Yes ☐
b. No ☐

iii) State some of the messages that you have heard from the radio about safe sex methods ----------

iv) Which of these messages do you think are most convincing and effective in preventing the spread of HIV/AIDS? ----------

v) Which is your favorite radio channel on HIV/AIDS awareness messages and why it is the most favorable? ----------

14. i) When did you first hear about AIDS? State the year ----------

ii) Where did you first hear about HIV/AIDS?

a. Radio ☐
b. Newspapers ☐
c. Bill boards ☐
d. A friend told me ☐
e. At a funeral of an aids victim ☐
f. Other, specify ----------

15. i) Apart from the radio and other mass media sources, what are your other reliable sources of information on safe sex and HIV/AIDS prevention?

a. A friend ☐
b. A colleague ☐
c. A wife ☐
d. A relative ☐

ii) State why you think he/she is well informed about safe sex methods/HIV infection. ----------
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16. i) In your view what are some of the traditional practices in your community, which you think may lead to the spread of HIV/AIDS? ----------
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ii) If you were placed in a situation which demands that you should practice polygamy, inherit your deceased brother's wife, how would you respond? Choose the most appropriate response indicated below.

a. Opt to practice polygamy in order to have many children and to have many sons in particular. Accept to marry my deceased brother's wife, as required by my traditions. ☐
b. I would reject polygamy as it is too expensive to maintain two or more wives, and for similar reasons i would not inherit a widow. ☐
c. I would not engage in any traditional practices that prescribe to engaging in multiple sexual relationships as this could put me in danger of contracting HIV infections. ☐
d. I would strictly adhere to Christian teachings and stick to monogamous marriage. ☐

e. Other (specify) ----------

iii) Have you been commanded by your community or family to inherit a wife of your deceased brother, cousin or a friend?

a. Yes ☐

b. No ☐

iv) If yes, did you accept to inherit her?

a. Yes ☐ b. No ☐

17. i) Do you perceive aids as a danger to your health or life?

a. Yes ☐

b. No ☐

ii) If yes, have you taken any deliberate step to protect yourself from contracting HIV infection?

a. Yes ☐

b. No ☐

iii) If the answer is yes, consider the choices below and indicate the method you have been using to protect yourself from HIV infections and state why you think it is the best method for HIV prevention?

a. Abstinence----------

b. Being faithful to my spouse ----------

c. Condom use----------

d. Other, specify ----------

18. With your current monthly income, can you afford to buy condoms regularly when you need to use them?

a. Yes, I can afford to buy regularly wherever I need them.

b. No, they are too expensive I cannot afford to buy condoms; as such I don't use them even when engaged in multiple sexual relationships.

c. Because they are too expensive I can only afford to buy them rarely. Therefore, due to cost factors, I cannot use them as regularly as I should.

d. Other specify----------

19. i) Have you ever visited a VCT center for purposes of determining your HIV-status?

a. Yes ☐

b. No ☐

ii) If yes, what is your HIV- status?

a. Positive ☐

b. Negative ☐

iii) Are you prepared to visit a VCT in order to establish your HIV-status if offered the opportunity now?

a. No----------if no, please state why?

b. Yes----------if yes state why? ----------

20. i) Do you ever use condoms during sexual intercourse?

a. Yes ☐

b. No ☐

ii) If you use condoms during sexual intercourse, which type of condoms do you prefer to use? ----------

iii) Do you use it regularly?

a. Yes ☐

b. No ☐

iv) f you do not use it regularly choose an appropriate reason why you don't use it regularly:

a. Because it is expensive

b. Because I don't like having sex with condoms

21. i) Do you have more than one sex partners?

a. Yes ☐

b. No ☐

ii) If yes, how many do you sex partners do you have?

a. Two

b. Three

c. Four

d. Five

e. Other specify----------

iii) What prompts you to have more than one sex partners?

a. Because my wife is far in the country side ☐

b. Because it its normal for men to have many sex partners ☐

c. Because most of my friends also have girl friends, so they have influenced me ☐

d. Other, specify ----------

22. i) Do you reject safe sex methods?

a. Yes ☐

b. No ☐

ii) If yes, why do you reject?

a. Abstinence ----------

b. Being faithful to spouse. ----------

c. Using condoms. ----------

23. What are some of the traditional beliefs that hinder you from using sex methods? --------
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24. i) Do you discuss sexual matters and HIV prevention sexual methods freely with your wife?

a. Yes ☐

b. No ☐

ii) If yes, how did you agree to deal with the problem? ----------
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---

iii) Who makes decisions concerning sexual matters in your family?

a. You as the man ☐

b. Your wife ☐

c. Both of you have a say ☐

d. Other, specify ----------

25. i) Does your church have support groups that provide information about

HIV/AIDS prevention?

a. Yes ☐

b. No ☐

ii) If yes, do you participate in such groups?

a. Yes ☐

b. No ☐

iii) Does your church support condom use as a protective safe sex method?

a. Yes ☐

b. No ☐

iv) If no, do you avoid condoms because your church is against it?

a. Yes ☐

b. No ☐

26. i) What problems do you encounter while looking for information about safe sex methods? ----------

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ii) What problems do you encounter with the information on safe sex methods? ----

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iii) What do you think about spending money on safe sex (buying condoms regularly at the expense of more urgent needs e.g. food, rent, fees, clothing, health care, etc)? Is it worthy to continue buying condoms while family financial obligations continue to suffer? ----------

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a. Yes ☐

b. No ☐

iv) Do you feel embarrassed to discuss your sexual matters openly with peers and counselors?

a. Yes ☐

b. No ☐

v) In your opinion whom would you feel free to discuss your sexual matters, i.e. your fears about HIV/AIDS, safe sex methods, etc.? ----------

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27. i) Which safe sex method you prefer for prevention of HIV? ----------

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ii) Give reasons for your answer ----------

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28. HIV/AIDS is a national disaster which has led to many deaths and untold suffering in the entire world. It has also affected many families in Kenya and now it is threatening the Kenyan social structure. It s impact is extreme and irreversible. As a result AIDS is presumably everyone's concern. Consequently what recommendations would you give for preventive and or eradication measures? ----------

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