The Role of Interpersonal Communication in Shaping and Influencing Behavioral Responses to HIV and AIDS among the Youth in Secondary Schools in Nairobi County

By

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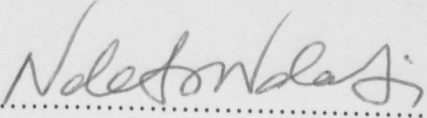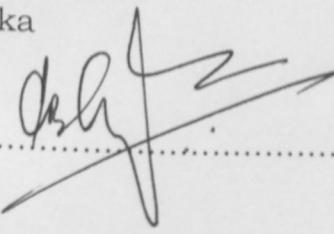
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DECLARATION

I declare that this Thesis is my original work and has not been submitted for the award of a degree in any other University.
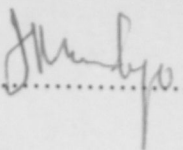
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This Thesis has been submitted to the University of Nairobi for examination with our approval as the candidate's supervisors.

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DEDICATION

To my loving wife Jackie, my sons Ndeto and Mutinda, and my daughter Ndanu.

ACKNOWLEDGEMENTS

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LIST OF ABBREVIATIONS AND ACRONYMS

BCC	– Behavior Change Communication
CBO	– Community Based Organizations
CBS	– Central Bureau of Statistics
EFA	– Education for All
GOK	– Government of Kenya
KAIS	– Kenya AIDS Indicator Survey
KDHS	– Kenya Demographic Health Survey
KIE	– Kenya Institute of Education
KNBS	– Kenya National Bureau of Statistics
MOH	– Ministry of Health
MDGs	– Millennium Development Goals
MOE	– Ministry of Education
NACC	– National AIDS Control Council
NASCOP	– National AIDS/STD Control Program
NGO's	– Non – Governmental Organizations
PDE	– Provincial Director of Education
TSC	– Teachers Service Commission
UNFPA	– United Nations Population Fund
UNGASS	– United Nations General Assembly Special Session
UNAIDS	– United Nations Program on HIV/AIDS
UNESCO	– United Nations Educational, Scientific and Cultural Organization
UNICEF	– United Nations Children's Fund
WHO	– World Health Organization

ABSTRACT

The basic question that this study set out to answer was why there are disparities between knowledge of HIV and AIDS and behavior change among the youth in Kenya. The overall objective of this study was to investigate the role of interpersonal communication in shaping and influencing behavioral responses to possible risks of HIV infection among the youth with a view to identifying the existing gaps.

The study was guided by the Social Construction Theory and the Symbolic Interaction Theory. The study was conducted among students in public secondary schools in Lang'ata District, Nairobi County. The research design was mixed methods. Quantitative data was collected from a sample of 340 respondents using a self-administered questionnaire. Respondents for the survey were selected using multi-stage sampling technique. Qualitative data were collected from focus group discussions and key informants. Participants in the FGDs and the key informants were selected purposively. Ten FGDs each with eight participants were held while 10 key informants were interviewed.

Descriptive and inferential statistics were used to interpret the quantitative data obtained on variables relevant to the study objectives and hypothesis. The themes in qualitative data were interpreted using thematic analysis. The data collected were triangulated to enhance the reliability and validity of the results.

The study found that the youth use interpersonal communication to engage in discourses that generate meanings, interpretations and understanding of HIV and AIDS with their peers. The interpersonal discourses generated form a common stock of lay knowledge from which the youth made decisions about their behavioral responses to HIV and AIDS.

The study concluded that the HIV and AIDS preventive behaviors are not only the outcome of an individual decision but are "rational" decisions stemming from a blending of lay discourses juxtaposed with limited bio-medical knowledge. Therefore, interpersonal exchange is important in mediating mass media campaigns' influences on people's attitudes and beliefs.

The study recommended that media initiatives that are already objects of young people's exchanges be used as channels for disseminating HIV and AIDS preventive messages because they have a greater chance of becoming part of the youth's discourses. The study recommends further research to establish the extent of interpersonal networks among the youth and how these networks impact on their behavior.

CHAPTER ONE

INTRODUCTION

1.0   Background of the Study

More than 60 million people worldwide have been infected with the HIV virus since the beginning of the epidemic, and nearly 30 million have died of AIDS (UNAIDS, 2010). In 2009, there were an estimated 33.3 million people living with HIV, 2.6 million new HIV infections, and 1.8 million AIDS-related deaths. The African region was the most affected, where 1.8 million people acquired the virus in 2009 (UNAIDS, 2010). An estimated 1.3 million people in Africa who died of HIV-related illnesses in 2009 accounted for 72 percent of the global deaths of 1.8 million as a result of the HIV epidemic (WHO 2010).

The United Nations Population Fund's report (2008) showed that 5.4 million young people worldwide were estimated to be living with HIV by the end of 2007. In 2007 alone, there were 2.7 million new HIV infections while two million HIV- related deaths were reported worldwide. Today, it is estimated that about half of all new infections worldwide are among young people aged 15 to 19 years (UNGASS, 2011). This age group also has the highest rates (over 500, 000 infections daily) of infection of sexually transmitted infections excluding HIV (UNAIDS, 2010) due to their physical, social, psychological and economic vulnerabilities. Every day, 6000 young people become infected with HIV – more than five

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people every single minute. Often, these young people may not perceive themselves to be at risk (UNAIDS, 2010).

The United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Declaration of Commitment on HIV and AIDS (July 2002) set the target of reducing HIV prevalence by 25 percent among 15 – 24 year olds by 2010 globally (UNESCO, 2002). According to the 2010 report on the global AIDS epidemic released by the joint United Nations Program of HIV and AIDS (UNAIDS), young people aged 15 – 19 accounted for about 40 percent of new infections. Young people are particularly vulnerable to HIV infection for many reasons, including age, biological and psychosocial development, lack of comprehension to self-risk, social norms that make it difficult for them to learn about HIV and AIDS and reproductive health, and peer pressure which easily influences them in ways that can increase their risk (UNAIDS, 2010).

The reality of the acquired immune-deficiency syndrome (AIDS) as a worldwide social phenomenon is not disputable (Nzioka, 1994). In our world today, knowledge of AIDS as a biomedical reality is well articulated and ways in which to avoid infection are well known. However, social responses to AIDS are still fearful, moralistic and emotive (Nzioka, 1994). It is this aspect of AIDS rather than its medical reality which problematises AIDS management, and which has to be dealt with if youth-based HIV and AIDS communication strategies will be successful.

1.1 Prevalence of HIV and AIDS in Kenya

The first HIV case was diagnosed in Kenya in 1984 and since that time, it is estimated that over 1.5 million people have died due to AIDS related illnesses, resulting in 1.8 million children being orphaned. It is further estimated that 1.6 million people in Kenya were living with HIV by 2009 (NACC, 2010).

In the 1990s, HIV spread rapidly in Kenya – reaching prevalence rates of 20 – 30 percent in some antenatal care (ANC) sites – with major social and economic impact at all levels of society. In 1999, the government of Kenya declared HIV a national disaster and established the National AIDS Control Council (NACC) to implement a multi-sectoral national response by coordinating two five-year strategic plans covering the periods 2000 to 2005 and 2005/6 to 2009/10 (NACC, 2009). Since 1999, the national adult HIV prevalence dropped from 14 percent to about 7.4 percent in 2007 (KAIS, 2007; KDHS, 2008/09). Overall, the HIV and AIDS prevalence rate is just below that of the sub-Saharan African region, that is, 6.3 percent compared to 7.5 percent (WHO 2010).

Unlike Uganda and Senegal, Kenya missed the early opportunity of facing the seriousness of the HIV and AIDS pandemic, through denial (Kiai, 2009). There was the misguided view that admission would damage one of Kenya's key revenue earners-the tourism industry (Singhal & Rogers, 2003). This early denial contributed to the exacerbation of the pandemic (Kiai, 2009).

The highest rates of infection were initially concentrated among the marginalized and special risk groups but in the last decade the impact of HIV and AIDS epidemic has been mixed; new infections are occurring among the sub-groups hitherto assumed to be safe as well as those considered vulnerable and high-risk groups (NACC, 2010). For instance, in spite of all the efforts – including the social marketing of condoms - there was little behavior change reported among the youth. Young people continued to expose themselves to unprotected sex (KAIS, 2007; KDHS, 2008/09; NACC, 2010).

1.1.1 Prevalence of HIV and AIDS among the youth in Kenya

The trends in HIV prevalence among the youth aged 15 – 19 years was captured by the 2003 Kenya Demographic Health Survey report, the 2007 Kenya AIDS Indicator Survey report and the 2008/09 KDHS report. According to the three national surveys, HIV prevalence in 2003 KDHS report was 1.6 percent, 2.3 percent in KAIS 2007 report, and 1.7 percent in the 2008-09 KDHS report. This trend showed that HIV infection levels increased between the years 2003 and 20098-09 among this age group.

The KDHS report (2008-09) suggested that the youth start engaging in sexual intercourse early, where 7 out of 10 girls and 8 out of 10 boys had engaged in sex by the age of 20, with a median age at first sexual intercourse of 17 years. The youth consequently face many risks and challenges that come with early sexual debut such as struggling to remain in school (NACC, 2010).

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Okigbo et al. (2002) pointed out the knowledge – behavior gap in AIDS communication which they said was at the heart of the difficulties in containing the epidemic among the youth. Nzioka (2004) noted that early sexual debut and premarital sex among the youth in Kenya exposed them to not only sexually transmitted diseases but also to HIV and AIDS. He observed that despite high levels of knowledge concerning the protective value of condoms and other contraceptives, unprotected sex was still a common feature.

The government introduced an integrated HIV and AIDS education program in various subjects like Biology, Agriculture, History, Languages and Religious education in the year 2000 in secondary schools (Ongunya et al., 2009). The objectives of the program include: acquisition of necessary knowledge and skills about HIV and AIDS and sexually transmitted diseases; appreciation of the facts and issues related to HIV and AIDS and sexually transmitted diseases; identify appropriate sources of information on HIV and related issues; make decisions about personal and social behavior that reduce risk of HIV and other sexually transmitted infections (KIE 1999; Ongunya et al., 2009).

Studies have, however, found that though there were high levels of HIV and AIDS knowledge among students, there was still lack of observable behavior change amongst them (Likoye, 2004; Ochieng, 2005; Nyinya, 2007; Ongunya et al., 2009). The HIV and AIDS education program had not enabled the youth to acquire the readiness and ability to adopt

lifestyles that were compatible with prevention attitude and practice in relation to HIV and AIDS prevention (Likoye, 2004). The knowledge which was envisaged by the current HIV and AIDS program in schools therefore had not brought about positive behavior change to the students (Ongunya, et al., 2009).

Scholars say that there is a mismatch between HIV and AIDS program objectives and behavior change among the youth (Ongunya et al. 2009). They state that there is a gap between the objectives and actual HIV and AIDS education program delivery and behavioral changes among the youth in secondary schools. There is a need therefore to address this gap between HIV and AIDS knowledge and behavior among the youth in secondary schools. As UNFPA (2007) observes, young people are assets, not liabilities, and their voices need to be heard and their talents cultivated so that they can be instruments of change.

1.1.2 HIV and AIDS in Secondary Schools in Nairobi

The high levels of HIV infection in sub-Saharan Africa has led to an increased interest in understanding the determinants of sexual activity among young people, who are at risk of sexually transmitted infections, including HIV and AIDS. Studies conducted within school settings demonstrate that in-school youth are also at risk of negative sexual and reproductive health outcomes stemming from risky sexual behavior, such as multiple sexual relationships and unprotected sexual intercourse (Kabiru & Orpinas, 2009).

In their examination of premarital sexual activity among school adolescents in Kenya, Kiragu & Zabin (1993) reported that 69 percent of male and 27 percent of female secondary school students were sexually experienced, and of these, 53 percent of males and 45 percent of females reported at least four sexual partners in their lifetime. Kabiru & Orpinas (2009) found that about half of the boys and girls in secondary schools in Nairobi had already initiated sexual activity. They also found that adolescents in co-educational schools (schools that admit both boys and girls) were more likely to be sexually experienced than adolescents in single-gender schools.

According to Ongunya et al. (2009), there is a mismatch between HIV and AIDS program objectives and behavior change among the youth. The scholars say that there is a gap between the program objectives, the actual HIV and AIDS education program delivery and behavioral changes among the youth in secondary schools. There is need therefore to address this gap between HIV and AIDS knowledge and behavior among the youth in secondary schools.

While schools have been the setting of many studies on adolescent sexual behavior, few have examined the role played by interpersonal communication on sexual behavior. Examining the role of interpersonal communication and how it influences sexual behavior among young people contributes to the body of knowledge that informs the development of effective school-based HIV prevention interventions.

1.2 Problem Statement

The Kenya National HIV and AIDS Communication Strategy for Youth (NACC, 2008), shows that the majority of the youth have heard about HIV and AIDS but many of them do not believe themselves to be at risk. Further, the youth lack adequate decision – making skills or the ability to adopt safer sexual behaviors. Information alone has not led to behavior change among young people. There is need therefore for greater attention to be focused on addressing the contextual realities faced by young people with regards to the decisions they make about their sexual behavior.

Scholars observe that meanings, perceptions, understandings and knowledge of the world are not pre-given, but rather actively constructed (Burry, 1986; Nzioka, 2004). This is why social discourses and constructions about HIV and AIDS among young people are important in mediating the impact of HIV and AIDS preventive campaigns. The purpose of this study was therefore to explore why there are disparities between knowledge of HIV and behavior change among the youth in the context of the role of interpersonal communication.

In spite of high levels of awareness of HIV and AIDS among the youth, there is no dramatic change in their sexual behavior (Likoye, 2004; Ochieng, 2005; Nyinya, 2007; Ongunya et al., 2009). Scholars have found that high levels of knowledge of HIV and AIDS among students have not always translated into behavior change. Instead, more and more

young people continue to engage in risky sexual practices that might lead to high rates of infection of STIs and HIV. This is the knowledge – behavior gap in HIV and AIDS communication that this study sought to investigate in the context of the role of interpersonal communication.

1.3 Research Objectives
1.3.1 General Objective
The purpose of this study was to investigate the role of interpersonal communication in shaping and influencing behavioral responses to possible risks of HIV infection among the youth in Kenya.

1.3.2 Specific Objectives
   (i)   To assess the level of knowledge of HIV and AIDS among the youth
   (ii) To investigate how young people perceive and anchor their self-protection from possible risks of HIV infection
   (iii) To find out how interpersonal communication informs and influences behavioral responses to HIV and AIDS among the youth.

1.4 Research Questions
   (i)   How do young people create and mediate social knowledge of HIV?
   (ii) How do young people perceive their own vulnerability to HIV infection?

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(iii) How do the youth anchor their self-protection against HIV infections?

(iv) How does interpersonal communication shape and influence behavioral responses to HIV and AIDS among the youth?

1.5 Justification of the Study

Scholars agree that the ongoing HIV and AIDS epidemic prevalence rates are evidence of the failure of many preventive and educational efforts. Among the youth, it is appears evident that providing HIV and AIDS information is not enough to change unsafe practices. More complex psychosocial processes, mainly still unexplored, seem to influence the efficacy of education about health risk minimization. This study provided an opportunity to establish how to bridge the gap between health knowledge (about the disease and how to avoid it) and safe practices.

From the findings of the study, appropriate recommendations were made that are useful to Government policy makers, planners and interventionists for strengthening communication strategies applied in HIV and AIDS prevention campaigns. The findings could inform public health policy and program formulation towards HIV and AIDS communication, including intervention programs by NGOs and CBOs. Policy makers can structure campaigns and awareness messages so that they are more appealing to the youth, form part of their interpersonal exchanges, and as a result, are able to bring about the desired behavior change.

The findings of this study may be helpful in determining the communication needs of the youth and therefore provide ways in which HIV communication interventions can be effectively packaged with the knowledge, consultation and participation of young people.

The study findings may also inform the academy so provoke them to think of more relevant, context sensitive models of health communication. Stakeholders such as the government and NGOs should receive information regarding areas that need more attention and resources in the fight against HIV and AIDS. The findings have helped to identify areas for further research in field of health communication.

1.6 Scope of the Study

The focus of this study was on the role of interpersonal communication in shaping and influencing behavioural responses to HIV and AIDS among the youth in Kenya. The study was conducted in all public secondary schools in Lang'ata District, Nairobi County.

It entailed the following:

- An assessment of the level of knowledge of HIV and AIDS among the youth.

- An investigation of how young people perceived and anchored their self-protection from possible HIV infection.

- An investigation on the role of interpersonal communication in shaping and informing behavioural responses to HIV and AIDS among the youth

1.7 Study Assumptions

This study was guided by the following assumptions:

(i) Young people create their own social knowledge of HIV and AIDS

(ii) Most young people do not perceive themselves to be at risk of HIV infection

(iii) Interpersonal communication shapes and influences behavioural responses to HIV and AIDS among the youth.

1.7 Limitations of the Study

This study was limited to in-school students in public secondary schools in Lang'ata District, an urban centre. A further study should be conducted to include rural schools. The study may also include a sample of young people who are outside the school system.

2.1 Introduction

This chapter focuses on scholarly works that address the social discourses and interaction among the youth and how these influence their behavioral response to HIV and AIDS media messages. It begins with a look at the context of HIV and AIDS communication among the youth in Kenya. This is then followed by a review of the literature based on the objectives of the study.

2.2 The context of HIV and AIDS Communication among the youth in Kenya

The National AIDS Control Council (NACC) in collaboration with stakeholders in the national HIV and AIDS response developed the first Kenya National HIV and AIDS Communication Strategy for the youth in 2008 (NACC, 2008). This strategy emphasizes the use of communication approaches to address all aspects of prevention, care and support as well as mitigation of social-economic impact of HIV and AIDS among young people. The purpose of the youth strategy is to provide the framework to guide partners and stakeholders in implementing evidence-based as well as evidence informed youth programs for the wholesome development and success of youth in life's journey.

During the development of this strategy, various issues emerged that can help improve HIV and AIDS communication programming in Kenya (NACC, 2008). These are:

(a) Involvement of Young People: Young people are not adequately involved in the design and implementation of communication program engaging them; hence they are not effectively influencing their communication choices. Additionally, there are perception differences between rural and urban areas in understanding some messages.

(b) Coordination of Mass Media Campaigns: There are various information sources for the youth on HIV and AIDS but, at the same time, the youth significantly differ in their preferences of communication channels and messages. The campaigns and programs are based on existing reproductive health issues, designed along the Abstinence, Be faithful and Condom (ABC) theme and do not adequately incorporate real life situations.

(c) Message Content: In some instances, BCC messages are prescribed for young people without consulting them about what they consider to be viable behavior.

(d) Disconnect between Media and Young People: The mass media are perceived to portray young people negatively as a group to be feared and their sexuality issues treated as a problem. The mass media often cover sensational and negative things that the youth do, while offering no solutions.

With regard to knowledge of HIV and AIDS, the strategy notes that, although the majority of the youth have heard about AIDS, many still do not believe themselves to be at risk of HIV infection. In addition, the youth lack adequate decision – making skills or the ability to adopt safer sexual behaviors. The strategy rightly observes that information alone will not lead to behavior change among young people. Instead, greater attention must be focused on addressing the contextual realities faced by Kenya's young people.

The government, academics and civil society are still searching for new solutions to what appears to be an old problem. Change needs to be enacted from institutional, governmental, and community levels. Dialogue and participatory communication should be supported as a means of social change, through a process of defining who the youth are, what they want and how to go about getting what they want (Figueroa et al, 2002).

HIV and AIDS communication among the youth requires a move away from debates about whether HIV is a health related problem or a development problem. As observed by Kiai (2009), one of the opportunities lost in addressing HIV and AIDS was the early perception of HIV as a health problem rather than a development one. This resulted in a focus that neglected the other facets of the pandemic, namely, economic, political, social and cultural (Panos Institute, 2004). Behaviour change can be usually an outcome of social change and

requires addressing social issues such as norms and values, stigma and discrimination, power relations and repressive domination within a specific cultural, political and economic context (Lie, 2008).

2.3 Characteristics of Interpersonal Communication

Beebe, et al, (1996) describe interpersonal communication as a written or oral communication that occurs in a one-on-one or group setting. It is a means of relating to different people in different situations, and making them feel at ease. Interpersonal communication occurs when one or more people interact more simultaneously and mutually influence each other. Oladimeji (2005) regards interpersonal communication as the lifeblood of any transaction.

Borchers (1999) discusses interpersonal communication from two different perspectives. He observes that interpersonal communication differs from other forms in that there are fewer participants involved, the interactants are in close physical proximity, many sensory channels are used, and feedback is immediate. Borchers also asserts that interpersonal communication means communication that occurs between people who have known each other for some time, viewing each other as unique individuals.

According to Ankanbi (2005), interpersonal communication is a crucial and fundamental phenomenon in life and no human endeavours can

substitute or thrive without it. For any activity or venture to succeed, the exchange of ideas or information must be given due attention.

Interpersonal communication describes participants who are dependent upon one another. It can involve one on one conversations or individuals interacting with many people within a society. It helps to understand how and why people behave and communicate in different ways to construct and negotiate a social reality.

Interpersonal communication is the process that we use to communicate over ideas, thoughts and feelings to another person. It includes message sending and message reception between two or more individuals. This can include all aspects of communication such as listening, persuading, asserting and nonverbal communication.

A primary concept in interpersonal communication looks at communicative acts when there are few individuals involved. Successful interpersonal communication assumes that both the message senders and the message receivers will interpret and understand the messages being sent on a level of understood meanings and implications.

2.3.1 Functions of Interpersonal Communication

Interpersonal communication is important because of the functions it achieves. Whenever we engage in communication with another person, we seek to gain information about them. We also give off information

through a wide variety of verbal and nonverbal cues. The functions of interpersonal communication include the following:

(i) Gaining information – we engage in interpersonal communication so that we can gain knowledge about another individual. We attempt to gain information about others so that we can interact with them more effectively. We can better predict how they will think, feel and act if we know who they are. We gain this information passively by observing them; actively, by having others engage them; or interactively, by engaging them ourselves. Self-disclosure is often used to get information from another person.

(ii) Building a context of understanding – we also engage in interpersonal communication to help us better understand what someone says in a given context. The words we say can mean very different things depending on how they are said or the context in which they are said. Interpersonal communication helps to understand each other better.

(iii) Establishing identity – Another reason why we engage in interpersonal communication is to establish identity. So too does the face, the public self –image we present to others. Both roles and face are constructed based on how we interact with others.

(iv) Interpersonal needs – We engage in interpersonal communication because we need to express and receive

interpersonal needs. These are the needs of inclusion, control and affection.

2.3.2 Interpersonal Communication and behavior change

Interpersonal communication is the most effective means in influencing the behavior of an individual or a small group of people because of the following reasons:

(i) the message is delivered by a person who belongs to that particular group to whom the message is constructed

(ii) the content of message is harmonized with local culture, traditions, norms and values

(iii) Interpersonal communication has been considered a successful way of addressing the sensitive issues of sexual behavior

(iv) Interpersonal communication ensures a sustained promotion of behavior change especially in HIV and AIDS prevention campaigns among individuals and groups.

2.4 Empirical Review

The following section contains a review of the studies that have been done in relation to the objectives of this study.

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2.4.1 Assessment of HIV and AIDS knowledge among the youth

The Kenya Demographic Health Survey reports of 2003 and 2008/09 gave a trend in knowledge of HIV prevention methods among the women and men aged 15 – 19 years. According to the KDHS report (2003), 58 percent of women and 70 percent of men had heard of HIV. The KDHS 2008/09 report gave the percentages of HIV knowledge at 99 percent for women and 100 percent for men of the same age bracket. In average, knowledge of HIV prevention methods among women and men aged 15 – 19 years was 62 percent.

According to the KDHS report (2003), women and men aged 15 – 19 years who knew that they could reduce the risk of getting AIDS virus by using condoms every time they had sexual intercourse was 61 percent and 72 percent respectively. In comparison, the 2008/09 KDHS report showed an increase in this knowledge to 75 percent for women and 81 percent for men among the same age group.

Those who knew that they could reduce the risk of getting AIDS virus by having one sexual partner who was not infected and who did not have other partners increased from 81 percent for women and 89 percent for men in 2003 to 92 percent for women and 93 percent for men aged 15 – 19 years in 2009 (KDHS, 2003; 2008/09). Regarding knowledge about reducing the risk of getting the AIDS virus by abstaining from sexual intercourse, the KDHS report (2003) showed 79 percent of women and 89

percent of men while the 2008/09 KDHS report showed an increase of this knowledge to 88 percent for women and 90 percent for men.

In addition those who rejected misconceptions about HIV and AIDS were 84 percent women and 85 percent men (KDHS 2008/09). The percentage of women and men aged 15 – 19 years who knew that AIDS cannot be transmitted by mosquito bites was 77 and 82 respectively. Those who knew that AIDS cannot be transmitted by supernatural means stood at 91 percent for women and 95 for men. The youth also knew that a person may not become infected by sharing food with a person who had AIDS. Data from KDHS (2003) showed that 50 percent of women and 65 percent of men knew of the misconceptions about HIV transmission and prevention. These youth knew that AIDS cannot be transmitted through mosquito bites or sharing utensils with someone with AIDS. They also knew that a healthy looking person could have the AIDS virus. The level of this knowledge stood at 88 percent for women and 91 percent for men aged 15 – 19 years (KDHS 2008/09).

The KDHS data above shows that between 2003 and 2010, there was a marked improvement in knowledge of HIV prevention methods among women and men aged 15 – 19 years. In addition to knowing about effective ways to avoid contracting HIV, it is useful to be able to identify incorrect beliefs about AIDS in order to eliminate misconceptions. However, as noted in the problem statement, the 2008/09 KDHS report observes that the high levels of awareness about HIV and AIDS and its

modes of transmission have not translated to a dramatic behavior change as more and more young people have continued to engage in risky behavior leading to high rates of infection.

Mulwo and Tomaselli (2009) carried out a study about the perils of moralistic discourses in HIV prevention campaigns among university students which involved seven campuses at three universities in KwaZulu-Natal, South Africa. They analyzed the interpretative positions students take in relation to abstinence-only messages, and how these affect the meaning formation and relevance of abstinence within the students' social networks.

The study suggests that the predominant interpretation of abstinence messages through moralistic code often generates oppositional responses among students. The authors observe that programmes focused on the individual as an agent of change fail to critically address the social, cultural and economic conditions that may inhibit the ability to carry out certain decisions at individual level.

The study by Mulwo & Tomaselli (2009) is relevant to this study because the findings indicate that students use their knowledge generated from their discussions and social networks to assign meaning to HIV and AIDS messages. As a result, their behavioral response to media messages depends on their acquired lay knowledge.

A similar study done by Sifunda et al. (2006) observes that socio-cultural meanings and terminology of diseases are important in understanding how different groups perceive and interpret illness. The study looked at social construction and cultural meanings of STI/HIV-related terminology among Nguni-speaking inmates and warders in four South African correctional facilities.

It reiterates the need for cultural sensitivity in order to appreciate the extent to which cultural characteristics, experiences, norms, values, behavioral patterns and beliefs of selected populations should be incorporated in the design, delivery and evaluation of targeted health promotion materials and programs. Since this study was carried out in South Africa, a similar study was necessary in Kenya to investigate how the youth interpret HIV messages and how this interpretation informs their behavioral responses.

Graffigna & Olson (2009) say that providing HIV and AIDS information is not enough to change unsafe conduct. They reiterate the role of young people's interpersonal exchanges in determining HIV and AIDS preventive conduct and show the importance of social discourses about HIV and AIDS in mediating the impact of preventive campaigns on young people's attitudes and beliefs.

From their perspective, the case of HIV and AIDS prevention provides an opportunity to study how to bridge the gap between health knowledge

(about the disease and how to avoid it) and safe practices. The present study sought to bridge this identified gap by investigating how knowledge of HIV and AIDS informs HIV risk perceptions among the youth.

Kermyt and Bentel (2007) point out that the youth who are in school may have more exposure to HIV and AIDS education and prevention methods than the youth who are not in school. The authors also observe that the youth have continued to engage in high risk HIV and AIDS behaviors despite their knowledge about HIV and AIDS prevention methods. Kagawa-Singor and Kassim-Lakka (2003:578) agree with Sifunda et al. (2006) when they say that 'every culture defines what health is for its members, determines the aetiology of disease, establishes the parameters within which distress is defined and signaled, and prescribes the appropriate means to treat the disorder both medically and socially'.

The "In Schools Program" facilitated by Copperbelt Health Education Project (CHEP) in Zambia recognizes the importance of considering not only the medical but also social issues surrounding HIV and AIDS (World Bank, 2003). Melkote et al. (2000) say that social change is a complex, unstructured and quite often, an uncontrollable process. Having knowledge of what to do and why to do it may not be sufficient, in many cases, to change behavior. A shift beyond behavior to a focus on social change is crucial. Change interventions must then deal with what is circulating within the social domain, since social change does not take

place at individual level but in circulated culture and in shared beliefs (Govender, 2010).

Most of the studies that focused on the relationship between social construction of HIV and AIDS and safe behaviors studied marginalized segments of the population (needle users, gay men, people in Western societies, and so forth; e.g., Marston, 2004; Holt & Stephenson, 2006) rather than on the more common targets of health education messages (see Kitzinger, 1994; Allen, 2003; Morrison, 2004). It follows that scant attention has been paid to young people's discourses about HIV and AIDS in developing societies, and on how these discourses play a mediating role in the translation of health knowledge (i.e., about the disease and how it is transmitted) into safe practices (i.e., prevention).

2.4.2 Perceptions of HIV risk among the youth

Understanding the way perception of HIV risk is shaped and constructed is crucial in understanding why it has been so difficult to mitigate the spread of HIV and AIDS. The association between HIV infection and the perception of risk in different regions of the world has emphasized the need to reevaluate the public health measures being implemented to control the spread of HIV and AIDS, particularly among the youth who are mostly at risk.

According to Tsasis & Nirupama (2008), risk perception varies in that risk perception is linked to an individual's pre-disposition to be risk-averse or risk-seeking and to the individual's knowledge regarding the object or situation at hand. The authors say that the process of negotiating risk demonstrates how people organize their universe through cultural and social biases and choose what to fear based on their way of life and patterns of cultural and social norms. These biases cause selective attention to risk and preferences for different types of risk taking behaviors, informed by an inherent compulsion to defend one's way of life. Although risk perception may be clouded by the individual's inability to accept the reality of risks that are involuntary, unfamiliar, and catastrophic, the problem is not necessarily with the individual, but rather with society at large (Tsasis & Nirupoma, (2008).

The argument advanced by these scholars is that one's inability to accept reality of risks is caused by the society in which they live. Thus, understanding the way perception of risk is shaped and constructed is crucial in identifying why it has been so difficult to mitigate the spread of HIV and AIDS.

Odu and Ankanle (2008) conducted a study to investigate the relationship between the knowledge of HIV and AIDS and the sexual behavior of youth. The study found out that there was a lack of balance between the knowledge of HIV and AIDS and the advancement in sexual behavior of many youths. The study also revealed that the majority of

youth were aware that HIV and AIDS exist, but there existed an underestimation of personal risk. The study also found out that there was a significant relationship between the perception of HIV and AIDS among the youth and their sexual behavior. Whatever perceptions the youth had about HIV and AIDS would influence how they behaved sexually.

This implied that there was a significant and positive relationship between perceptions of HIV and AIDS risk and the sexual behavior of the youth. The scholars observed that the way the youth label, interpret, think and imagine issues related to HIV and AIDS is responsible for the abnormal mode of sexual behavior. They further say that the greater percentage of youth was sexually active and were already engaged in high risk sexual behavior. Odu and Ankanle (2008) did not, however, investigate how the youth construct HIV risk perception which was the subject of the present study.

Risk perception has been theorized as an important antecedent for adopting protective behavior change. In relation to HIV, risk perception is an indicator of perceived susceptibility to infection, a measure of one's understanding of HIV transmission as well as the willingness to consider behavioral changes.

Perception of risk is a key determinant in the Health Belief Model (Janz & Becker, 1984) and the Theory of Reasoned Action (Ajzen & Fishein, 1980). The argument is that people use condoms (or have only one partner or postpone sexual initiation) if they think the costs of the potential illness outweigh the costs of buying condoms, and overcoming reluctance to wear a condom. Scholars argue that these models that are based on rational, logical thought processes also acknowledge that emotion (self-efficacy and self – esteem) may have a mediating effect on the risk perception, but the mechanism behind this emotion has not been examined (Sobo, 1995; Jessor, 1998).

Those at low risk of HIV infection are the ones that not yet sexually active. Adolescents and young adults make up the majority of this group. Tomaselli et al. (2002) suggested that this group did not require behavior change but rather a commitment to delayed onset of sexual activity or to the establishment of safer sexual practices from the onset of sexual activity.

2.4.3 HIV and AIDS knowledge and the Youth's Self Protection

HIV and AIDS knowledge is an important component of HIV and AIDS risk prevention strategies that may influence engagement in high risk behavior. This objective attempts to assess the HIV and AIDS prevention knowledge among the youth. Peltzer and Promtassananon (2007) carried out a study about HIV and AIDS knowledge and sexual behavior among junior secondary school students in South Africa.

The aim of the study was to assess the HIV and AIDS knowledge and sexual behavior amongst the students. The findings indicated a relatively low behavioral response in spite of the high levels of HIV and AIDS awareness. The study found out that there was infrequent use of condoms and other contraceptives and that a significant proportion of adolescents had two or more lifetime sexual partners. The findings of this study support those of Ongunya et al. (2009) who found that there was a mismatch between HIV and AIDS program in Kenya's secondary schools and behavior change. As such, the study found that there was minimal behavioral response to HIV and AIDS prevention.

HIV and AIDS knowledge is an important component of HIV and AIDS risk prevention strategies that may influence engagement in high risk behavior. In their study carried out among the youth in Cape Town, South Africa, Kermyt & Beutel (2007) found that engagement in high risk HIV and AIDS behaviors (e.g. multiple sex partners, inconsistent condom use) despite knowledge of HIV and AIDS was rampant among the youth. The authors argued that that a more in-depth knowledge about HIV and AIDS was needed among the youth in order to ensure proper protection from the disease and that HIV and AIDS education would be more successful if the audiences were more segmented.

Ongunya et al. (2009) suggest that whereas students believed they had begun exhibiting the expected change of behavior, teachers felt that this was inadequate in enabling them to prevent and control the spread of

HIV among the youth. This meant that there seemed to exist a gap between the objectives and actual HIV and AIDS education program delivery and behavioral changes among the youth in secondary schools.

The HIV and AIDS communication strategy (2008) for youth noted that with regard to knowledge of HIV and AIDS, majority of the youth had heard about this epidemic but they did not believe themselves to be at risk. The communication strategy called for greater attention to be focused on addressing the contextual realities faced by Kenya's young people (NACC, 2008).

2.4.4 The role of Communication in HIV and AIDS behavior change

Tomaselli et al. (2002) argued that there was no single example of media campaign that had demonstrably reversed HIV infection trends worldwide, yet such campaigns remained the centerpiece of many government responses. According to the authors, the core of the problem lay in the assumption that knowledge and awareness led to behavior change. They observed that media campaigns achieved objectives of knowledge and awareness but it was the terrain beyond that awareness that was harder to achieve. Accordingly, the contexts which framed HIV pandemic were never understood within a theoretical whole. It was the contextual factors that problematised the notion of behavior change.

Swanepoel (2007) said that mass mediated campaigns formed important components of HIV and AIDS prevention and support programs as they aimed to persuade those at risk to practice safer sex, go for HIV test and utilize the available care and support infrastructure should they test HIV positive. Behavioral indicators suggest, though, that these campaigns are not optimally functional, even if one acknowledges the need for policies and structural interventions to support the required behavioral changes. Swanepoel (2007) argues that there are fundamental problems in the design of the messaging of HIV and AIDS campaigns. One of these is the fact that the design of the message is still very much left to the "gut feelings" of campaign designers and copy writers. Yet, professionally it would be inappropriate to use subjectivity and personal feelings to design HIV campaign messages.

Albright (2007) suggests that researchers must take into consideration the characteristics of their target populations including demographics as well as the specific social and cultural context, in order to advance their understanding. In addition she says that the circumstances of the particular set of individuals or target audiences must be clearly understood in order to design an information strategy. Another way of looking at this is to consider why people continue to engage in risky behaviors. This can be accomplished through a needs analysis which will identify attitudes, norms, beliefs and perceptions regarding desirable behavior (e.g. safe sex practices) and will help to shape the design of the implementation (Albright 2007).

Albright (2007) says that strategies that are designed to target the identified variables will likely be more successful. For example, people in their late teens are not as likely to respond to fear messages because developmentally at that age they are more likely to be in denial of their mortality (Albright 2007). As Albright puts it, AIDS messages need to be targeted to smaller groups or individuals because of the range of individual information needs and processes through which individuals make sense of their worlds and their realities. A mass media approach designed to change behavior is inadequate to provide incentive for all members of the society (Albright 2007).

HIV and AIDS communication in Kenya has been provided to institutions like schools, religious organisations and health care centres (Kiai, 2009). Several communication approaches have been used or adopted in communicating on HIV and AIDS. Social marketing is a concept developed in the population education sector and has been used widely to promote condoms, particularly among segments of the population who are prone to high risk sexual behaviour.

The concept involves packaging, pricing and presenting a product or behaviour to the target market in an appealing manner and soliciting for the participation of wholesalers and retailers in the distribution and conventional trade promotions. The mass media are utilised to convey the benefits of the desired behaviour for a particular target audience (AIDSCAP/FHI, 1997; Okeyo et al., 1998).

Peer education as a strategy of HIV and AIDS prevention education has gained prominence and been used at workplaces, colleges, universities and social gatherings. The method has been found by some organisations to be practical and cost-effective while reaching a large number of people (Nduati & Kiai, 1996). A modification of peer education is the anti-aids clubs which can be started as extra-curricular activities in schools and in workplaces. The strength of the peer education approach lies in its ability to reach people through their own peers and this has contributed to its success especially in the workplaces (Nduati & Kiai, 1996). It has been recommended, however, that peer educators should be trained in the different communication methods and strategies in order to increase their effectiveness (Kiai, 2009).

Another method which has proved effective in the discussion of sexuality is that of group discussion where peers share information based on their experiences. Being with their peers allows them to openly talk about subjects which would otherwise appear to be taboo (NASCOP, 1998).

Literature indicates that various media have been used HIV and AIDS communication and prevention intervention (NACC, 2009). These media include posters, leaflets, booklets, comic stories, cartoons, drama and poems, including the mainstream mass media. However, as Kiai (2009) suggests, the important concern should be the participation of the target audience in the whole communication process - from the planning to evaluation. This is important given concerns that many information,

education and communication (IEC) images in Kenya have presented conflicting messages in the text and visually.

The mass media are important agents in communicating HIV and AIDS messages because they have the ability to influence public opinion and to stimulate debate. In addition, the media can be used for advocacy as they can sustain a topic or theme in the public forum for long periods of time. The main observation has been that the media are useful in raising HIV and AIDS awareness, but this awareness has not translated into behaviour change (Nzioka, 2004; Kiai, 2009; Ndeti, 2011).

According to UNICEF (2003), there is a growing body of evidence that approaches to HIV and AIDS such as information campaigns focusing only on transmission and prevention of HIV and AIDS have resulted in increased levels of knowledge but have had little effect on risk taking behavior patterns and reduction of vulnerability to infection and consequently on the pace of the epidemic (UNICEF, 2003).

Kiai, et al. (2004) sought to critically identify and examine the communication needs, patterns of utilization and their existing strengths and gaps among female adolescents in Kenya in regard to sexuality, HIV and AIDS. The authors posit that previous styles of HIV-related prevention for adolescents have employed individualistic approaches based on theoretical frameworks such as Health Belief Model and Social Learning Theory that emphasize the need to help the young people to

acquire accurate information and skills relating to HIV and AIDS. Such approaches, however, the scholars argue, are being criticized for failing to take account of the contextual, environmental and structural factors influencing young peoples' choices, actions and behavior.

In this study, Kiai et al. (2004) point out that effective communication for the youth such as behavior and attitude change is necessary if HIV and AIDS campaign activities are to achieve the desired results. They further add that while attempting to understand the communication needs of the youth in Kenya, it should be appreciated that the adolescent is a product of diverse socio-cultural background and economic lifestyles, which collectively impact on the communication needs. It is thus important to identify the challenges and opportunities created by the diverse socio-cultural realities in our society, so as to design effective communication strategies for the youth on HIV and AIDS.

Sneijder and Molder (2004) have pointed out that an understanding of interpersonal discourses is fundamental in constructing individuals' opinions and attitudes about health, underlining that discourses are not the result of a cognitive process but, rather, are social actions. From this perspective, social interactions produce not only shared norms that individuals integrate but also symbolic meanings that frame individuals' understanding of reality and, thus, their behaviors. It follows that because discourse is considered an action, then changes in discourse might result in changed actions.

Muturi (2005) argues that reproductive health programs have used the mass media and other communication interventions to inform and educate the public about the disease and to promote behavior change and healthy sexual practices. Muturi's research looks at the discrepancy in Kenya from a communications perspective addressing socio-cultural and related factors contributing to the lack of change in behavior and sexual practices. However, the study does not address interpersonal communication discourses of HIV and AIDS among the youth which this study examined.

Obregon (2005) analyzes young viewer relate to health messages dealing with HIV and AIDS and sexuality issues. The study looks at the presence of media effects at attitudinal and behavioral levels and active construction of meaning among young viewers. The study suggests that viewers, both alternately and simultaneously, can negotiate meanings of health issues. These findings have implications for health communication researchers and practitioners who often overlook people's experience of media reception while focusing primarily on the potential existence of message effects.

Researchers have studied the ways in which expert discourse (e.g., physicians' information, mass media messages) becomes part of lay discourse (e.g., everyday communication), how expert discourse is re-elaborated by individuals in their social exchanges, and how these social exchanges eventually influence individuals' versions of reality (Kline,

2003). Several authors have applied this perspective to the study of media messages, claiming that the meanings of the media messages are symbolically constructed by becoming part of individual discourses (Kline, 2003; Kitzinger, 2007). Furthermore, some authors have suggested that media messages themselves are forms of expert discourse that have precise sociopolitical meanings (Gwyn, 2002).

2.4.5 Knowledge Gaps Emerging from the Literature Review

The literature reviewed in this chapter brought to the fore a number of gaps that this study sought to investigate.

Mulwo & Tomaselli (2009) found that HIV and AIDS intervention programs which focused on the individual as an agent of change failed to critically address socio-cultural conditions which may prevent the individual from making certain key decisions about their health.

Graffigna & Olson (2009) found that providing HIV and AIDS information to young people was not enough to change unsafe conduct. The scholars observed that there was need to bridge the gap between health knowledge and safe practices.

Obregon (2005) observed that the youth had the potential to negotiate meanings of health issues. However, communication researchers and practitioners often overlooked the youth's experiences of media reception while they focused primarily on the potential existence of media effects.

Marston et al. (2004) suggested that most studies that focus on the relationship between social construction of HIV and AIDS and safe behaviors had targeted mostly marginalized segments of the population such as need users, gay men, among others. They argued therefore that little attention had been paid to the role played by social discourses in translating health knowledge about the disease into safe practices.

Tsasis & Nirupama (2008) suggested that one's inability to accept the reality of risks was involuntary and was caused by the society in which they lived. The scholars supported the need to carry out a study to investigate how the youth shape and construct perception and how this construction influences the spread of HIV and AIDS.

In their study meant to assess the HIV and AIDS knowledge and sexual behavior amongst secondary school students in South Africa, Peltzer & Promtassananon (2007) found that that there was relatively low behavioral response in spite of the high levels of HIV and AIDS awareness. This finding was also supported by Kermyt & Beutal (2007) and Ongunya et al. (2009) who found that the youth engaged in high risk behaviors despite their knowledge of HIV and AIDS. The findings of these scholars supported what Okigbo et al (2000) called the knowledge – behavior gap in HIV and AIDS which communication among the youth.

Toamselli et al. (2000) pointed out that most media campaigns had not been able to reverse HIV infection trends worldwide, yet they remained the centerpieces of many government responses. The authors say the problem lay in the assumption that knowledge and awareness led to behavior change. They called for a study to investigate the social contexts which appeared to frame the HIV pandemic but were never understood within the theoretical whole.

This study was an attempt to investigate these emerging trends and knowledge gaps in the context of the role of interpersonal communication.

2.5 Theoretical Framework

Since HIV and AIDS was first reported, broad-ranging strategies based on social psychological theories and models of behavior that are believed to be effective in guiding communication approaches to HIV and AIDS prevention and care have been introduced. Some of the most important theories and models used in health communication include the health belief model, the theory of reasoned action, social learning/cognitive theory, diffusion of innovation and social marketing.

Melkote et al. (2000) have discussed the various socio-psychological theories/models that inform AIDS prevention. The authors say that though psychosocial theories have provided conceptual frameworks that

have contributed to AIDS communication campaigns; they have not been reliable predictors of behavior change. They further posit that the theoretical models do not account for contextual and socio-cultural variables such as gender and racial or ethnic culture. The authors argue that although behavior and attitude change play a crucial role in the prevention of HIV and AIDS, such behaviors and attitudes are produced and reproduced by individuals living in larger communities and being impacted by cultural, economic, social, and political influences.

Airhihenbuwa and Obregon (2000) agree with Melkote et al. (2000) that most theories and models used to develop HIV and AIDS communication strategies are based on social psychology that emphasize the western cultural inclination towards individualism. Airhihenbuwa and Obregon (2000) argue that today, researchers including health scholars are questioning the global relevance of these models and thus the need to develop innovative theories and models that take into account regional socio-cultural contexts. Below is a critique of each of these theories and models.

2.5.1 Health Belief Model

The health belief model (Janz & Becker, 1974) grew out of research in the 1950s by social scientists in the U.S. Public Health Services to explain the widespread reluctance of people to participate in tuberculosis screening programs provided at no charge. Later, the model was extended to apply to people's responses to symptoms and to their

behavior in response to diagnosed illness, particularly compliance with medical regimens (Becker, 1974). For more than three decades, the model has been one of the most influential and widely used psychosocial approaches to explaining health-related behavior (Glanz et al. 1990).

The theory assumes that individuals will take preventive actions (risk-reduction behaviors) when they are susceptible to a disease (self-perception of risk) and acknowledge the consequences as severe; taking preventive actions will be beneficial in reducing the threat of contracting the disease (e.g. condoms are effective against HIV infection and that their perceived benefits will be sufficient to overcome perceived barriers such as cost or inconvenience of undertaking the actions). This is a risk learning model because the goal is to teach new information about health risks and the behaviors that minimize those risks. The overall premise of the HBM is that knowledge will bring change.

One perennial criticism of the HBM is that the belief-behavior relationship has never been uniformly established. It is of course true that behavior cannot always be accounted for by reference to beliefs. Further research is therefore needed to specify the conditions under which specific beliefs and behaviors are causally related and conditions under which they are not (Glanz et al. 1990). To reject approaches to explaining behavior that emphasize the role of beliefs seems tantamount to throwing out the baby with the bathwater.

Kirscht and Rosenstock (1974) have pointed out that the model does not presuppose or imply a strategy for change. Although the model emphasizes the importance of knowledge, this is not a sufficient condition for behavior change. Both individual and socio-environmental factors should be targeted for health interventions. Since the HBM is a psychosocial model, it is limited to accounting for as much of the variance in individual's health-related behaviors as can be explained by their attitudes beliefs. It is therefore clear that other forces influence health actions as well. These factors include intrapersonal factors, interpersonal processes, institutional factors, community factors and public policy, including law (Janz & Becker, 1984).

Another criticism is that by focusing on the individual determinants of health behaviors, there is a danger that victim-blaming will be encouraged. This might be true if one adopted a moralistic view of responsibility for a problem. In general, the HBM is a rational-cognitive model and assumes a "rational" decision-maker. Most adolescents, and many adults, do not seem to approach the AIDS issue from such a logical perspective, but seem quite capable of discounting risks and optimistically perceiving themselves as invulnerable to harm.

2.5.2 Theory of Reasoned Action

The Theory of Reasoned Action (Fishbein & Ajzen, 1975) is an extension of HBM. It suggests that a behavioral performance is primarily determined by the strength of the person's intention to perform a specific

behavior. The theory predicts individual behavior by examining attitudes, beliefs, and behavioral intentions as well as observed and expressed acts. In this linear progression from attitude to action, a given behavior will be determined by an individual's intention.

The strength of a person's intention to perform a specific behavior is a function of two factors: attitude toward the behavior and the influence of the social environment or general subjective norms on the behavior. Attitude toward the behavior is determined by an individual's belief that a given outcome will occur if he or she performs the behavior. In health education applications, outcomes may include such things as side effects associated with medication or the time and personal problems that a person might confront in participating in a regular health program. Social norm is determined by a person's normative belief about what others think he or she should do and by individual's motivation to comply with those people's wishes (Glanz et al. 1990).

This theory also assumes that individuals are rational in their decision-making process. This presumption "may not entirely be relevant for AIDS-related behaviors that are heavily influenced by emotions" (Michael-Johnson & Bowen, 1992, p.101). Moreover, individuals evaluate information that may result in action within external constraints, which are mediated also by power relations in a society. Power relations explain why marital rape takes place in marriages.

2.5.3 The Social Learning Theory

The Social Learning Theory (SLT) addresses both the psychosocial dynamics underlying health behavior and the methods of promoting behavior change (Glanz et al. 1990). The social learning (also called cognitive) theory (Bandura, 1986), postulates that an individual behavior is the result of the interaction among cognition, behavior, environment, and psychology. The cognitive version of this theory emphasizes what people think, that is, their cognitions and their effect on behavior.

In this theory, human behavior is explained in terms of a triadic, dynamic and reciprocal model in which behavior, personal factors (including cognitions), and environmental influences all interact to uniquely determine an individual's behavior (Glanz et al, 1990). Among the crucial personal factors are the individual's capabilities to symbolize the meanings of behavior, to foresee the outcomes of given behavior patterns, to learn by observing others, to self-determine or regulate behavior, and to reflect and analyze experience (Bandura, 1986). These ideas have been particularly valuable in designing effective health education programs. The two primary domains widely used in HIV and AIDS programs are modeling (imitation of the behavior of a role model) and self-efficacy (one's perceived ability to adopt a recommended behavior).

Although this model is believed to be very useful in HIV and AIDS communication campaigns in the United States, there remains the question about its relevance in cultures where individual decisions are the result of group norms whereby being individualistic is going against the grain (Airhihenbuwa & Obregon, 2000). After all, the social learning is an individual psychological model of behavior change. In later studies Bandura (1998) advocates the need to focus on collective efficacy.

2.5.4 Diffusion of Innovation Theory

The Diffusion of Innovation Theory (Rogers, 1983) focuses on the communication process by which a new idea or product becomes known and used by people in a given population. The theory suggests that increasing target group participation is one strategy for improving the efficiency of innovation development and the effectiveness of diffusion efforts (Glanz et al. 1990). Two relevant principles of diffusion of innovations widely used in AIDS campaigns are creating awareness of HIV and using opinion leaders to influence attitudes and behaviors.

However, diffusion of innovation has been criticized for being too linear, for having a pro-innovation bias, and for widening the gaps between the 'information haves' and 'have-nots' in a social system. This gap has certainly been observed in AIDS awareness and knowledge, given the positive correlation between knowledge of HIV and level of education.

In spite of its limitations, however, the use of opinion leaders in helping to shape culturally appropriate strategies is a component of diffusion of innovation that offers possibilities in HIV and AIDS communications. This is particularly salient since the content (focusing on a community interpretation of disease meaning rather than an imposed germ theory), context (relationships and negotiation in families and communities), and language (codes of elasticity of usage) of communication will be a factor in the outcome of HIV and AIDS prevention and care.

The theories reviewed above which are commonly used in health communication and promotion clearly show that HIV and AIDS communication is often based on the behavior and decision-making process of the so-called rational individuals who follow an established linear path from awareness to attitude and then action. However, decisions about preventing HIV and AIDS are based on cultural norms that often mediate individual decisions in ways that they may not always realize (Airhihenbuwa & Obregon, 2000; Okigbo et al. 2002). Moreover, decisions about HIV and AIDS are often based on emotion and thus may not follow any pre-established pattern of decision-making as advanced in most theories and models. Studies also criticize the current models for focusing on individual behavior rather than the social context in which the individual functions and for disregarding the influence of contextual variables (Melkote et al. 2000; Duta-Bergman 2005).

As Okigbo et al. (2002) say, for prevention campaigns to be successful, they must involve communication and education efforts that are properly planned and implemented with the peculiarities of the target audience in view. Sexual behaviors are cultural manifestations and are reflective of sub-cultures and idiosyncratic behaviors (Okigbo et al., 2002). This accounts for the widely acknowledged gaps between knowledge of HIV and AIDS and continuing engagement in risky sexual behavior.

This study incorporated the elements of two distinct behavioral theories which are the Social Construction Theory and Symbolic Interaction Theory in order to make up for the inadequacies of the above discussed theories. The two theories explain how meanings, knowledge and decisions are socially created in every day interactions. It is in these social interactions within social groups that knowledge is generated. This is the knowledge that informs behavioral responses among the youth.

2.5.5 The Social Constructionist Theory

Berger and Luckmann's (1990) social constructionism has its roots in phenomenology. The scholars argue that all knowledge, including the most basic, taken-for-granted common sense knowledge of everyday reality, is derived from and maintained by social interactions. In their book *The Social Construction of Reality*, Berger and Luckmann suggest that when people interact, they do so with the understanding that their respective perceptions of reality are related, and as they act upon this understanding, their common knowledge of reality becomes reinforced.

In social construction theory, the idea of an objectively knowable truth does not exist. Knowledge is constructed through social interpretation and the inter-subjective influences of language, family and culture (Hoffman, 1990). The basic contention of social constructionism is that reality is socially constructed (Berger, 1967), that is, what we perceive as reality has been shaped through a system of social, cultural and interpersonal processes. There are four assumptions made by social constructionists:

(i)   The way we go about studying the world is determined by available concepts, categories, and methods. Our concepts often incline us toward or even dictate certain lines of inquiry while precluding others, making our results the products of more of our language than empirical discovery.

(ii)   The concepts and categories we use vary considerably in their meanings and connotations over time and across cultures.

(iii)   The popularity or persistence of a particular concept, category or method depends more on its usefulness than on its validity.

(iv)   Descriptions and explanations of the world are themselves forms of social action and have consequences (Gergen, 1985, pp. 266-275).

Social construction theory explores an evolving set of meanings that are continuously created from people's interactions. The development of concepts is a social phenomenon, a fluid process that can only evolve within a cradle of communication (Hoffman, 1990). It is only through

interaction of the socio-cultural processes with the intrapersonal self (ideas, beliefs, history) that the construction of knowledge is nurtured. Persons are constructors of knowledge in their lives assisted by the prevalent discourses in their societies and cultures, and their own life experiences.

Through social constructionism, researchers can look for diverse meanings of HIV and AIDS within and between social groups (Thomson, 1992). Social construction theorists contend that physically identical sexual acts may have different social and personal meanings depending on how they are defined and understood in their different cultures and historical periods (Vance, 1991). Besides influencing the way individuals define and act on their behaviors, socio-historical constructions also organize and give meaning to collective sexual experience through, for instance, constructions of sexual identities, definitions, ideologies and regulations (Vance, 1991).

According to the social constructionist approach, the world becomes intelligible to us in the way it does only because of the ideas and beliefs we have about it (Bury, 1986). Social constructionists argue that it is human beings who give meanings to diseases (Berger and Luckmann, 1984) so much so that one disease can be experienced differently across and between individuals and communities. The definition of a sign or symptom as illness depends on cultural values, social norms and culturally shared rules of interpretation. Diseases are socially

constructed products of cultural and social arrangements (Turner, 1990). In the field of psychology and illness, Crystal & Jackson (1992) note that diseases are not mere biological entities but rather socially constructed phenomena. Concurringly, Crimp (1988:3) suggests that: "AIDS does not exist apart from the practices that conceptualize it, represent it and respond to it. We know AIDS only through those practices."

HIV and AIDS as a disease of the society (Gatter, 1985) is typically constructed by a set of social, economic and political discourses (Cullen, 1998) in which the media play a vital role (Lippmann, 1992). Social constructionist theory was used in this study to explain and understand how the youth construct reality and knowledge around the HIV and AIDS communication and how such constructed knowledge informs their behavioral response.

2.5.6 Symbolic Interaction Theory

The term symbolic interactionism was coined by Herbert Mead to capture what he claimed was the most human and humanizing activity that people can engage in, that is, talking to each other. Mead holds the premise that humans act towards people or things on the basis of the meanings they assign to those people or things. Mead also asserts that meaning arises out of the social interaction that people have with each other. In other words, meaning is not inherent in objects neither is it preexistent in a state of nature. Instead, meaning is negotiated through

the use of language; hence the term symbolic interactionism (Griffin, 1997).

Symbolic interaction theory comes from the socio-cultural perspective in that it relies on the creation of shared meaning through interactions with others. This theory focuses attention on the way that people interact through symbols in order to give meaning to the world (LaRossa & Reitzes, 1993). According to this theory, meaning evolves from people's interactions with their environment and with other people. These interactions are subjectively interpreted.

Symbolic interaction is the way we learn to interpret and give meaning to the world through our interactions with others. The theory argues that meaning is not inherent in objects. Meaning arises in the process of interaction between people, that is, it takes place in the context of relationships. During such interactions, human beings act toward things on the basis of meanings that they assign to them. In the context of this study, it is the knowledge and understanding that the youth acquire about HIV and AIDS which is of concern.

Symbolic interaction sees reality as being created by people who are struggling to define themselves and the world around them. These meanings are then shared with the rest of the people. In other words, our interactions with others, which we collect over time, and through past experiences, create perceptions of 'reality' which are not objective (out

there) but they do become internalized within us to the extent that these perceptions and definitions of reality appear as if they are objective facts. Ultimately, the shared expectations which are established through our interactions with others shape our behavior and establish our routines.

Constructs for this theory include creation of meaning, social norms, human interactions, and signs and symbols. Littlejohn and Foss (2006) suggest that reality is not an objective set of arrangements outside of us but is constructed through a process of interaction in groups, communities and cultures. This theory was used in this study to explain how young people create meaning during interpersonal communication processes.

Littlejohn and Foss (2006) suggest that these two socio-cultural theories show that our meanings for words and objects are intimately connected to our actions within situations. As communicators, we have many socially constructed meanings from which we draw in understanding and response to events. The human mind is powerful, enabling us to sort out what we see, organize stimuli into categories, apply reasoning to what we experience, and integrate what all of this information means into an existing system of beliefs, attitudes, values, and perceptions. When we act in the world, we are acting on the basis of a highly organized and systematic set of set of understandings. These two theories show how individual's attitudes, beliefs or values can change when messages are received.

Within this frame, the youth interact socially and adjust behavior in response to the actions of one another. As people interpret actions of others, so they adjust their own actions and behavior. The youth socialize as active beings, not passive objects and engage actively as they construct their social world, hence creating their own social reality. Social reality and human behavior from the Symbolic Interaction perspective are conceptualized as symbolic, communicated and subjective.

2.6 Conceptual Framework

As discussed above, various socio-psychological theories have continued to inform HIV and AIDS prevention. However, scholars have argued that though psychosocial theories have provided conceptual frameworks that have contributed to AIDS communication campaigns, they have not been reliable predictors of behavior change. These theories/models are the Health Belief Model, Theory of Reasoned Action, Social Learning Theory and Diffusion of Innovations. This is because the theoretical models do not account for contextual variables such as lay knowledge, peer influence, meanings and social discourses.

In order to operationalize this research, it was necessary to develop a conceptual framework to explain how the youth use social discourses to continuously create meanings about HIV and AIDS. It is from these socially constructed meanings that young people draw understanding and response to HIV and AIDS. The theories that were found to be

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applicable to this study were the Social Construction Theory and the Symbolic Interaction Theory.

Independent Variables	Dependent Variables
• Interpersonal Communication • HIV/AIDS knowledge	• Behavioral responses to HIV/AIDS • Perception of vulnerability to HIV infection • Self-protection against HIV infection

Intervening variables

- Interactions
- Language
- Meanings
- Lay knowledge
- Social discourses
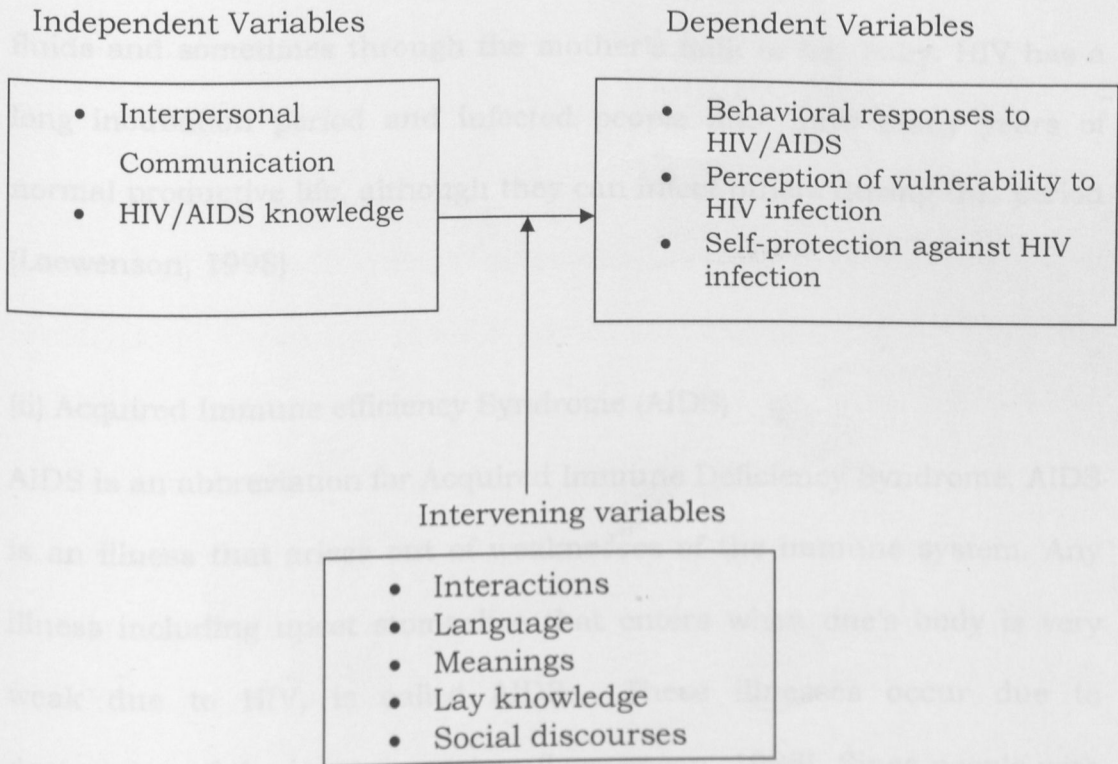
Figure 2.1 Conceptual framework (Researcher 2011)

This framework was used to guide this study as it lays emphasis on meanings, knowledge and decisions that are socially created in every day interactions. This is the knowledge that informs behavioral responses to HIV and AIDS among the youth.

2.7 Functional Definition of Terms

(i) Human Immunodeficiency Virus (HIV)

HIV is an abbreviation for Human Immunodeficiency Virus. It is not AIDS; it is spread through specific body fluids, blood, semen, vaginal fluids and sometimes through the mother's milk to her baby. HIV has a long incubation period and infected people may have many years of normal productive life, although they can infect others during this period (Loewenson, 1998).

(ii) Acquired Immune efficiency Syndrome (AIDS)

AIDS is an abbreviation for Acquired Immune Deficiency Syndrome. AIDS is an illness that arises out of weaknesses of the immune system. Any illness including upset stomach – that enters when one's body is very weak due to HIV, is called AIDS. These illnesses occur due to destruction of the immune system (Loewenson, 1998). Since people with HIV appear healthy and those with AIDS have detectable medical illnesses, it is important to differentiate between these two states.

(iii) Communication

Communication has been used in this study to describe the process of dialogue, exchange of information and resources, and the capacity that enables understanding, negotiation and decision making around an issue (in this case HIV and AIDS knowledge)

(iv) Interpersonal communication

In this study, interpersonal communication is used to refer to oral and nonverbal communication processes that occur during one-on-one or group settings to young people. It involves negotiation, construction and attribution of meaning.

(v) Discourses

Stuart Hall (1997:6) defines discourses as "ways of referring to or constructing knowledge about a particular topic of practice." They are the clusters, or formations of ideas, images and practices, that provide us with modes of talking about, forms of knowledge and conduct associated with a particular topic, social activity, or social institutions in society. Discourses are seen to affect our views on all things; and it is not possible to avoid discourses.

In this study, discourses are used to refer to systems of meaning that are uttered whenever we make intelligible utterances aloud with others.

(vi) Discursive formations

These define what is and is not appropriate when talking about, or acting in relation to, a particular subject or area of social activity. Discursive formations define what knowledge is considered useful, relevant and 'true' in a particular context, as well as what sorts of persons or 'subjects' embody its characteristics.

In this study, the discursive approach was used to examine how knowledge produced by HIV and AIDS discourses regulated conduct, made up or constructed identities, and defined the way certain things were represented, thought about and practiced.

(vii) Perception

Perception has been defined as the process by which we interpret sensory data (Severin & Tankard, 2001). This is the process of becoming aware of, understanding, recognizing or observing something in the environment.

In the context of this study, risk perception means the subjective judgment that the youth make about health with regards to HIV and AIDS epidemic.

(viii) Selective perception

This term is used in this study to explain the tendency for people's perception to be influenced by wants, needs, attitudes, and other psychological factors. Selective perception means that different people can react to the same message in very different ways. No communicator should assume that a message will have the intended meaning for all receivers. The message can reach the receiver (hit the target) and still fail to accomplish its purpose because it is subject to the interpretation of the receiver.

(ix) Youth

This study targeted the in-school youth (boys and girls) aged between 15 and 19 years in public secondary schools in Nairobi. In this study, the term youth was used interchangeably with other terms such as adolescents, teenagers, students and young people.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This section describes the procedures that were followed in conducting the study. It is organized under the following sections: HIV and AIDS in secondary schools in Nairobi, research site, target population, sample size and sampling procedures, sampling techniques, data collection techniques, data analysis and presentation.

3.1 Research Site

The research site was Lang'ata District in Nairobi County. Lang'ata District was selected purposively to represent the low and middle income settlements in Nairobi County. It is also cosmopolitan in nature with people from different cultural backgrounds. HIV and AIDS epidemic continues to poses significant challenges to people living in low and middle income settlements (NACC, 2010).

3.2 Target Population

The target population was both male and female students in the public secondary schools in this District. The District has five public mixed secondary schools. The total number of students enrolled in all the five public schools was 2,163. Out of these, there were 1,334 boys and 829 girls (MOE, 2011). The schools are Lang'ata Barracks, Raila Educational Centre, Olympic High School, Karen C and Lang'ata High School.
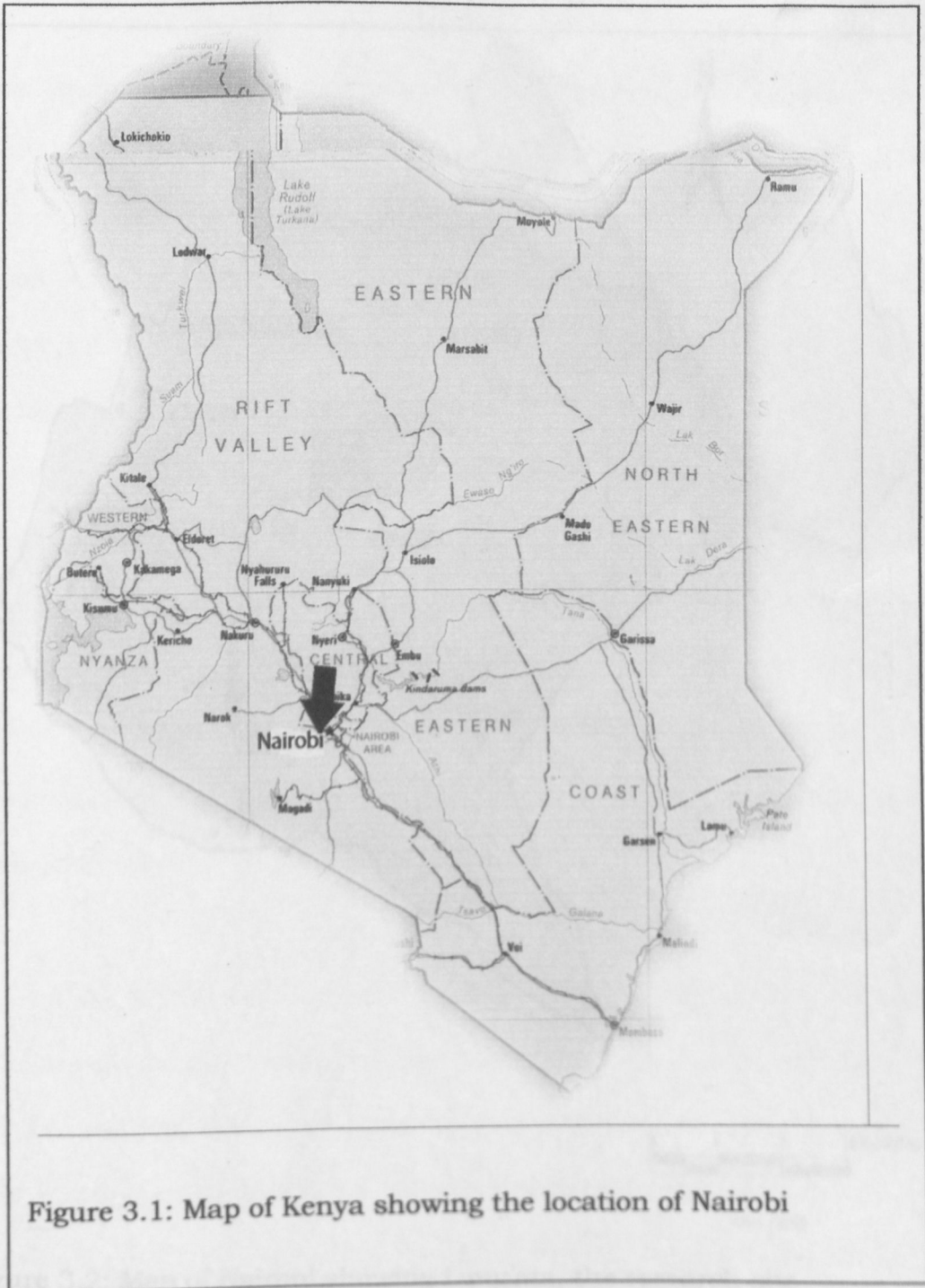
Figure 3.1: Map of Kenya showing the location of Nairobi
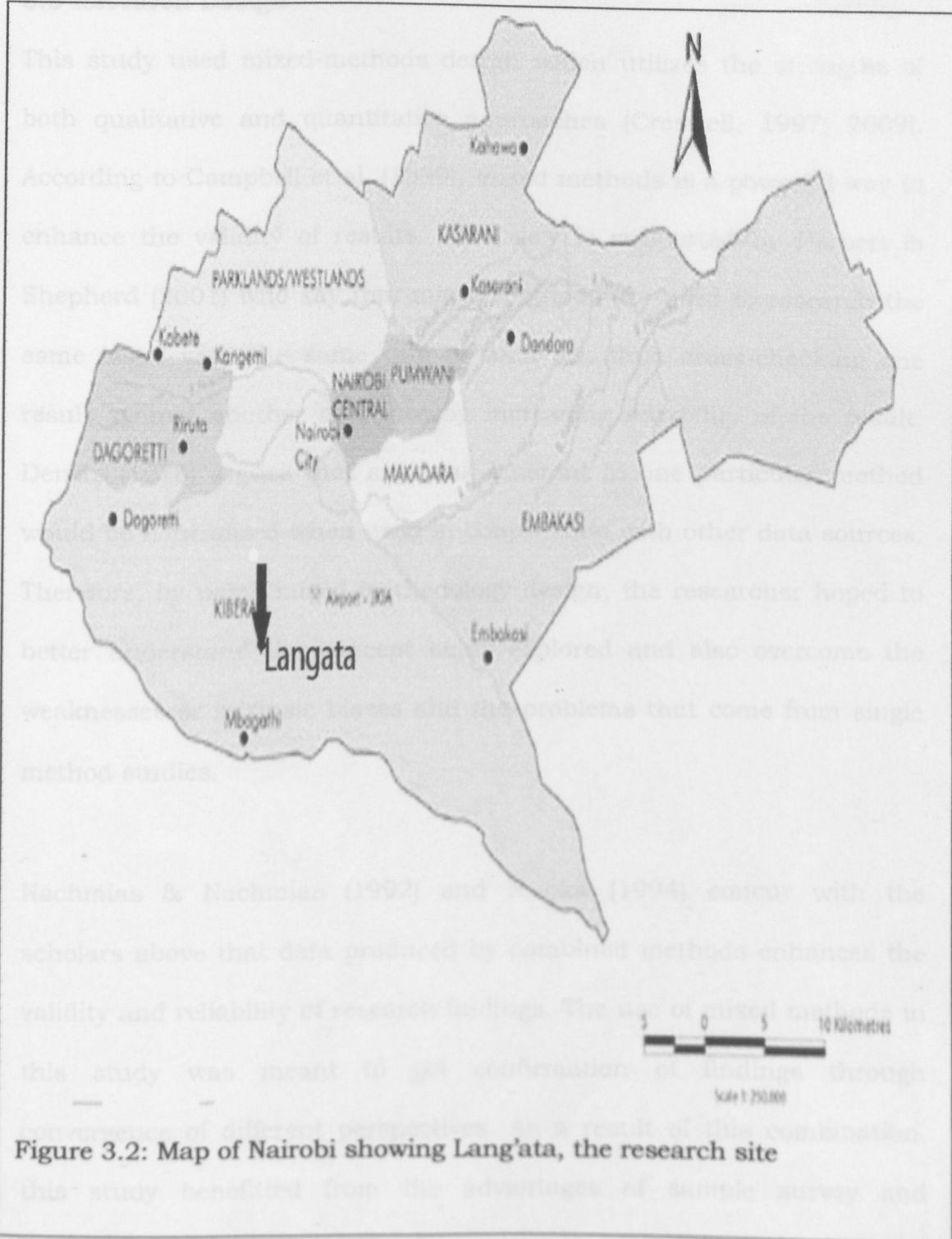
Figure 3.2: Map of Nairobi showing Lang'ata, the research site

3.3 Research Design

This study used mixed-methods design which utilizes the strengths of both qualitative and quantitative approaches (Creswell, 1997; 2009). According to Campbell et al. (1999), mixed methods is a powerful way to enhance the validity of results. This view is supported by Herbert & Shepherd (2001) who say that mixed methods are used to research the same issue with the same unit of analysis, thus cross-checking one result against another and thereby increasing reliability of the result. Denzin (1978) argues that any bias inherent in one particular method would be neutralized when used in conjunction with other data sources. Therefore, by using mixed-methodology design, the researcher hoped to better understand the concept being explored and also overcome the weaknesses or intrinsic biases and the problems that come from single method studies.

Nachmias & Nachmias (1992) and Nzioka (1994) concur with the scholars above that data produced by combined methods enhances the validity and reliability of research findings. The use of mixed methods in this study was meant to get confirmation of findings through convergence of different perspectives. As a result of this combination, this study benefitted from the advantages of sample survey and statistical methods (quantification, representativeness and attribution) and the advantages of the qualitative and participatory approaches (ability to capture the diversity of opinions and perceptions). Mixed

methods were also used to find contradictions and new perspectives, and to add scope and breadth to the study.

3.4 Sample Size and Sampling Procedures

3.4.1 Sample Size

Based on the target population indicated above, a sample size of 325 respondents was determined using Fisher et al. (1983) as shown below. Other scholars who agree with Fisher (1983) on the sample size of 325 (if the target population is less than 10,000) are Moser and Kalton (1979); Mulusa (1990) and Mugenda and Mugenda (2003).

If the target population is less than 10,000, the required sample size will be smaller. In such cases, the final sample estimate (nf) is calculated using the following formula:

$$nf = \frac{n}{1 + (n/N)}$$

Where:

nf = the desired sample size (when the population is less than 10,000)

n = the desired sample size (when the population is more than 10,000)

N = the estimate of the population size

The sample size therefore was:

$$nf = \frac{384}{1 + (384 / 2163)}$$

$$nf = \frac{384}{1.18}$$

$$= 325$$

In order to get the sample size of the boys and girls that were studied, the formula below was used:

$$\frac{n}{N}$$

Where:

n is the sample size (325)

N is the entire population

Therefore, the number of boys sampled was calculated as follows:

$$\frac{325}{2163} \times 1334 = 200 \text{ boys}$$

Similarly, the number of girls sampled was calculated as shown below:

$$\frac{325}{2163} \times 829 = 125 \text{ girls}$$

This therefore means that the sample size of 325 respondents consisted of 200 boys and 125 girls.

3.4.2 Sampling Procedures

Multi-stage sampling design was used to select the study sample for the survey. This sampling technique was appropriate because the study sample was selected in stages using stratified and systematic sampling techniques. In stratified sampling, the population is first subdivided into mutually exclusive segments, based on relevant variables. First, the study population was stratified into males and females. Secondly, a random sample was taken from each stratum using proportional stratified sampling. Proportional stratified sampling ensured that the sub-samples of both boys and girls were calculated proportionately to their sizes in the population in each school. Stratified sampling was also used in order to capture the internal differences in the sample characteristics such as sex.

Table 3.1 below shows the sample sizes of both boys and girls selected from their respective schools.

Table 3.1 Sample Sizes of both boys and girls

Name of School	Sex	n	%
Lang'ata Barracks	Boys	9	2.7
	Girls	5	1.5
Raila Educational Centre	Boys	39	11.5
	Girls	25	7.4
Olympic High School	Boys	57	16.8
	Girls	39	11.5
Karen C	Boys	21	6.2
	Girls	18	5.3
Lang'ata High School	Boys	84	24.7
	Girls	43	12.7
Total		340	100.0

Source: Researcher 2011

The third stage was to get the exact number of respondents needed from each class in the schools selected above. The study proportion (for each school) was multiplied by the number of students in each class, and then divided by the total population of the school, as shown below:

$$\frac{X}{Y} = z$$

Where:

x = the study proportion

y = the total population of the school

z = the intended respondents in each class

In the fourth stage, systematic sampling technique was used to pick the corresponding sample once the number of respondents in each class had been calculated (as shown above). Systematic sampling consists of selecting every *kth* case from a complete list of the population (Singleton, 1988). Using class lists as the sampling frame, the researcher divided the total number of students in each class by the number of students needed (from each class) in order to get the sampling interval. The sampling interval is the ratio of the number of cases in the population to the desired sample size.

The researcher then selected a random number between 1 and this value to give the first respondent of the sample and also act as a starting point for the selection of the rest of respondents (Mulusa, 1990). From this point, every **kth** entry on the class list was selected using this sampling

interval until the selection was completed. This sampling procedure was applied in all the five schools.

3.5 Data Collection Procedures

Data were collected using mixed methods approach with the aid of structured questionnaires, focus group discussions and key informant interviews. Both quantitative and qualitative data were collected concurrently and then the two databases were triangulated to determine if there was convergence, differences or some combination (Creswell, 2009). The purpose of using this strategy was to offset the weakness inherent within one method with the strengths of the other.

The quantitative data were necessary to guarantee a generalization of the results and to statistically test the hypothesis. Complementary qualitative data were collected to ensure consistency with the survey research or comparison. In other words, the qualitative data were needed to provide plausible explanations for quantitative data (Cresswell, 2009). Using both the structured questionnaire and the interview schedule to collect data also served as a mutually validating procedure. According to Campbell *et al* (1999), while the survey is useful for measuring the incidence of a specified behavior, it is often unsatisfactory for full investigation of motivations, beliefs and values that may have a major influence on behavior. Alternative approaches, including key informant interviews and focus group discussions can complement large-scale survey methods. This is consistent with the assertion of Lincoln & Guba

(2000) that double measure of the same construct enables the researcher to get more accurate data and thus reduce measurement errors. Hence, the mixed methods approach was used to increase the trustworthiness of the conclusions made from this study.

The side-by-side integration of data provided quantitative statistical results which were followed by qualitative quotes that supported or disapproved the quantitative results. The advantage of mixed methods was that it resulted in well – validated and substantiated findings. The quantitative data were collected from a sample size of 340 students using self-administered questionnaires. Although the desired sample size was 325, an additional 15 respondents were sampled in order to guard against drop out and attrition.

3.5.1 Piloting

Piloting was carried out in a mixed public secondary school in South B which. A sample size of ten boys and ten girls was selected through simple random sampling from the school. The primary purpose of the test was to check content validity of the questionnaire. It also provided feedback on the wording of the questions. After piloting, the researcher made changes to the questionnaire to remove ambiguity and double meanings. In addition, the researcher adjusted the completion time for the questionnaire since respondents complained that it was very long. The time was thus changed from the initial 15 minutes to 30 minutes.

Reliability of the questionnaire was attained through the use of Cronbach's Coefficient Alpha. Scholars suggest that an Alpha value of above 0.50 is an indication of reliability. In this study, 0.50 value was used to indicate reliability of the questionnaire (Mugenda & Mugenda, 2003; Cresswell, 2009).

3.5.2 Survey

The survey method was used to assess incidence of behaviors among the target group. A self-administered questionnaire was used to obtain data from the respondents. The main advantage of the questionnaire method was that it avoided the potential embarrassment of face-to-face dialogue and guaranteed complete anonymity. Campbell *et al* (1999) say that the use of self-administered questionnaires is particularly useful in the collection of data on sensitive topics, such as sexual behavior.

Another advantage of self-administered questionnaires, according to Campbell *et al* (1999), is that they are appropriate methods for obtaining data from literate study populations. In this case, the study population was literate. Since there was no probing, the self-administered questionnaires were short, simple and very easy to follow. The respondents filled the questionnaires in their classrooms. The researcher supervised this exercise assisted by their teachers.

3.5.3 Focus Group Discussions

Focus group discussions were used primarily to investigate the normative aspects of behavior. They were used in this study to explore the ways in which the youth interacted in their discussions and the extent of agreement in opinion and attitude (Campbell et al, 1999). The advantage of these group discussions was the greater breadth of ideas, opinions and experiences that were expressed by the participants.

Two focus group discussions were held in each school; one with form one and two students combined, and then the other with form three and four students combined. Each FGD consisted of eight students - four girls and four boys drawn purposively from each form. Thus form one produced 2 girls and 2 boys, and so did form two, three and four. From each school, 8 girls and 8 boys participated in the focus group discussions. In total, 80 students participated in the FGDs.

Attempts were also made to ensure equal representation of boys and girls in each group. Care was also taken to ensure that the groups were as homogeneous as possible in terms of sex, educational background, and other relevant characteristics like familiarity with each other. Familiarity had advantages such as reducing initial tension or embarrassment. Homogeneity also reduced the danger of the discussions being inhibited by considerations of status or hierarchy (Campbell et al., 1999). Each discussion lasted between 60 and 90 minutes and was tape recorded.

The researcher facilitated all the discussions. He also made some field notes. Each focus group discussion began with an introduction. The researcher then outlined the goals of the research and the reasons for recording the sessions. In order to exploit group dynamics and enhance the quality of data collected using this method, the participants were allowed a free atmosphere to express themselves. Issues that were covered in the focus group discussions included: the meanings and or beliefs associated with HIV and AIDS, how discussions generate knowledge about the youth's understanding of HIV and AIDS, HIV risk perceptions, self-protection against possible HIV infection, and how interpersonal communication influenced behavioral responses to HIV and AIDS among the youth. The researcher only intervened to bring out salient issues, particularly when group participants did not do so.

The choice of the venue was also an important practical consideration. The venue was neutral with regard to the substance of the discussion, informal and congenial. Eight focus group discussions were held under trees in the open fields. This helped to guard against eavesdropping by the rest of the students. The other two focus group discussions in one of the schools were held in a classroom. The teacher on duty helped to identify a classroom that was ideal and away from the glare of the rest of the students.

3.5.3 Key Informant Interviews

Key-informant interviews were of a conversational style rather than having a question-answer format (Campbell et al., 1999). These were conducted using a semi-structured interview guide. Key informants were mostly the professionals in the schools who had knowledge and experience about HIV and AIDS and the youth. They included two head teachers, two guidance and counseling teachers, two games teachers, one school nurse and three school captains. A total of ten key informants were interviewed.

The in-depth interviews were used to provide insights in understanding the context in which behavior occurred and its broader structural determinants. Other advantages included a greater depth of detail of information; greater opportunity to share and understand the viewpoints of informants, and how their beliefs, experiences and vocabulary related to the wider issues.

In this study, two key informants were purposively selected from each school for the key interviews. The researcher encouraged the respondents to talk freely and guided the discourse towards new topics from time to time.

The researcher started by establishing a rapport with each informant. He then provided information on the issues to be covered during the interview. These included the youth's knowledge and understanding of

HIV and AIDS, their (youth) HIV risk perceptions, the youth's self protection against HIV infection, and whether HIV and AIDS messages influenced their behaviors. The emphasis here was on understanding the youth's perspectives and descriptions (according to the informants) of the context in which events and actions took place.

The interviews were tape-recorded to enable the researcher to listen to the flow of discussion and to take note of the exact vocabulary used by the informants. The researcher also wrote down some field notes which were expanded at the end of each interview.

3.6 Data Analysis Procedures and Presentation

3.6.1 Quantitative Data

According to Kombo & Tromp (2006), data analysis refers to examining what has been collected in a survey and making deductions and inferences. It involves scrutinizing the acquired information and making inferences. Descriptive and inferential statistics were used to interpret the quantitative data obtained on variables relevant to the study objectives and hypothesis. Statistical Package for Social Sciences (SPSS) was used to in the analysis. Data were presented using tables.

3.6.2 Qualitative Data

The qualitative data produced from the focus group discussions and key informant interviews were transcribed and coded into common themes. The themes in qualitative data were interpreted using thematic analysis. A narrative report enriched with quotations from key informants and focus group participants was written and triangulated with quantitative responses in order to capture convergence or differences (Creswell, 2009). Data from the survey, the key informant interviews and the focus group discussions were triangulated to enhance the reliability and validity of the results.

3.7 Ethical Considerations

Participants in the study were informed about the purpose, procedure and benefits of the study. They were assured of privacy and confidentiality. They were also informed that their participation was voluntary and that they had a right to refuse to answer any questions or even withdraw from the study at any time. Before each session, respondents and participants were asked to sign a consent form. All individuals were allowed to ask for any clarification they needed. Participants in key informant interviews and FGDs were asked to consent to audio recording of their discussions. No monetary incentives were provided.

CHAPTER FOUR

KNOWLEDGE OF HIV AND AIDS AND SEXUAL BEHAVIOR AMONG THE YOUTH

4.0 Introduction

This chapter presents the findings of the study concerning knowledge of HIV and AIDS and risk perceptions among the youth aged 15 and 19 years. Both quantitative and qualitative data have been triangulated in order to enhance validity and reliability of the results.

Table 4.1: Socio-Demographic Profile of Survey respondents

Demographic Characteristics	Percentages (%)		Total	Number of respondents		Total
Age (years)						
	Boys	**Girls**		**Boys**	**Girls**	
15	10.0	12.1	22.1	34	41	75
16	16.0	12.5	28.5	54	43	97
17	10.9	10.6	17.5	37	36	93
18	8.4	9.0	17.4	28	31	59
19	6.6	4.0	10.6	22	14	36
			100.0			**340**
Religion						
Catholics	26.0	16.1	42.1	88	55	143
Protestants	27.6	20.0	47.6	94	68	162
Muslims	2.0	2.4	4.4	07	08	15
Other	3.2	2.7	5.9	11	09	20
Class						
Form one	12.1	8.3	20.4	41	28	69
Form two	16.6	11.0	27.6	57	37	94
Form three	14.1	15.3	29.4	48	52	100
Form four	12.2	10.4	22.6	42	35	77
			100.0			**340**

Source: Researcher 2011

Table 4.1 above presents the distribution of 130 girls and 210 boys, aged 15 – 19, by age, religion and class. The distribution of the respondents by their sex was proportional to their numbers in the study sample. The table also shows that cumulatively, Catholics and Protestants were more (89.7 percent) compared to other religions.

Since young people are diverse, interventions targeting them must be tailored to meet their individual characteristics and circumstances including age, sex, religion and educational level. The findings in this study showed that there was need therefore for greater attention to be focused on addressing the contextual realities faced by young people.

4.1 Knowledge of HIV and AIDS among the youth

The first objective of this study was to assess knowledge and understanding of HIV and AIDS among the youth. In order to understand the actions of young people who are potentially facing HIV infection, it was necessary to understand their common sense knowledge about AIDS and also their methods of addressing the AIDS threat, that is, their own constructed safer-sex rules, guidelines or practices. From a social constructionist perspective, the youth are both authors and actors in the realities they construct. As authors, they rely on common stock of knowledge rooted within existing institutions, every day language, shared meanings and understandings. The youth make sense of new phenomena or events as they occur. They follow systematic procedures in selectively choosing from their stock of knowledge to construct a base

of common sense knowledge and associated surface rules. These rules reflect deeper norms and structures which form the base of social relationships.

When the respondents were asked if they had heard of AIDS, 98.8 percent of them agreed as shown in Table 4.2 below. Those who had not heard of AIDS were 1.2 percent. Studies have found that general awareness of HIV and AIDS in Kenya is high. For example, among young people aged 15-19 years, four in five (80 percent) young men and 74 percent of young women knew that a healthy looking person could be infected with HIV (KDHS, 2008-09).

Table 4.2: Knowledge of AIDS

Whether respondents have heard of AIDS	n	%
Yes	336	98.8
No	4	1.2
Total	340	100.0

Source: Researcher 2011

Information from the focus group discussions indicated that participants knew about the existence of HIV and AIDS. HIV and AIDS were defined as "huge," "terrible," "horrible," "sad," and a "big deal." These terms used to describe HIV and AIDS denote the relevance of this problem for interviewees and its emotional connotation (mainly negative feelings). The link between HIV and AIDS, and death stood out.

Nzioka (1994:176) observed that "the ways in which people make sense of their sexual meanings of AIDS depends on their perceptions of the risk of HIV infection, and their knowledge and experiences of sexually transmitted diseases, as well as on their compatibility of HIV and AIDS education messages with meanings and practices embedded in social and cultural lifestyles."

This study found that students talked about sex and HIV and AIDS. In the course of their discussions, they created their own meanings of HIV and AIDS. They used metaphors and forms of figurative language to refer to HIV and AIDS as a disease or to refer to those who were already infected with HIV virus.

> Q: How do young people describe HIV?
>
> P1: Some refer to it as 'kamdudu' (small insect)
>
> P2: Oh, simple...HIV is like a bee ... you know that small
>
>   insect? Kali sana mazee! (it's very dangerous)
>
> P3: Some of us call it a 'worm' coz it 'eats' from inside ...
>
>   (laughter) Yenyewe ni kweli....as in...huwezi jua kaa niko
>
>   nayo (more laughter). (You can't tell whether I am infected)
>
> P4: We talk of 'ngwengwe' to describe someone suspected
>
>   to have the HIV virus.

HIV and AIDS was often the object of an interpersonal reframing discourse; often, the relevance of the disease was discussed by comparing it with other diseases or social problems that present some of its key features. For instance, HIV and AIDS were often compared to cancer because both lead to death. It was also often compared to other sexually transmitted diseases (STDs) because all of them are transmitted sexually. Moreover, HIV and AIDS were often compared to poverty in developing countries because both were considered political problems. It is interesting to notice that this discursive construction of HIV and AIDS allowed participants to reframe the problem and thus moderate both its gravity and its relevance:

P1:   HIV and AIDS are like hepatitis which is just as bad.

P2:   Yeah, both can cause cervical cancer, infertility and death.

P3:   HIV is like some STDs such as gonorrhea which are equally fatal. It will not only lead to loss of vital parts like STDs do, but can also cause death.

The reframing of the relevance of HIV and AIDS was evident in all focus group discussions. Participants claimed not to know anyone with HIV and AIDS, but reported knowing people suffering from cancer and STDs. Thus HIV and AIDS appeared much less common, at least according to the participants in focus group discussions, than other diseases, and this lessened its relevance. The participants said they didn't have any

direct experience with people affected by HIV and AIDS and so there was a contradiction between one's personal experience (i.e., "nobody I know has HIV and AIDS") and mass media campaign messages (i.e., "HIV and AIDS is a big issue in Kenya and there are many people with HIV in our country").

This contradiction seemed to trigger questions about the reliability of preventive campaigns and diminished their rhetorical effectiveness. This was reinforced by a 17 year old female school captain:

> "I would like to tell you that most students in my school are not aware of anyone who is HIV positive. I am in that category, of not knowing anyone who is infected. I am also curious to know whether there are people I know, but who I don't know are HIV positive."

Q: Where do you get information about HIV and AIDS from?

P6:   Mostly from the media. We rarely talk about sex but we get information from the media   most of the time.

P7:   At times we hear stories about HIV from friends flying around.

P2:   *Pia vitu kaa 'maradio' hivi*, TV, *wasee wa* home, that is, *'marelas'* (also from radio or television)

P4:   Pia church! (More laughter)....but rarely anyway

The participants attributed this knowledge to various sources such as teachers, the media (posters, radio & television), peers, religious leaders, the HIV and AIDS curriculum taught in primary and secondary schools, relatives and health centre.

When asked if the information about HIV and AIDS they had received helped them to make informed decisions about HIV protection, the students said they had.

P3:   We are okay. Hii story ni sawa. As in, we have enough.

P5:   *Tumechanuka!* (laughter). *Tuko* far...*una-get?* (we

understand, it is enough)

However, a 48 year old female nurse, who worked in a mixed school, opined that in spite of the information that young people purported to have, she believed that students still needed a lot of persuasion and understanding to change their attitude towards HIV and AIDS.

> "*I believe you and I can help these children. I doubt whether they have the right facts about HIV and AIDS. Am telling you, there is a lot of influence in this school. For over ten years now, I have interacted with these them. I also talk to their parents, who seem not to bother much about their children. I can tell you, mwalimu that young people feed each other with the wrong information about HIV. Trust me, they always tell me. And as a parent, I also counsel them. Actually, they confide to me a lot.*"

One could imagine and even feel the motherly touch and concern expressed by the nurse given her interaction with students on a daily basis. She said that the students confided to her most of the time. They would express their fears and concerns about the kind of information they were getting out of their discourses with friends. It is these discourses that generated lay knowledge which young people relied on in their decision making efforts. This knowledge did not seem to assist the youth in making right decisions about their health.

The respondents were asked if they knew whether AIDS was curable. The responses to this question are given in Table 4.3 below.

Table 4.3: Whether AIDS is curable

Is AIDS is curable?	n	%
Yes	45	13.3
No	295	86.7
Total	340	100.0

Source: Researcher 2011

Table 4.6 above shows that 86.7 percent of the respondents knew that AIDS was not curable. 13.3 percent of the respondents thought that AIDS was curable.

During the focus group discussions, the lack of a cure for HIV was seen by the participants as the most dramatic aspect of this disease. This made it extremely frightening. Death at a young age was considered

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abnormal, and it is something that interviewees preferred not to think about. They said they were 'scared to death' of getting AIDS:

Q: Does HIV have any cure?

P1.   Not at all, I hear doctors haven't found one yet. This is

      bad, you know. Guys just die, like chicken, you know.

P2:   Of course not. *Mazee inabidi tujipange.* (we have to be

      careful But it is okay. Somehow we have managed to

      cope.

P3:   There is no discovery about a cure. It's just that you

      will get AIDS and then you die. Yeah, I mean, there is

      no cure, after all.

That AIDS had no cure was summed up symbolically by an 18 year old school male captain, who said that he was speaking on behalf of his peers in school.

> "AIDS is a 'stupid' disease. 'Gava' is yet to get
> the 'herbs' for it. But what do we do? Ngoma
> lazima tucheze. Mifupa tutavunja. Ok? If you
> can't beat them, join them."

A 38 year old male principal added his voice to the debate about the knowledge and consequences of HIV and AIDS. To him, students engaged in discussions about the effects of HIV and AIDS and how to protect themselves.

"I have interacted with students for the last 15 years now. I believe that I understand them. I listen to them quite often. I can then tell you that my students have information about HIV and AIDS. They know how to protect themselves against. We teach them using the HIV and AIDS syllabus. However, there is also a lot of peer influence around. I can tell you then that most students don't make independent decisions. Instead they are heavily influenced by their peers. These are fellows who may not be reliable at all, and I understand some of them are quite persuasive!

You can imagine then the extent to which they will mislead their colleagues. Nevertheless, we keep telling all of them to avoid casual sex. In fact, the message we preach is about abstinence. However, when push comes to shove, we equally tell them to use protection if they are not able to abstain. But the question is, do they really use them? Your guess is as good as mine."

Table 4.4: Knowledge of HIV transmission modes

How HIV is transmitted	n	%
Through kissing	17	5.0
Through sexual intercourse	317	93.2
Through handshake	6	1.8
Total	340	100.0

Source: Researcher 2011

In Table 4.4 above, 93.2 percent of the respondents indicated that HIV was mainly transmitted through sexual intercourse. This knowledge was supported by reviewed literature which showed that the main mode of HIV transmission was heterosexual relations (KDHS, 2003; 2008-09). According to KDHS (2008-09), knowledge of HIV transmission modes increased from 67 percent in 2003 to 75 percent among the youth. The report also indicated that 92 percent of the youth aged 15 – 19 years

knew that AIDS could not be transmitted by supernatural means such as cursing.

However, Wodi (2005) noted that the levels awareness did not necessarily reflect an understanding of how sexually transmitted diseases (STIs) such as HIV could be transmitted or prevented. Nyinya (2007) and Ongunya et al., (2009) found that in spite of the understanding that HIV was mostly transmitted through sexual intercourse, students continued to engage themselves in risky sexual behaviors.

Table 4.5: Respondents' assessment of contracting HIV

Self assessment of personal risk to HIV	n	%
No sexual intercourse	194	57.1
No sex with prostitute	2	.6
Use condoms	62	18.2
No sharing of injections	79	23.5
No response	3	.9
Total	340	100.0

Source: Researcher 2011

Table 4.5 above shows that 57.1 percent of the respondents did not perceive themselves to be at risk since they did not involve themselves sexual intercourse. Another 18.2 percent indicated that they used condoms during sexual intercourse and so they did not consider themselves to be at risk of HIV infection.

Table 4.6 below shows that 48.5 percent of the respondents would avoid sex completely in order to prevent HIV and AIDS infection. This response

corroborates the main reason given by the majority of the respondents in Table 4.5 where 57.1 percent of the respondents did not perceive themselves to be at risk since they did not indulge in sexual intercourse. Those respondents who said they could avoid AIDS by staying faithful to their partners were 32.6 percent.

This knowledge of HIV and AIDS prevention is corroborated by Hanan (1994); Muturi (2005); Kabiru (2009); Mulwo & Tomaselli (2009); Govender (2010).

Table 4.6: Knowledge of HIV and AIDS prevention

Ways of preventing HIV infection	n	%
Avoid sex completely	166	48.8
Stay faithful to one partner	111	32.6
Use condoms during sexual intercourse	45	13.2
Avoid sharing needles	11	3.2
No response	7	2.1
Total	340	100.0

Source: Researcher 2011

Although respondents said that one way of avoiding HIV was to abstain from sex completely (48.8 percent), this knowledge had not been translated to positive behavior change. Young people continued to engage in sexual activities as noted by Kabiru and Orpinas, (2009) and in APHRC (2010).

Table 4.7: Whether a healthy-looking person can have the HIV virus

Whether a healthy-looking person can have the HIV virus	n	%
Yes	317	93.2
No	23	6.8
Total	340	100.0

Source: Researcher 2011

The majority of the respondents (93.2 percent) were right in stating that a healthy – looking person may have the HIV virus that causes AIDS. Only 6.8 percent of the respondents disagreed. This knowledge was corroborated by participants during the focus group discussions:

Q: Can a healthy-looking person have the HIV virus?

P1:   Yes, we have learnt this in class and we know that anyone, including those who look healthy, may have the virus that causes AIDS.

P4:   It is a pity that you can't tell who is sick by looking at people. So, there is real danger here.

P5:   The information is all over the place....but how you can tell, even you?

P2:   Yeah, I mean, anyone can have the big one, but who cares? Sickness or not, life has to go on!

When the respondents were asked to rate their knowledge of HIV and AIDS, 46.5 percent of them rated their knowledge as 'very good' as Table 4.8 below shows. Another 42.4 percent rated their knowledge of HIV and

AIDS as 'good' while 9.4 percent rated their knowledge as 'not good'. Literature reviewed showed that knowledge about HIV and AIDS was high and satisfactory among young people (Kermyt & Bentel, 2007; KAIS, 2007; Odu & Ankanle, 2008).

Table 4.8: Self-rating of HIV and AIDS knowledge

Rating of HIV/AIDS knowledge	n	%
Very good	190	55.8
Good	144	42.4
Poor	6	1.8
Total	340	100.0

Source: Researcher 2011

4.2 Perceptions of HIV and AIDS risk among the youth

Perception of risk has been theorized as an important aspect for adopting protective behavior change (Janz & Becker, 1984). In relation to HIV, risk perception is an indicator of perceived susceptibility to infection, and a measure of one's understanding of AIDS transmission. It is also a measure of one's willingness to consider behavior changes. Scholars suggest that people use condoms if they think the costs of the potential illness outweigh the costs of buying condoms and overcoming the reluctance to wear them (Ajzen & Fishbein, 1980; Janz & Becker, 1984).

The results in Table 4.9 below show that 60.9 percent of the respondents did not perceive themselves to be at risk of HIV infection. Another 35.9 percent said they perceived themselves to be at risk of HIV infection.

Lack of risk perception is corroborated by Tsasis & Nirupama (2008) who suggested that one's inability to accept reality of risks was caused by the society in which they lived. Thus, understanding the way perception of risk is shaped and constructed is crucial in identifying why it is has been difficult to mitigate the spread of HIV and AIDS (Tsasis & Nirupama, 2008).

Table 4.9: Risk perception of HIV infection

Perception of risk	n	%
Yes	122	35.9
No	207	60.9
No response	11	3.2
Total	340	100.0

Source: Researcher 2011

During the focus group discussions, participants said that the knowledge they acquired during social interactions with their schoolmates did not change their perception and understanding of HIV and AIDS.

Q: Do you perceive yourself to be at risk of HIV infection?

P3:   Oh no.... why should I be? I am not at risk.

Q: Why?

P3:   Coz my friends are not at risk either.

P8:   For me, I use protection, though not always.

P5:   We trust each other. We zero graze. No away matches for us

P6:   Infection happens to others....*Sisi tuko Poa* (we are okay)

During these discussions, participants reacted to HIV risk by simply denying its existence and considering themselves not at risk. They called this 'it-cannot-happen-to-me" syndrome which seemed very common in social circles. Their school captain, a likeable, straight talking, 18 year old boy summed it up thus:

> "Young people don't think about HIV infection. To them it is like something that happens somewhere else, and to other people. These guys don't regard it as a serious disease. If anything, it is not a big issue anymore. AIDS is somehow a non-issue nowadays. In fact for me, I usually don't think about it in my life."

The participant's perception that they were not at risk may explain why they continued to engage in sexual activities:

P3:   I am a man, you know....

Q: And so?

P3:   I need to deliver bwana! A man has got to be a man, yeah?

P4:   So there is no room for these risks you talk about, do you get?

This argument is tied up to local notions of masculinity, which is, trying to understand who a man is. This requires men to be attractive and to have sex with as many women as possible. In a bid to demonstrate this, some boys even exaggerate their levels of masculinity.

Whether respondents had sexual partners	n	%
Yes	273	80.3
No	63	18.5
No response	4	1.2
Total	340	100.0

Source: Researcher 2011

As the table 4.10 above shows, 80.3 percent of the respondents agreed that they had sexual partners, while 18.5 percent of the respondents said they did not have sexual partners. As noted earlier in Table 4.5, 57.1 percent of the respondents said they were not at risk of HIV infection because they did not engage themselves in sexual relations. This disparity was explained during the focus group discussions.

Q: Do you or your colleagues in this school have sexual partners?

P1:   Of course! I thought you knew.

P2:   It would be a lie for anyone to tell you that they did not have a sexual partner.

Q: So you guys engage in sexual relations, don't you?

P5:   Certainly yes, many times. The pressure is irresistible.

P3:   And everyone is doing it after all, why not us?

P4:   By the way, if I don't have sex with my girlfriend, someone else will do it. Do you know that?

Q: Don't you fear getting infected with HIV?

P6:   If you die, you die. Period. You know, one has to live
       their lives. After all, life is not a rehearsal, or it is?

P4:   If anyone tells you they are not having sex, they are
       lying. Maybe one or two virgins who are yet to start?
       Otherwise, to us it is fun. No fear of infection. May be
       the fun and the experience overshadows the risk
       perception, I think.

One of the shared thinking among many youth about HIV and AIDS was
that it was a normal disease just like malaria. In fact, a term that
students commonly used was 'homa', meaning fever. As a consequence of
the intense negative emotional connotation of HIV, a sort of denying
discourse occurred: HIV and AIDS as a "big deal" was transformed to a
"nonissue" that was not worthy of being considered in one's daily life.
This is an extremely interesting paradox: because it is not easy to cope
with such a terrible disease, the psychosocial strategy for facing HIV and
AIDS was to deny its relevance in daily life.

Table 4.11: Influence from colleagues to have sex

Whether influenced to have sex	n	%
Yes	203	59.7
No	122	35.9
No response	15	4.4
Total	340	100.0

Source: Researcher 2011

When asked whether students influenced each other to have sex, 59.7 percent of the respondents agreed that there was influence. However, 35.9 percent said they were not influenced by their colleagues to have sex. This finding was corroborated by Kermyt & Bentel (2007) who observed that the youth continued to engage in high risk HIV and AIDS behaviors. Instead, Mulwo & Tomaselli (2009) suggested that the youth used their knowledge generated from their discussions and interpersonal networks to not only assign meaning to media messages but to determine their behavioral responses. This is what scholars have called contextual realities from which young people generate their knowledge of HIV and therefore assign meaning to HIV and AIDS messages (Kiai, 2009; APHRC 2010; Ndeti 2011).

Ongunya et al. (2009) pointed out that there was a mismatch between HIV and AIDS program objectives and behavior change among the youth. The scholars suggested that there was a gap between HIV and AIDS program objectives and actual HIV and AIDS education program delivery and behavioral changes among the youth in secondary schools. This may mean that what students learnt about HIV and AIDS from the AIDS education syllabus did not persuade them to make informed decisions and stop relying on lay knowledge from their social interactions and interpersonal exchanges.

The Kenya National HIV and AIDS Communication Strategy for Youth showed that majority of the youth had heard about AIDS but many of them did not know how to prevent HIV infection neither did they perceive themselves to be at risk (NACC, 2008). The strategy further pointed out that the youth lacked adequate decision – making skills or the ability to adopt safer sexual behaviors. Accordingly, information alone did not lead to change of behavior.

When the respondents were asked if they knew the consequences of unprotected sex, 64.1 percent of them agreed that they knew about the consequences of unprotected sex. 32.1 percent did not know the consequences of unprotected sex. Table 4.12 below shows the findings.

Table 4.12: Knowledge of the consequences of unprotected sex

Knowledge of the consequences of unprotected sex	n	%
Yes	218	64.1
No	109	32.1
No response	13	3.8
Total	340	100.0

Source: Researcher 2011

Literature from the Kenya AIDS Indicator Survey report and the Kenya Demographic Health Survey report showed that young people continued to indulge in sexual relations even when they knew the dangers of such relations (KAIS, 2007; KDHS, 2008-09).

Participants in the focus group discussions explored some of the consequences of unprotected sex:

P1: Unprotected sex can bring about sexually transmitted diseases, like syphilis or gonorrhea or even both.

P2: Yes, and it can lead also to unwanted pregnancies. And who wants to be a mother or daddy anyway?

P3: There is also the possibility of contracting the HIV virus.

Q: How can you protect yourself from these consequences?

P4: By abstaining from sexual relations

P5: One can use condoms during sexual contacts

P6: Or remain faithful to one sexual partner

P7: Some of us visit VCT centers for advice on How to practice safe sex

P8: As a girl, if I have sex without protection I can use a pill to protect me from possible pregnancy

A youthful female nurse who declined to disclose her exact age, pointed out that most of the students she had interacted with made sexual decisions based on fear and not knowledge. She added that girls would always abstain from sex not because they had sufficient information about HIV and AIDS, but simply because they feared falling pregnant.

"Those girls who delay their sexual debut do so because they want to please or obey their parents or even their pastors in case they are regular churchgoers. Most parents that I know do not interact with their children at an early age. Many of them wait until they are teenagers.

These parents find it difficult to talk about sexuality or HIV in particular, perhaps because cultural considerations. Others are never frank and forthright about sexuality. In fact, they want to talk to their children instead.

A case in point is one girl who wanted her mother to give her information about HIV and AIDS but her mother declined. Instead, she was insulted. The mother threatened to report her to their pastor for unspecified action. Now, you know what, this is what I call intimidation. And it makes most girls not to get the right information from the right people and at the right time. Such teenagers, especially the girls, develop an interest for sexual exploration. How will they then keep off the risks of HIV infection?"

The nurse further observed that there were many misconceptions about

HIV and AIDS amongst students, particularly the female ones.

"The society expects girls to remain pure. Now, in order for them achieve this, in the midst of all the peer pressure to have sex, what they do is to endeavor to retain their virginity but they will still have sex. Now, you ask how they will do it? Listen to this. They have opted for either anal or oral sex or both. Did you hear that? They will entertain fondling, kissing and caressing. Remember, their ultimate goal is to protect their virginity but they forget that by doing all these other things, they still expose themselves to HIV infection. In the end, the girls remain virgins....yes, get married, yes...but the probability of being infected with HIV still remains very high. This is the reality on the ground."

These views were corroborated by a 26 year old games master, who spends most of his time in the fields with the students:

"Notwithstanding their knowledge of the risks of HIV infection, my students sadly continue to be sexually active. I regret this occurrence, honestly. I do not even know whether they use protection or not. I know many would want to stop this habit, but perhaps the favors they get from their sexual partners make them not to care about the risks they expose themselves to. But I can tell you that a lot social influence goes on."

Participants in the focus group discussions said that their colleagues had in the recent past been drawn into 'chips funga' business, a phrase that is used to describe a sexual behavior where boys negotiate and then pay for sexual favors from girls. The practice is rampant in urban centres.

P3: It happens mostly during weekends or school holidays. Also, when we have extracurricular activities, some us seize such moments to engage in illicit sex. As long as your friends do it, you can't escape it.

P5: Yes. This is also a practice that is common with out-of-school teenagers in most towns today

The general feeling shared by the key informants and participants in focus group discussions was that students had continued to refer to their lay knowledge about HIV and AIDS generated from their social interactions and interpersonal communication networks. It is this socially constructed knowledge which students had continued to rely on to assign meanings to HIV messages. These concerns correlate with observations made by Nzioka (2004) that the ways in which the youth 'make sense' of the sexual meanings of AIDS depends among other things, on their perceptions of the risk of HIV infection as well as on the compatibility of HIV and AIDS messages.

4.3 Knowledge of HIV and AIDS and the youth's self-protection against possible HIV infection

The findings of this study showed that interpersonal communication regulated the forms of experience and perception among the youth toward HIV and AIDS communication for behavior change. Consequently, the youth's perceptions and meanings of HIV and AIDS were constructed through available discursive understandings. According to Burry (1996), interpersonal communication restricts and enhances meaning, dialogue and thinking. Burry observed that diseases were not merely biological entities but rather they were socially constructed phenomena. Those meanings that the youth attributed to HIV and AIDS were decisive in shaping their responses to this condition.

As earlier observed, HIV and AIDS was an unthinkable disease for the youth. The only way to talk about it was by defining it as a problem that was related only to particular places or segments of the population. For example, in their communication, participants tried to locate the virus propagation in distant areas and among groups such as commercial sex workers. This sort of virus circumscribing discourse allowed the youth to represent HIV and AIDS as a confined and remote problem. Below is an excerpt from a 19 year old head boy:

> "When I think of AIDS, I don't really associate it with the youth. I imagine the prostitutes or far off places like the beaches in Mombasa which are frequented by tourists. I think needle users and gay men are more likely to catch HIV and AIDS than us the youth."

Thus, individuals with HIV and AIDS were perceived as socially undesirable, and HIV was often attributed to the "others." The perception of the divergence between oneself and those who are exposed to the risk of infection seemed o be based on stereotypes about the disease and on the "it-cannot-happen-to-me" syndrome: HIV and AIDS was discussed as something that affects "not normal" people. Participants defined themselves as normal and, thus, not at risk.

HIV and AIDS were defined as something for which individuals were responsible; it was perceived to be a consequence of individual's irresponsible behaviors. It followed that getting HIV was the individual's fault, and it was an object of social blame, as observed by the 17 year school captain:

> "I don't want to generalize and say we are all at risk. No. I can't relate HIV infection to real people here. I think it is a lifestyle disease. Unless you are born with it, it is your lifestyle that gets you. I think it is a preventable disease. For me, I am normal, so HIV is not an issue for me."

When the respondents were asked whether they had ever engaged in sexual intercourse, 94.1 percent agreed. Those who said they didn't have sex were only 5.9 percent. The findings in Table 4.13 are interpreted together with those in Table 4.14 below.

Table 4.13 Engagement in sexual intercourse

Ever had sexual intercourse	n	%
Yes	320	94.1
No	20	5.9
Total	340	100.0

Source: Researcher 2011

As seen in Table 4.14 below, a cumulative 89.7 percent had sexual intercourse as indicated by the categories in the table.

Table 4.14 Age at first sexual intercourse

Age at first sexual intercourse	n	%
10 and below	25	7.4
11-15 years	110	32.3
16-19 years	185	54.0
Total	320	93.7

Source: Researcher 2011

These results corroborate literature by scholars that the youth were engaged in premarital sex (Nzioka, 2004; Wodi, 2005; Kermyt & Beutel, 2007; Fuglesang et al., 2009; NACC, 2010).

The KDHS report of 2008/09 indicated that the youth start engaging in sexual intercourse early, where 7 out of 10 girls and 8 out of 10 boys had engaged in sex by the age of 20. The report put the median of first sexual intercourse at 17 years. This early sexual debut exposed the youth to numerous health risks (NACC, 2010).

When the respondents were asked whether they had any knowledge about condoms, 90.6 percent of them said they knew about condoms. This is illustrated in Table 4.15 below. Only 5.6 percent of the respondents said they had no knowledge about condoms. Another 3.8 did not give any response. These findings are supported by the KDHS reports of 2003 and 2008-09 which suggested that the youth aged 15-19 years had knowledge about condoms and that one could use them for protection against HIV infection.

Table 4.15 Knowledge of condoms

Knowledge of condoms	n	%
Yes	308	90.6
No	19	5.6
No response	13	3.8
Total	340	100.0

Source: Researcher 2011

As seen in Table 4.16 below, when respondents were asked to state who they had sex with, 69.1 percent of them said they had sex with their friends. This was followed by 25.3 percent who mentioned schoolmates as their sexual partners. Those who said they did not have a sexual partner were 5.9 percent. This percentage of those who did not have sexual partners corroborated the 5.9 percent (Table 4.13) of the respondents who had never had sex.

Table 4.16 Respondents' sexual partner

Sexual partner	n	%
School mates	86	25.3
Friends	234	69.1
No sexual partners	20	5.9
Total	320	94.4

Source: Researcher 2011

Table 4.17 below shows that friends played a major role in providing venue to their colleagues for sexual activities. Friends accounted for 66.8 percent. Other venues were school (13 percent) and home (12.1 percent). 5.9 percent of the respondents are those who had never had sexual intercourse as shown in Table 4.13 above.

Table 4.17: Where they had sex

Venue	n	%
At home	41	12.1
In school	44	13.0
Friend's house	227	66.5
Lodging	8	2.1
Total	320	93.7

Source: Researcher 2011

During the focus group discussions, participants attributed their sexual activities to peer pressure particularly from their close friends and school mates.

Q: Why do you engage in sexual relations?

P1: There is a lot of pressure from friends. It is difficult to survive in a group of friends without engaging in sex, because that is always the main activity.

P2: And so you will want to prove a point. That you are capable just like them

P3: The fear of possible consequences will drive you to comply. These guys can beat you up if you don't accept their plans.

Q: Do girls experience such pressure from other girls?

P7: Oh, my! They are worse. If cliques of girls discover that you want to be different from them, they insult, or even organize with the boys to attack you. You have to play ball.

P4: And you can't even report their threats to the teachers. One time, a form two girl reported some girls from her classmates to their class teacher. I wish she was here to tell her story. Imagine her parents had to transfer her to another school, but not before she had received a thorough beating from people she did not know. And this happened on her way home from church!

Table 4.18 below shows the responses the respondents gave when they were asked whether they had used a condom the last time they had sex.

Those who did not use a condom the last time they had sex were the majority at 80.9 percent compared to 13.4 percent who said they had used a condom. Failure to use a condom during sexual intercourse is supported by Nzioka (2004) who asserted that unprotected sex was still a common feature among young people in spite of the levels of knowledge concerning the protective value of condoms and other contraceptives being high. This showed a very low risk perception.

Table 4.18: Whether they used a condom in the last sexual encounter

Used a condom	n	%
Yes	45	13.4
No	275	80.9
Total	320	94.3

Source: Researcher 2011

While condoms remain one of the best weapons against HIV transmission, studies continue to show limited use of this protective method in sexual intercourse among the youth in Sub-Saharan Africa (MacPhail, 1998; Wodi, 2004). These scholars cite several socio-cultural and religious factors in the limited use of condoms. These findings corroborate earlier studies about condom use and beliefs among the youth in Nairobi (Kiai, 2004; Ongunya et al., 2009; Kabiru & Orpinas, 2009; KDHS, 2008-09; APHRC, 2010; NACC, 2010).

From the focus group discussions, it emerged that a condom was an important prevention strategy in theory, but in practice it was not in

neutral action: it implied specific relational meanings that made its use less frequent:

Q: Do you use condoms during sex for protection against HIV infection?

P5: Condoms? No, I don't because I am in a serious relationship with my partner. I believe we are healthy.

P8: I don't use them because the level of trust between us is very high. As such, I am not worried at all.

P3: The problem is, what kind of world do we live in if you cannot ever trust the person you are with?

Q: Supposing they cheat and put you at risk?

P1: Yes they can slip, but it is always difficult to ask your partner to wear a condom....I mean, where do you begin?

P2: Buying condoms is also embarrassing for young people coz it means that you are having sex. And remember you don't want people to label you loose!

P5: Condom use is only common in casual intercourse or at the beginning of a relationship.

As noted in the above discussion, participants pointed out that long – term relationships were perceived as not risky, and thus using condoms seemed unnecessary. Moreover, participants said that asking a long – term partner to wear a condom would imply not trusting in his or her commitment to the relationship and fidelity.

Sometimes this discourse of trust between partners was issue even at the beginning of a relationship. The decision to have sex with a new partner was often contemplated seriously and was based on the individual's perceived honesty and reliability. Asking a new partner to use a condom would mean not being totally confident in the correctness of the partner's previous behavior. Girls, in particular, declared their shyness in negotiating condom use and their concern about meanings implied by this request.

Another problematic aspect related to the discourse of condom use was the discourse of birth control pills. Preventing unwanted pregnancies was the main concern of sexually active youth. This tended to lessen the relevance and urgency of HIV and AIDS prevention in their sexual relationships. Since young people's main preventive concern in relation to sexual activity was avoiding unplanned pregnancies (rather than preventing HIV and AIDS), girls who were using birth control pills felt protected and were not concerned about the risk of HIV and AIDS:

P5:   With birth control becoming relatively reliable, many people I know, myself included, don't pay as much attention to the secondary reasons for wearing a condom.

P8:   When I think of using a condom, I think of preventing a pregnancy, not preventing AIDS.

MacPhail (1998) suggested that much of the research had shown that the youth had high levels of knowledge about the transmission of the HIV virus and were fully cognizant of the value of barrier contraception, such as condoms in preventing HIV transmission. Despite the high profile given to HIV, few adolescents were able to translate their knowledge into adopting safe sex behavior. Jemmot (2000) also observed that most sexually active youth did not consistently use condoms although their use may reduce the risk of sexually transmitted diseases.

Data from the KDHS reports of 2003 and 2008-09 showed that there had been a marked improvement in knowledge of HIV prevention methods among adolescents aged 15-19 years. For instance, 75 percent of adolescents knew that someone could reduce the risk of getting the HIV virus by using a condom every time one had sexual intercourse. This knowledge of condom use increased from 67 percent in 2003 to 75 percent in 2009 (KDHS, 2003; 2008-09).

The respondents who supported the use of condoms argued that they considered this as the only option of self-protection since they found it very difficult to abstain. However, they were uncomfortable with condoms since they reduced sexual pleasure.

P1: It is not easy at all to abstain. Sex is very much addictive.

P3: It is just like smoking. Once you start smoking, it becomes very hard to stop the same.

P7: By the way, girls want favors, gifts, money, outings, shopping, among other niceties. Which girl will not fall prey to a man ready to provide these things? And if such a man wants sex, they insist on unprotected sex anyway. How can you refuse?

P8: I would advice those who are still virgins to try, yes, try coz it is not easy, to remain so. But I can tell it is not easy. I tried it will little   success before I finally gave in.

The respondents were asked if they thought they could protect themselves from HIV infection by abstaining from sex. Table 4.19 below shows that 86.2 percent of the respondents agreed that they could abstain from sex as one way of protecting themselves from HIV infection. Only 13.8 percent of the respondents said they were not able to abstain.

Table 4.19: Protection from HIV infection by abstaining from sex

Ability to abstain from sex	n	%
Yes	293	86.2
No	47	13.8
Total	340	100.0

Source: Researcher 2011

However, the respondents stated that owing to the influence and pressure from their friends, it was hard to practice abstinence. They said that only those who had not involved themselves in sexual relations could be encouraged to abstain, if that were possible.

When the respondents were asked whether they discussed HIV with their friends, 91.7 percent of the respondents said they did while only 8.3 percent of them said they did not as Table 4.20 below shows. The majority of the respondents (91.7 percent) discussed sex with their friends.

Table 4.20: Whether discussed HIV with friends

Whether discussed HIV with friends	n	%
Yes	312	91.7
No	28	8.3
Total	340	100.0

Source: Researcher 2011

However, during the focus group discussions, some participants were of the view that HIV and AIDS were not that easy to talk about. One reason for this difficulty in talking about HIV and AIDS was the social taboo surrounding its main method of transmission: sexual intercourse. Such participants referred to the difficulty of talking openly about sex and sex-related topics with friends. In a conservative culture such as that of Africa, sex before marriage is not accepted, and sexually active unmarried youth are always part of a blaming discourse especially by adults:

Q: Do you discuss HIV with your friends?

P1:   I talk about HIV with my friends but not as a standalone subject. The discussion has to involve other issues such as entertainment, which as young people we like.

P2:   We discuss issues related to HIV and especially if they are interesting

P7:   I have a very protective father and two overprotective brothers. If I can't talk about HIV at home, where do I begin even when I am with my friends?

P3:   Yes, as friends we do, though it or no friends, no one wants to hear about this thing at all...they don't want to hear it. Not anyone!

P5:   A few of my friends never ever talk about HIV. My family members don't talk about sex to me; neither do I hear them talk about the same to my siblings. Nothing.

P6:   Some of my friends are Catholics like me and our faith doesn't allow us to talk about sex or contraceptives like condoms. But at times we engage in conversations that help us to understand HIV as a disease.

P8:   To me, it is ridiculous that there is so much of taboos around HIV and sex in general.

From these discussions, it was established that students talked about HIV and AIDS though others felt that it was a taboo to engage in sex-related discussions. Some of the observations raised during these discussions supported the UNFPA report (2008) which stressed the fact that discussing sex was taboo in many countries, and this denied a large number of people especially the 15 – 19 age group the necessary information to negotiate for safe sex (UNFPA, 2008). The report

supported the need to develop a culturally sensitive educational intervention program.

A few of the participants during the focus group discussions noted that talking about HIV and sex was embarrassing to them. However, the majority of the participants observed that talking about HIV and AIDS among friends was not unusual. They argued that though HIV and AIDS was in itself "boring" and "sad", discussion of sex-related topics was perceived to be easier with one's sexual partner. In other instances, the participants argued that talking about the disease and its prevention implied a lack of trust in one's partners' past sexual behaviors, and so some participants avoided it for this reason.

Furthermore, participants categorized sexual relationships as acceptable or promiscuous. Among those in acceptable relationships, the participants considered themselves not at risk and noted that HIV was a mentionable topic but still was seldom discussed, even at the beginning of a relationship. The consequences of HIV and AIDS were not a young person's concern.

Q: Is it difficult to talk about HIV and AIDS with your partner?
P3:   Yes, it is very difficult to bring it up sometimes. All I say is....let's make sure you will not kill me with some horrible disease. It's not very romantic.

P8:   It may be a bit awkward to bring it up, at first, but it has to be done.

P1:   Talking about HIV and AIDS is not always the first thing in my mind, so it doesn't arise naturally. But we end up talking about it anyway.

When the respondents were asked whether they discussed how to protect themselves against HIV infection, the majority of them (83.2 percent) said they didn't. Only 16.8 percent said that they discussed HIV protection with their friends.

Table 4.21: Whether discussed HIV protection

Whether discussed HIV protection	n	%
Yes	57	16.8
No	283	83.2
Total	340	100.0

Source: Researcher 2011

From the focus group discussions, it emerged that having sex with a partner whom the young person knew well, in the long-term relationship, for instance, was not a deplorable behavior for participants. It was considered acceptable, at least among the youth and not an example of a risky behavior, in their view. The only sexual relationships that the youth viewed as risky were the same-sex relationships and casual intercourse. These were classified as promiscuous relationships, and were more likely to be the object of social blaming among the peers.

Furthermore, because promiscuous sexual relationships were not considered acceptable or socially desirable, they could not be part of the social conversations, and thus the risks, such as HIV and AIDS, could not be communicated. Participants reported that HIV and AIDS prevention seemed to be an issue only in promiscuous relationships. This has important consequences for attitudes regarding the use of condoms in sexual intercourse.

Table 4.22 below shows that students attached a lot of importance to opinions from their friends regarding sexual practices. Those who rated these opinions as extremely important were 40 percent, while another 50.3 percent said they were important. Only 9.7 percent rated their friend's opinions as not important at all. These ratings point to the importance of interpersonal communication among the youth.

Table 4.22: Friends' opinions concerning sexual practices

Importance of friends' opinions	n	%
Extremely Important	136	40.0
Important	171	50.3
Not important at all	33	9.7
Total	340	100.0

Source: Researcher 2011

When asked if they involved themselves in extracurricular activities while in school, 84.4 percent said they did while 15.6 percent did not. Table 4.23 below shows these scores.

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Table 4.23: Involvement in extra-curricular activities

Whether involved in extra-curricular activities	n	%
Yes	287	84.4
No	53	15.6
Total	340	100.0

Source: Researcher 2011

During focus group discussions, participants said that extracurricular activities as such as sports, drama, athletics, music among others provided with avenues for social interactions and an opportunity to discuss topics of interest.

Q: Are you involved in any extra-curricular activities?

P1:   Yes.

Q: Which ones?

P2:   Ball games, drama, athletics, music...they are many.

Q: Do you like these activities?

P3:   Very, very much so. We really enjoy being outside

       class, for whatever reason.

P4:   You know, being in class all the time is boring. We

       need time to unwind.

P6:   Games give us a chance to interact with friends, to

       travel to new places, to enjoy the adventures, you

       know, all these. You forget that young people have a

       lot of curiosity and want to discover?

P7:   Yes, and to meet new friends and have fun with them. A lot of fun. It feels nice meeting colleagues from other schools.

Q: Do you talk about sex during such outings

P5:   What do you mean? (Appearing shocked, followed by a prolonged laughter from other group members). Yes, obviously. If anything, the reason we want to be out of class is for us to get time to talk about these things when we are far away from our teachers.

P4:   And many of us negotiate for sexual favors during such times. I can tell you….this is always a major engagement ….negotiating. Whether one ends up having sex or not, I may not say now.

P8:   Extracurricular activities afford us time to learn a lot from friends, teachers and at times our parents. If anyone wanted to make a case for HIV and AIDS education to students, such forums are ideal.

Within the discourse of HIV and AIDS knowledge, information about self-protection from the key informants and the focus group discussions complemented the findings of the survey about self-protection against HIV infection. Both data indicated that most young people did not bother with self-protection against possible HIV infection, even when they knew the risks of unprotected sex.

CHAPTER FIVE

INTERPERSONAL COMMUNICATION FOR BEHAVIOR CHANGE

5.0 Introduction

Communication is the transmission of meaning from one person to another or to many people, whether verbally or nonverbally. Communication from one person to another is commonly depicted as a simple triangle consisting of the context, the sender, the message, and the receiver (Barrett, 2006). The success of communication depends on several factors. Transmission of the message by the process of encoding and decoding the message, which may result in short term-term perception, is not adequate for adequate for success of communication. Communication should be in such a way that it will give opportunity for the respondent or receiver to take decision with regard to the message perceived (Master, 2008).

5.1 Role of Interpersonal Communication

Papa & Singhal (2008) pointed out that programs that spark interpersonal discussion are more likely to promote behavioral change. This relationship has been especially relevant when considering discussion of sensitive or taboo subjects such as HIV and AIDS. When interpersonal discussion occurs, it can substantially influence subsequent behavior. A study carried out in Tanzania about the role of interpersonal communication in promoting behavioral change showed that exposure and interpersonal communications were associated with behavior change (Singhal, 1999). According to Papa et al. (2000),

conversations about educational content of a media program can create a socially constructed learning environment in which people evaluate previously held ideas, consider options, and identify steps to initiate social change.

The importance of interpersonal communication is consistent with Bandura's assertion that, in addition to direct effects, the media can also influence audiences indirectly, through a socially mediated pathway in which interpersonal communication can promote knowledge, change attitudes, and guide behavior. Interpersonal discussions can also serve to reinforce the E-E messages (Bandura, 2004).

Interpersonal communication on the role of the media in HIV and AIDS preventive campaigns were common in all discussions. Participants recognized the importance of communicating HIV and AIDS preventive information through the media. However, media campaigns were often objects of a blaming discourse. Participants thought the campaigns were responsible for shaping people's attitudes and for constructing the "face of HIV and AIDS." They also noted that the media contributed to the representation of HIV and AIDS by assuming specific contents or communication styles in their messages, or even by the frequency with which they broadcast a preventive message. The media were also considered a source of misconceptions and prejudices about HIV and AIDS:

P1: I think there are many misconceptions and prejudices about this disease.

P2: For me, the media keeps associating AIDS with mostly drug users

P3: I expect to see people like myself on television talking about AIDS. I want to identify with someone my age, possibly a student like me.

P5: If the media would involve young people who suffer from with AIDS that would be good. We need the truth to be told. We need evidence.

P7: Media campaigns don't speak the language of young people.

P8: Show us messages that we can identify with while we are school. Bring them on and infuse them in our day-to-day activities, for example, in drama, in music festival, among others. Only then will we begin to own them.

Kiai, et al. (2004) point out that effective communication for the youth such as behavior and attitude change was necessary if HIV and AIDS campaign activities were to achieve the desired results. The scholars observe that young people should be understood through the leisure activities that they pursue, their media preferences and their common language. Nzioka (2004) suggested that social responses to AIDS were still fearful, moralistic and emotive. He said that this aspect had to be dealt with if youth-based HIV and AIDS communication strategies were to be successful.

Table 5.1 below shows majority of the respondents (85.6 percent) had received information about HIV and AIDS. Only 14.4 percent said they had not received the information.

Table 5.1: Information about HIV and AIDS

Received information about HIV and AIDS	n	%
Yes	291	85.6
No	49	14.4
Total	340	100.0

Source: Researcher 2011

During the focus group discussions, participants said that they were aware of HIV and AIDS preventive media campaigns. They said that they were aware of the campaigns and that many were run through media such as Radio, Television, and newspapers. However, most participants agreed that these campaigns were not as influential as they expected them to be:

P1:   We receive information about HIV and AIDS mostly from television and radio

Q: Do you have television and radio in your school?

P2:   We have a television set in the dining hall

Q: And radio?

P3:   No. We listen to radio in public service vehicles, at home and from our mobile phones.

P4:   We also read newspapers found in the library

Q: Any other source of information about HIV and AIDS?

P5:   May be from the AIDS education syllabus, but it is scanty

P: For me, I would say that this information is all over the place, but who cares? Very few of us, me included, take note of them or regard them seriously anyway.

Q: Why don't you take the information seriously?

P8:   Campaigns that are broadcast too often risk losing public attention. They become boring.

During the focus group discussions, participants said that they only talked in general terms about the mass media campaigns on HIV and AIDS without mentioning any details. This lack of interpersonal exchange about mass media campaigns may be based on the limited memory of preventive initiatives and, thus, of the campaigns' low efficacy in changing the youth's attitudes and behaviors towards HIV and AIDS.

When the respondents were asked to rate how informative HIV and AIDS media campaigns were, 73.8 percent said they were not very informative, while 17.9 percent rated them as very informative. The majority of the respondents were of the view that HIV and AIDS were not very useful to them. Another 8.2 percent of the respondents said the media campaigns were not informative at all. These findings are shown on Table 5.2 below.

Table 5.2: Opinion on the current HIV and AIDS media campaigns

HIV and AIDS media campaigns	n	%
Very informative	61	17.9
Not very informative	251	73.8
Not informative at all	28	8.2
Total	340	100.0

Source: Researcher 2011

Participants in the focus group discussions observed that HIV and AIDS media campaign messages were making very little impact, if any. According to them, young people continued to involve themselves in sex indiscriminately, in spite of the information being passed across through these media campaigns. They took issue with the timings of the campaigns. A number of the campaigns were aired at a time when the students were in class. One focus group participant, a 16 year old form three girl summed it up thus:

"Our class schedules are tight. We have very limited time to watch television. We don't even listen to radio. Only during weekends do we afford some time to watch television, but when we do that, our interest is mostly entertainment. We want to watch movies, soaps or listen to music. You can see therefore that such chances may not afford us much time to follow these campaigns."

Her colleague, 17, in form three and also the prefect in charge of entertainment in her school supported her:

"Media messages should be tailored to target the youth. They must also use the language of the youth like sheng. The timings are also critical because they should target the youth when they are available, particularly during holidays or weekends."

In addition to radio and television, key informants were of the view that HIV and AIDS messages could be passed across to the youth through drama, plays, skits and songs, among others. This observation was made by a 42 year old male senior principal, who said he was very passionate about the welfare of his students. He argued that HIV and AIDS messages could only have an impact if the campaign planners involved the youth in the entire preparation process of the campaign. This would make them own the campaigns and also identify with them.

The informant talked of composing poems about HIV and AIDS messages, which could be recited during schools' drama festivals, or during school functions such as prize giving days, sports days, and thanks giving days, among others:

> *"Young people love entertainment. The Kenya Institute of Education can make movies that not only entertain but also educate. This is called edutainment and it is a powerful way of communicating with students. There is need to take advantage of the wave brought about by Nigerian movies and create our own movies that have HIV and AIDS information. In addition, KIE can also come up with set books for HIV and AIDS messages. Such books would be used in school as class readers and a lot of information about HIV can ultimately be passed across to the students.*
>
> *By the way, HIV and AIDS education should be taught separately from other subjects and made examinable. By so doing, students will take the contents therein seriously. In addition, let us have posters put up on our notice boards where our students can access them, read and internalize information about HIV and AIDS. Students too love music and poems. We should allow them to write such. Poems should not be written by teachers. We need to allow students to do that...as one way of involving them. If we do this, I can tell you the perception towards HIV and AIDS media messages will change."*

This observation about entertainment supported Singhal & Rogers (2002) who said that entertainment –education (EE) had been found effective in motivating individuals to talk to each other about what they learned from E-E messages. The scholars also said that E-E messages enabled individuals in what they called socially supportive behavior change. In their earlier work, Singhal & Rogers (1999:144) suggested that "entertainment – education has certain effects as a catalyst for triggering interpersonal peer communication leading to changes in the social discourse of the audience."

When respondents were asked to name their most memorable HIV and AIDS media campaign, the majority of the respondents (68.3 percent) named *Nimechill* campaign. This was followed by *Nakufeel* at 15.9 percent and then *Mpango wa Kando* was third with 14.4 percent. The results are shown in Table 5.3 below.

Table 5.3: Most memorable HIV and AIDS media campaign

HIV and AIDS Media campaigns	n	%
Nimechill	232	68.3
Nakufeel	54	15.9
Mpango wa kando	49	14.4
No response	5	1.5
Total	340	100.0

Source: Researcher 2011

During one of the focus group discussions, participants were of the opinion that the sign used in the *Nimechill* campaign to symbolize "not having sex" was not appropriate. They observed if "chilling" was to mean "not having sex", then the symbol should have been made using a clenched fist but not open fingers.

> "How can you use an open-finger symbol to show that you are not having sex? It's a contradiction. The symbol should be made using closed fingers. As it is now, young people interpret it to mean 'opening up'."

Table 5.4 below shows what students disliked most about the HIV and AIDS media campaigns. The majority of the respondents (56.5 percent) said that they disliked the campaigns because young people had not been involved in the planning, design and dissemination of the campaigns. Another 25 percent of the respondents disliked the language used in the campaigns. 15.9 percent of the respondents disliked the lack of clarity in the messages. Only 1.8 percent disliked the medium used to convey the messages.

Table 5.4: What students disliked most about the campaigns

Most disliked aspect of the campaigns	n	%
The language used	85	25.0
Failure to involve young people	192	56.5
Lack of clarity in the messages	54	15.9
The medium used	6	1.8
No response	3	.9
Total	340	100.0

Source: Researcher 2011

This finding was supported the work of Govender (2010) who observed that HIV and AIDS messages that were created by 'experts' and then transmitted to the audience in a one-way, linear manner were likely to fail. During a study conducted at the University of KwaZulu-Natal in South Africa, students were asked their perceptions of South Africa's Abstinence, Be Faithful, and Condomize (ABC) Campaign. Ninety-one percent suggested the importance of young people being active participants in HIV and AIDS communication (Govender, 2010).

The students did not support or relate to the ABC campaign because they believed that it was contradictory and that its confusing messages stemmed from a failure to have engaged or consulted with them as the target audience. Govender suggested that instead of top-down behavior change communication, more participatory approaches were needed.

Graffigna & Olson (2009) suggested that effective campaigns were those that targeted specific audiences. Among young people, such campaigns would often focus on young people's main problems, sex-related issues included, and they suggest how these problems might be negotiated in interpersonal exchanges. The scholars observed that effective campaigns must speak the language of young people and be perceived to be "close" to their experiences, concretely reflecting young adults' daily problems (Graffigna & Olson, 2009).

When respondents were asked if HIV and AIDS messages had influenced their sexual behavior, 81.1 percent of them disagreed while 18.9 said there was influence on behavior. Table 5.5 below shows these results.

Table 5.5: Whether HIV and AIDS messages influenced the students' sexual behavior

Influence on sexual behavior	n	%
Yes	64	18.9
No	276	81.1
Total	340	100.0

Source: Researcher 2011

The discourse of media influence was often scanty. Little attention was paid to preventive campaigns. There was lack of interest on the part of the participants and their rejection of the information, produced by the perceived distance of the campaigns from them, making it difficult for preventive information to become part of the young people's interpersonal exchanges or even influence their sexual behavior.

Particularly interesting in this regard was the fact that the participants talked only in general terms of mass media campaigns about HIV and AIDS, without mentioning any details. The lack of interpersonal exchange about mass media campaigns might have been based on limited memory of preventive initiatives and, thus, of campaigns' low efficacy in changing youths' attitudes toward the HIV and AIDS:

P1: I think we need shows where all the topics discussed identify with the youth in their everyday situations. We can relate to something like that

P2: Shows that look at the problems and challenges of young people are popular with the youth. That's what we need, nothing else.

P6: I tell you, movies and testimonials by celebrities can have considerable impact.

In his characteristic passion and finality, the 42 year old male senior principal summed it up thus:

> "I appeal to all students to choose carefully the company they keep. The people they relate with influence them most of the time. Peers dictate our lifestyles – our dressing, the mannerisms, the content our talk, the people we interact with, who to go out with, among other things. This is peer pressure, and unless young people get their priorities right, they will always give in to it. Young people should get mentors and role models whose character is beyond reproach and they should endeavor to live up to this character. This is why I always say that if you show me your friends, then I will tell you your character.
>
> I think, also, that TV series that are objects of young people's discourses (topics of conversation) are likely to increase the possibility that a preventive message will be discussed and "metablized" in their interpersonal exchanges. I believe these interpersonal exchanges among the youth are key to behavior change."

These observations are supported by Solomon (1989) who posits that for behavior change to occur, dissemination of right information through the right media is vital. He says that for a health message to be effective in

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changing behavior, it should be targeted to a specific group rather than a general audience. The importance of this lies in the fact that for communication to be effective, right messages must be passed through the right channels, to the right audience at an appropriate time.

In a study carried out by Joram (2010) about the effectiveness of interpersonal communication for HIV and AIDS, the mass media were found to be less communicative compared to interpersonal communication. Further, traditional media such as drama, songs and locally produced drama were found to more popular with people. According to Lie (2008), the mass media may be important in raising a general awareness, but are less effective in actually bringing about behavioral change. Rather than simply mass media, forms of interpersonal interaction are seen as the most effective means of creating preventive consciousness (Lie, 2008).

Media campaigns and interpersonal communication complement each other in the development of communication interventions for HIV and AIDS prevention and care. When the mass media convey information, interpersonal communication can provide effective face-to-face support. The combination of mass media with interpersonal communication allows the addressing of diverse individual and group concerns while honoring the delicate private nature of human sexuality.

5.2 Discussion of results

Despite the high awareness of the specific ways in which HIV and AIDS is transmitted and how it can be prevented, AIDS is still treated with fear and carries many negative symbolic and sexual meanings. It is the social meanings of HIV and AIDS which have made the communication of HIV and AIDS media messages among the youth a challenge for those involved in interventions.

The study found that students engaged themselves in conversations which contributed to their understanding of HIV and AIDS. These interpersonal exchanges led to acquisition of lay knowledge about HIV and AIDS epidemic and its resulting consequences. Majority (98.8 percent) of the respondents in this study knew about HIV and AIDS and its ways of transmission. This finding is consistent with the literature reviewed.

This study has shown that in the face of significant risk of contracting HIV and AIDS among sexually active students, the practice of preventive behaviors was still low. For example, 80.9 percent of the respondents reported that they did not use a condom in their last sexual intercourse. This was in spite of the knowledge of preventive value of condoms being at 89.1 percent. It may therefore necessary to build on this knowledge among the youth; that the disease is real and dispel any counterproductive information generated from other discourses. In turn,

this will help to encourage behavior that can reduce personal risk and further spread of the disease.

The literature reviewed demonstrates that there is need to seek other innovative ways of addressing HIV and AIDS prevention among the youth. Kiai (2009) and Govender (2010) have proposed, for example, that parents should act as role models to their children as they discuss matters of sexuality with them. These scholars suggest also that for HIV and AIDS communication to be effective, issues of societal norms and values must be fully addressed.

Discourse on HIV in many countries has revolved around the fact that most communication models have proved insufficient in addressing HIV and AIDS, and that long-term social change is vital in effectively addressing the epidemic (Kiai, 2009). This study has shown that there is need for HIV and AIDS communication interventions that are consistent with the unique mannerisms and lifestyles of young people. This has found that forms of interpersonal interaction are the most effective means of creating preventive consciousness.

As the study found out, majority of the respondents (60.9 percent) did not perceive themselves to be at risk of HIV infection, because, as they argued, they usually had sex with their friends whom they trusted and believed to be healthy. As indicated in the literature, many approaches to managing HIV and AIDS fail to consider the evidence that risk perception

is culturally influenced and therefore risky behavior is a social rather than an individual issue (Tsasis & Nirupama, 2008). The scholars suggest that it is wrong therefore to assume that decision-making and behavior are always rational. This study found out that social factors such as relationships have a major impact on behavior, and at times may prevent individuals from adopting safe sex practices that prevent HIV and AIDS transmission.

An important factor emerging from many studies in the African context is the need to take into consideration local African cultural values and practices. Communication initiatives have a chance of succeeding only when situated within the cultural and social context of the target audience (UNAIDS, 2010). Early HIV and AIDS initiatives failed in the African context since they were created for a Western context, where individualism instead of community orientation was favored (Airhihenbuwa and Obregon, 2006). Similarly, Kunda and Tomaselli (2009:5) reiterate that "effective health communication interventions depend on understanding the knowledge, attitudes and practices of people from given cultural vistas."

This study supports Mulwo and Tomaselli (2009) who observed that HIV and AIDS programs focused on the individual as an agent of change and therefore failed to critically address the social, cultural and economic conditions that may inhibit the ability to carry out certain decisions at individual level. They further say that human sexuality should be

understood as a social construction that needs to be analyzed within a broader context in which it is practiced. Other scholars such as Nzioka (1994) agree with them.

In Kenya, numerous HIV and AIDS education and prevention programs that target young people exist (NACC, 2008; KHDS, 2008-9). In spite of these efforts, there are important gaps in HIV and AIDS prevention methods and how that knowledge is used. Thus, more audience sensitive prevention programs may be needed which, not only increase young people's knowledge about HIV and AIDS prevention, but also assist them in acting upon that knowledge.

It is important to understand young people through the leisure activities that they pursue, including fun activities indulge in, their media preferences, their common language among youth and their views on sexuality. Others include music tastes, leisure time activities, language and fashion.

Kiai et al. (2004) suggest the need to understand the needs and motivations of young people, including their hopes, dreams and aspirations. Other factors to consider are their media preferences, their common language, music tastes, and fashion, among others.

Respondents in this study supported strongly the use of edutainment in HIV and AIDS communication. This finding is supported by Chesser

(2010) who said that through the use of films supported by curriculum components, young people's awareness of positive health behaviors were found to increase. If the intervention strategy uses clear, simple messages, with characters that the audience can relate to, then edutainment can increase awareness of values (such as self control, responsibility) and teach young people better behaviors which can affect health status. Bandura (1986) posits that individuals can learn by observing and imitating or modeling others in real life or drama (television). By allowing students to observe others (film characters), models positive behaviors, they are exposed to new guides for action.

This study also confirmed the observations made in the HIV and AIDS Youth Strategy (NACC, 2008) that there was disconnect between media interventions and young people. The mass media were perceived as portraying young people negatively, as a group to be feared and their sexuality issues treated as a problem.

The study found that the mass media can raise awareness of specific facts because they are assumed to carry a certain authority and reliability. However, later on in the process, target populations appear less interested in media authority than they are in the opinions and behaviors of people to whom they feel close to. In this case, interpersonal communication becomes primary while the mass media play a supporting role.

This study underscores the importance of continuing to assess knowledge about HIV and AIDS among the Kenyan youth, and sheds new light on the importance of interpersonal communication to the process by which young people learn about HIV and AIDS and use that knowledge in relation to their perception of risk and behavior. HIV and AIDS programs must be culturally appropriate and work toward influencing risk perception, while addressing social norms and values that negatively impact vulnerable populations. By impacting cultural and social expectations, individuals will be able to more readily adopt safer sex behaviors. The development of policies and programs addressing the issues in context, as opposed to individual behaviors alone, allows for effective public health intervention.

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter contains a summary of key findings from the study, a conclusion drawn from the study findings and recommendations based on the objectives of the study.

6.1 Summary of key findings

6.1.1 Assessment of HIV and AIDS knowledge

The findings of this study show that majority of the youth (98.8 percent) had knowledge about HIV and AIDS. This knowledge was about the meaning of HIV and AIDS, its methods of transmission, and whether it was curable.

This study found that students talked about sex and HIV and AIDS. In the course of their discussions, they created their own meanings of HIV and AIDS. They used metaphors and forms of figurative language to refer to HIV and AIDS as a disease or to refer to those who were already infected with HIV virus. HIV and AIDS were defined as "huge," "terrible," "horrible," "sad," and a "big deal." These terms used to describe HIV and AIDS denote the relevance of this problem for interviewees and its emotional connotation (mainly negative feelings). The link between HIV and AIDS, and death stood out.

The study found that young people relied on common stock of knowledge rooted within existing institutions, every day language, shared meanings and understandings to make decisions affecting them.

The study also found out that HIV and AIDS was often the object of an interpersonal reframing discourse. Quite often, the relevance of the disease was discussed by comparing it with other diseases or social problems that present some of its key features. It is interesting to notice that this discursive construction of HIV and AIDS allowed participants to reframe the problem and thus moderate both its gravity and its relevance.

The students expressed their fears and concerns about the kind of information they were getting out of their discourses with friends. It is these discourses that generated lay knowledge which young people relied on in their decision making efforts. At times this knowledge did not seem to assist the youth in making right decisions about their health.

During the focus group discussions, the lack of a cure for HIV was seen by the participants as the most dramatic aspect of this disease. This made it extremely frightening. Death at a young age was considered abnormal, and it is something that interviewees preferred not to think about. They said they were 'scared to death' of getting AIDS.

6.2.2 Perceptions of HIV and AIDS risk among the youth

The study found out that 60.9 percent of the respondents did not perceive themselves to be at risk of HIV infection. Lack of risk perception is corroborated by Tsasis & Nirupama (2008) who suggested that one's inability to accept reality of risks was caused by the society in which they lived. Thus, understanding the way perception of risk is shaped and constructed is crucial in identifying why it is has been difficult to mitigate the spread of HIV and AIDS (Tsasis & Nirupama, 2008).

The study found that students reacted to HIV risk by simply denying its existence and considering themselves not at risk. They called this 'it-cannot-happen-to-me" syndrome which seemed very common in social circles. One of the shared thinking among many youth about HIV and AIDS was that it was a normal disease just like malaria.

The study established that students entertained a sort of denying discourse in which HIV and AIDS, earlier seen as a "big deal", was now transformed to a "nonissue" that was not worthy of being considered in one's daily life. This is an extremely interesting paradox. The students argued that since it was not easy to cope with such a terrible disease, the psychosocial strategy for facing HIV and AIDS was to deny its relevance in their daily lives.

The findings also corroborated the Kenya National HIV and AIDS Communication Strategy for Youth which showed that majority of the youth had heard about AIDS but many of them still did not perceive themselves to be at risk of HIV infection (NACC, 2008). The study found that information about HIV and AIDS alone did not lead to adoption of safer sexual behaviors.

An important finding shared by the key informants and participants in focus group discussions was that students had continued to defer to their lay knowledge about HIV and AIDS as generated from their social interactions and interpersonal communication networks to make decisions about sex. It is this socially constructed knowledge which they relied on to assign meanings to HIV communication.

Another important finding was that most female students make decisions about sex based on fear and not knowledge. For example, girls were found to abstain from sex simply because they feared falling pregnant but not because they had sufficient information about HIV and AIDS. Owing to peer pressure, the students said that they found it quite difficult to resist the temptation to engage in casual sex with their friends, the dangers of these behaviors notwithstanding.

6.2.3 Knowledge of HIV and AIDS and the youth's self-protection against possible HIV infection

The study found that 80.9 percent of the students did not use a condom the last time they had sex. This response shows a very low risk perception. This finding supported Nzioka (2004) who suggested that unprotected sex was still a common feature among young people in spite of the high levels of knowledge concerning the protective value of condoms and other contraceptives.

Students pointed out that they did not perceive long – term relationships as risky and thus using condoms seemed unnecessary. Moreover, participants said that asking a long – term partner to wear a condom would imply not trusting his or her commitment to the relationship and fidelity.

The decision to have sex with a new partner was often contemplated seriously and was based on the individual's perceived honesty and reliability. Students observed that asking a new partner to use a condom would mean not being totally confident in the correctness of the partner's previous behavior. The study found that in particular, girls declared their shyness in negotiating condom use and their concern about meanings implied by this request.

The discourse of birth control pills also came to the fore. The youth observed that preventing unwanted pregnancies was their main concern. This perception tended to lessen the relevance and urgency of HIV and AIDS prevention in their sexual relationships. Since young people's main preventive concern in relation to sexual activity was avoiding unplanned pregnancies (rather than preventing HIV and AIDS), girls who were using birth control pills felt protected and were not concerned about the risk of HIV and AIDS.

However, the respondents stated that owing to the influence and pressure from their friends, it was hard to practice abstinence. They said that only those who had not involved themselves in sexual relations could be encouraged to abstain, if that were possible.

Students said that HIV and AIDS were not easy to talk about given the social taboo surrounding its main method of transmission: sexual intercourse. Participants referred to the difficulty of talking openly about sex and sex-related topics with friends. In a conservative culture such as that of Africa, sex before marriage is not accepted, and sexually active unmarried youth are always part of a blaming discourse especially by adults. This observation supported the UNFPA report (2008) which stressed the fact that discussing sex was taboo in many countries, and this denied a large number of people especially the 15 – 19 age group the necessary information to negotiate for safe sex (UNFPA, 2008).

The report supported the need to develop a culturally sensitive educational intervention program. It was found that talking about HIV and sex was considered embarrassing. Participants noted that talking about HIV and AIDS among friends was unusual, not because of its link with sex but because it was perceived to be too "boring" and "sad" to discuss. Furthermore, participants categorized sexual relationships as acceptable or promiscuous. Among those in acceptable relationships, the participants considered themselves not at risk. The only sexual relationships that the youth viewed as risky were the same-sex relationships and casual intercourse.

The study found that most young people did not bother with self-protection against possible HIV infection, even when they knew the risks of unprotected sex.

6.2.4 HIV and AIDS communication for behavior change

This study found out that the discourse of media influence was often scanty. Students paid little attention to media preventive campaigns. There was lack of interest on the part of the participants and their rejection of the information produced by the perceived distance of the campaigns from them. This may cause difficulties for preventive information to become part of the young people's interpersonal exchanges or even influence their sexual behavior.

The study also found out that interviewees talked about HIV and AIDS media campaigns only in general terms without mentioning any details. This lack of interpersonal exchange about mass media campaigns might be based on the limited memory of preventive initiatives and, thus, of campaigns low efficacy in changing the youth's attitudes and behaviors towards HIV and AIDS.

The study also found out that according to the students, HIV and AIDS media campaign messages were making very little impact, if any. 73.8 percent of them said the campaigns were not very informative. According to them, young people continued to involve themselves in sex indiscriminately, in spite of the information being passed across through these media campaigns.

Students in FGDs and key informants argued that HIV and AIDS messages could only have an impact if the campaign planners involved the youth in the entire preparation process of the campaign. This would make them own the campaigns and also identify with them. They argued in support of various forms of edutainment which would ensure youth involvement and ownership. This observation about entertainment supported Singhal & Rogers (2002) who said that entertainment – education (EE) had been found effective in motivating individuals to talk to each other about what they learned from E-E messages.

The scholars also said that E-E messages enabled individuals in what they called socially supportive behavior change. In their earlier work, Singhal & Rogers (1999:144) suggested that "entertainment – education has certain effects as a catalyst for triggering interpersonal peer communication leading to changes in the social discourse of the audience."

The study found that students disliked HIV and AIDS messages because they were created by 'experts' and then transmitted to the audience in a one-way, linear manner. Such messages were likely to fail. The students supported strongly the importance of young people being active participants in HIV and AIDS communication. Campaign planners always failed to engage or consult their target audience, the youth in this case.

An important finding of the study was that campaigns should always focus on the young people's main problems, sex-related issues included, and suggest how these problems might be negotiated in interpersonal exchanges. Effective campaigns must speak the language of young people and be perceived to be "close" to their experiences, concretely reflecting young adults' daily problems. The study found that embedding media in interpersonal relations made the media much more effective. In other words, if edutainment approaches are to be used in behavior change communication, they should be closely integrated with other youth

activities and also with the interpersonal communication process (Tufte, 2008; Joram, 2010).

The study found out that there was no relationship between knowledge of HIV and AIDS and the sexual behaviors of the youth. Knowledge acquired from the mass media such as radio and television did not seem to influence young people either to abstain or use condoms. Young people continue to engage themselves in risky sexual relations.

The study also established that meanings and interpretations that the youth held about HIV and AIDS were generated from their interpersonal communication exchanges with their peers.

6.3 Conclusions

6.3.1 The primacy of Interpersonal Communication

HIV and AIDS did not seem to be real issues for the youth, at least not in their daily lives. Participants in the focus group discussions acknowledged the relevance of this epidemic but did not consider it as a concrete danger for them and their social groups. They all defined HIV and AIDS as a stigmatizing problem, represented as "someone else's" disease that was contracted by individuals who were "wrong" and who did not behave correctly. This discourse of fault and individual responsibility led to the belief that HIV risk was something far from oneself and a feeling of not being personally at risk (the "it-cannot-happen-to-me" discourse).

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The perception of the participants was that HIV and AIDS were linked to death, and this provoked fear and refusal to think about the problem. HIV and AIDS were discussed (though not easily) because of the social taboos surrounding sex-related issues. In the course of interpersonal exchanges, HIV and AIDS were transformed from being a "big deal" to being a "non-issue" through a psychosocial denying discourse. HIV and AIDS seemed to be something not really worth thinking about or mentioning in daily life.

This psychosocial denial process is extremely important because it fosters some sort of mass media blackout, for at least two main reasons. First, because young people consider themselves not to be at risk, they pay little attention to media campaigns about HIV and AIDS. Second, because HIV and AIDS is not an easy or interesting matter to discuss, it is unlikely that a preventive campaign would become an object of interpersonal exchange, and this diminishes its (campaign) effectiveness in changing people's attitudes and behaviors.

The findings of this study also suggest that HIV and AIDS preventive behaviors are not only the outcome of an individual decision but are also the result of an interpersonal regulation process. The results presented in this study testify to the importance of interpersonal exchange in mediating mass media campaigns' influences on people's attitudes and beliefs. The findings show that this is a complex process and that multiple factors are involved, enhancing or blocking young people's

exchanges about preventive messages. In this regard, media campaigns like *Nimechill* that are popular and already objects of young adults' exchanges could be powerful channels for broadcasting a preventive message because they have a greater chance of becoming part of youth's discourses.

This study holds that inclusive processes need to be implemented in such a way that lay discourses about HIV and AIDS are researched, analyzed and internalized into HIV control and mitigation programs, otherwise preventive campaigns will continue to record minimal achievements. Forms of interpersonal interaction have also been found to be the most effective means of creating HIV and AIDS preventive consciousness and need to be considered (Joram, 2010).

The impact of dominant social discourses on the norms and values which influence adolescent behaviors have to be grasped in order to move understanding of sexual decision-making away from models that suggest rationality based on knowledge (MacPhail, 1998). Research in this country should be moved towards understanding of adolescent sexuality for the two reasons: First, the importance of norms, values and entrenched social beliefs provide some answers for the failure of existing HIV interventions. Second, future interventions are likely to benefit from an understanding of the complexities facing the youth in the decisions which govern their sexual lives.

An important contribution of this study, in addition to analyzing the role played by interpersonal communication in influencing behavior change, was to develop further the methodology for analyzing youth involvement in HIV and AIDS communication for behavior change. By combining quantitative and qualitative methods of data collection and the triangulation of data during analysis, this study has managed to get under the surface of figures and numbers of the otherwise most commonly used quantitative analysis. Through the extensive quoting of views of the focus groups participants and key informants, this study has given voice to the growing youth of this country that have the potential to engage in our country's development challenges. This is a group of young people that have expressed their interest and willingness to contribute to social change.

The findings have demonstrated the ability of young people to establish an interpersonal dialogue with their peers. Such interpersonal dialogues can be used to encourage their colleagues to abstain from risky sexual relations and if possible, give them hope and the desire to adapt one's life to positive circumstances. The findings also showed that interpersonal relations of friendship, respect and commitment were of crucial importance.

In addition, this study has contributed to literature that emphasizes the role of interpersonal communication in HIV and AIDS behavior change. The findings demonstrate that effective communication in HIV and AIDS

is more complex than simply talking to the youth about abstinence and faithfulness which are the key issues in HIV and AIDS communication messages.

This study underscores the importance of continuing to assess knowledge about HIV and AIDS among Kenyan youth and sheds new light on the importance of interpersonal communication as a process by which young people can learn more about HIV and AIDS and use that knowledge for behavioral response.

6.4 Recommendations

Based on the findings of this study, the following policy recommendations are made:

(i) There is need for edutainment programs. The success of entertainment-education in mixing production soap opera formats with subject matter based on the realities, needs and passions of audiences facing HIV and AIDS are evident in South Africa, India, Tanzania and other countries (Singhal & Rogers, 2006). Since young people love movies as a form of entertainment, HIV and AIDS messages should be incorporated in these movies. Tufte et al. (2010) suggests that E-E programs often lead to discussions about programs and their educational themes among peers and in their communities. A study carried

out by Chesser (2010) among secondary school students in South Africa suggests teenagers are interested in participating in learning environments which include entertainment (i.e. films).

(ii)   As much as possible, edutainment approaches should be closely integrated with various youth activities and with the interpersonal communication processes where meaning is constructed by all those participating.

(iii)   The Kenya Institute of Education should introduce books specifically written for HIV and AIDS syllabus. Such books could be used as reference texts for HIV and AIDS teaching. Presently, KIE has only one resource text for teaching HIV and AIDS. This is "Bloom or Doom: Your Choice, an AIDS Resource Book for Youth in and out of Secondary schools.

(iv)   Young people are not adequately involved in the planning, design, implementation and evaluation of communication interventions that target them. There is need to involve the youth in the design and dissemination of HIV and AIDS messages. Furthermore, because of lack of engagement of the youth in health communication messages, retention of knowledge is minimal and this leads to lack of acceptance of the message. It is important to listen to what young people think

and believe in order to ensure acceptable and appropriate interventions.

The participation of students in HIV and AIDS campaigns can be ensured by involving them in the writing poems, plays or skits with HIV and AIDS messages. Here, the students may have the opportunity to enact their own feelings and by extension, own the process of developing HIV and AIDS media messages. This can be done during the schools and colleges drama festivals held every year.

(v) The Ministry of Education should make HIV and AIDS education syllabus examinable like other subjects. It is not enough to teach HIV and AIDS as an integrated subject. Making it a stand-alone subject will demonstrate the seriousness of the content therein. There is need therefore to revise the HIV and AIDS curriculum with a view to meeting student's needs. It should focus more on life skills such as decision – making and interpreting social settings.

Adopting these recommendations may require enormous resources and the commitment of the political class. However, investments made at this time to match the scope of the problem will cost less compared to later.

6.4.1 Recommendations for further research

This study presents a number of possibilities for future research as indicated below:

(i) There is need to carry out further research to establish how extensive interpersonal networks are among the youth and how these networks impact on their behavior.

(ii) Since this study was limited to public secondary schools in Nairobi, there is need for a comparative study to be conducted in schools in rural areas. Future studies could also be conducted in private secondary schools.

(iii) The findings also confirm the relevance of studying young people's discourses and interpersonal communications on HIV and AIDS in other parts of this country so as to cast light on how health knowledge may be translated into safe practices, and also to find out the conditions that could promote preventive behavior.

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CONSENT FORM

My name is Ndeti Ndati. I am a PhD student in Communication and Information Studies at the University of Nairobi. I am collecting data for my Dissertation titled: The role of interpersonal communication in influencing behavioral responses to HIV and AIDS prevention among the youth. I kindly request you to participate in this study. The exercise will take 30 minutes of your time.

The information that you provide during the study will be kept confidential. By participating in this study and answering the questions, you will help to increase my understanding of the needs of young people in terms of sexual health and HIV and AIDS communication.

Your participation in this study is voluntary and you have the right to refuse to participate or answer any questions that you feel uncomfortable with. If you change your mind about participating during the course of the study, you have the right to withdraw at any time.

Declaration of the respondent

I have understood the purpose of this study and therefore consent voluntarily to participate as a respondent.

Signature of the respondent: --

Date: --

APPENDIX 2

SURVEY QUESTIONNAIRE

SECTION I: SOCIO-DEMOGRAPHIC INFORMATION

N°	QUESTIONS	ANSWERS	SKIP
101.	Sex of the respondent	01 = Male 02 = Female __||__	If NO, go to 205
102.	How old are you?	Record number of years 99 = Don't Know __|__	
103.	What is your religion?	01 = Catholic 02 = Protestant __||__ 03 = Muslim 04 = Other (Specify) _____ 98 = No answer 99 = Don't know	
104.	In which class are you?	01= Form one 02 = Form Two 03 = Form three __||__ 04 = Form four 98 = No answer	

SECTION 2: ASSESSMENT OF HIV AND AIDS KNOWLEDGE AMONG THE YOUTH

N°	QUESTIONS	ANSWERS	SKIP
201	Have you ever heard of HIV/AIDS?	01 = Yes 02 = No __||__ 98 = No answer 99 = Don't know	If NO, go 203
202	Do you think AIDS is curable?	01 = Yes 02 = No __||__ 98 = No answer 99 = Don't know	
203	Do you know how HIV is transmitted?	01 = Yes 02 = No __||__ 98 = No answer 99 = Don't know	If NO, go to 205
204	How is HIV transmitted?	01 = Through mosquito bites 02 = Through kissing 03 = Through sexual intercourse __||__ 04 = Through handshake 05 = Through sharing food 06 = Other (specify) _____ 98 = No answer 99 = Don't know	

N°	QUESTIONS	ANSWERS	SKIP
205	What are the chances that you might get infected with HIV?	01 = High chance 02 = Moderate chance |__|__| 03 = Small chance 04 = No chance 04 = Already infected with HIV 98 = No answer 99 = Don't know	
206	Is there anything you can do to avoid getting AIDS?	01 = Yes |__||__| 02 =No 98 = No answer 99 = Don't know	If NO, go to 208
207	If yes above, what can you do?	01 = Avoid sex completely 02 = Stay faithful to one partner 03 = Use condoms during sexual intercourse 04 = Avoid sharing needles |__||__| 05 = Avoid commercial sex workers 06 = Avoid casual sex 07 = Avoid sharing needles 98 = No answer 99 = Don't know	
208	Can you get infected with HIV through a mosquito bite?	01 = Yes 02 = No |__||__| 98 = No answer 99 = Don't know	
209	Is it possible for a healthy-looking person to have HIV, the virus that causes AIDS?	01 = Yes |__|__| 02 = No 98 = No answer 99 = Don't know	
210	How would you rate your knowledge of HIV/AIDS?	01 = Very good |__|__| 02 = Fairly good 03 = Not good 04 = Poor	

SECTION 3: PERCEPTIONS OF HIV AND AIDS RISKS AMONG THE YOUTH

N°	QUESTIONS	ANSWERS	SKIP
301.	Do you perceive yourself to be at risk of HIV infection?	01 = Yes 02 = No |__||__| 98 = No answer 99 = Don't know	If YES, go to 303
302	If no above, why?	01 = I abstain |__|__| 02 = I use condoms 03 = I am faithful to my partner 04 = I have sex with my friends only 98 = No answer 99 = Don't know	

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N°	QUESTIONS	ANSWERS	SKIP
303	Do your school mates have sexual partners?	01 = Yes 02 = No |__||__| 98 = No answer 99 = Don't know	If NO, go to 403
304	Do students in your school influence their colleagues to have sex?	01 = Yes 02 = No |__|__| 98 = No answer 99 = Don't know	If NO, go to 306
305	If yes, how?	01 = By telling them how good it is 02 = By threatening them 03 = By giving them condoms |__|__| 04 = Other (specify) ------------------ 98 = No answer 99 = Don't know	
306	Which categories of students are mostly encouraged to have sex?	01 = Those in lower classes 02 = Those in upper classes |__|__| 03 = Girls 04 = Boys 05 = All students 98 = No answer 99 = Don't know	
307	Why do you think students are easily influenced to have sex?	01 = They have interest in sex |__|__| 02 = They have little knowledge about sexual health 03 = They fear other students 98 = No answer 99 = Don't know	
308	Do these students know the consequences of unprotected sex?	01 = Yes |__|__| 02 = No 98 = No answer 99 = Don't know	If NO, go to 401
309	If yes above, what is the most probable consequence?	01 = Contracting HIV 02 = Contracting STIs |__|__| 03 = Becoming pregnant 04 = Other (specify) ------------------ 98 = No answer 99 = Don't know	

N°	QUESTIONS	ANSWERS	SKIP
401.	Have you ever heard about condoms?	01 = Yes ⊔⊔⊔ 02 = No 98 = No answer 99 = Don't know	If NO, go to 403
402.	Can condoms be used for protection against HIV/AIDS?	01 = Yes ⊔⊔⊔ 02 = No 98 = No answer 99 = Don't know	
403 (a)	Have you ever had sexual intercourse?	01 = Yes ⊔⊔⊔ 02 = No 98 = No answer 99 = Don't know	If NO, go to 406
403 (b)	At what age?	Record number of years ⊔⊔⊔ 99 = Don't know	
403 (c)	With whom did you have sex?	01 = School mate 02 = Brother 03 = Sister 04 = Uncle ⊔⊔⊔ 05 = Teacher 06 = Friend 07 = Foreigner 08 = Other (specify) -------------------- 98 = No answer	
403 (d)	Where did you have the sex?	01 = At home 02 = In School 03 = In a bush ⊔⊔⊔ 04 = At a friend's house 05 = Other (specify) ----------------- 98 = No answer 99 = Don't know	
404 (a)	Did you use a condom the last time you had sex?	01 = Yes ⊔⊔⊔ 02 = No 98 = No answer 99 = Don't know	If NO, go to 406
404 (b)	Who suggested the use of the condom?	01 = Male partner 02 = Female partner ⊔⊔⊔ 03 = Self 98 = No answer	
405	Why did you or your sexual partner use a condom?	01 = To protect myself from HIV infection 02 = To avoid pregnancy ⊔⊔⊔ 03 = To protect myself from STIs 04 = Because my friends use them 05 = Other (specify) ---------------------- 98 = No answer 99 = Don't know	
406	Do you think you can protect yourself from HIV infection by abstaining from sex?	01 = Yes 02 = No ⊔⊔⊔ 98 = No answer 99 = Don't know	
407	Do you talk about HIV/AIDS with your friends?	01 = Yes 02 = No ⊔⊔⊔ 98 = No answer 99 = Don't know	If NO, go to 410

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N°	QUESTIONS	ANSWERS	SKIP
408	Do you discuss how to protect yourselves from HIV infection?	01 = Yes 02 = No 98 = No answer |__||__| 99 = Don't know	
409	How important are your friends' opinions about sexual practices?	01 = Extremely important 02 = Important 03 = Not important at all |__||__| 98 = No answer 99 = Don't know	
410	Are you involved in any extra-curricular activities in school?	01 = Yes 02 = No |__||__| 98 = No answer 99 = Don't know	If NO, go 501
411	If yes, what are they?	01 = Sports clubs 02 = Drama club 03 = Debate club 04 = Religious club |__||__| 05 = Other (specify)------------ 98 = No answer 99 = Don't know	

SECTION 5: ROLE OF COMMUNICATION IN HIV AND AIDS ATTITUDE AND BEHAVIOR CHANGE

N°	QUESTIONS	ANSWERS	SKIP
501.	Have ever received information about HIV/AIDS?	01 = Yes 02 = No |__|__| 98 = No answer 99 = Don't know	If NO, go to 503
502	From which source did you receive information about HIV/AIDS?	01 = Radio |__||__| 02 = TV/ Video 03 = Newspaper/magazines 04 = Poster/pamphlet 05 = School teacher 06 = Friends 07 = Other (specify) -------------	

N°	QUESTIONS	ANSWERS	SKIP
503.	From what sources would you *prefer* to receive information on HIV/AIDS? (More than one answer allowed)	**Mass media** 01 = Radio 02 = TV/ Video 03 = Newspaper |___||___| 04 = Poster/pamphlet **Health services** 05 = School clinic 06 = VCT centre **People** 07 = Community health worker 08 = Friends 09 = Family member 10 = Peer educator **Other places** 11 = Youth centres/clubs 12 = Others (specify) _____	
504	What is your opinion about the HIV/AIDS media campaigns that target young people?	01 = Very informative 02 = Not very informative |___|___| 03 = Not informative at all 98 = No answer 99 = Don't know	
505.	Which is your most memorable HIV/AIDS media campaign?	01 = Nimechill 02 = Nakufeel |___|___| 03 = Mpango wa kando 04 = Other (specify) ------------ 98 = No answer 99 = Don't know	
506	What do you dislike most about the campaigns?	01 = The language used 02 = Failure to involve young people 03 = Lack of clarity in message |___|___| 04 = The media used 98 = No answer 99 = Don't know	
507	How would you rate these campaigns in terms of teaching you how to protect yourself from contracting HIV?	01 = Extremely high 02 = Very high |___|___| 03 = Somewhat high 04 = Not high at all 98 = No answer 99 = Don't know	

N o	QUESTIONS	ANSWERS	SKIP
508 (a)	Have HIV/AIDS media messages influenced your sexual behaviour?	01 = Yes 02 = No |__|__| 98 = No answer 99 = Don't know	If NO, go to 509
508(b)	If yes, which among these sexual behaviours has changed most?	01 = Increase in condom use 02 = Reduced number of sexual partners 03 = Abstinence |__|__| 04 = Remaining faithful to one sexual partner 05 = Other (specify) ------------------ 98 = No answer 99 = Don't know	
509	What is your general feeling about HIV/AIDS media messages?	01 = They are boring |__|__| 02 = They are difficult to understand 03 = They don't address issues about the youth 04 = Other (specify) ----------------- 98 = No answer 99 = Don't know	

Write down any comments or additional information

Thank you very much for your time and help.

FOCUS GROUP DISCUSSION GUIDE

Note: For each group, the age, sex and educational level (i.e., which class they are in) of the participants will be written down

Knowledge of HIV and AIDS among the youth

1. What does HIV and AIDS mean? *(Probe for the meaning of HIV and AIDS. What is the source of their knowledge? Which names or descriptions do they give to HIV and AIDS?)*

2. Which meanings or beliefs do you associate with HIV and AIDS? *(Probe for specific discussions that generate knowledge about HIV and AIDS. Who initiates and or controls these discussions?*

Perception of HIV risks among the youth

3. How does the knowledge and experience you acquire during social interactions with friends influence your perception of risks of HIV infection? *(Probe for access to and consistent use of condoms, delay in sexual debut, support for safe sex, abstinence or reduction in number of sexual partners)*

HIV and AIDS knowledge and Self-Protection against possible HIV infection

4. How do discussions about HIV and AIDS help you to protect yourselves against possible HIV infections? *(Probe for HIV meanings arrived at, responses to HIV, feelings of protection against possible HIV infection)*

The role of communication in HIV and AIDS attitude and behavior change

5. Awareness and knowledge of HIV/AIDS campaigns *{Probe about their content, what they mean, reaction to campaigns, how campaigns have affected or altered their sexual behavior (if at all)}*

6. Do HIV and AIDS messages conform to the knowledge and understanding you have of the risks of HIV and AIDS? *(Probe for information on whether the youth like HIV messages. What are their attitudes, behaviors, habits, language? Do HIV messages address their unique mannerisms?)*

7. Would you say that HIV and AIDS media messages are packaged and communicated in ways or in a manner that you easily understand? *(Probe for information about language used in these messages, the lifestyles of young people and how these influence acceptance or rejection of the messages. What do they like and dislike about HIV/AIDS preventive media messages? How can they be improved to reach teens more effectively?)*

Thank you very much for your time and cooperation.

INTERVIEW SCHEDULE FOR KEY INFORMANTS

Note: For each interview, the designation of the interviewee will be written down

Knowledge of HIV and AIDS among the youth

1. Do students in your school have knowledge about HIV and AIDS? *(Probe: How do they get this knowledge? What type of knowledge and understanding about HIV and AIDS do they have? What have they learned from the HIV/AIDS curriculum?)*

2. Which meanings or beliefs do students associate with HIV and AIDS? *(Probe for specific discussions among the youth surrounding HIV and AIDS epidemic, the metaphors and may be symbols that the students associate with HIV and AIDS. What interpretations do they have about HIV/AIDS?)*

Perception of HIV risks among the youth

3. How does the knowledge and experience the students acquire during social interactions influence their perception of risks of HIV infection? *(Probe for access to and consistent use of condoms, delay in sexual debut, and support for safe sex, abstinence or reduction in number of sexual partners. Have they received information that can help them take precautions against HIV infections?)*

HIV and AIDS knowledge and Self-Protection against possible HIV infection

4. How do discussions about HIV and AIDS help the students to protect themselves against possible HIV infections? *(Probe for HIV meanings and responses, feelings of protection against possible HIV infection. In which particular ways do the students protect themselves against HIV infection? Are these protective measures informed by the right knowledge of HIV/AIDS?)*

5. Awareness and knowledge of HIV/AIDS campaigns *{Probe about their content, what they mean, reaction to campaigns, how campaigns have affected or altered the students' sexual behavior (if at all)}*

6. In what ways do HIV and AIDS messages conform to what the students know and understand about HIV and AIDS? *(Probe for information on whether the youth like or dislike HIV messages. What are their attitudes, behaviors, habits, language? Do HIV messages address their unique habits, attitudes and mannerisms? Do the students accept or reject these massages? If so, what reasons do they give for rejecting these messages? On the other hand, what do they like about the messages?)*

7. How are HIV and AIDS messages packaged and communicated? Do you think the students understand these messages? Give reasons for your answer? *(Probe for information about the language used in these messages, the lifestyles of students and how these influence acceptance or rejection of the messages. What do they like and or dislike about channels used to communicate HIV/AIDS preventive messages? How can they be improved to reach teens more effectively?)*

Thank you very much for your time and cooperation.