

**BEHAVIOURAL FACTORS THAT CONTRIBUTE TO THE RISK
OF HIV INFECTION AMONG COLLEGE STUDENTS: THE
CASE OF CO-OPERATIVE COLLEGE OF KENYA**

UNIVERSITY OF NAIROBI
EAST AFRICANA COLLECTION

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AWARD OF THE DEGREE OF MASTER OF ARTS IN GENDER AND
DEVELOPMENT STUDIES OF THE UNIVERSITY OF NAIROBI**

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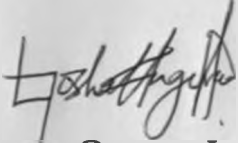
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DECLARATION

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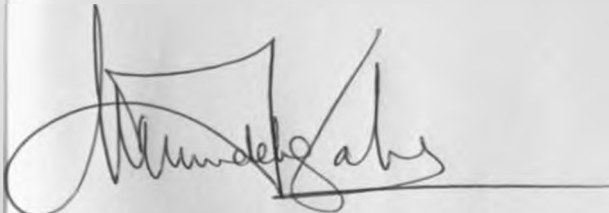


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Date

This project has been submitted for examination with my approval as a University Internal Supervisor



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13.02.09

Date

DEDICATION

To my parents: Alice and Alfayo, siblings; Joram, Jared Jerusha and John and my friend Gladys.

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TABLE OF CONTENTS

DECLARATION.....	i
DEDICATION.....	ii
ACKNOWLEDGEMENTS.....	iii
TABLE OF CONTENTS.....	iv
LIST OF TABLES.....	vi
LIST OF FIGURES.....	vii
LIST OF ABBREVIATIONS.....	vii
ABSTRACT.....	ix
CHAPTER ONE: INTRODUCTION.....	1
1.1 BACKGROUND OF THE STUDY.....	1
1.2 PROBLEM STATEMENT.....	3
1.3 OBJECTIVES OF THE STUDY.....	5
1.3.1 OVERALL OBJECTIVE.....	5
1.3.2 SPECIFIC OBJECTIVES.....	6
1.4 STUDY JUSTIFICATION.....	6
CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK.....	9
2.0 INTRODUCTION.....	9
2.1 KNOWLEDGE LEVELS AND SEXUAL BEHAVIOUR.....	10
2.2 BEHAVIOURAL FACTORS THAT CONTRIBUTE TO THE RISK OF HIV INFECTION.....	11
2.2.1 PEER INFLUENCE ON SEXUAL BEHAVIOUR.....	11
2.2.2 SEXUAL BEHAVIOUR AND HIV INFECTION.....	12
2.2.3 CONDOM USE.....	13
2.2.4 POVERTY AND HIV/AIDS.....	14
2.2.5 DRUGS AND HIV INFECTION.....	15
2.2.6 AVAILABILITY AND ACCESS TO VOLUNTARY COUNSELLING AND TESTING.....	18
2.3 GENDER AND HIV/AIDS.....	20
2.4 THEORETICAL FRAMEWORK.....	24
2.4.1 SOCIAL COGNITIVE THEORY.....	24
2.5 ASSUMPTIONS.....	26
2.6 OPERATIONALIZATION OF KEY VARIABLES.....	26
2.6.1 HIV/AIDS KNOWLEDGE.....	26
2.6.2 PEER PRESSURE.....	27

2.6.3	GENDER INEQUALITY.....	27
2.6.4	ACCESS TO HIV TESTING, CONDOMS, CARE AND SUPPORT SERVICES.....	27
2.6.5	BEHAVIOUR CHANGE.....	27
CHAPTER THREE: METHODOLOGY.....		28
3.0	INTRODUCTION.....	28
3.1	STUDY DESIGN.....	28
3.2	RESEARCH SITE.....	28
3.3	SAMPLE: POPULATION, SAMPLING PROCEDURE AND SAMPLE SIZE.....	29
3.4	METHODS OF DATA COLLECTION.....	30
3.4.1	IN-DEPTH INTERVIEWS.....	30
3.4.2	STRUCTURED INTERVIEWS.....	30
3.4.3	DOCUMENTARY SOURCES.....	31
3.5	DATA ANALYSIS.....	31
3.6	ETHICAL CONSIDERATIONS.....	32
CHAPTER FOUR: RESULTS OF THE STUDY AND DISCUSSION.....		33
4.0	INTRODUCTION.....	33
4.1	SOCIO DEMOGRAPHIC CHARACTERISTICS.....	33
4.2	THE RELATIONSHIP BETWEEN HIV/AIDS KNOWLEDGE AND BEHAVIOR....	35
4.3	BEHAVIORAL FACTORS THAT CONTRIBUTE TO HIV INFECTION AMONG CO-OPERATIVE COLLEGE OF KENYA STUDENTS.....	40
4.4	THE INFLUENCE OF GENDER ON SEXUAL BEHAVIOR.....	48
CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS.....		54
5.0	CONCLUSION.....	54
5.1	RECOMMENDATIONS.....	55
BIBLIOGRAPHY.....		57
APPENDIX 1 QUESTIONNAIRE		65
APPENDIX 2 KEY INFORMANT INTERVIEW GUIDE.....		77

LIST OF TABLES

Table 4.1 Specific topics Respondents have been trained on.....	36
Table 4.2 Number of sexual partners for those who have attended training and those who have not attended training.....	38
Table 4.3 Percent of students involved in various leisure activities (only one most enjoyed activity is considered per respondent).....	43

LIST OF FIGURES

Fig 4.1 Gender Representation of the respondents.....	34
Fig 4.2 Percent of marital status of students.....	34
Fig 4.3 Percent of students who have attended HIV/ AIDS training.....	35
Fig 4.4 Training on VCT verses knowledge of HIV status.....	37
Fig 4.5 Percent of students using condoms and taking alcohol for those who have attended & not attended training.....	39
Fig 4.6 Percent of respondents who have ever had sexual intercourse.....	41

LIST OF ABBREVIATIONS

ABC	Abstinence, Being Faithful and Condom use
ACU	Aids Control Unit
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral Drug
BCCGS	Behaviour Change Communication Groups
FAO	Food and Agriculture Organization of the United Nations
HIV	Human Immunodeficiency Virus
ICL	I Choose Life
IEC	Information Education and Communication
KDHS	Kenya Demographic and Health Survey
MTCT	Mother To Child Transmission
NACC	National AIDS Control Council
NIDA	National Institute on Drug Use
PLHIV	People Living with HIV
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UNAIDS	United Nations Program on AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office On Drugs and Crime
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

ABSTRACT

This study investigated the behavioural factors that contribute to the risk of HIV infection among Co-operative College of Kenya students. Factors in the social life of the students, the college environment and its neighbourhood that could encourage students to engage in risky sexual behaviour were explored. The study unlocked factors that are affecting sexual behaviour change even when majority of the students have information on HIV/AIDS. Gender dimensions of sexual behaviour were also looked at.

The study subjects consisted of 132 students who were selected using random systematic sampling and 5 key informants who were purposefully selected from among members of staff due to their interaction with students. A questionnaire with closed and open ended questions and key informant guide were the major methods used to generate data for this study. Quantitative data was then analyzed using SPSS while thematic and content analysis was used to analyze qualitative data.

From the findings, it was revealed that HIV/AIDS knowledge alone is not effective in sustaining behaviour change among students. Peer pressure, drug abuse and the media were identified as some of the factors that contribute to HIV infection risk among students. Overall the study recommends strategies that should be applied for students to adopt less risky sexual behaviours. The recommendations made are useful to the college AIDS Control Unit, Educational policy researchers, gender practitioners, National Aids Control Council and future researchers.

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND OF THE STUDY

HIV/AIDS is a world pandemic threatening to undo the gains made in the post independence decades. Globally, there were an estimated 33 million [30.3 million-36.1 million] people living with HIV in 2007 (UNAIDS, 2008). Sub-Saharan Africa remains the region most heavily affected by HIV, accounting for 67% of all people living with HIV and for 75% of AIDS deaths in 2007. Young people aged 15-24 account for an estimated 45% of new HIV infections worldwide (UNAIDS, 2008). According to UNAIDS (2008) an estimated 1.9 million [1.6 million- 2.1 million] people were newly infected with HIV in sub-Saharan Africa in 2007, bringing to 22 million [20.5 million-23.6 million] the number of people living with HIV.

The epidemic in Kenya peaked in the late 1990s with an overall HIV prevalence of 10% in adults; this declined to 7% in 2003, and declined further to 6.1% as at the end of 2004 (NACC, 2005). Infection levels in urban residents peaked in the mid-1990s; this occurred before similar peak in rural residents. Infection levels in rural populations subsequently dropped, though at a slower rate than the urban residents (Republic of Kenya, 2005). This is only the second time in more than two decades that a sustained decline in national HIV infection levels has been seen in a sub-Saharan African country (UNAIDS et al., 2006). The KAIS (2008) however, indicates that 7.4% of Kenyans are living with HIV. According NACC (2005) despite the progress made, enormous challenges remain. The rate of new

infections is unacceptably high particularly among vulnerable groups including; young girls, individuals in HIV discordant relationships, commercial sex workers and their clients, migrant workers and injecting drug users. Equally critical is the availability of affordable treatment for those in need of antiretroviral therapy. Other challenges include the negative socio-economic impact that HIV/ AIDS inflicts on society as evidenced by the cumulative number of orphans and other vulnerable children, widows and the elderly as well as high levels of poverty and unemployment in the country.

According to the Ministry of Cooperative Development and Marketing, the cooperative sector in the country contributes 63% towards the Gross Domestic Product estimated at about Ksh. 100 billion. There are about 10,000 cooperative societies in Kenya with direct membership of 6 million and a total of 26 million dependants on the sector. If HIV interventions do not begin to address the risks to this invaluable population, the foundation of Kenya's future may be lost to preventable illness and death.

The Co-operative College of Kenya, being the hub of cooperatives in the country offers courses on management of cooperatives. The socio-economic and political development of the country therefore, heavily depends on this sector. The "gold rush" phenomenon whereby older male students prey upon naive female students, is widely believed to be the reason behind the drastic change of sexual activity among Cooperative College of Kenya students. The risky sexual behaviour among some of the male students is blamed partly on

substance abuse particularly the excessive use of alcohol which appears to be on the increase. There is also a noted unawareness among the students of their HIV status. In addition, there seems to be a disconnect between the high knowledge levels about HIV/AIDS and sexual practice which is a widely spread phenomenon in most of the Kenyan adult population.

1.2 PROBLEM STATEMENT

HIV/AIDS threatens to undermine the gains that have been made in education and Cooperative Movement sectors at large. According to the Co-operative College of Kenya HIV and AIDS policy (2007), the college recognizes that HIV and AIDS can impact negatively on its core mission of training and producing skilled manpower for the Cooperative Movement and the national economy due to illness and subsequent deaths of workers. College students are likely to engage in risky sexual behaviours such as multiple sexual partnerships (Ellington & Flannery, 2003). A report by the Republic of Kenya (2002) behavioural surveillance survey confirms that the youth report high sexual activity and low condom use, which puts them at increased risk of infection with sexually transmitted infections, including HIV. Given that there are a significant number of married students, who have left their spouses at home, most of them engage in extra marital sex. While the majority of Co-operative College of Kenya students are sexually active, only a minority take the necessary preventative precautions to protect themselves against HIV and other STIs. The Republic of Kenya (2002) behavioural surveillance survey indicates that despite

the high awareness of the disease, a significant number of sexually active respondents had non regular and many sex partners unabated. This persistent behaviour suggests that the heightened awareness of HIV/ AIDS and sexually transmitted infections and knowledge of condoms and other HIV prevention methods were not translating into safe sex. The influence of peers at the college is high and new students, particularly female students, succumb to the influence and pressure of the older students to begin sexual activity. Among youth age 15-24, women are 4 times more likely to be infected than men (6.1 percent compared to 1.5percent) (KAIS, 2008) giving HIV/ AIDS practitioners the need to give special attention to female students in college. According to National Institute and Drug Use (2008) scientific research has demonstrated that the use of alcohol and drugs is related to the occurrence of unsafe sexual behaviour that places adolescents at risk for pregnancy or contracting STDs, such as HIV/ AIDS. The high level of knowledge about HIV/ AIDS and its transmission does not seem to result in preventative practices. Indeed the Republic of Kenya (2002) behavioural surveillance survey showed that Kenyans were knowledgeable about HIV/ AIDS, sexually transmitted infections and condoms, but that this knowledge had not translated into desired behaviour. Nonetheless, several programs targeted to the college students have demonstrated an opportunity for behavior change among students. Unfortunately, such programs have been few, short-lived and often piecemeal. Despite efforts by the college administration to implement HIV/ AIDS policies and programs for students, a lot needs to be done in the fight against HIV/ AIDS.

This study aimed at filling the gap in understanding behavioral factors that contribute to the risk of HIV infection among Co-operative College of Kenya students. Factors in the social life of the students, the college environment and its neighborhood that could encourage students to engage in risky sexual behavior were explored. The study unlocked the factors that are affecting sexual behavior change even when majority of the students have information on HIV/ AIDS. Gender dimensions of sexual behaviour were also looked at. More specifically, the study answered the following questions:

1. Does HIV/ AIDS knowledge necessarily lead to sexual behavior change?
2. What are the behavioral factors that contribute to HIV infection among Co-operative College of Kenya students?
3. What influence does gender have on sexual behaviour?

1.3 OBJECTIVES OF THE STUDY

1.3.1 OVERALL OBJECTIVE

To investigate the behavioural factors that contribute to the risk of HIV infection among Co-operative College of Kenya students.

1.3.2 SPECIFIC OBJECTIVES

- a) To determine whether the level of HIV/ AIDS knowledge contributes to change of sexual behaviour.
- b) To explore the behavioural factors that contribute to the risk of HIV infection among Co-operative College of Kenya students
- c) To examine the influence of gender on sexual behaviour among Co-operative College of Kenya students

1.4 STUDY JUSTIFICATION

In the countries most heavily affected, HIV has reduced life expectancy by more than 20 years, slowed economic growth, and deepened household poverty. In sub-Saharan Africa alone, the epidemic has orphaned nearly 12 million children aged less than 18 years (UNAIDS, 2008). Women account for half of all people living with HIV worldwide, and nearly 60% of HIV infections are in sub-Saharan Africa. Over the last 10 years, the proportion of women among people living with HIV has remained stable globally, but has increased in many regions (UNAIDS, 2008). Young people aged 15-24 account for an estimated 45% of new HIV infections worldwide (UNAIDS, 2008). Young people aged between 15 and 24 are included within the high risk group and yet this is the group viewed as the future of the nation, individually they are at an enormous risk of contracting HIV and other STIs (ICL, 2006). Youth represent the future of Kenya and need special attention in HIV prevention programs (Republic of Kenya, 2002).

The United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa has identified three key factors that contribute to the greater vulnerability of the sub-region's women and girls to HIV infection, each of which must be addressed (UNAIDS et al, 2004). These factors are the culture of silence surrounding sexuality, exploitative transactional and intergenerational sex and violence against women within relationships. All three factors must also be understood in the context of the poverty and inequalities that define the daily lives of both women and men in the region.

In Africa the prime mode of transmission is through heterosexual contact, with minor parts being played by homosexual contact, mother- child transmission, blood transfusions, and injecting drug use (Kalipeni et al, 2004). There are many diverse challenges that face efforts to address HIV, gender and education issues. Consequently, there is need to develop a clear and comprehensive policy framework to address these challenges (Republic of Kenya, 2004). There is a growing literature that drug abuse has an association with HIV/AIDS (UNODC, 2004). Students are not restricted in their movement after they have attended class. They may take the freedom as an opportunity to engage in drug abuse and alcohol consumption. Most Co-operative College of Kenya students are fresh from high schools who get freedom when they are admitted to the college. The concepts of *external auditors* where men and women from outside college come to have sex with students and *internal auditors* where students have sex with other students within the college are common.

Effective prevention is composed of many facets—including education, health services, media campaigns, behaviour change, life skills-building and job training. All these components must address the critical role that gender plays in sexual and reproductive life, and how it affects HIV prevention (UNAIDS, 2001). Identifying behavioral factors that influence HIV infection risk among students will facilitate the development of strategies that will contribute to the reduction of HIV infection among students. A multipronged approach that involves abstinence, faithfulness and condom use is urgently needed (Republic of Kenya, 2002) hence the need and importance of this study.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 INTRODUCTION

The advent of HIV infection has eventually brought humanity closer to the reality of the dangers of risky sexual behaviour (Tabifor, 2002). Jackson (2002) notes that in many parts of Sub-Saharan Africa many high risk settings occur for HIV transmission, largely far beyond an individual's control. Nonetheless, they can be influenced by general development efforts, strengthened social unity and reduced gender inequity, reduced population mobility and displacement, and by targeted national, organisational and community policies and programmes, by peer pressure and broader social and cultural influences (Jackson, 2002). In many families and communities, sexual relationships are greatly influenced by social, cultural and religious factors. According to NACC (2005), the rate of AIDS deaths has risen dramatically and it is estimated that there are about 150,000 AIDS deaths per year, double the rate in 1998. This increasing death rate, which exceeds the rate of new infection, tends to reduce overall prevalence as the epidemic in Kenya moves into the "death phase" (NACC, 2005). The impact of HIV/AIDS on economic growth and development, coupled with the direct impact of increased mortality and morbidity on the lives of the poor, makes HIV/AIDS a uniquely corrosive threat to poverty reduction efforts. Societies often compound young people's risk by making it difficult for them to learn about HIV/AIDS and reproductive health. Moreover, many

youth are socially inexperienced and dependent on others. Peer pressures easily influence them, often in ways that can increase their risk.

Female students, especially those in their first year at the college will specifically be targeted, as they more often fall prey to sexual advances from older students and off-campus men. As the Republic of Kenya (2002) notes there is an urgent need for the government and its development partners to develop and promote special programs to empower female youth and equip them with life and negotiating skills.

2.1 KNOWLEDGE LEVELS AND SEXUAL BEHAVIOUR

Kalipeni et al. (2004) notes that current knowledge confirms that sexual behavior, the primary target of AIDS prevention efforts worldwide, is deeply embedded in individual desires, social and cultural relationships, and environmental processes. Because sex takes place in context, social cultural factors surrounding the individuals must be considered in designing prevention interventions. Thus, giving information alone is not sufficient to induce behavioural change among most individuals (Kalipeni, et al, 2004). Focus on the individual psychological process ignores the interactive relationship of behavior in its social, cultural, and economic dimensions and thus misses the opportunity to fully understand crucial determinants of sexual behavior (Kalipeni et al, 2004). Kalipeni et al. (2004) argues that societal norms, religious criteria, and gender - power relations infuse

meaning into sexual behaviour and facilitate or impede both positive and negative changes.

Given the powerful socio-economic and cultural forces driving the epidemic, we argued that IEC campaigns could increase knowledge, but would not suffice to reduce the spread of HIV (Kalipeni et al., 2004). Current prevention strategies have increased knowledge about HIV and AIDS in many African countries, but they have not made an overall difference in rate of transmission. More effective prevention strategies will need to address those underlying causes of HIV and AIDS that are rooted in inequitable gender relations, lack of employment opportunities for both men and women, and cultural meanings surrounding forms and functions of sexual exchange (Kalipeni et al. 2004).

2.2 BEHAVIOURAL FACTORS THAT CONTRIBUTE TO THE RISK OF HIV INFECTION

2.2.1 Peer influence on sexual behaviour

Peer influence is great among young people who would want to experiment. Peer influence on young people could press them to adopt risky sexual behaviours especially when combined with the perception of invulnerability to diseases (Hope, 2001). Peer influence leads young people to do things that they may not necessarily do without influence. Peer pressure can be both positive and negative. In normal circumstances, the youth do not access factual information from their peers and as Jackson (2002) notes,

numerous pressures arise for girls and boys to engage in sexual activity, not the least being their emerging sexual desires. Biological, social and economic pressures may encourage young people to have sex, while tradition, religion and family pressure are likely to discourage girls from engaging in sex, but not necessarily boys. Idleness is also a factor that can encourage behaviours that can put students at risk of HIV infection. Most students do not engage in extra curricular activities after classes. The free time that they have may encourage them to engage in activities that may increase their vulnerability to HIV infection.

2.2.2 Sexual Behaviour and HIV infection

Patterns of sexual behaviour in a population are determined by much wider factors than individual morality, personal choice and private decisions about risk. Socio-economic, cultural, religious, political, legal and other factors are all important in creating the risk environment in which people live (Jackson, 2002). How the risk environment affects individuals will depend, in turn on, for instance, the person's age, gender, education, socio-economic standing, cultural values, religious views, personality, and freedom from sexual abuse (Jackson, 2002).

Choice and patterns of sexual partnerships also significantly influence risk (Jackson, 2002). The choice of sexual partners affects the chance of having sex with somebody who is infected with HIV. Having a sexual relationship with a person who has other multiple sexual partners increases the risk of HIV infection. The more sexual partners, the greater

the chance that one has HIV. Therefore reducing the number of sexual partners can help reduce risk if it means only having sex with partners likely to be at low risk of infection (Jackson, 2002). The age at first sexual intercourse is also thought to affect risk of HIV infection.

2.2.3 Condom use

To date, consistent condom use is undoubtedly the most effective way to reduce the risk of HIV (and other STI) transmission in risky sexual encounters (Jackson, 2002). Consistent condom use also reduces infection risk substantially. Jackson (2002) continues to argue that strategies to provide condoms and promote their use are quite compatible with promoting abstinence and fidelity, and both should be accepted as elements of overall strategies to slow the spread of HIV and STIs. The male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted infections (UNAIDS, 2004). In addition to male condoms, female condoms are now on the market. Condoms are a key component of combination prevention strategies individuals can choose at different times in their lives to reduce their risks of sexual exposure to HIV. Condom use is more likely when people can access them at no cost or at greatly subsidized prices. Effective condom promotion targets not only the general population, but also people at higher risk of HIV exposure, especially women, young people, sex workers and their clients, and men who have sex with men. Young girls and women are regularly and repeatedly denied information about, and access to, condoms.

Often they do not have the power to negotiate the use of condoms (UNAIDS, 2004). Jackson (2002) notes that using condoms is the smallest behaviour change to make risky sexual behaviour safer. Condom promotion through peer education, social mobilization, advocacy, mass media promotion, social marketing and other strategies combined with ensuring adequate condom supplies at a wide range of outlets, can make a major difference (Jackson, 2002). By promoting dual protection, family planning programs can help prevent unintended pregnancies among youth and at the same time contribute to controlling the spread of HIV/AIDS (The Johns Hopkins University, 2006). WHO (2003) has urged family planning programs to do more to address prevention of HIV/AIDS and other STIs. Programs can stress that condoms can be effective against HIV and some STIs when they are used correctly and can assure that good-quality condoms are widely available at reasonable cost. Condoms are currently the only available means of preventing the sexual transmission of HIV and some other sexually transmitted infections (UNAIDS, 2001).

2.2.4 Poverty and HIV/AIDS

Poverty is clearly a factor in the spread of HIV/AIDS. The effects of poverty accelerated the spread of the virus in the 1980s. By the 1990s, the ravages of AIDS in turn plunged afflicted regions deeper into economic crisis (Kalipeni et al, 2004). The struggle to survive everyday overshadows attention and concern about a virus that does not demonstrate any immediate harm. HIV/AIDS is a distant threat until it has a visible presence manifested by

illness and death. Poverty, in depriving people of access to health facilities, schools and media also limits their access to information and education on HIV/ AIDS.

According to UNDP (2005) when HIV/AIDS appears in an already impoverished household there are limited means for response, the mortality rate is high, the impact is severe hence leading to poverty increase. As increasing numbers of infected young adults are unable to contribute to their communities through their work as parents, teachers, laborers, drivers, farmers, etc., entire economic and social structures of communities suffer and demands for services increase with fewer able people to provide them.

The AIDS epidemic adds to food insecurity in many areas, as agricultural work is neglected or abandoned due to household illness. A recent study in Kenya demonstrated that food production in households where the head of the family died of AIDS were affected in different ways depending on the sex of the deceased (Avert, 2007).

In the college, students who hail from humble backgrounds and have a desire to live large just like those who hail from affluent families may end up trading sex for money. Poverty pushes some women into risky behaviour or dangerous situations (UNAIDS, et al. 2002). With no other options in site, women may resort to sex work to feed their families, pay their school fees or even buy luxuries for themselves.

2.2.5 Drugs and HIV infection

Drug abuse has an association with HIV/AIDS (UNODC, 2004). Adolescents and other young adults who use drugs and alcohol often take risks that endanger their health and the

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health of others. One of the most harmful risks is that of engaging in risky sexual activities. Scientific research has demonstrated that the use of alcohol and drugs is related to the occurrence of unsafe sexual behavior that places adolescents at risk for pregnancy or contracting sexually transmitted diseases (STDs), such as HIV/AIDS (NIDA, 2008). The connections between drugs and sex, sexual exploitation and sexual abuse are well established. UNODC (2004) notes in their research that people under the influence of drugs may lose inhibition, leading them to indulge in risky sexual behaviour that exposes them to HIV/AIDS. Due to this nexus, many young people find themselves vulnerable to HIV infection, as well. Some examples of this are: engaging in sex work for money and in case of addiction an individual can exchange sex for drugs. Guilt and shame for the youth who engage in extra marital sex may make them to use drugs. Others may argue that sex is better when drugs have been used.

Drug injecting is a high-risk activity for HIV and other infections if different people share one needle and syringe (Jackson, 2002). Shared equipment for using drugs can carry HIV, and drug use is linked with unsafe sexual activity. Drug use can also be dangerous for people who are taking anti-HIV medications. Drug users are less likely to take all of their medications, and street drugs may have dangerous interactions with HIV medications. When the blood of an HIV-infected drug user is transferred to a drug user who is not HIV infected, an infection can occur. People on Injecting Drug Use will expose themselves to

HIV/AIDS through direct blood -to-blood transmission (UNODC, 2004). Sharing and multiple uses of syringe and needles lead to the transfer of HIV-infected blood.

People take drugs for their immediate and short-term effects. Usually many young people use drugs because they either add something to their lives or help them to feel that they have solved their problems, however fleeting this feeling might be. Young people need to recognize the deadly consequences of HIV/AIDS, and that they are potential targets for infection (NIDA, 2008). They feel caught between conformity and the urge to be different, or the urge to fit in with their peer group. They lack the skills necessary for dealing with stress and pressures of life, and drugs may be seen as a way of dealing with them. They believe that drugs are helpful in releasing stress, worries etc. Friends and peers have a great influence on young people, and among them drug use may be considered normal and a part of growing up.

The most commonly abused drug is alcohol. There is also a local brew found in the slum adjacent to Co-operative College of Kenya preferred by students because of its price. College ladies may fall victim of forced sex when drunk. According to the National Academies Press (1989), intravenous drug users occupy a unique position in the transmission chain of HIV; they pose risks not only for each other but also for their sexual partners and offspring. College rules, availability of drugs, promotion of alcohol and

drugs, and their access are factors that must be looked at in order to make the fight against HIV/AIDS a reality.

2.2.6 Availability and Access to Voluntary Counselling and Testing

Counselling and testing is a key sexual behaviour change strategy. Jackson (2002) argues that access to information on one's HIV status is a human right as well as a public health measure: people have the right to know their HIV status so they can protect themselves and others from infection, improve their health care and plan for the future. Individuals who test HIV negative are motivated to guard their sero-status, while those that test HIV positive can be counselled on how to protect their partners from infection, and be referred for ART where appropriate. Scaling up voluntary counselling and testing services in the country is a key HIV infection prevention strategy (NACC, 2005). The quality of services provided through Voluntary Counselling and Testing (VCT), including testing, counselling and referral of those testing positive need to be constantly strengthened. Interventions include direct capacity building, such as training and provision of test kits, and the establishment of a national VCT quality assurance framework.

Achieving equity in the provision of VCT services by ensuring that there is at least one VCT centre in each administrative division in the country is a key issue. The VCT communication strategy plays a key role in ensuring increased VCT uptake. The communication strategy is focused and targeted at those at high risk of contracting HIV.

The strategy is used to raise awareness about the issue of discordant couples and encourage couples to seek testing and counselling services. In addition to VCT, the diagnostic testing and counselling policy is meant to lead to an accelerated increase in the number of people tested for HIV in the clinical setting.

According to UNAIDS et al. (2006) VCT, which is currently available to only 12 per cent of the people who want to be tested leads to behaviour change that contributes to a reduction in HIV transmission. Studies show that VCT can contribute to a decrease in unprotected sexual relations, a reduction in multiple partners, an increase in condom use and more people choosing abstinence. Research in Kenya, Trinidad and Tobago and Tanzania found that VCT was more effective in reducing reported risk behaviours than just providing information on HIV transmission (UNAIDS, et al., 2006).

According to UNAIDS et al. (2006) VCT is also critical for reducing the numbers of infants born with HIV. MTCT is the primary cause of all HIV infections in children under 15, yet in 2003, only 1 per cent of pregnant women in countries heavily affected by AIDS had access to testing and ideally, VCT should not only allow women who are HIV positive to receive treatment that would prevent their children from becoming infected known by the acronym PMTCT, preventing mother-to-child transmission—but also receive treatment for themselves (UNAIDS, 2004). Once a woman has given birth, prevention concerns extend to infant feeding. A major risk of MTCT involves infants who are born free of HIV, only to be

infected through breastfeeding. Public health facilities must seek to support optimal breastfeeding that helps prevent death and illness from diarrhoea and respiratory infections while avoiding the risk of HIV transmission. Access to VCT services therefore can be a key indicator to measure whether the population has actually changed. The college HIV and AIDS Policy (2007) indicates that the college will not require any person(s) to undergo HIV test prior to employment, admission or in the course of their stay within the college. However the college will encourage VCT and that openness and disclosure will be encouraged within a safe, supportive and accepting environment.

2.3 GENDER AND HIV/AIDS

Gender inequity and inequality are critical factors in the spread of HIV in Africa, in how people are cared for when they are sick, in what happens when they die and in who inherits what (Jackson, 2002). To reverse the global spread of HIV/AIDS, we must therefore, break the chains of gender inequality that help the disease to spread. All over the world, greater efforts are required to address the concrete needs of women and girls and to increase the roles and responsibilities of boys and men. It is critical at this point in the global pandemic that efforts focus simultaneously on individual behaviour change and on wider social, cultural and economic change. Realistic strategies must be found that address the triple challenge of poverty, gender inequality and HIV/AIDS (UNAIDS et al. 2004).

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HIV/AIDS is not only driven by gender inequality but it entrenches gender inequality, putting women, men and children further at risk. Today, more than 20 years into the epidemic, women account for nearly half the 40 million people living with HIV worldwide (UNAIDS et al., 2004). According to KAIS (2008) a higher proportion of women age 15-64 (8.7 percent) than men (5.6 percent) are infected with HIV.

Girls and women are highly susceptible to HIV infection, both biologically and as a result of gender inequality and discrimination. Yet, in most countries, they know less than males about HIV/AIDS and how it is transmitted. Globally, more than 80 per cent of young women do not have 'sufficient' knowledge about HIV/AIDS (UNAIDS et al., 2006). The silence surrounding issues of sexuality, the realities of gender inequality and the lack of education about sexual and reproductive health are putting girls and women at risk.

Marriage, often viewed as a source of protection against HIV, can be especially risky for young women who marry older men. According to UNAIDS et al. (2006) recent studies in Africa indicate that young married women are at higher risk of HIV infection than their sexually active unmarried counterparts. Wives' inability to make demands on their husbands, especially those who are much older; increased frequency of sexual relations; and less use of condoms all play a role. Meanwhile, with no cure in sight, access to condoms and female-controlled methods of prevention female condoms and, in the future, microbicides are an essential means of reducing the spread of HIV/AIDS. All health care

settings, including sexual and reproductive health centers, should provide HIV prevention and treatment services.

Protecting the human rights of women and girls also protects them from HIV/AIDS. More than any other disease in recent decades, HIV/AIDS has exposed the social inequities that make girls and women vulnerable to infection. Women need to know that they have rights, that they can act in their own self-interest and that they will be supported by their communities and nations. We have seen the power of this kind of awareness and action among women and girls living with HIV and AIDS, who are speaking out for their rights (UNAIDS et al., 2006).

Violence against women is both a cause and consequence of HIV/AIDS. According to UNAIDS et al. (2004) research has confirmed a strong correlation between sexual and other forms of abuse against women and women's chances of being HIV-infected. Male (or female) condoms are irrelevant when a woman is being beaten and raped. Moreover, forced vaginal penetration increases the likelihood of HIV transmission. At its heart, this is a crisis of gender inequality, with women less able than men to exercise control over their bodies and lives. Nearly universally, cultural expectations have encouraged men to have multiple partners, while women are expected to abstain or be faithful. There is also a culture of silence around sexual and reproductive health. Simply by fulfilling their

expected gender roles, men and women are likely to increase their risk of HIV infection (UNAIDS et al. 2004).

Many HIV strategies assume an idealized world in which everyone is equal and free to make empowered choices, and can opt to abstain from sex, stay faithful to one's partner or use condoms consistently. In reality, women and girls especially college going face a range of HIV-related risk factors and vulnerabilities that men and boys do not face, many of which are embedded in the social relations and economic realities of their societies. These factors are not easily dislodged or altered, but until they are, efforts to contain and reverse the AIDS epidemic are unlikely to achieve sustained success. Ladies at co-operative College of Kenya are also at a bigger risk of HIV infection than their male counter parts. It is mostly older male students who prey on the fresh female students admitted at Co-operative College of Kenya. Most students are enticed with presents and influenced by other students to enter into premarital sex. The culture of silence, exploitative transactional sex and violence against women are also factors that make female students more vulnerable to HIV infection. The college HIV and AIDS Policy (2007) recognizes that gender issues are important in the prevention of HIV and will endeavour to provide equal gender relations and empowerment. It continues to state that there will be zero tolerance to sexual harassment, abuse and exploitation in line with the college rules and regulations.

2.4 THEORETICAL FRAMEWORK

A number of theories and models can be used to analyze behaviour; however, Social cognitive theory discussed below will guide this study.

2.4.1 Social cognitive theory

The social cognitive theory explains how people acquire and maintain certain behavioural patterns, while also providing the basis for intervention strategies. The theory is credited to Bandura (1986). The theory identifies human behaviour as an interaction of personal factors, behaviour, and the environment (Bandura 1986). Social cognitive theory revolves around the process of knowledge acquisition or learning directly correlated to the observation of models. The models can be those of an interpersonal imitation or media sources. Effective modelling teaches general rules and strategies for dealing with different situations (Bandura, 1988). According to this theory, an individual's behaviour is determined by personal, behavioural and environmental factors. It emphasizes the effect of the social environment, thoughts, and behaviour. It stresses that learning takes place through the synthesis of environmental factors, thoughts and beliefs. Because of the bidirectionality of influence between behavior and environmental circumstances, people are both products and producers of their environment. They affect the nature of their experienced environment through selection and creation of situations (Bandura, 1989). Environment can be social or physical. Social environment include family members, peers and colleagues. Physical environment is the size of a room, the ambient temperature or the

availability of certain foods. The environment provides models for behaviour. People's beliefs in their capabilities affect how much stress and depression they experience in threatening or taxing situations, as well as their level of motivation. Such emotional reactions can affect action both directly and indirectly by altering the nature and course of thinking. The role of perceived self-efficacy and anxiety arousal in the causal structure of avoidant behavior has also been examined extensively. The results show that people base their actions on self-perceptions of coping efficacy in situations they regard as risky. The stronger the perceived coping efficacy, the more venturesome the behavior, regardless of whether self-perceptions of efficacy are enhanced through mastery experiences, modeling influences, or cognitive simulations (Bandura, 1988). Social cognitive theory is helpful for understanding and predicting both individual and group behaviour and identifying methods in which behaviour can be modified or changed. The way people perceive the environment determines their behaviour.

The Social Cognitive Theory explains how people acquire and maintain certain behavioural patterns. The theory can also be used for providing the basis for intervention strategies. It predicts both individual and group behaviour and identifies methods in which behaviour can be changed. In relation to my study, the college setting offers individuals an opportunity to choose those friends who they want to associate and interact with. The friends chosen will have a great influence on an individual's behaviour. This explains why students will be influenced to drink alcohol by their friends in college and

asserts the power of peer pressure on an individual. The theory is applicable to the fight against HIV/AIDS by encouraging the youth to associate with individuals who can influence them positively, have a greater sense of self-efficacy, and then imitate their actions in order to learn the proper actions for a more informative AIDS aware community. The theory's strengths include accumulation of an impressive research record and its concern with human behaviour which is a key factor in the fight against HIV/AIDS. It has limitations as it excessively relies on self reports and it ignores maturation and changes over the lifespan.

2.5 ASSUMPTIONS

1. HIV/AIDS knowledge will lead to adoption of safer sexual behaviour.
2. Negative peer pressure increases risky sexual behaviours.
3. Gender inequality increases HIV infection risk among female students.
4. Alcohol and drug abuse increases HIV infection risk.

2.6 OPERATIONALIZATION OF KEY VARIABLES

Terms as used in this study are explained below.

2.6.1 HIV/AIDS knowledge

It refers to the level of information individuals have concerning HIV/AIDS. The knowledge includes methods of transmission and prevention, antiretroviral therapy and factors that promote the spread of HIV/AIDS.

2.6.2 Peer pressure

A peer is someone you consider an equal in age or ability. And when we talk about the term "pressure" in the negative sense as exerted by these peers, we refer to the pressure that these people place on others to persuade them to do something that they would not normally consider doing of their own accord.

2.6.3 Gender inequality

Gender inequality refers to those factors that make one gender more vulnerable to HIV/AIDS than the other. The factors can be social, cultural or biological

2.6.4 Access to HIV testing, condoms, care and support services

Access means the ability to obtain the use of a resource. In this particular case it means ability to obtain and utilize VCT, Condoms, ARVs and psychosocial care

2.6.5 Behaviour Change

It refers to adopting a practise that can be regarded as better than the previous one in the fight against HIV/AIDS. For example if one begins using condoms, that can be behaviour change, if one reduces the number of sexual partners, that can also be referred to as behaviour change.

CHAPTER THREE: METHODOLOGY

3.0 INTRODUCTION

This chapter discusses the research strategies that were used in the study. It includes the study design, research site, sample, data analysis, ethical consideration and methods of data collection.

3.1 STUDY DESIGN

This was a descriptive study aimed at generating qualitative and quantitative data. It was designed to investigate behavioural factors that contribute to the risk of HIV infection among college students. Data was collected by research assistants through the use of questionnaires and interviewing of key informants. Data collected was edited, coded and analysed.

3.2 RESEARCH SITE

Co-operative College of Kenya in Karen, Nairobi was the selected study site. The College is situated at the end of Ushirika road off Lang'ata road after Bomas of Kenya. It is 18 KM from the city centre. The college is bordered by Rongai and Ngon'g. It is an institution of higher learning that offers certificate, diploma and degree programs in cooperative management and cooperative administration. The college has instituted an Aids Control Unit to spearhead its HIV/AIDS interventions. Through the Aids Control Unit an

HIV/AIDS policy has been developed which guides the college response in regard to HIV/AIDS.

3.3 SAMPLE: POPULATION, SAMPLING PROCEDURE AND SAMPLE SIZE

The college's main campus has a total of 300 students and 50 staff. Because of limited time and money, this study only interviewed a sample of the population as a representative of the entire population. Those interviewed in the study were students and key staff. Respondents interviewed from among students were selected from their hostels. There are six hostels in the college, three of which are occupied by female students and three by male students. In the hostels, students either stay two or three in a room. Systematic simple random sampling was used by the researcher in selecting the specific respondents. A halls register was drawn and the 2nd person in the register in each hall of residence was interviewed. 132 respondents took part in the structured interviews.

5 key informants for in depth interview were sampled purposefully by the researcher due to their close association with students and the position they hold in the college. The key informants were the Deputy Director, Senior Human Resource Officer, HIV/AIDS Coordinator, the Assistant House Keeper and a lecturer. The deputy director was selected in her capacity as the person in charge of academics. She is also conversant with college rules and regulations as applicable to students. The HIV/AIDS coordinator has previously held seminars with students to sensitize them on HIV/AIDS. She is knowledgeable on

HIV/AIDS due to various trainings she has attended. The house keeper interacts with students on day to day basis in their hostels. She is aware of the students' behaviour in the college especially on the way they stay in their halls of residence. The lecturer interviewed interacts with students in class and has substantial information on students' behaviour in class and outdoor activities in which students engage themselves in.

3.4 METHODS OF DATA COLLECTION

3.4.1 In-depth interviews

The aim of carrying out in-depth interviews was to supplement the information given by students from the perspective of members of staff. The target was to have views on students' behaviour from representatives in administration, teaching and support sections. An in-depth interview guide was developed to guide data collection. The 5 key informants provided crucial information on students' behaviour and gave recommendations on what measures the college should take to discourage students from indulging in activities that may increase their risk of HIV infection.

3.4.2 Structured Interviews

A structured interview guide was developed to guide the study. The questionnaire which had both closed and open ended questions was administered to 132 students in their residential rooms. The target was to interview at least a third of the students' population. The respondents filled the questionnaire on their own. All the 132 questionnaires were

returned and analysed by the researcher. The questionnaires were appropriate given the private and sensitive information being sought by the researcher on the sexual behaviour of the students. The open ended questions probed further responses from the closed ended questions. 6 assistants distributed and collected the questionnaire. The questionnaire was pre tested before being administered.

3.4.3 Documentary sources

This method of data collection supplemented the primary data. Literature on the topic under study was sourced from different sources including the internet, books and journals. A lot of study has been done on HIV/AIDS which was helpful during this research. Whereas a lot of literature is available on the youth in Kenya, little literature was available on youth in tertiary institutions.

3.5 DATA ANALYSIS

Both qualitative and quantitative techniques of data analysis were used to analyze information gathered for this study. They included frequency tables, averages, medians and percentages. Cross tabulations were made to aid better understanding of the results. Content analysis was also done. Reporting of the results from content analysis was done in form of direct quotes from respondents.

3.6 ETHICAL CONSIDERATIONS

This study adhered to appropriate research procedures and all sources of information have been acknowledged as far as possible. Before the questionnaire was administered, consent was sought and given by the respondents. The respondents were informed of their right not to take part in the survey. Full confidentiality has been maintained especially when dealing with questionnaires and the identity of the respondents has been kept secret. Personal information will only be used for the purpose of the study and the respondents will not be revealed to any other source. Participants were informed of any potential limitations to the confidentiality of any information supplied. Procedures were put in place to protect the confidentiality of information and the anonymity of the participants in all research materials. The participants have been offered access to the results of the study.

CHAPTER FOUR: RESULTS OF THE STUDY AND DISCUSSION

4.0 INTRODUCTION

This chapter presents the findings of the study and discusses the findings. It focuses on behavioural factors that contribute to the risk of HIV infection among Co-operative college of Kenya students with a specific focus on:

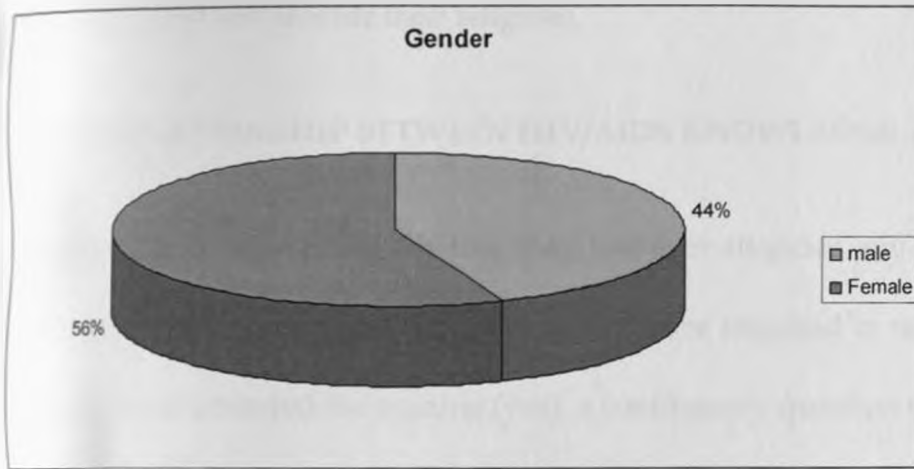
- a) Whether the level of HIV/AIDS knowledge contributes to change of sexual behaviour;
- b) The behavioural factors that contribute to the risk of HIV infection among Co-operative College of Kenya students;
- c) The influence of gender on sexual behaviour among co-operative college of Kenya students.

The chapter is organised in two sections. The first section covers the demographic characteristics of the respondents. The second section covers descriptive information and discusses the major questions explored in the study. The data is presented using frequency tables, charts and graphs. Statistic analysis has been performed on the major findings to test the significance.

4.1 SOCIO DEMOGRAPHIC CHARACTERISTICS

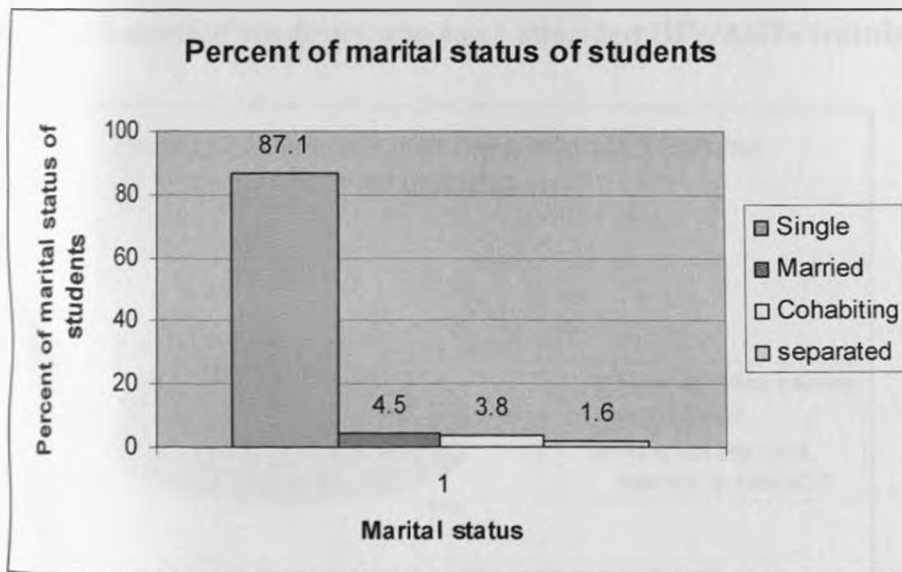
A total of one hundred and thirty two respondents were interviewed. Majority of them were aged between 21-22 years (49.2%), 25% were aged below 20 years and 15.2% were aged between 23-24 years. Only 1(0.8%) was aged over 30 years. Two respondents did not give their ages.

Fig 4.1 Gender Representation of the respondents



With regard to gender, 43.9% were male while 56.1% were female.

Fig 4.2 Percent of marital status of students



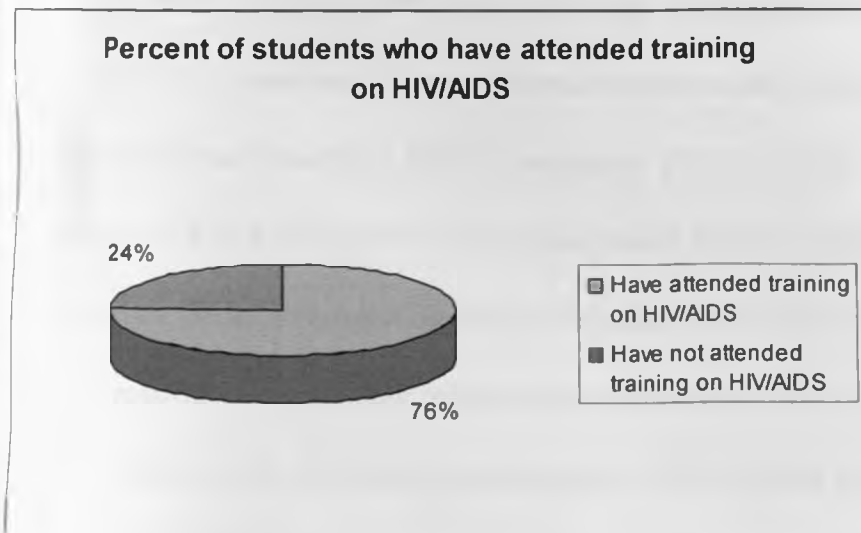
Most of the respondents (87.1%) were single, 4.5% were married while 3.8% were cohabiting. Two respondents (1.6%) reported to have separated.

The majority of the respondents (95.5%) were Christian while 3.0% were Muslims. (Two respondents did not provide their religion).

4.2 THE RELATIONSHIP BETWEEN HIV/AIDS KNOWLEDGE AND BEHAVIOR

The respondents were asked whether they had ever attended any training on HIV/AIDS. This was a closed ended question where they were required to tick either yes or no. For those who had attended the training (yes), a contingency question was asked to shed more light on the specific topic(s) of training by ticking on a pre coded list of seven topics of training. A response of attendance was used as an indicator to HIV/AIDS knowledge on the specified topic while non attendance did not.

Fig 4.3 Percent of students who have attended HIV/AIDS training



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Most respondents (75.8%) reported to have attended training on HIV/AIDS.

Specific topics Respondents have been trained on

	%
of HIV transmission	97
Transmitted Infections	93.1
7 (Abstinence, faithfulness and condom use)	92.1
ry Counselling and testing	86.1
nd sexual responsibility	82.2
with and management of HIV/ AIDS	78.2
and sexual Violence	75

istic used to summarise the topics they were trained on was the mode where
ds of HIV transmission" was the most common topic (97%). This was followed by:
7 transmitted infections (93.1%), sexuality (92.1%), VCT (86.1%), drugs and sexual
ibility (82.2%), living with and management of HIV/ AIDS (78.2%) and gender and
violence (75%). From the figures in the table above, HIV/ AIDS knowledge was high
the respondents. The key informants also revealed that HIV/ AIDS being a common
it enables students to have knowledge on HIV/ AIDS. Students through the ACU,
volved in behaviour change communication groups through which HIV/ AIDS
ges are communicated to other students. The lecturer who participated in the

Table 4.1 Specific topics Respondents have been trained on

Topic	%
Methods of HIV transmission	97
Sexually Transmitted Infections	93.1
Sexuality (Abstinence, faithfulness and condom use)	92.1
Voluntary Counselling and testing	86.1
Drugs and sexual responsibility	82.2
Living with and management of HIV/ AIDS	78.2
Gender and sexual Violence	75

The statistic used to summarise the topics they were trained on was the mode where "Methods of HIV transmission" was the most common topic (97%). This was followed by: sexually transmitted infections (93.1%), sexuality (92.1%), VCT (86.1%), drugs and sexual responsibility (82.2%), living with and management of HIV/ AIDS (78.2%) and gender and sexual violence (75%). From the figures in the table above, HIV/ AIDS knowledge was high among the respondents. The key informants also revealed that HIV/ AIDS being a common course, it enables students to have knowledge on HIV/ AIDS. Students through the ACU, are involved in behaviour change communication groups through which HIV/ AIDS messages are communicated to other students. The lecturer who participated in the

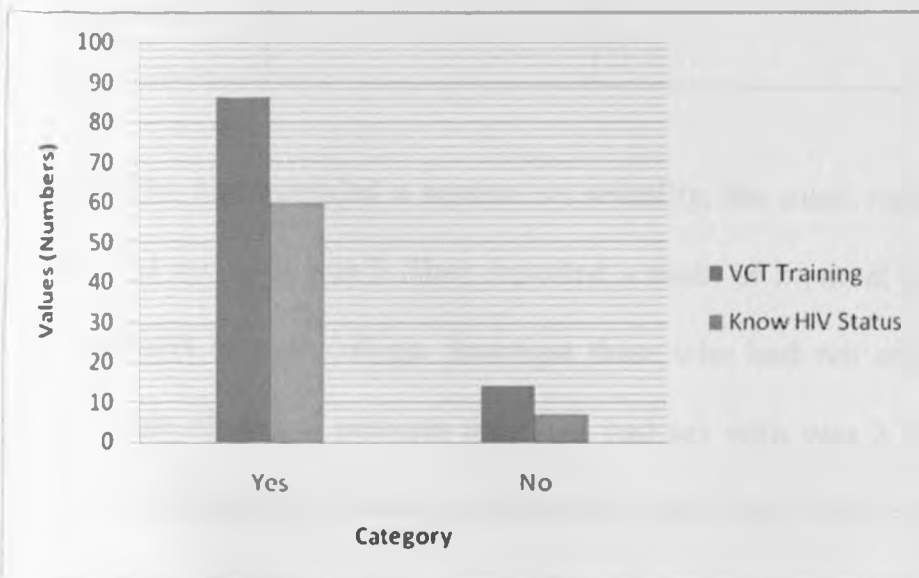
in depth interviews noted: '...the college has introduced HIV/AIDS as a common course giving the students an equal opportunity to access HIV/AIDS information...'

In determining whether HIV/AIDS knowledge necessarily leads to sexual behaviour change, an analysis was done based on the information given by the respondents on whether they had attended the training vis a vis their sexual behaviour in relation to that specific topic i.e. Knowing ones HIV status, drug abuse, condom use, number of sexual partners in and out of college.

Eighty six respondents said that they had attended training on VCT while 14 respondents reported to have not attended. A question was asked on whether they knew their HIV status irrespective of whether they had attended the course or not.

The findings were as shown in the graph below:

Fig 4.4 Training on VCT verses knowledge of HIV status



Majority (59.7%) of those who had training on VCT reported to have gone for VCT while only 50% of those who had not attended the training knew their HIV status. ICL (2006) also found out that the higher the level of HIV/AIDS training students had received, the more likely they were to report they had gone for HIV testing.

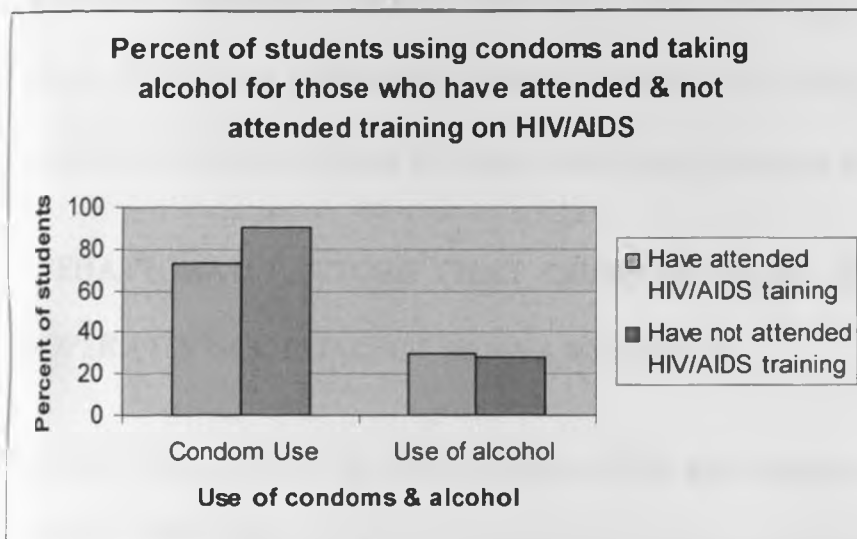
Table 4.2 Number of sexual partners for those who have attended training and those who have not attended training

Category	No of sexual partners on college (median)	No of sexual partners out of college (median)	Total number of sexual partners
Attended Training (n=57)	1	2	3
Not attended training (n=18)	1	1	2

On those who had attended a session on sexuality, the mean number of sexual partners one had had sex with was 3. They reported a mean of 1 sexual partner in college and 2 sexual partners outside college. Amongst those who had not attended the training, the mean number of sexual partners they had had sex with was 2. They reported 1 sexual partner for the number of sexual partners they had in and out of college respectively. The findings show a higher number of sexual partners outside college amongst those who had

attended a training session on sexuality and sexual responsibility than those who had not attended. Jackson (2002) notes that the more sexual partners, the greater chance that one will be infected with HIV. Therefore reducing the number of sexual partners can help reduce risk of HIV infection.

Fig 4.5 Percent of students using condoms and taking alcohol for those who have attended & not attended training



As pertains condom use, 72.9 % of those who had training on condom use reported to have used a condom compared to 90 % among those who had not had training but had used a condom.

Most of the respondents (44.7%) reported pregnancy prevention as the main reason for using condoms. Jackson (2002) notes that consistent condom use reduces infection risk substantially. The findings were consistent with those of other researchers. ICL (2006) also

found out in a research among Kenyatta University students that even though most students have knowledge on condom use, 27.6% of the students had not used a condom the last time they had sex.

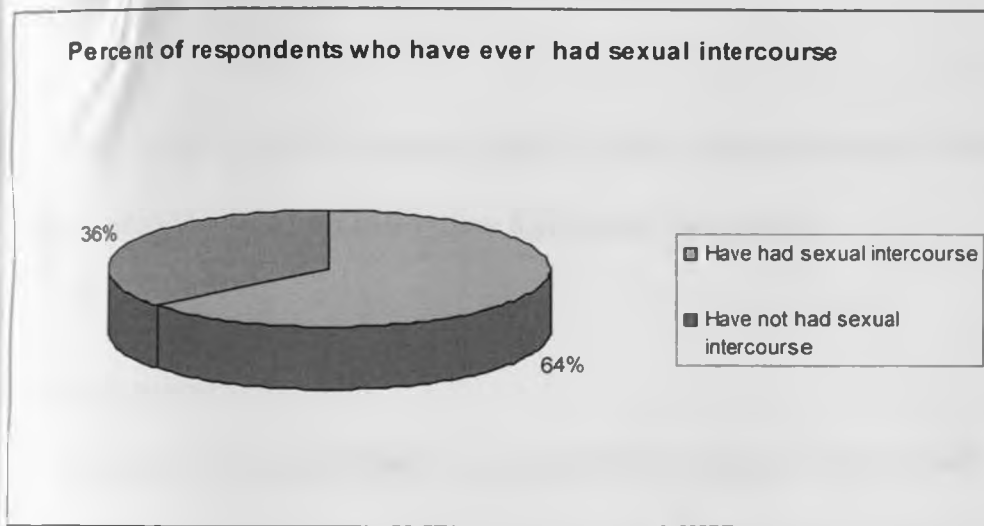
Thirty five percent of the respondents reported to be taking alcohol. In relation to training, 30.1% of those who had been trained on alcohol abuse reported to be taking alcohol compared to 27.8% who had not attended a session/topic on drugs.

The findings therefore, indicate that despite the knowledge levels being high among students, it does not necessarily translate to behaviour change. From the findings, most students have had sex while at the same time having multiple sexual partners.

4.3 BEHAVIORAL FACTORS THAT CONTRIBUTE TO HIV INFECTION AMONG CO-OPERATIVE COLLEGE OF KENYA STUDENTS

To answer this question, the respondents were to give responses focusing on their sexual experiences, HIV risk perception, participation in extra curricular activities and the role of media in determining their sexual behaviour.

Fig 4.6 Percent of respondents who have ever had sexual intercourse



Most of the respondents (64%) reported to have had sex before. The mean age at which they had their first sexual intercourse was 18. Although most (34.6%) of the respondents had one sexual partner ever since, the average number of sexual partners among all the respondents was 3 sexual partners. Ever since joining college, the majority (52.4%) have never had a sexual partner in college. 24.4% had had one and 23.2% had more than one sexual partner in the college.

However, the number was higher on the sexual partners outside college where 37.8% reported that they had more than one sexual partner outside college while 62.25% reported having one sexual partner outside college compared to 32.9% who did not have a sexual partner outside college.

Majority of the respondents (22.2%) cited curiosity and break up in relationships as the main reasons for having multiple sexual partners.

In a related study by ICL as cited in (ICL, 2006) among Kenyatta University students, 65% of the students reported having ever had sexual intercourse.

Risk perception

Most respondents (49.2%) did not perceive themselves to be at risk of contracting HIV while 39.4% perceived themselves to be at risk. 11.4% were not sure whether they were at risk or not.

To probe further among those who perceived themselves to be at risk, an open ended question was asked requiring them to specify why they thought they were at risk. This elicited a ray of responses that were categorized into 6 responses. The most common response given as a reason for those who perceived themselves to be at risk was that "everyone is at risk". This was cited by 34.6% of the respondents followed by 23.1% who cited getting into contact with the infected blood. 19.2% said they did not know their partners HIV status. Although at risk 21.2% of the respondents did not give a reason.

Leisure

The respondents were asked to state whether they participate in any extra curricula/leisure activity. Those who participate were asked to specify the extra curricula

activities they engage in for leisure. This was an open ended question and most respondents gave a list of the activities.

Most of the respondents (91.3%) participate in extra curricular activities. However, given the varying responses, it was difficult to analyse all the activities listed by each of the respondents. Thus, the first activity on the list was the one considered and therefore, coded for analysis. The list of games or leisure activities is summarised in the table below;

Table 4.3 Percent of students involved in various leisure activities (only one most enjoyed activity is considered per respondent)

Activity	frequency	%
Tennis	8	6.9
Socializing	15	12.9
Watching Movies	23	19.8
Soccer	16	13.8
Volleyball	6	5.2
Reading Novels	7	6.8
Chess/indoor games	3	2.6
Listening to Music	4	3.4
Jogging	6	5.4
Swimming	3	2.6
Dancing	17	4.7
Chatting	2	1.7
Basketbal	2	1.7
Rugby	1	9
Christian Union Singing	3	2.6
Total	116	100

The most common activity listed was watching movies (19.8%), followed by dancing (14.7%) and soccer (13.8%). In relation to the risk of contracting HIV, 36.1% did not think that what goes on while participating in their extra activities makes them vulnerable to risky behavior. Watching movies was highly mentioned (23.1%) as a risk activity followed by socializing (21.3%). Most respondents (56.9%) were not satisfied with the facilities and opportunities for leisure in college. The most common reason given was inadequate equipment (93.3%).

The most common/popular media was the internet (email) at 57.5%, video (Nigerian movies) (34.5%) and radio (kiss fm radio) 27.9%. Sexual arousal was given by most respondents (46.8%) as an effect the media had on them. This was followed by those who said the media makes them want to experiment (29.8%) while those who said the media encourages them to abstain (23.4%).

In their own opinion, drug abuse was the most common (46.9%) behavioral factor that promotes HIV infection risk among the respondents. There was a tie between Idleness and peer pressure (13.3%). From the in-depth interviews, the key informants cited alcoholism and drug abuse, lack of proper knowledge on HIV transmission and excessive leisure time as key factors promoting HIV transmission risk. The respondents felt that the college administration is not strict on rules and regulations touching on students' behaviour like

hostel visitation. However, other key informants felt that discipline among students is high given that the college has a strong Christian background.

Drug Abuse

The proportion of male who take alcohol was higher (48.2%) than the female (24.7%).

For those who had sex before, 20.8% of the male respondents and 10.2% of the female reported to have had sex under influence of alcohol. The findings indicate that the most commonly abused drug in the college is alcohol which students get from the college canteen. Other students get alcohol from an adjacent slum neighbouring the college called *Gathaka*. The respondents revealed that most students start taking alcohol when admitted to the college. They therefore, end up abusing alcohol. From the survey, most male students buy alcohol for the female students and eventually end up taking advantage of them sexually.

Injecting drug use is not common in the college from the survey but a few respondents mentioned it as one of the reasons that may make students vulnerable to HIV infection. A study by Weinreich & Benn (2004) revealed that injecting drug use in which needles, syringes and other injection equipment are shared between different users and used repeatedly entails an extremely high risk of HIV infection, if one or several users are HIV infected.

Idleness

Some respondents noted that there are few recreational facilities in the college making them indulge in risky sexual behaviours. Most respondents said that they get bored in the college because there are few activities they can engage in. Lack of enough competitive games contributes to increasing free time for students.

Lecturers missing class was also identified by 7% of the respondents as one of the reasons that makes students to be idle and eventually indulging in risky sexual behaviours. Some respondents (8.2%) said that weekends are even more boring making them (especially ladies) to opt going out of school to visit their boyfriends instead of staying in college.

In his own words, a male respondent said:

'There are limited sporting activities e.g. there is no hockey'.

Another male respondent reported:

'Just imagine we only have a TV and nothing more'

Expressing why female students spend their time with men, a female respondent said:

'The college is too boring making us spend our time with men'

Peer Pressure

Peer pressure was identified by respondents as one of the reasons that is contributing to students to involve themselves in risky sexual behaviours. A female respondent said:

'Most students come to college fresh from high school and thus get the freedom they are

not used to and hence tend to misuse that freedom by having several sexual partners'.
influence from students to their colleagues is high resulting in other students doing what
they may not do in normal circumstances. The lecturer interviewed said that most students
begin drinking when they come to college whereas others end up missing classes because
of influence from other students.

Media

The media was identified as one of the reasons that make students to engage in risky
sexual behaviours. According to most respondents, there are those students who have TVs
and computers in their rooms who screen pornographic movies.

A male respondent said:

Watching movies may lead to watching pornographic materials that may make you feel
like having sex'

A female respondent said:

'...when I see them kissing in movies and holding each other I feel like being the one...'

There was no significant gender variation when it comes to activities that make the
students vulnerable to risky sexual behaviours. Most students said they watch movies that
make them aroused and thereafter indulging in risky sexual behaviours.

1.4 THE INFLUENCE OF GENDER ON SEXUAL BEHAVIOR

Questions on the age at which the participants had their sexual debut, the number of sexual partners in and outside college, type of sexual relationship and experience of coercive and transactional sex were used in analyzing the influence of gender on sexual behavior. Responses to these questions were cross tabulated against the sex of the respondents.

The findings indicate that 77.6% of the male respondents had had sexual intercourse compared to 52.6% of the female respondents.

Mean age at sexual debut for males was 17 years while the female respondents had a higher mean age of 19 years.

The mean number of sexual partners one had was 2 for female respondents since their first sexual encounter. The number was higher for males where the mean was 4. Worth noting here is that for the male respondents the majority (28.6%) reported to have had over 7 sexual partners since their sexual debut. Many HIV/AIDS interventions have identified women and girls as target groups. Conventional male stereo types, which regard multiple sexual partners, sexual violence or unprotected sexual intercourse as proof of manhood, must be critically analyzed and corrected (Weinreich & Benn, 2004).

Glorification of sex among male students is another reasons why male students have had more sexual partners than the female students. Just like is the case in most African

societies, women are discouraged from having multiple sexual partners, probably the reason why those who have had sex before have had fewer sexual partners than their male counterparts. According to Crose-Galis (2008) power imbalances between men and women exist in varying degrees in most cultures. In the context of HIV/AIDS, these power imbalances result in women's increased vulnerability to HIV infection. Due to cultural influence, most men begin sexual activity early whereas women are encouraged to remain virgins till marriage. From the findings, that explains the reasons why the proportion of respondents who gave abstinence as the reason why they have not engaged in sexual intercourse is higher for female students (64.5%) and lower for male students (35.5%). These findings were consistent with other studies. According to (Siegel, 1999, Hong Kong, 2002) university students reported multiple sexual partnerships with female students reporting less sexual partners compared to male students.

The findings indicate that 58.3% of the female respondents and 47.6% of the male respondents had no sexual partner in college. The reasons given by students as to why they engage in sexual activity included poverty, use of alcohol and peer pressure. Most male students lack the financial capability to support female students. Female students therefore prefer having relationships with men from outside college who can support them financially. In the same note, the respondents identified the use of alcohol as an influencing factor in the risk of HIV transmission. Male students may not be able to buy alcohol for the

female students in college, female students therefore, prefer relationships with people who can be able to take them out and buy them alcohol. The culture of female students looking down on their colleagues explains why most female students do not have sex partners in college. Most male students who do not have relationships in the college indicated that it is expensive having a relationship with a student in the college. They avoid such relationships therefore, because they are not financially endowed. Lack of trust by male students on their female counterparts also makes male students to avoid having sexual relationships in college.

Sexual coercion/violence

Most respondents (77.9%) said that their partner would seek their acceptance before having sexual intercourse with them. Very few (22.1%) reported to have experienced partners forcefully having sexual intercourse with them. With regard to gender, 20.5% of female compared to 15.2% of the male reported to have experienced their partners forcefully having sexual intercourse with them.

Voluntary Counseling and Testing

The percentage of the respondents who knew their HIV status was: Male- 59.6% and female 65.3%. The main reason given by the respondents for going for VCT was "to know my status" (47.6%).

However, there was a variance along gender lines where the common reason given by female was "to plan my life" (62.5%), while the male said "to know my status" (67.6%).

On the other hand, the common reason given for not going for VCT was fear (51.1%) given by 43.5% of male respondents and 58.3% female. This is unlike the situation in most countries in developing countries. The recently published KAIS (2008) states that overall, 36 percent of Kenyan adults' ages 15-64 have tested at least once for HIV and received results. Nearly two-thirds of Kenyans report never having been tested for HIV, and are therefore, unaware of their status and may not access appropriate services for prevention, care and management of HIV.

According to Weinreich and Benn (2004) 95% of people in poor countries - including HIV - infected persons - have no knowledge of their own HIV status. Weinreich and Benn (2004) give many reasons for that: HIV testing and counselling services are not available in sufficient quantity, tests are often relatively expensive compared to people's incomes and that the demand for VCT is low because of predominant stigma and lack of treatment, which make many people fearful of positive HIV test result. According to KAIS (2008) among those who have never been tested for HIV, the most common reason for not testing among both sexes was low perception of risk (61%). This underscores the importance of ongoing campaigns to improve knowledge about risk factors for HIV transmission and attitudes toward testing. Sixteen percent have never tested because they did not want to know their test results or were afraid others would know the results. Inter- Parliamentary Union et al. (2008) acknowledges that in many countries, only a small proportion of

persons living with HIV know their HIV status, at least in part because of the stigma related to HIV testing. HIV testing without adequate counseling is not helpful, but rather in many cases can be harmful. Support must be on hand after the test, since many clients experience a positive test result as a shock (Weinreich and Benn, 2004).

Condom Use

On use of condom, 66.6% male and 35.4% of female respondents reported to be using the condom always. The most common reason given by the male respondents for using condoms was protection against STIs (77.1%) as opposed to the female who gave prevention from getting pregnant (73.7%) as their most common reason.

From the study, it was noted that male and female students use condoms for various reasons. A big percentage of male students use condoms for prevention of STDs including HIV/AIDS whereas most female students use condoms for pregnancy prevention. Weinreich and Benn (2004) also found out in their research that in many countries, there are religious and cultural reservations about promoting the use of condoms. A study in Uganda showed that condom use was low (21% occasionally and 4.4% always) and that consistent condom use definitely lowered the risk of HIV infection. From the low consistent condom use among female students, Weinreich and Benn (2004) argue that women are often more willing than men to use condoms. They also frequently have greater difficulties in getting them to be used, since many men refuse. The same case applies to Co-operative College where female condoms are not easily available compared

to male condoms which are available in the Aids Control Unit office, dispensary and seminar centre.

Weinreich and Benn (2004) notes that in general women have a greater vulnerability to HIV infection. Unequal power positions in social life also manifest themselves in sexual relationships. Women generally have fewer possibilities than their male partners to determine whether and under what conditions sexual intercourse will occur, whether condoms are used (safer sex), etc. Gender dimensions in the fight against HIV/AIDS are important because according to KAIS (2008) a higher proportion of women age 15-64 (8.7 percent) than men (5.6 percent) are infected with HIV. This means that 3 out of 5 HIV-infected Kenyans are female.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.0 CONCLUSION

This study aimed at filling the gap in understanding behavioural factors that contribute to the risk of HIV infection among Co-operative College of Kenya students. The knowledge levels on HIV/ AIDS of the respondents were assessed. The gender dimensions and sexual behaviour of the students were also looked at. With that in mind, structured questionnaires were administered and key informants interviewed in order to collect the relevant information. The social cognitive theory provided the framework that guided the gathering and analysis of data.

Most students indicated that they have engaged in sexual intercourse and that they have multiple sexual partners both in the college and outside college. Drug abuse, idleness, peer pressure and the media were identified as factors that could increase the risk of HIV infection among students. The findings also revealed that knowledge of HIV and AIDS does not necessarily lead to behaviour change. This conclusion is made from the large number of students who have information on HIV/AIDS in relation to their sexual practices.

5.1 RECOMMENDATIONS

Recommendations from this study can be used to develop HIV/AIDS programs to address students in institutions of higher learning. They can also be adopted by researchers, HIV/AIDS practitioners and administrators in institutions of higher learning in the implementation of HIV/AIDS programs. The recommendations are outlined below.

- Lecturers should give more assignments to students and more extra curricular activities introduced so as to reduce idleness in the college. With more assignments students will have less free time to engage in non productive activities.
- Strategies to provide condoms and promote their use, are quite compatible with promoting abstinence and fidelity, and both should be accepted as elements of overall strategies to slow the spread of HIV and STIs. Condom dispensers should be placed at strategic places in halls of residence.
- Respondents felt that BCCGs that are in the college are more elitist controlled by few students. They recommended for a drive in which all students will be encouraged to join them. This will result in more students involving themselves in positive activities especially during weekends when students leave college for their homes and visitations due to boredom.

- The AIDS Control Unit should involve more Persons Living with HIV in its advocacy campaigns in the college. This will result in stigma reduction leading to more people going for VCT and having a positive attitude to PLHIV.
- Rules and regulations need to be put in place on hostel visitation. Students who miss class should also be punished to discourage students from engaging in any other activities during class time.
- Counselling sessions should be held regularly in the college to enlighten students on dangers of unsafe sex, drug abuse and negative peer pressure. This is because drug abuse and peer pressure were identified as reasons that could increase the risk of HIV infection among students. The use of role models should also be encouraged as way of fighting HIV/AIDS.

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APPENDIX 1

QUESTIONNAIRE

Dear respondent,

My name is Joshua Ongwae, a second year postgraduate student pursuing MA (Gender and Development Studies) in the University of Nairobi. I am carrying out a study to determine the behavioural factors that contribute to HIV infection risk among college students: The case of Co-operative College of Kenya. I am kindly requesting you to voluntarily answer this questionnaire to the best of your knowledge. The findings will be helpful in developing HIV/AIDS intervention strategies for the college. The information you give will be treated with **strict confidentiality** and will **only** be used for purposes of this study. For confidentiality purposes do not write your name on the questionnaire. You are free to decide either to participate or not to participate in this study and there are no repercussions for deciding not to participate. I will however, be glad if you accept and choose to fill this questionnaire.

SECTION A: PERSONAL INFORMATION

001 Age	002 Gender	003 Religion	004 Year of study	005 Course	006 Marital status
a. Below 20yrs <input type="checkbox"/>	1. Male <input type="checkbox"/>	1. Christian <input type="checkbox"/>	1 st yr <input type="checkbox"/> 2 nd yr <input type="checkbox"/>	a. Dip P/S 111 <input type="checkbox"/>	1. Married <input type="checkbox"/> 2. Single <input type="checkbox"/>
b. 21-22 yrs <input type="checkbox"/>	2. Female <input type="checkbox"/>	2. Muslim <input type="checkbox"/>	3 rd yr <input type="checkbox"/>	b. Dip P/S II <input type="checkbox"/>	3. Cohabiting <input type="checkbox"/> 4. Divorced <input type="checkbox"/>
c. 23-24 yrs <input type="checkbox"/>		3. Hindu <input type="checkbox"/>		c. Dip P/S I <input type="checkbox"/>	5. Separated <input type="checkbox"/>
d. 25-30 yrs <input type="checkbox"/>		4. Buddhist <input type="checkbox"/>		d. Dip I/S Mvmt <input type="checkbox"/>	6. Widowed <input type="checkbox"/>
e. 30+ <input type="checkbox"/>		5. Others (specify) <hr/>		e. CCA <input type="checkbox"/>	7. Other (specify) <hr/>
				f. CBAI <input type="checkbox"/>	
				g. CBAII <input type="checkbox"/>	
				h. DCB <input type="checkbox"/>	
				i. CCB <input type="checkbox"/>	

SECTION B

TO DETERMINE WHETHER THE LEVEL OF HIV/AIDS KNOWLEDGE CONTRIBUTES TO CHANGE OF SEXUAL BEHAVIOUR

1. Have you ever attended any training on HIV/AIDS?

a. Yes

b. No

(If 'NO' proceed to question 2)

b. If YES, what topics were you trained on?

a. HIV/AIDS Transmission.....

b. Sexually Transmitted Infections.....

c. Sexuality (Abstinence, Being Faithful and Condom Use).....

d. Voluntary Counseling and Testing.....

e. Gender and sexual Violence.....

f. Drugs and Sexual responsibilities.....

g. Living With and Management of HIV/AIDS.....

h. Any other.....

2. Do you think you are at risk of contracting HIV?

a. Yes

b. No

(If No, proceed to Section C)

B.) If yes, why do you think you are at risk of contracting HIV?

SECTION C

THIS SECTION CONSISTS OF QUESTIONS SEEKING DATA ON YOUR SEXUAL EXPERIENCES. PLEASE TICK/EXPLAIN WHERE APPLICABLE

1. Have you had sexual intercourse before? () YES () NO

(If 'NO' proceed to question 3)

If YES,

(A) At what age did you have your first sexual intercourse? _____

(B) How many partners have you had sexual intercourse with since then?

() 1 () 2 () 3 () 4 () 5 () 6 () 7 or more

(C) (i) Since you joined college to date, how many sexual partners have you had

(a) ON COLLEGE _____

(b) OUT OF COLLEGE _____

(D) If you had more than one in [(C) i] above, what reason(s)

Encouraged/influenced you to have more than one sexual partner?

(E) What type of sexual relationship do you currently have?

a. *Regular/dating*

b. *Casual*

c. *Cohabiting*

d. *Married*

e. *Engaged*

f. *Others (specify)* _____

F. (a) Have you had any of the following experiences?

(i) Your partner forcefully having sexual intercourse with you () YES () NO

(ii) Your partner seeking your acceptance before having sexual intercourse

with you () YES () NO

(G) In F above, if you ticked YES in any of the question(s), please indicate in the table below how often you have had the experience(s)

	LESS OFTEN	OFTEN	MORE OFTEN	ALWAYS
I				
II				
III				

H.) Have you ever been paid to have sexual intercourse?

() YES () NO

2. (a) (i) have you used a condom before? () YES () NO

(If 'NO', proceed to C)

(ii) If YES, how often do you use a condom?

Never Less often Often More often Always

(b) Why do you use a condom?

(i) To prevent myself from contracting HIV, YES NO

(ii) To prevent pregnancy, YES NO

(iii) To prevent myself from contracting other STDs YES NO

(iv) I did not trust my partner YES NO

(iv) OTHERS:

(c) If NO, why don't you use a condom?

(i) It is time wasting YES NO

(ii) It is not fashionable YES NO

(iii) My partner does not like it YES NO

(iv) My church forbids YES NO

(v) I have never had sex () YES () NO

(vi) I trust my partner () YES () NO

(vii) I enjoy sex best without a condom () YES () NO

(viii) Others _____

d. Would you recommend the use of condoms to your friends?

a. Yes

b. No

3. a.) Do you take alcohol?

a. Yes

b. No

b. If you have had sex before, have you at any time had sex because you were under the influence of alcohol?

A Yes

b. No

4. If you have **NOT** had sex before, what are the two main reasons that you have not had sex?

(i) _____

(ii) _____

5. a.) Have you ever been tested for HIV?

a. Yes

b. No

b.) If No, what are the main reasons why you have not gone for HIV testing?

c.) If Yes, Why did you go for VCT?

SECTION D

QUESTIONS IN THIS SECTION SEEK INFORMATION ON HOW YOU SPEND YOUR LEISURE TIME AND HOW YOUR LEISURE ACTIVITIES AND EXTRA CURRICULA ACTIVITIES INFLUENCE YOUR SEXUAL BEHAVIOUR. PLEASE TICK/ LIST/ EXPLAIN AS APPLICABLE;

1. Do you participate in any leisure/ extra curricula activities? () YES () NO

If YES, Please continue to question 2

If NO, why? _____

2. (a) which leisure/ extra curricula activities do you involve yourself with?

_i) _____

_ii) _____

_iii) _____

(b) In view of what goes on during these leisure/ extra curricula activities (2a above), which ones of them do you feel make you vulnerable to risky sexual behaviours?

4. (a) Are facilities and opportunities for leisure / extra curricula in college satisfactory?

() YES () NO

(b) If NO, please explain;

5. (a) What are your popular media programmes (shows)? Please indicate below:

(i) Radio _____

(ii) Television _____

(iii) Internet _____

(iv) Video _____

(b) Do they in anyway influence your sexual behaviour? () YES () NO

If YES, please explain _____

6. What steps would you recommend for the college to take so as to reduce students' involvement in activities that predispose them to risky sexual

behaviours?

(a) _____

(b) _____

(c) _____

(d) _____

21. In your opinion, what behavioural factors promote HIV infection risk among Cooperative College of Kenya students?

APPENDIX 2

KEY INFORMANT INTERVIEW GUIDE

QUESTIONNAIRE

Dear respondent,

My name is Joshua Ongwae, a second year postgraduate student pursuing MA (Gender and Development Studies) in the University of Nairobi. I am carrying out a study to determine the behavioural factors that contribute to HIV infection risk among college students: The case of Co-operative College of Kenya. I am kindly requesting you to voluntarily take part in the survey. The findings will be helpful in developing HIV/AIDS intervention strategies for the college. The information you give will be treated with **strict confidentiality** and will **only** be used for purposes of this study. You are free to decide either to participate or not to participate in this study. I will however, be glad if you accept and choose to take part in the survey.

1. In your opinion, are students at risk of contracting HIV/AIDS?

YES NO

If YES, why?

2. a.) Do you think the college administration is doing enough in the fight against HIV/AIDS?

YES NO

b.) If NO, what more can the college do in the fight against HIV/AIDS?

c.) If YES what is the college doing in the fight against HIV/AIDS infection in the college?

3. What is your opinion on the level of HIV/AIDS knowledge among students?

(Probe)

4. a.) Are there any college rules regulating the behaviour of students in regard to the time they should be in school or visitation in their hostels?

YES NO

b.) Please explain your answer.

5. In your opinion, what behavioural factors promote HIV infection risk among students?

6. a.) What facilities has the college provided for leisure and extra curricula activities for students?

b.) Do you think they in anyway influence the students' sexual behaviour?

YES NO

c.) If YES, please explain _____

What steps would you recommend for the college to take so as to reduce students' involvement in activities that predispose them to risky sexual behaviours?

(a) _____

(b) _____

(c) _____

(d) _____

Open it up for other comments or questions.