# KNOWLEDGE, ATTITUDES AND PRACTICES CONCERNING HIV/AIDS PREVENTION AMONG YOUTH IN EASTLEIGH LOCATION IN NAIROBI COUNTY

**BY**

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**DECLARATION**

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

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This research project has been submitted for examination with my approval as University of Nairobi supervisor.

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**DEDICATION**

To my Dear mother Felister Wairimu Ndeng’e.

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I would like to express my gratitude to God for being with me through the process of writing this research project and also for giving me the gift of patience, perseverance especially when things did not go the way I had planned. A great lesson I learnt.

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| | |
|---|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| ARRM | Aids Risk Reduction Model |
| HIV | Human Immunodeficiency Virus |
| HBM | Health Belief Model |
| KDHS | Kenya Demographic Health Survey |
| MARPS | Most at Risk Populations |
| NACC | National AIDS Control Council |
| NASCOP | National AIDS and STD Control Program |
| SPSS | Statistical Package for Social Scientist |
| STD/I's | Sexually Transmitted Diseases/Infections |
| PLWHA | People Living with HIV/AIDS |
| UNGASS | United Nation General Assembly Special Session |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| WHO | World Health Organization |

**ABSTRACT**

Good knowledge, attitudes and practices (KAP) of HIV prevention are essential in order not to acquire HIV infection and to prevent the disease from spreading. A proper and well-functioning prevention of HIV requires clear and relevant information and instructions from health care givers. The purpose of this study was to investigate the knowledge, attitudes and practices concerning HIV prevention among youth in Eastleigh location in Nairobi County and compare these between genders. A descriptive and comparative cross sectional survey design was used.

A sample of fifty youth was drawn by use of simple random sampling, as it was considered appropriate for the reason of increasing the accuracy of the findings and also for it to ensure high percentage involvement by the subject. 50 Youth participated by answering a questionnaire on knowledge, attitudes and practices concerning HIV/AIDS prevention among the youth in Eastleigh.a group of 2 focus group discussion consisting of 10 members of whom were youths in Eastleigh and 5 key informants were included in the study.

The Health belief model (HBM) and Aids Risk Reduction Model (ARRM) was provided as theoretical framework. The data was collected in secondary schools and those in post-secondary learning institutions in Eastleigh location, Nairobi County. Most of the youths had heard of HIV/AIDS, and overall male had better knowledge than female.

Less than Fifty percent of the female reported they had ever received information on HIV/AIDS. There were significant differences between genders in several statements concerning knowledge, attitudes and practices. The male and female youths in Eastleigh had different knowledge, attitudes and practice of HIV prevention. Peer Educators, Teachers/Lecturers and Health care professionals should consider gender and culture when providing intervention programs to The Youth.

# CHAPTER ONE

# INTRODUCTION

## 1.1 Background

HIV/AIDS is a global challenge that has threatened the very existence of the human race. Acquired Immune Deficiency Syndrome (AIDS) is caused by a human immunodeficiency virus (HIV) that weakens the immune system, making the body susceptible to opportunistic diseases that often lead to death. Today HIV is a global disease and approximately 33 million people worldwide suffer from this disease (UNAIDS, 2010). The number of people living with HIV has increased by 27 % over the past 10 years. The impact of the disease has been mainly felt through the mortality that disproportionately affects women and men during the prime of their productive life. The consequences of the epidemic span across all spheres of life (individuals and communities nationwide). It has imposed a severe and unsustainable burden on the meager health sector resources, as funds are diverted from other areas to HIV prevention and AIDS care and treatment services. HIV infection has also given rise to an epidemic of opportunistic infections, notably tuberculosis (TB), (UNAIDS, 2008).

As a national priority, many countries have shown a great commitment in the fight against HIV/AIDS. Different programs and projects have been designed in such a way that individual and community organizations are involved and receive the appropriate share of national and international donor resources. Government tried to set multi-sectorial approaches to AIDS with the aim of reducing the spread of virus, protecting the rights of PLWHA and reducing the stigma and discrimination that often hamper prevention efforts.

In many of the developing countries there is lack of evidence-based HIV infection prevention and treatment, which increases the risk that the disease will spread even more. In some countries police harassment, incarceration, human rights violence and social stigma occur against people with HIV, which causes people not to seek medical care and uncontrolled spread of the disease continues (Mayer & Beyrer, 2007). Certain behaviors can also put individuals at greater risk of being infected with HIV and inconsistent condom use is one of the major risk factors for acquiring the virus (Pinkerton & Abramson, 1997). Having unprotected vaginal or anal sex,

suffering from other sexual transmitted infections, having multiple sexual partners, sharing injection equipment and not having enough prevention knowledge and education about the virus are other risk factors (Coates, Richter & Caceres, 2008). Receiving blood transfusions, unsafe injections and medical operations that involve unsterile cutting also put people at risk (WHO, 2011). Insufficient knowledge about the disease is also a major risk factor for contracting HIV (Fuller & Chamratrithirong, 2009).

HIV attacks multiple cell types in the body. These cells have receptors on their membranes that the virus can bind to and then penetrate into the cell. The virus infects the cells and destroys them and causes the body's immune system to break down. Many people have a short period of fever, sore throat and swollen lymph nodes a few weeks after the virus first infected them (Coco & Kleinhans, 2005). It may take several years of actual infection though before individuals receive multiple symptoms. AIDS is the most advanced stage of HIV infection and occurs when a sufficient number of T4-lymphocytes have been destroyed. (Andreassen,Haegeland& Wilhelmsen, 2006). When the immune system is impaired by the disease common complications occur such as pneumonia, tuberculosis, chronic diarrhea, skin ailments and other opportunistic infections (Walensky et al. 2006). Cardiovascular diseases, neurologic impairment and tumors are other common complications (Ho & Hsue, 2009).

To diagnose HIV blood tests are taken to detect these antibodies or antigens. It can take the body a couple of weeks to develop antibodies to the virus and depending on the initial time of exposure follow-up tests may be needed (UCSF Medical Center, 2012). The enzyme-linked immunosorbent assay test (ELISA-test) is used to detect HIV infection and if the test is positive it is usually supplemented with the Western Blot-test to confirm the infection. RNA viral load test, saliva test and home tests are also used to confirm HIV (Chu & Selwyn, 2010). Retesting should also be done after three months to confirm earlier test results (WHO, 2011).

HIV cannot be cured but antiretroviral (ARV) drugs can control viral replication and allows an individual's immune system to regain and strengthen power to fight off infections. The treatment often consists of a combination of at least three drugs and the different drug Combinations are adjusted to each individual. It is essential that the treatment adherence sustains or the drug

concentrations may reduce and the virus can start to replicate again. If the virus starts to replicate when using drugs inconsistently there is a risk that the virus will develop resistance to these drugs (Läkemedelsverket, 2011). Adverse drug reactions are also a common problem, such as cardiovascular side effects (Friis-Möller et al. 2003).

Prevention is of great importance to combat the spread of HIV/AIDS globally, where multilayered social, political and economic efforts are needed to reduce the HIV risk and vulnerability. The biggest goal of HIV prevention is to change individuals risk behavior. For the past 30 years HIV prevention has been dominated by behavioral interventions that seek to influence attitudes, knowledge and behaviors. Where sexual-health education, promotion of condom use and education of injecting drug users about the dangers of sharing equipment are included (Gupta et al. 2008).

Over the past 15 years there has been a sharp increase in funding from WHO, United Nations, The World Health Bank and other organizations to fight HIV/AIDS in developing countries worldwide. Resources have primarily been used on prevention, treatment and care, and in several of the developing countries there is now possible to get HIV testing and counselling at no cost (Parekh et al. 2010). According to Piot, Bartos, Larson, Zewdie & Mane (2008), sexual education is of great importance to change individuals' attitudes, practices and knowledge about HIV and STIs. The results also showed that sex education increased the delay of first sexual activity, higher rates of protected sex and improved attitudes regarding HIV and STIs. Despite increased HIV-related knowledge among the youths, there still remains resistance to openly discuss sexuality and sexual health though. This can partly be explained by cultural and religious differences, and that social changes take time (Bradley et al., 2011).

The preventive knowledge of HIV has increased globally but still less than 50% of people living in the 15 countries with the highest HIV prevalence can correctly answer basic questions regarding HIV and its transmission. The proportion of individuals who used a condom during the last sexual intercourse and number of sexual partners varies widely globally where access and information about HIV are different from country to country (Crosby et al., 2012). Many developing countries are working in several ways to extend knowledge, attitudes and practices

(KAP) on HIV prevention though. Programs have been developed to encourage sexual risk reduction and protective behaviors, such as promotion of condom use and contraception, voluntary counseling and testing, targeted information provision and needle and syringe programs. Many of the programs have led to increased HIV knowledge and practices in the developing countries (Kirby, Laris & Rolleri, 2005).

HIV is a global burden and the lack of knowledge about the disease, sexual risk behavior, weak health care, infrastructure, poverty and political and economic instability are reasons to the pandemic of the disease (Coovadia & Hadingham, 2005). Sub-Saharan Africa is the most affected area and accounts for 68% of the persons living with HIV/AIDS in the world, and also accounts for 76% of all death due to AIDS. In the industrialized world, the prevalence is much lower but vulnerable groups are racial and ethnic minorities, men who have sex with men, injecting drug users and sex workers (Cohen, Hellmann, Levy, DeCock &Lange, 2008.

In Kenya, urban residents have a significantly higher risk of HIV infection (7.2%) than rural residents (6.0%). However, even in urban areas there are huge disparities in HIV prevalence with urban slum settlements having a significantly higher prevalence of HIV than non-slum urban areas. For example, a recent study conducted in two urban slum settlements in Nairobi showed that the overall HIV prevalence in these slum settlements is estimated at 12% which is much higher than the national average (7.1%) and the overall prevalence in Nairobi (97.0%), (KNBS, 2010).

All persons between 15 – 24 years are defined as youth, (WHO, 1989). The youthful stage is a time when most people are beginning to experiment with sex and are being exposed to the dangers inherent in the process. The combination of this experimental period with other socio-cultural factors and poverty makes youths particularly vulnerable to HIV infection. Youth constitute a considerable proportion of the world's population and are one of the most dynamic human resource bases (Ross et al., 2006).

In many African countries young people are denied access to information, education, and services. Since the existence of premarital sex is often denied, family planning services,

contraception and condom use are only acceptable and provided for married couples. While the acceptability of talking about HIV/AIDS in schools increases, sex education is still forbidden in many countries because of the belief that it incites young people to have sexual intercourse (Ross et al., 2006).

Data from the 2007 Kenya AIDS Indicator Survey show a dramatic difference in HIV prevalence between 15-19 year olds (2.35) and 20-24 year old (5.2%), (NASCOP, 2007). Female youth are significantly more likely to be infected than their male peers. For instance, among 15-19 years olds, 3.5 of females are 1% males are HIV positive, while among 20-24 year old, 7.4% and 1.9%, respectively, are infected (NASCOP,2007).

Nationally, roughly half of all 15-49 year olds (48% of women and 55% of men) reported becoming sexually active before age 18 (KNBS, 2010). One in nine women (11%) and more than one in five men (22%) surveyed in 2008-2009 said they had sex before age 15. Young women in Nyanza Province are especially prone to early sexual debut, with an average age of first intercourse of 16.5 years, compared to 20.3 years for women in Nairobi (KNBS, 2010). The percentage of Kenyans who became sexually active at an early age has declined over the course of epidemic. While 16.3% of Kenyan women reported first having sex before age 15 in 1993, only 11% interviewed in 2008-2009 said they had sex before 15. The percentage of men who reported becoming sexually active before age 15 fell from 32.5% in 1998 to 22% in 2008-2009. Survey documented similar reductions for both women and men who said they first had sexual intercourse between ages 15-19. Condom use is rare during young people's first sexual episode. In 2008-2009, 25.5% of Kenyan women (ages 20-54) and 28.4% of Kenyan men said the used a condom the first time they had sex (KNBS, 2010). However, these figures represent a notable increase over rates of condom use at first sex reported in 2003 (11.9% for women and 14.0% for men) (Central Bureau of National Statistics, 2004). Survey have consistently found that young men are more likely than young women to use a condom the first time they have sex (NASCOP, 2009).

Among young men in Kisumu, only 7% said they always used a condom, with 19% reporting that they never used one (Westercamp et al., 2008). As with their adult counterparts, young

people are more likely to use condom when they purchase or sell sex than during sexual intercourse with a regular partner (Westercamp et al., 2008). Among sexually experienced male high school students in Nairobi, consistent condom users typically initiated sexual activity at an older age, reported more positive peer attitudes about safe sex, and had higher condom self-efficacy (Kabiru, Orpinas, 2009).

Inter-generational relationship especially those involving younger women and older men have long been considered an important factor in the disproportionate risk of infection encountered by girls and young women. In Kisumu, 13.9% of 15-21 year old women surveyed reported having had sex with a man who was 10 or more years older (Hewett et al., 2004). There is some evidence that the prevalence of intergenerational partnership may be on the decline as the proportion of young women ages 15-24 reporting sex with partner more than 10 years older fell from 4.0% in 2003 to 3.7% in 2008-2009.

The probability that adolescents and young people will acquire HIV depends on many factors, including whether they engage in HIV risk behaviors such as unprotected sex with an infected partner or using non-sterile injecting equipment (UNICEF, 2008). The association between knowledge and sexual behavior has been reported by several researchers (Shapiro et al., 1999 & Ford et al., 2000). Many programs focused on young people fail to address some of the key determinants of vulnerability (UNAIDS, 2009) and the most effective prevention programs are those that use a combination of strategies to achieve maximum impact (Auerbach & Coates, 2009). This study makes several contributions to the growing literature on Knowledge, Attitudes and Practices Concerning HIV/AIDS Prevention in Kenya, specifically among youth age between 15-24 years in Eastleigh Nairobi-County.

## 1.2 Problem statement

HIV is a global disease especially spread in the developing countries, which is a major concern (UNAIDS, 2010). The African population represents almost 70% of total HIV cases worldwide where the majority is young Africans aged 15-24 (UNAIDS, 2010).

The impact of HIV/AIDS is felt first by the individual, the families and eventually it ripples outwards towards firms, business enterprises and then to the economy of the country. Youth are at the center of the global HIV/AIDS pandemic, they are the world's greatest hope in the struggle against this fatal disease. Today's youth have inherited a lethal legacy that is killing them. An estimated 11.8 million youth aged 15 – 24 years are living with HIV/AIDS, (UNAIDS, 2010). Studies suggest the target groups such as secondary, post-secondary (college and university) students are at increased risk of transmission (Yerdaw, Nedi, Wheeler, & Grosskurth, 2004), yet few authors have comprehensively examined the knowledge and attitudes of HIV/AIDS among vulnerable groups. A number of youth are reluctant to undergo positive behavior change in spite of extensive information through awareness campaigns.

At present, there is no country in the world without HIV cases (WHO 1995). Kenya has the largest population of people living with HIV in sub-Saharan Africa and the highest national HIV prevalence of any country outside Southern Africa (UNAIDS, 2008). As people living with HIV are living longer as a result of improved access to HIV treatment, it is anticipated that the total number of HIV infected individuals in Kenya will continue to increase, approaching 1.8 million by 2015 (NASCOP, 2012). As of December 2011, 1.6 million people in Kenya were living with HIV (NACC & NASCOP, 2012). An estimated 49,126 people died of AIDS-related causes in 2011, slightly more than one-third the annual numbers who died in 2002-2004 (NACC & NASCOP, 2012). Each year roughly 0.5% of the Kenyan adult population (or 1 out of every 200) is newly infected.

The future of HIV in Kenya will in large measure be determined by success in preventing new infection among the millions of young people who will become sexual active in the next few years. Although fewer young people are becoming infected in Kenya than at earlier stages of the

epidemic (UNAIDS, 2010), HIV represents a continuing threat to young people in Kenya. Among 20-24 years olds, more than 11 in 25 (4.2%)) are already infected when they enter young adulthood (Kenya National Bureau of Statistics, 2010). Among 15-19 year olds, women are nearly four times more likely to be infected than males (2.7% to 0.7%). In addition to being more physiologically vulnerable to sexual transmission than males, young women in Kenya (ages 15-24) are less likely than males their own age to have accurate and comprehensive knowledge of HIV (47.5% vs. 54.9%), (Kenya National Bureau of Statistics, 2010).

Early sexual debut is strongly correlated with increased risk of HIV infection for women in Kenya but not for men. Women who reported in 2008-2009 that they were less than 16 when they had their first sexual intercourse were more than twice as likely to be HIV-positive as women who begun having sex as a late age (KNBS, 2010). By contrast, men who first had sex after age 20 were more than twice as likely to be HIV-positive as men who had earlier sexual debut.

The disease is not curable and prevention is therefore crucial, but for a successful prevention an improved knowledge about the disease is needed. Lack of preventive knowledge increases the risk of acquiring the disease and transmitting it to others (WHO, 2011). In order to realize greater success of programs in Eastleigh, it is necessary to address the reason for the observed reluctance. Proper and functioning HIV prevention for youth require good knowledge about the disease and also access to health care. To inform the youth about the disease should be considered a major issue for health care providers to pay attention to.

Good knowledge, attitudes and practices (KAP) of HIV prevention are essential in order not to acquire HIV infection and to prevent the disease from spreading. A proper and well-functioning prevention of HIV requires clear and relevant information and instructions from health care givers. Therefore, it is important to examine the HIV prevention knowledge, attitudes and practices among the youth in order to increase knowledge and understanding among health care providers, to be aware about this risk group and to prepare information and intervention programs of HIV prevention for the youth.

This research endeavored to investigate the Knowledge, attitudes and practices concerning HIV/AIDS prevention among youth in Eastleigh location. This study was guided by the following questions:

i. What is the level of knowledge of HIV/AIDS among the youth in Eastleigh?
ii. What is the attitude of the respondents towards HIV/AIDS?
iii. Which are the sexual practices adopted by youth towards HIV/AIDS prevention?
iv. What extent are HIV/AIDS prevention practices informed by knowledge and attitudes towards HIV/AIDS?

## 1.3 Objectives of the Study

### 1.3.1 Main Objective

The main objective of the study is to investigate Knowledge, Attitudes and Practices Concerning HIV/AIDS Prevention among the youth in Eastleigh Location of Nairobi County.

### 1.3.2 Specific Objectives

The specific objective of this study is to:

i. To establish the level of knowledge of HIV/AIDS among youth in Eastleigh.
ii. To examine the attitudes of youth in Eastleigh towards HIV/AIDS.
iii. To identify sexual practices adopted by the youth towards HIV/AIDS prevention.
iv. To establish the extent to which HIV prevention practices are informed by knowledge and attitudes towards HIV/AIDS in Eastleigh.

## 1.4 Justification of the Study

At the end of 2010, an estimated 33 million people were living with HIV worldwide, up 17% from 2001. This reflects the continued large number of new HIV infections. (UNAIDS World AIDS Day Report 2011) The annual number of new HIV infections is roughly one-third the numbers in 1993, when Kenya's epidemic peaked. Young adults are a vulnerable population in Kenya, a country where the majority of the population becomes sexually active between 15 and 19 years of age. Young people's vulnerability is associated with several potentially risky situations, including experimental behavior, initiation into sex, alcohol and drug use and getting involved with different social groups (Bisol et al., 2008).

The future of HIV in Kenya will in large measure be determined by success in preventing new infections among the millions of young people who will become sexually active in the next few years. (UNAIDS, 2010). Among 20–24-year-olds, more than 1 in 25 (4.2%) are already infected when they enter young adulthood (Kenya National Bureau of Statistics, 2010). In countries with generalized epidemics, a combination of behavior changes, including reductions in numbers of sexual partners, increases in condom use, and delayed age of first sex, have reduced new infections (incidence) in several countries. (UNAIDS World AIDS Day Report 2011)

In African countries, with long severe epidemics, half of all infected people acquired HIV before they are 25 years. Infection with a sexually transmitted disease, especially one that causes genital ulcers, such as herpes or syphilis, puts one at increased risk of HIV infection, and sexually active youth in sub-Saharan Africa are at high risk for STD infection (UNAIDS 2003). Although Kenyans exhibit high levels of HIV-related knowledge and have collectively adopted notable changes in sexual behaviors, substantial unsafe sexual behavior still persists. Condom use remains sub-optimal, and many Kenyans have multiple sexual partners (UNAIDS World AIDS Day Report 2011). The focus of the many interventions put in place by the Government is to prevent new infections of people in all stages of their lives. Hence prudent to investigate the mechanisms individuals have put in place to prevent themselves from getting HIV.

Ross et al., (2006) observed that the second decade of life is a period of experimentation and risk taking and this factors increase young persons' vulnerability to HIV during these years of rapid physical and psychosocial development. These factors include a lack of knowledge about HIV/AIDS, lack of education and life skills, poor access to health services and commodities, early sexual debut, early marriage, sexual coercion and violence, human trafficking and growing up without parents or other forms of protection from exploitation and abuse.

Sub-Saharan African youth between the ages of 15 and 24 are particularly vulnerable to HIV and other sexually transmitted infections (STIs) (Bankole, Singh, Woog, and Wulf, 2004; Khan and Mishra, 2008), representing 41 percent of all new infections across the continent (UNICEF, 2011b). Globally, it is estimated that 2,500 new infections occur each day among youth, 79 percent of which take place in sub-Saharan Africa (UNICEF, 2011b). The 15 to 24 age group

represents the largest risk category in contracting HIV (Bankole et al., 2004; Hindin and Fatusi, 2009).

Significant drops in HIV/AIDS rates, later marriage, and increases in barrier protection are being reported in several Western European countries. These changes are directly associated to reproductive health beliefs, attitudes, values, and practices among youth. However, there are still groups that are vulnerable to lack of sex and relationships education and are not using protection against HIV/AIDS. Which are requirements for ushering the vision of a world with zero new HIV infections, zero AIDS deaths, and zero AIDS discrimination.

The future of Kenya's epidemic will be determined in large measure by the success of efforts to slow or stop completely the spread of HIV among young people. Prevention programs should aim to build on statistically significant declines in HIV prevalence that has occurred over the last decade among both young men and women**.** (The Kenya AIDS epidemic update 2011)

### 1.5 Scope of the study

This study was conducted among the Youth of Eastleigh between (15-24) years, those in Secondary Schools and tertiary colleges. A sample size of 50 respondents was selected to represent the general youth in Eastleigh, which consisted of two (2) schools; a mixed secondary school and a tertiary college. The research was conducted by extensive distribution of questionnaires and follow up. The scope of the study addressed issues involved with the knowledge, attitude and sexual practices among the youth in Eastleigh. The study will be limited to the youth in School and institutions of learning and therefore youth out of school were not included. The study provides an exploratory finding in the Kenyan context, and presents opportunities for further research.

### 1.6 Limitation

Although, this study is the first of its kind to be conducted among the youths in Eastleigh and it has revealed many interesting facts, this study has its limitations.

First of all, the questionnaire was a researcher made, although with due consideration and consultation, it still could be improved with different factors clearly distinguished. Secondly, since the questionnaire was a "self-report measure" the possibility of bias cannot be ruled out,

perhaps a personal interview with the youths might give much more in-depth information. Thirdly, there is a possibility of selection bias as the focus was only on the youth in secondary schools and those in post-secondary learning institutions. The youths outside the classrooms like the drop outs or those who have never enrolled in school were not taken into consideration.

## DEFINITION OF TERMS

**Knowledge:** A clear awareness of fact or situation. (Hornby, 1995) In this study it is defined as a clear and certain understanding of HIV/AIDS mode of transmission and prevention as well as condom use.

**Sexual Practices-** These activities associated with sexual intercourse

**Risk**- Refers to personal vulnerability to HV/AIDS.

**Risky sexual practices**: Unprotected sexual intercourse (sex without condom use consistently) with non-regular partner(s)

**Attitude:** Attitude is an opinion or general feeling about something. (Microsoft Encarta 2007) In this study, attitude is defined as a belief towards HIV disclosure (Perceived risk of getting HIV) and belief towards the effectiveness, perceived benefits of condom use in preventing HIV.

**Sexual active Youth:** Refers to students/ young people who have had sex.

**HIV/AIDS preventive practices:** These are actions or practices that the youth engage in that enables them not to acquire HIV

# CHAPTER TWO
# LITERATURE REVIEW AND THEORETICAL FRAME WORK

## 2.0 Background

Since detection in 1981 in the United States, AIDS has become a worldwide epidemic spreading albeit unevenly across continents, countries, age groups and socio-economic classes. AIDS results in progressive impairment of the human immune system and the consequent emergence of various opportunistic infections. HIV infection is the first stage of a process that leads to AIDS. After entering the human host, HIV attacks white blood cells of the immune system and destroys them. There are several modes of transmission of HIV; Female to male unprotected sex both virginal and anal, male to male unprotected anal sex, through contaminated instruments for example needles and safety pins, perinatal transmission from mother to child and transfusion of blood from an infected person to non-infected person. The most common mode of transmission is through heterosexual and homosexual unprotected intercourse. (Akol et al, 2000)

In sub-Saharan Africa the most common mode of infection is through heterosexual intercourse. The risk of infection increases with the number of sexual partners. High rates of partner exchange, the practice of certain types of intercourse and the presence of anal or genital lesions combine to increase the risk of HIV infection. (Akol et al, 2000)

Populations at risk of HIV infection and AIDS vary by geographical region. In Northern America homosexual males and injecting drug users have the highest prevalence of AIDS. In Africa and most parts of the Caribbean, the highest prevalence levels are found among heterosexual persons, especially those with numerous sexual partners (Palloni and Glicklich, 1989)

At the end of 2010, an estimated 34 million people were living with HIV worldwide, up 17% from 2001. This reflects the continued large number of new HIV infections and a significant expansion of access to antiretroviral therapy, which has helped reduce AIDS-related deaths, especially in more recent years. Sub-Saharan Africa also accounted for 70% of new HIV infections in 2010, (UNAIDS World AIDS Day Report | 2011)

The odds of being infected increase as individual's transition from adolescence to adulthood. HIV is most likely to affect young adults. (The Kenya AIDS epidemic update 2011)
Although HIV/AIDS was first diagnosed among Homosexuals in the United States in 1981, it remained largely unknown in Kenya until late 1984. Most Kenyans thought of it only in the abstract, as a disease of the homosexuals and immoral.

Kenya has what is known as a "generalized" epidemic, with the virus having spread beyond discrete groups to affect the whole of society. (The Kenya AIDS epidemic update 2011)With a significant proportion of the national population already infected, the risks of encountering HIV during any single episode of risk behavior are considerable, meaning that relatively low levels of risk behavior may nevertheless carry a substantial likelihood of transmission.

The first case of HIV was diagnosed in Kenya in September 1984 (The Kenya AIDS epidemic update 2011) which was then reported in an East African Medical journal. The victim was a Ugandan Journalist based in Kenya, which helped perpetuate the notion that HIV/AIDS was a disease of other people, not Kenyans. The disease spread very rapidly, this was aided by deafening silence and stigma attached to it because the first cases were among the commercial sex workers. HIV/AIDS was therefore considered as the disease of the immoral in the society.
By 1994 however, the negative impact of HIV/AIDS started to be felt in all sectors of the Kenyan Economy as the most productive members of the labor force begun to succumb to it. NGO's were formed to curb its spread and mitigate its impacts, but the government still maintained its silence and tackled HIV/AIDS mainly as a health problem.

By 1999, the devastating impact of HIV/AIDS was manifest in all sectors of the economy as the most productive members succumbed to the disease or became incapacitated, leaving massive labor vacuum and huge medical bills. Productivity decreased, the economy began regressing, the numbers of HIV/AIDS orphans increased by the day, families were left destitute upon the death of bread winners and the social system began to collapse as the resilience of families and communities began to diminish under the strain of coping with the impact of HIV/AIDS. The little gains so far made in reducing poverty and attaining development began reversing.
The Government could no longer maintain its silence.

In November 1999, HIV/AIDS was declared a National Disaster, 15 years after the first reported case. Even though the presidential declaration facilitated administrative changes, it lacked the force of law due to absence of appropriate legislation. In June 2001 the Attorney General formed a national task force on legal issues relating to HIV/AIDS, which drafted the HIV/AIDS Prevention and Control Bill which was adopted. The National Aids control council (NACC) was constituted to coordinate all HIV/AIDS interventions country wide and placed under the office of the President to underscore the importance of its role.

As of December 2011, 1.6 million people in Kenya were living with HIV (The Kenya AIDS epidemic update, 2011.) HIV transmission is influenced by a host of biological, social, legal, cultural and environmental factors that differ between and within settings and populations.
Heterosexual sex is the primary form of transmission in the country, and the epidemic varies greatly across demographic groups. According to the 2010 United Nations General Assembly Special Session (UNGASS) Country Progress Report in Kenya, Heterosexual sex within a union or regular partnership accounts for 44.1 percent of new HIV infections across adult population.
Young adults are a vulnerable population in Kenya, a country where the majority of the population becomes sexually active between 15 and 19 years of age.

Approximately one-quarter of young people use a condom the first time they have sex. While this is double the percent using a condom in 2003, it remains low for a country with a generalized HIV epidemic. As noted, women are disproportionately infected when compared to men, and young women are particularly vulnerable. Prevalence among young women 15 to 19 years of age (2.7 percent) is nearly four times higher than prevalence among young men of the same age (0.7 percent); prevalence in 20- to 24-year-old women (6.4 percent) shows a similar increase compared to that of their male counterparts (1.5 percent) (USAID, 2010)

Since Kenya recorded its first case of HIV in 1984, the AIDS epidemic has evolved to become one of the central impediments to national health, well-being and development. AIDS has deepened poverty; slowed economic growth; reduced life expectancy; worsened other infectious diseases; and visited particular ills on affected households, with the harshest effects experienced by women and children. (The Kenya AIDS epidemic updates 2011)

## 2.1 LITERATURE REVIEW

### 2.1.1 The HIV/AIDS prevalence among youth

In African countries, with long severe epidemics, half of all infected people acquired HIV before they are 25 years (Akukwe, 1999). Infection with a sexually transmitted disease, especially one that causes genital ulcers, such as herpes or syphilis, puts one at increased risk of HIV infection, and sexually active youth in sub-Saharan Africa are at high risk for STD infection.

The HIV/AIDS epidemic has devastating effects on most African youth who often lack access to sexual health information and services. In particular, unmarried youth have great difficulty getting sexual health services. At the same time, cultural, social and economic norms and pressures often put young African women at excess risk for HIV infection (Akukwe, 1999)

Young people are not only at the center of the HIV/AIDS epidemic, they are also the most vulnerable and the most affected section of the global population (World Health Organization, 1995). Young people's vulnerability is associated with several potentially risky situations, including experimental behavior, initiation into sex, going beyond family traditions, alcohol and drug use and getting involved with different social groups (Bisol et al., 2008)

Young people's egocentrism, belief in their invincibility, the need for self-expression and sensation seeking, which reaches its peak in late adolescence and the early twenties, make young people prone to engage in physical and social risk taking behaviors (Plattner, 2010). These behaviors are often part of the transition from childhood to adulthood that is characterized by getting to know oneself, while usually lacking the information, will and skills that would enable young people to avoid high risk behaviors (Odu et al., 2008)

Various factors make youth particularly susceptible to infection of HIV. They include some discussed below;

### 2.1.2 Limited recognition of personal risk of HIV infection

In studies of nine African countries, among sexually experienced adolescent women and men aged 15-19 years, between 40 and 87 percent of respondents in seven countries believed they had

little or no risk of contracting HIV/AIDS. There is a prevalent belief, in most cases, that one is not at risk by having only one partner, owing to awareness of other risk factors such as sexual history and partners having other sexual partners. (Population Bureau, 2001)

### 2.1.3 Biological factors

Women are more vulnerable to contracting HIV/AIDS due to their biological conditions as the receptive partner. The women biological characteristics consisting of a larger soft body surface exposed during sexual intercourse permit greater mucosal exposure to seminal fluids. In addition, the male seminal fluid contains a higher concentration of HIV than vaginal fluid and it remains in the vaginal canal for a relatively longer time. Tuju (1996) pointed out that men transmit HIV more efficiently to women than women to men. Other biological factors include transmission of HIV from mother to child during pregnancy, birth or after birth through breast feeding.

The time adolescence sets in, sexuality becomes the greatest single factor in play through developmental process of both mind and body. Human and youthful sexuality in particular involves inevitable and irresistible biological drives that always demand gratification. For young people the onset of menstrual and sperm development often marks the initiation into sexual activities, in an attempt to satisfy the newly discovered sexual urges and curiosity (Mitchell, 1971)

### 2.1.4 Sexual health behaviors among the youth

Early initiation in sexual activity places adolescent at health risk. Youth are less likely to require commitment to or from a partner before sex. The youth as a result, report having frequent sexual intercourse with casual contacts which means that they are often in multiple relationships. They change partners frequently (Kiragu, 1996) and thus are highly exposed to HIV.

### 2.1.5 Inadequate youth health services

Reproductive health services have largely been oriented towards serving needs of pregnant married women, consequently, young people especially sexually active youth do not seek such services for reasons that include inconvenient schedules and locations, lack of privacy and confidentiality, fear of social stigma, judgmental attitudes of service providers and unaffordable

fees. Lack of access to health services become a serious threat to youth reproductive health. (Caldwell, 2000)

### 2.1.6 Inadequate sexual health information and education

Many youth cite lack of knowledge, inaccessibility, and safety concerns as primary reasons for not using contraceptives. A study showed that less than 50 percent of the youth in Madagascar and Nigeria know about contraception (Caldwell, 2000)

In sub-Saharan Africa, as in other regions of the world, a culture of silence surrounds most reproductive health issues. Many adults are uncomfortable talking about sexuality with their children. Others lack accurate sexual health knowledge.

Many Africans feel unable to discuss sexuality across perceived barriers of gender and age differences. In many African countries, some people believe that men are biologically programmed to need sexual intercourse with more than one woman. Polygamy is a central, social institution and reinforces this belief. More over some men believe that this 'biological programmed need' makes high-risk sex unavoidable. (Buckley, 2001) In some impoverished communities, high HIV infection rates may be partly explained by early sexual initiation consensual or coerced. (UNAIDS/WHO, 2003)

### 2.1.7 Cultural and social factors

Young people who are socially and economically disadvantaged are at the highest risk of HIV infection. Lack of education, untreated STIs and sexual exploitation exacerbate the vulnerabilities of young people who live in poverty. Some faith tradition in Africa teach that AIDS is a shameful disease and a punishment for those who have been sexually promiscuous, and many adults are reluctant to admit to a disease that implies promiscuity.(Buckley, 2001)

### 2.1.8 Alcohol and drug abuse

Around the world, youth have high abuse rate of tobacco, alcohol and other hard drugs. This often accompanies early sexual experiences of youth increasing the risk of HIV infection (WHO, 2000)

Persons under the influence of drugs and alcohol lose their inhibitions and are more likely to engage in risky sexual behavior. Such behavior includes casual sex with a number of partners, having sex without a condom or using the condom wrongly. Injecting drugs is 'a most efficient way of getting infected' by using contaminated injection equipment, and it is emerging as an important vector in Kenya for transmitting HIV (AIDS in Kenya, 2005)

Alcohol intake before or during sexual intercourse may contribute to risky sexual behavior. (The Kenya AIDS epidemic update 2011) In a 36-month study of agricultural workers in rural Kenya, study participants who consumed alcohol during sexual intercourse were 2.4 times more likely to become infected with HIV (Shaffer et al., 2010).

### 2.1.9 Economic factors

A study done by Forsyth and Rau (1996) shows that economic factor plays a major role in the spread of and control of HIV/AIDS. For instance movements of large numbers of people involved in informal and formal sectors and they include mobile works in the transport, entertainment, fishing and tourism industries, migrant labor miners are particularly exposed to situations for casual sex, many whom may be away from their regular partners for a long time (Ochola-Ayayo and Muganzi, 1991)

Lack of employment for both young men and women have led them to engage in sex for money business hence exposing them to the risk of getting HIV. In Kenya, homosexuality has increased hence men in legal heterosexual unions tend to seek sex from male prostitutes hence putting themselves at risk of contracting the disease and eventually transmitting it to their legal partners. (Buckley, 2001)

### 2.1.10 Multiple partners and sexual concurrency

It is well established that the risk of becoming infected with HIV is directly correlated with the number of sexual partners (Mishra et al., 2009). Individuals who have multiple sexual partners increase their risk of contracting HIV as each new relationship introduces another pathway for HIV transmission.

Concurrent sexual partnerships are widely held to be one of the primary drivers of the HIV epidemic especially in sub-Saharan Africa. Concurrent sexual partnership is defined as having two or more partnerships that overlap in time. This increases the probability of an infected individual having sex with a susceptible partner during the acute HIV infection stage, when there is a higher potential for onward transmission of the virus. This finding has been repeatedly confirmed by epidemiological studies in Kenya (Amornkul et al., 2009; Mattson et al., 2007).

### 2.1.11 The socioeconomic impact of HIV/AIDS

The epidemic continues to have far-reaching social, economic, health and population effects. In addition to the harms directly inflicted on HIV-infected individuals and the households in which they live, AIDS has had indirect effects that are nevertheless real and substantial on communities and the whole of society.

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

The impact of HIV/AIDS on economic growth and development, coupled with the direct impact of increased mortality on the lives of the poor makes HIV/AIDS a uniquely corrosive threat to poverty reduction efforts. This impact has had major challenges in the society in that it has affected the productivity of the agriculture sector, upon which the majority of Kenyans rely for their livelihood. The sector has been undermined by negative impacts on supply of labour, crop production, agricultural extension services, loss of knowledge and skill and at a personal level the trauma associated with death. Consequences include reduced household and community food security. Commercial agriculture, a major source of employment and foreign earnings, is detrimentally affected by increasing health costs as well protracted mortality of key workers. (NACC, 2005)

Education services suffer as teachers are lost to AIDS and children drop out of school as parents die and household income falls. The health service loses trained staff and has to cope with increasing burden of HIV- related infections.

The direct cost and social problems associated with the caring for increasing numbers of orphans, coupled with existing high poverty levels place severe burden on family and societal structures.

Awareness of HIV, an understanding of how it may be transmitted, and a perception of individual risk are essential to sexual risk reduction, although they are often insufficient on their own to prevent transmission. Young people are less likely than adults to exhibit accurate, comprehensive understanding of how to prevent HIV transmission (Tegang et al., 2007)

Knowledge of HIV/AIDS is relatively high in Kenya, with 75 percent of women and 81 percent of men 15 to 49 years of age aware that the use of a condom can prevent the transmission of HIV. HIV testing and counseling is provided both through voluntary sites and through provider-initiated sites, with 73 percent of health facilities currently offering provider-initiated HIV counseling and testing. Mobile outreach sites target MARPs and other vulnerable populations. (KDHS 2008-2009). The widespread availability of counseling and testing services through multiple outlets has resulted in significant increases in the number of people tested for HIV between 2003 and 2009. In 2003, 14.3 percent of adult men and 13.1 percent of adult women received an HIV test. By 2009, the proportion of adult men and women tested had risen to 40.4 percent and 56.5 percent, respectively.

Stigma toward people living with HIV/AIDS (PLWHA) has decreased markedly in recent years, though it remains a challenge. The 2003 and 2008–2009 KDHS asked if respondents would be willing to care for an HIV-positive family member in their home, would buy fresh vegetables from an HIV-positive vendor, believe an HIV-positive female teacher who is not sick should be allowed to continue teaching, and would not want to keep secret that a family member got infected with the AIDS virus. The proportion of men and women who answered yes on all four

accounts increased, from 39.5 and 26.5 percent in 2003 to 47.5 and 32.6 percent, respectively. In the same period, there was a decline in the proportion of respondents willing to disclose a family member's HIV-positive status, and the number of Kenyans with an overall accepting attitude toward PLWHA remains low. The KDHS also found stigma towards PLWHA decreases as both level of education and wealth quintile increase.

### 2.1.12 HIV/ AIDS- related knowledge among the youth

HIV/AIDS education is an essential part of HIV prevention. In Kenya AIDS education is part of the curriculum in both primary and secondary schools (UNGASS 2006) and for a number of years Kenya has delivered educational campaigns to raise national awareness on the issue. As a result the awareness of about HIV and AIDS in Kenya is high. Awareness of HIV, an understanding of how it may be transmitted, and a perception of individual risk are essential to sexual risk reduction, although they are often insufficient on their own to prevent transmission.
HIV/AIDS education and awareness is one of the key elements in comprehensive HIV prevention. It is believed that increased knowledge, along with positive attitudes and beliefs about HIV/AIDS, will lead to positive behavior changes, that is, behaviors that are less risky, or safer, such as use of condoms, abstinence, and avoidance of risky situations.

Globally a majority of the youth aged 15-24 have heard of HIV/AIDS, however, evidence have established that the vast majority of youth do not know how HIV is transmitted or how to protect themselves (United Nations Children's Fund, The Joint United Nations Program on HIV/AIDS and World Health Organization, 2002)

Knowledge on how HIV is transmitted is one of the several factors that enable youth to protect themselves from the virus. Correct knowledge can also reduce stigma and discrimination against people living with HIV/AIDS. Several studies have shown that health related knowledge has power to change people's attitudes and health care behaviors in different health contexts, including, oral and dental health (Kinirons and Stewart, 1998). Widespread evidence shows that knowledge about HIV/AIDS and STIs and reproductive health are key strategies for empowering young people to delay the onset of sexual activity and to make their sexual behaviors safer (Jackson, 2002). Knowledge of pregnancy risks and knowledge about HIV/AIDS

has been associated with consistent use of condoms and a reduction in the number of sexual partners among Zambian adolescents (Magnani et al., 2000).

Although various studies (Ochieng, 2005; Nyinya, 2007) suggest high level of awareness of HIV and AIDS among students, there is still lack of observable behavior change amongst them. Likoye (2004) in a study on knowledge and praxis: the implication of Freire's concept of critical consciousness for HIV and AIDS awareness, observes that despite evidence that a large proportion of older adolescents and young adults in both rural and urban settings in Kenya appear to have high level of knowledge and awareness about the prevalence, method of transmission and deadliness of HIV and AIDS however, this does not imply that they have changed their sexual behavior.

Likoye (2004) observes further that knowledge's failure to generate or develop in the people a disposition that translates into practice or action definitely casts doubt on the kind (usefulness) of that particular knowledge. A reflection is therefore needed on the ultimate nature and meaning of HIV and AIDS awareness especially within the education context. The reflection should therefore be in terms of what should be the objectives and actual behavior change among the recipients of the program.

Jensen and Schnack (1994) argue that the objectives of a program like the HIV and AIDS education in secondary schools should be able to give direction on the type of knowledge that would focus on making the learners agents and to enable them participate in the transfer of that change in the society so as to make more people to embrace that change; youth should therefore transform the community towards HIV and AIDS control. However, the HIV and AIDS education program has not enabled the young adults to acquire the readiness and ability to adopt lifestyles that are compatible with prevention attitude and practice in relation to HIV and AIDS prevention (Likoye, 2004); there seems to exist a gap between knowledge and actual behavior towards HIV and AIDS prevention. Freire (1974) observes that critical consciousness enables people to evaluate their environments and their situation and critically examine myths therein. The objectives of the HIV and AIDS Education therefore should take on the manifestation of

practical response characterized by reflect ability, creativity and liberated action that positions human beings as actors and subjects in the world.

Right from the beginning, the HIV/AIDS epidemic has been accompanied by an epidemic of fear, ignorance, and denial, leading to stigmatization of and discrimination against people living with HIV/AIDS (PLWHA) and their family members (International Center for Research on Women 2002).

Ross et al., (2006) observed that the second decade of life is a period of experimentation and risk taking and many other factors increase young persons' vulnerability to HIV during these years of rapid physical and psychosocial development. These factors include a lack of knowledge about HIV/AIDS, lack of education and life skills, poor access to health services and commodities, early sexual debut, early marriage, sexual coercion and violence, human trafficking and growing up without parents or other forms of protection from exploitation and abuse.

Sub-Saharan African youth between the ages of 15 and 24 are particularly vulnerable to HIV and other sexually transmitted infections (STIs) (Khan and Mishra, 2008), representing 41 percent of all new infections across the continent (UNICEF, 2011).

Globally, it is estimated that 2,500 new infections occur each day among youth, 79 percent of which take place in sub-Saharan Africa (UNICEF, 2011b). Though the World Health Organization defines 'youth' as 10 to 24 years old (NCPD, 2003), the 15 to 24 age group represents the largest risk category in contracting HIV. In addition to HIV and STIs, these youth are prone to early pregnancy and subsequent anemia, high-risk births, maternal malnutrition and development of obstetric fistulae (Bankole et al., 2004; Hindin and Fatusi, 2009).

It is believed that increased knowledge, along with positive attitudes and beliefs about HIV/AIDS, will lead to positive behavior changes, that is, behaviors that are less risky, or safer, such as use of condoms, abstinence, and avoidance of risky situations.

According to Adegbola, et al. (1995) knowledge essentially is the recall recognition of specific and universal elements in a subject area. In the context of HIV/AIDS, having knowledge implies ability to recall facts concerning causes, transmission, prevention, concerning HIV/AIDS. In an attempt to eradicate HIV, there is a need to educate people, most especially the youths who are very sexually active. According to Kaiser Family Foundation (2005), young adults are in the centre of the epidemic because young people ages 15-24 account for approximately half of new adult HIV/Aids infections and 28% of the global total adults living with HIV/AIDS.

### 2.1.13 Myths and misconceptions

In addition to knowing about effective ways to avoid contracting HIV/AIDS, it is also useful to be able to identify incorrect beliefs about AIDS to eliminate misconceptions. Common misconceptions about AIDS include the idea that all HIV infected people appear ill and the belief that the virus can be transmitted through mosquito or other insect's bites, by sharing food with someone who is infected or by witch craft or other supernatural means.

In sub-Saharan Africa, surveys continue to indicate that young people between 15-24 years harbor serious misconceptions about HIV and how it is transmitted (Cohall, et.al. 2001). Even though it is now common knowledge that the HIV agent cannot be transmitted through mosquito bites, many people still believe that mosquitoes are a good vehicle for HIV transmission. In sub-Saharan Africa where mosquitoes are endemic, this misconception is significant because it implies a defeatist attitude that regardless of what one does, one is subject to HIV infection as a resident of a mosquito infested region. It also poses a compliance challenge for any educational intervention effort targeted at this group. (Wodi, 2005)

Families that will not discuss sexuality issues with their children fearing that it will make them more promiscuous, religious organizations and community activists that preach chastity education and abstinence only, political leadership that would not infuse available resources to match the magnitude of the problem, all contribute to the etiology of HIV transmission in Kenya. Individuals that suddenly learn of their positive HIV status and begin acts of personal vendetta by engaging in unprotected sex have also been implicated in the spread of the disease (The

Guardian, 2002). It is clear that this degree of ignorance and attitude relative to sexuality must be addressed if the disease is to be controlled in the region.

### 2.1.14 Knowledge of condom sources among youth

While condoms are the best weapons against HIV transmission, studies continue to show limited use of this barrier method in sexual intercourse in sub-Saharan Africa (Eaton, et. al. 2002). Several factors, such as low availability, cost, lack of education about condoms and how to use them, and relationship factors contribute to low usage. In particular, Kenyans have often received conflicting messages about condom use. Many religious leaders have expressed opposition to condom use especially the Catholic clerics.

Condom use among young people plays an important role in the prevention of transmission of HIV and other sexually transmitted infections, as well as unwanted pregnancies. Knowing a place to get condoms helps youth to obtain and use condoms. Furthermore knowing where condoms can be got puts youth in a better position to make informed decisions on issues pertaining their sexuality. Although the use of condoms can reduce the risk of sexually transmitted diseases, most sexually active youth in sub-Saharan Africa do not consistently use condoms because they are too expensive for the youth and they do not know where to get them among many other reasons (Jemmot, 2000).

In Kenya the Government has only actively promoted condom use since 2001, when an estimated 12.8 percent of its population was infected with HIV. That year the Government announced its intention to import 300 million condoms. Since then, condom distribution has been radically scaled up; 10 million were distributed in 2004 and 124.5 million in 2008. (UNGASS, 2008)

### 2.1.15 Voluntary HIV counseling and testing among youth

Awareness of HIV status can motivate individuals to further protect themselves against infection or to protect their partners from acquiring the disease. It is particularly important to measure testing behavior among youth. Not only are they especially vulnerable to infection, but they also may experience barriers to accessing testing services because of their young age.

Most youth in sub-Saharan Africa do not have access to sexual health advice, condoms, and forms of contraception, voluntary counseling and testing services for HIV. Reproductive health services are seldom geared towards the needs of the people, who therefore tend to avoid them-putting themselves and their sex partners at risk of infection (UNAIDS 2008).

Voluntary counseling and testing is a critical entry point for access to HIV/AIDS treatment and care, it is also a powerful prevention tool. By providing personalized counseling as well as information about high risk behaviors, VCT could motivate people to adopt safer sexual behavior and prevent transmission of HIV. This could be particularly important for adolescents and young adults, who typically have their sexual debut but might not have perfect information about HIV risk.

### 2.1.16 Attitudes related to HIV/ AIDS

#### 2.1.16(a) HIV/AIDS related stigma

The stigma associated with HIV has long undermined HIV prevention and treatment efforts (UNAIDS, 2008). HIV-related stigma inhibits open discussion of the epidemic, and fear of discrimination or disapproval may also deter individuals from seeking the services they need. In some instances, individuals may actually avoid taking steps to protect against HIV transmission out of fear that they may be considered potentially infectious or thought to belong to a marginalized group that has been heavily affected by the epidemic. (The Kenya AIDS epidemic update 2011)

Stigma refers to a situation when people living with HIV/AIDS are viewed as shameful and the disease is perceived to be a result of personal irresponsibility. If not counteracted, such attitudes fuel prejudice against those living with HIV/AIDS, marginalizing and excluding individuals. Ultimately such attitudes allow societies to excuse themselves from the responsibility of caring for and looking after those who are infected. More importantly, stigma leads to secrecy and denial that hinders people from seeking counseling and testing for HIV, as well as care and support services.

In Sub-Saharan Africa, communities have appeared insensitive to the plight of HIV positive youth as a result victims chose not to disclose their HIV status for fear of being ostracized by society. Overt discrimination against HIV positive youth could cause dropping out of school for the victims (Wodi, 2005). In Kenya, efforts have been made to reduce fear and discrimination towards those living with HIV/AIDS but the stigma has not completely disappeared.
Even though awareness of HIV and AIDS in Kenya is high, many people living with the virus still face stigma and discrimination. Studies have shown that although people are aware of the basic facts about HIV and AIDS, many are not informed of the more in-depth knowledge that addresses issues of stigma.

Stigmatizing attitudes among health care workers can be especially dangerous, given their potential deterrent effect on utilization of essential health services. A national survey of health care workers in 2005 found that 15% of physicians believed health workers had the right to reduce care to people living with HIV. (The Kenya AIDS epidemic update 2011)

Negative attitudes regarding people living with HIV may be abating somewhat over time. From 2003 to 2008 and 2009, increases were reported in the percentage of both women and men who expressed willingness to care for a relative with HIV, a willingness to buy food from an HIV-infected vendor, and a belief that HIV-positive teachers should be allowed to continue to teach.
However, stigmatizing attitudes persist. Nearly half of all Kenyan women surveyed in 2008–2009 said they would want to keep a family member's HIV infection secret (Kenya National Bureau of Statistics, 2010). One-third of individuals surveyed in North-East Province and in the Eastleigh neighborhood of Nairobi said it was reasonable to refuse to buy goods from a person living with HIV, and one in four respondents said it was appropriate to refuse to rent a room to someone who is HIV-positive (Pathfinder International, 2009).

**2.1.16(b) Attitudes towards negotiating safer sex**

While condoms are the best weapons against HIV infection, studies continue to show limited use of condoms in sub-Saharan Africa (Eaton.et.al, 2008).These studies implicate socio-cultural and religious factors in negotiating for safer sex. Knowledge about HIV transmission and ways to prevent it are less useful if people feel powerless to negotiate safer sex with their partners. To

gauge attitudes towards safer sex, there is need to know if people think a wife is justified in refusing to have sex with her husband when she knows he has a disease that can be transmitted through sexual contact. There is also need to know whether a woman in the same circumstances is justified in asking her husband to use a condom.

## 2.2 THEORETICAL FRAMEWORK

This study is guided by two theories: The health Belief Model and AIDS risk reduction model.

### 2.2.1 The Health Belief Model (HBM)

The Heath Belief Model was developed to explain health behavior and was applied to illness or sickness behavior (Resenstock, 1966).This model argue that for individuals to engage in health behaviors, such as safe sex, an individual has to perceive himself as vulnerable or susceptible to a health threat. That health threat has to be perceived as having serious consequences. The protective action that is available has to be perceived as outweighing the perceived cost of the action. However even when individual, perceive that they could adopt a particular course of action, some trigger might be required to nudge them into action (Rosenstock, 1974).

In managing the risk of HIV infection, youth may therefore practice safe sex if the perceive; HIV/AIDS as a serious infection, themselves as vulnerable to HIV/AIDS, safe sex as having more benefits than unprotected sex and the death of a close or known AIDS patient may trigger the quicker adoption of safer sex practices.

### 2.2.2 Aids Risk Reduction Model (ARRM)

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

Stage 1: Recognition and labeling of one's behavior as high risk. This is based e knowledge of sexual activities associated with HIV transmission, belief that one is personally susceptible to contracting HIV and belief that HIV/AIDS is undesirable.

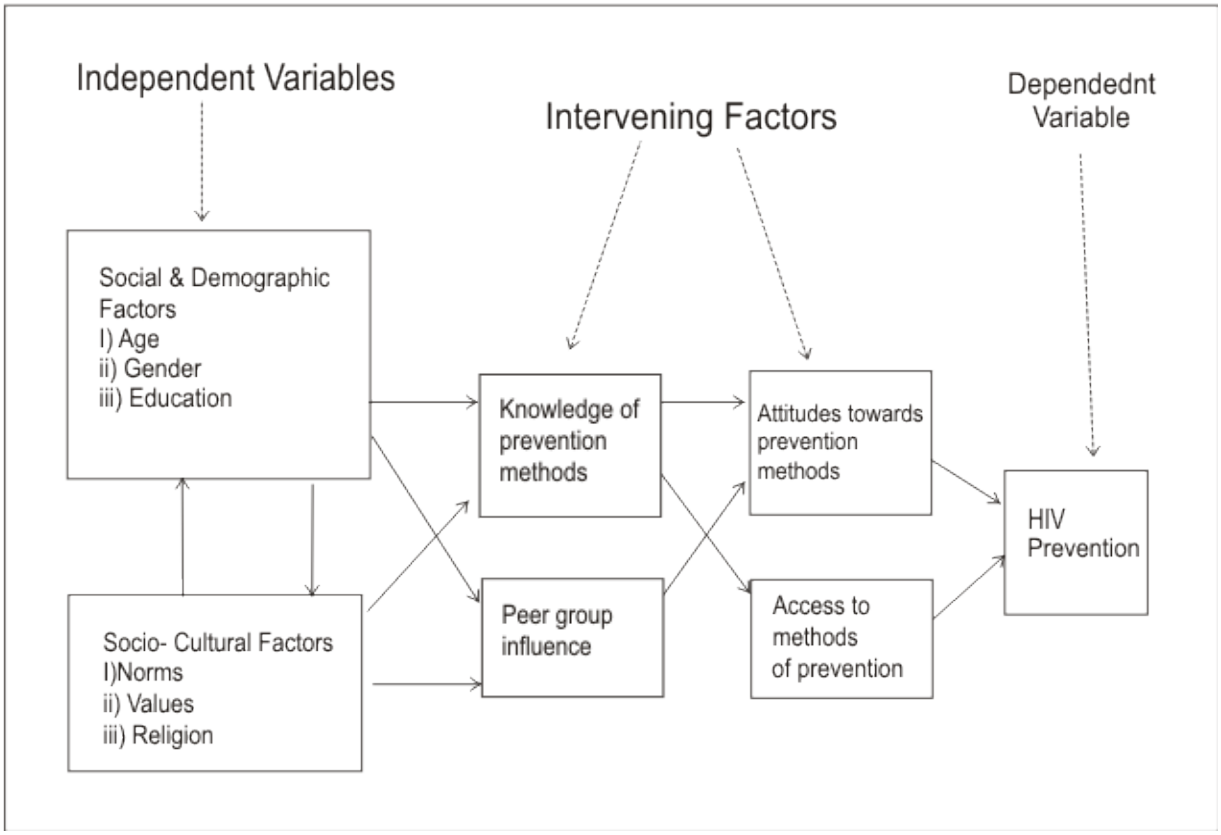
Stage 2: Making a commitment to reduce high-risk sexual contacts and to increase low risk activities. The main assumptions in this stage include cost and benefit analysis of the risk, importance of sexual practice as seen by the individual and its potential risk, and knowledge of the healthy utility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

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

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

## 2.3 CONCEPTUAL FRAMEWORK

**Figure 2.11: Conceptual Framework**



# CHAPTER THREE

# RESEARCH DESIGN AND METHODOLOGY

## 3.1 Introduction

This chapter describes the methodology that was used in data collection and its analysis in order to answer the research questions addressing the knowledge, attitude and sexual practices towards HIV/AIDS prevention. It details the target and sample population of the respondents that the researcher focused on in the study. As such, this chapter covers site selection, site description, research design, target population and sampling design, Unit of observation and Analysis, Type and source of data, a description of data collection instruments to be used and analysis of the data collected.

## 3.2 Site selection

Eastleigh area was purposely selected for two main reasons. First, because of monetary constraints for its coverage as the researcher is familiar with the area and did not need prior visits to familiarize with the people and the area. Secondly, Eastleigh area is not unique when compared to other low income areas in Nairobi which have been seriously affected by the HIV/AIDS pandemic.

Eastleigh is termed as a low income area because it has characteristics that associate it with such places. One characteristic is that it has poor infrastructure. It has dilapidated roads and sewer system. This area has limited access to safe drinking water and lacks proper sanitation facilities.
Most of the residents in Eastleigh have low income levels and most of the Youth lack employment .Those residents who engage in the informal sector of the local economy derive their income from small scale businesses, trade and casual labor. Hence the findings of this study can be generalized to the entire low income areas of Nairobi.

## 3.3 Site description

Eastleigh is located in Nairobi City, east of the central business district. It was founded in 1921. The colonial Government allotted Nairobi's residential estates by Race and Eastleigh was pointed for Asians and elite Africans who worked as clerks, builders or shoemakers Eastleigh

was originally a large Kenyan Asian enclave until independence in 1963. It has a population of 109,512 people according to 2009 population census.

Eastleigh has a diverse and Multi-cultural composition. There are a number of Churches and Mosques. It is also synonymous with its Businesses especially fashion and apparel retailers in 'Garrisa lodge' where many shopping malls are located. There are also grocery stores, restaurants and bars.

Major health centers in Eastleigh are privately owned, but there is also a Government owned health Centre whose services are free of charge. Non-Governmental organizations like the Doctors without Borders, have also put up health facilities which mainly cater for targeted patients; HIV/AIDS patients.

### 3.4 Research Design

The study was quantitative in nature, using a cross sectional survey design. According to Mugenda and Mugenda (2003), a survey is an attempt to collect data from members of a population in order to determine the current status of that population with respect to one or more variables. This method has been selected because it is excellent for the measurement of characteristics of large populations.

### 3.5 Unit of observation and Units of Analysis

The unit of observation are the objects, entity or subjects from which data required for the study is obtained, the unit of observation in this study were the youth age between 15 to 24 years in Eastleigh Location. Unit of analysis according to Mugenda and Mugenda (2003) are the individual units about which or whom descriptive or explanatory statements are to be made. It is what the researcher seeks to explain or understand. The unit of analysis for this study is knowledge, attitudes and practices concerning HIV/AIDS prevention among youth in Eastleigh Location in Nairobi County.

### 3.6 Study population

The population consisted of male and female youth aged between 15 and 24 years in Eastleigh. This study focused on youth in secondary schools and those in post-secondary learning institution in Eastleigh Location. The study population was drawn from two Schools: A mixed secondary school and a Post-secondary college institution. These schools were Maina Wanjigi Secondary School and Penuel Computer College. A group of 2 Focus Group Discussion consisting of at least 10 members of whom were the youths in Eastleigh and 5 Key Informant who included A guidance and counselling teacher, a school chaplain in the college, a Peer educator, a Nurse and a director of a VCT. The estimated number of population depended on the identified students in the institutions who had attained the ages between 15 and 24 years.

### 3.7 Sampling Design

Sampling refers to the process of selecting number of individuals for a study in such a way that the individuals selected represents the large group from which they were selected. The study used 3 sampling procedures namely purposive sampling, Multi stage sampling and simple random sampling. The study area has 4 secondary schools and 4 colleges. The secondary school and the College were purposely selected due to their convenience and proximity to the researcher.

Multi stage sampling was used to select the clusters in the secondary school from a stream of 2 classes which acted as two different clusters. The researcher picked one cluster, from each form in the secondary schools. In the clusters, a sampling frame from a population of students who had attained the required age was created. A sample of 50 youth was drawn by use of simple random sampling, as it was considered appropriate for the reason of increasing the accuracy of the findings and also for it to ensure high percentage involvement by the subject.A sample of 15 students from form 2 were drawn from a population of 28 students who had attained the age of 15 and 16 years. A sample of 10 students from form 3 a population of 11students who had attained 17 and 18 years was drawn. In form four a sample of 5 was drawn from a population of 8 students who had attained the age of 19 and 20. In The tertiary college a sample of 10 was drawn from a population of 23 students who had attained the age of 23 from the First year

diploma student. And finally from a population of 25 students who had attained the age of 23 and 24 years a sample of 10 respondents was drawn.

### 3.8 Type and source of data

The study used Primary data collected by using questionnaires administered to Youths, Key Informant guides and Focus Group Discussions in Eastleigh.

### 3.9 Data Collection Methods

The instrument of data collection integrated both questionnaire and interviews which were carried out by the researcher herself, to ensure the efficiency and effectiveness of the data collected. The questionnaire comprised of both open ended and close ended questions. The questionnaire had 4 sections. Section one contained 5 questions that dealt with demographics of the respondents. Section 2 had 18 questions that were based on Knowledge related to HIV/AIDS. Section 3 has 13 questions that dealt with attitudes of youths towards HIV/AIDS and the last section dealing with preventive practices had 14 questions dealing with risk practices.

Key informant guide was also used. Key informants were purposely selected as they were more conversant with the issues and social environment important to the research. A discussion guide consisting of unstructured questions was used to gather information from the informants.
Focus group discussion was also used to collect additional information. A focus group discussion guide was used to facilitate a discussion and to capture views of the young people. The focus group discussion was made up of 20 young people in the area of study.

### 3.10 Data Analysis and Presentation

The researcher used Statistical Package for the Social Sciences (SPSS) program to analyze data. After the data was collected, it was keyed into the computer using the Statistical package for Social Scientists (SPSS). This will be done after assigning codes to the questions. Using SPSS the data will be presented in form of tables, percentages and frequency distributions in form of descriptive statistics.

The Key informant interview and focus group discussions, data will be summarized on the basis of the major themes and the patterns of responses that emerge across the various respondents on each question.

# CHAPTER FOUR

# DATA PRESENTATION AND ANALYSIS

## 4.1 Introduction

This chapter provides statistical presentation and analysis of the data collected. The data has been presented in Table and Figures with summaries being given for each Table and Figure. From the study population target of 50 youths, a total of 41 questionnaires were returned representing a response rate of 82%.

## 4.2 Social Demographic characteristics of the respondents

The study analyzed to see the effects of the youth's demographic characteristics on their Knowledge, Attitudes and Practices towards HIV/AIDS. See Table 4.2 below, presents these demographic factors.

**Table 4.2: Respondents' background information**

| **Age (Years)** | **Frequency** | **Percentages (%)** |
|---|---|---|
| 15-16 | 12 | 29 |
| 17-18 | 6 | 15 |
| 19-20 | 5 | 12 |
| 21-22 | 8 | 20 |
| 23-24 | 10 | 24 |
| **Total** | **41** | **100** |
| **Gender** | | |
| Male | 24 | 59 |
| Female | 17 | 41 |
| **Total** | **41** | **100** |

The total number of respondents was 41; (59%) male and 41% female. The age of the respondents was between 15-24 years, with 29% representing ages between 15-16 and15% representing 17-18 years of age, followed by age 19-20years representing 12%, ages 21 -22 representing 20% and finally 23-24 with 24%. The respondents were students in schools in Eastleigh consisting of secondary and college level. Those in secondary represented 54% of the sample representation while 46% represented those at the college level. Christians constituted a higher percentage with 85% while the Muslim constituted a 15% response rate no other religions were identified.

### 4.3 Knowledge related to HIV/AIDS

#### 4.3.1 HIV/AIDS prevention knowledge

All the youth have heard of HIV/AIDS representing 100%. 97.6% of the respondents had received information on HIV/AIDS and there was a difference between genders where 100% of the Males had received information on AIDS where 94.1% of the females had received this information. This shows that more males than females had received this information.

About 4.3% of the male students had wrong knowledge that HIV is a bacterium while there were no females who responded that HIV is a bacterium. All respondents had correct knowledge that HIV is a Virus. This shows a great confusion on the males on the correct information of what causes the disease.

About 87.2% of the respondents were in agreement that HIV causes AIDS with 10% more females than males agreeing. HIV/AIDS is a growing problem in Eastleigh with 91.9% reporting so and a significant difference between males and females with 95.6% and 85.7% respectively. 74.3% of respondents considered HIV/AIDS a fatal disease with a significant number (25.7%) reporting it's not a fatal disease. About 83.3% of the respondents had correct knowledge that HIV cannot be cured. More males 18.2% than females 14.3% reported that there is a cure for AIDS.

Approximately 62.2% of the respondents reported that a person can be infected with HIV and not have the disease, 37.8% reported the opposite. Majority of the respondents reported that a

healthy looking person could have HIV (97.4%). All the males agreed with the statement while 62.5% of females agreed with the statement hence a difference of 35.5% between the genders.

The above statistics show a difference in the information that the different genders have regarding HIV/AIDS. See Table 4.3.1 (a) below.

**Table 4.3.1 (a) HIV/AIDS prevention knowledge among the Youth (N=41).**

| HIV/AIDS knowledge | TOTAL | | | GENDER | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Male | | | Female | | |
| | YES | NO | TOTAL% | YES | NO | TOTAL | YES | NO | TOTAL % |
| Are you aware of HIV/AIDS? | 100 | 0.00 | 100 (N=41 ) | 100 | 0.0 | 100 (N=24) | 100 | 0.00 | 100(N=17) |
| Have you ever received information on HIV/AIDS? | 97.6 | 2.4 | 100(N=41) | 100 | 0.0 | 100(N=24) | 94.1 | 5.9 | 100(N=17) |
| Is HIV a bacterium? | 2.6 | 97.4 | 100(N=39) | 4.3 | 95.7 | 100(N=23) | 0.0 | 100 | 100(N=16) |
| Is HIV a virus? | 100 | 0.0 | 100(N=41) | 100 | 0.0 | 100(N=24) | 100 | 0.0 | 100(N=17) |
| Does HIV cause AIDS? | 87.2 | 12.8 | 100(N=39) | 83.3 | 16.7 | 100(N=24) | 93.3 | 6.7 | 100(N=15) |
| Is HIV/AIDS a growing problem in this community? | 91.9 | 8.1 | 100(N=37) | 95.6 | 4.4 | 100(N=23) \ | 85.7 | 14.3 | 100(N=14) |
| Is HIV/AIDS a fatal disease | 74.3 | 25.7 | 100(N=35) | 76.2 | 23.8 | 100(N=21) | 71.4 | 28.6 | 100(N=14) |
| Is there a cure for AIDS? | 16.7 | 83.3 | 100(N=36) | 18.2 | 81.8 | 100(N=22) | 14.3 | 85.7 | 100(N=14) |
| A person can be infected with HIV and not have the disease AIDS | 62.2 | 37.8 | 100(N=37) | 61.9 | 38.1 | 100(N=21) | 62.5 | 37.5 | 100(N=16) |
| Can a healthy-looking person have HIV/AIDS | 97.4 | 2.6 | 100(N=40) | 100 | 0.0 | 100(N=24) | 62.5 | 37.5 | 100(N=16) |

The majority of the respondents correctly had the knowledge that an individual can protect him/herself from getting HIV/AIDS represented by 97.5%; another 2.5% answered incorrectly. This is shown in the Table figure 4.3.1 (b) below;

**Figure 4.3.1 (b) Knowledge on how to protect him/herself from HIV/AIDS**

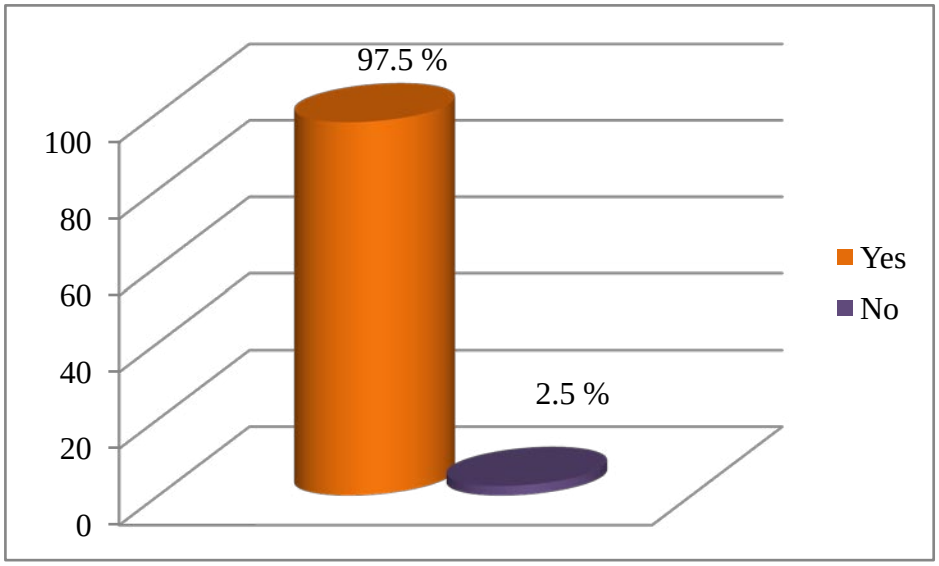



Table 4.3.1 (c) below presents the respondents' knowledge on how one can protect themselves from HIV/AIDS. The majority of the respondents seem to have adequate knowledge with 78% identifying Abstain from sex as the best form of protecting oneself from HIV/AIDS. Other two ways that were identified by half the respondents were; always using a condom and having only one sex partner representing 71% and 51% respectively. An interesting finding was that 44% of respondent who reported that avoiding a sex worker and the 5% that having sex with a virgin can protect one from acquiring HIV/AIDS. See Table 4.3.1 (c), below;

**Table 4.3.1 (c) Knowledge of ways to protect themselves from HIV/AIDS**

| **Protection from HIV/AIDS** | **Frequency** | **Percentage (%)** |
|---|---|---|
| Abstain from sex | 32 | 78 |
| Always use condoms | 29 | 71 |
| Have only one sex partner | 21 | 51 |
| Avoid sex workers | 18 | 44 |
| Require partner to take blood test | 16 | 39 |
| Limit number of sex partners | 12 | 29 |
| Non penetrative sex/thigh sex | 9 | 22 |
| Use sterilized needles | 9 | 22 |
| Have sex with a virgin | 2 | 5 |

### 4.3.2 HIV/AIDS Information

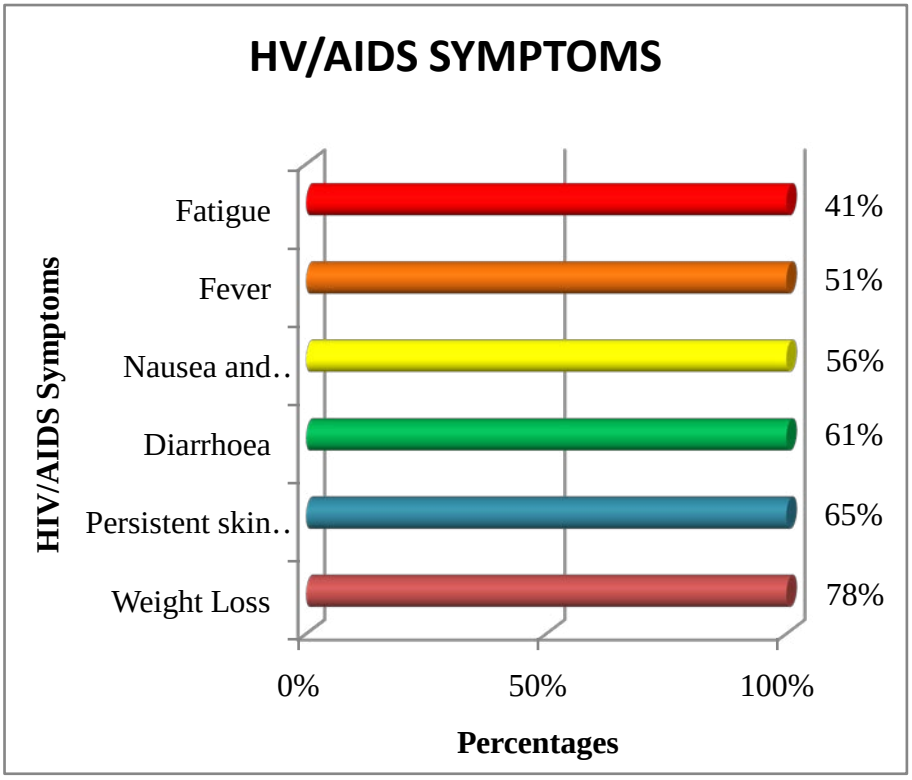
The youths had received more information on HIV/AIDS from television and internet with 43.9% and 36.6% respectively and it was more common to have received information on HIV/AIDS from health care workers, friend, family member and radio representing 34.1% of the respondent. The least source of information was from newspapers and sexual partner representing 17.1% and pamphlet/poster representing 12.2%, Most of the participants of the focus group discussion reported receiving the information on HIV/AIDS from friends, Television, In school and a few reported to have received the information from the internet and sexual partners. See table 4.3.2 (a) below

**Table 4.3.2 (a) HIV information sources among the youth (N=41)**

| | No | Little | Some | A lot | Total | |
|---|---|---|---|---|---|---|
| | % | % | % | % | N | % |
| Television | 7.3 | 17.1 | 31.7 | 43.9 | 41 | 100.0 |
| Internet | 29.3 | 9.8 | 24.4 | 36.6 | 41 | 100.0 |
| Radio | 19.5 | 31.7 | 14.6 | 34.1 | 41 | 100.0 |
| Family member | 24.4 | 26.8 | 14.6 | 34.1 | 41 | 100.0 |
| Friend | 12.2 | 22.0 | 31.7 | 34.1 | 41 | 100.0 |
| Health care workers | 26.8 | 26.8 | 12.2 | 34.1 | 41 | 100.0 |
| School health education | 24.4 | 22.0 | 24.4 | 29.3 | 41 | 100.0 |
| In class at school | 14.7 | 41.5 | 17.1 | 26.8 | 41 | 100.0 |
| Peers | 31.8 | 19.5 | 24.4 | 24.4 | 41 | 100.0 |
| Religious Leaders | 29.3 | 19.5 | 29.3 | 22.0 | 41 | 100.0 |
| Campaigns | 19.5 | 19.5 | 41.5 | 22.0 | 41 | 100.0 |
| Newspapers | 26.8 | 31.7 | 24.4 | 17.1 | 41 | 100.0 |
| Sexual Partner | 43.9 | 22.0 | 17.1 | 17.1 | 41 | 100.0 |
| Pamphlet/Poster | 19.3 | 34.1 | 24.4 | 12.2 | 41 | 100.0 |

Figure 4.3.2 (b) below represents HIV/AIDS symptoms identified by the respondents. They include weight loss, persistent skin rashes, diarrhoea, nausea and vomiting, fever and fatigue represented by 78%, 65%, 61%, 56%, 51% and 41% respectively.

**Figure 4.3.2 (b) HIV/AIDS Symptoms**




### 4.3.3 Probability of infection

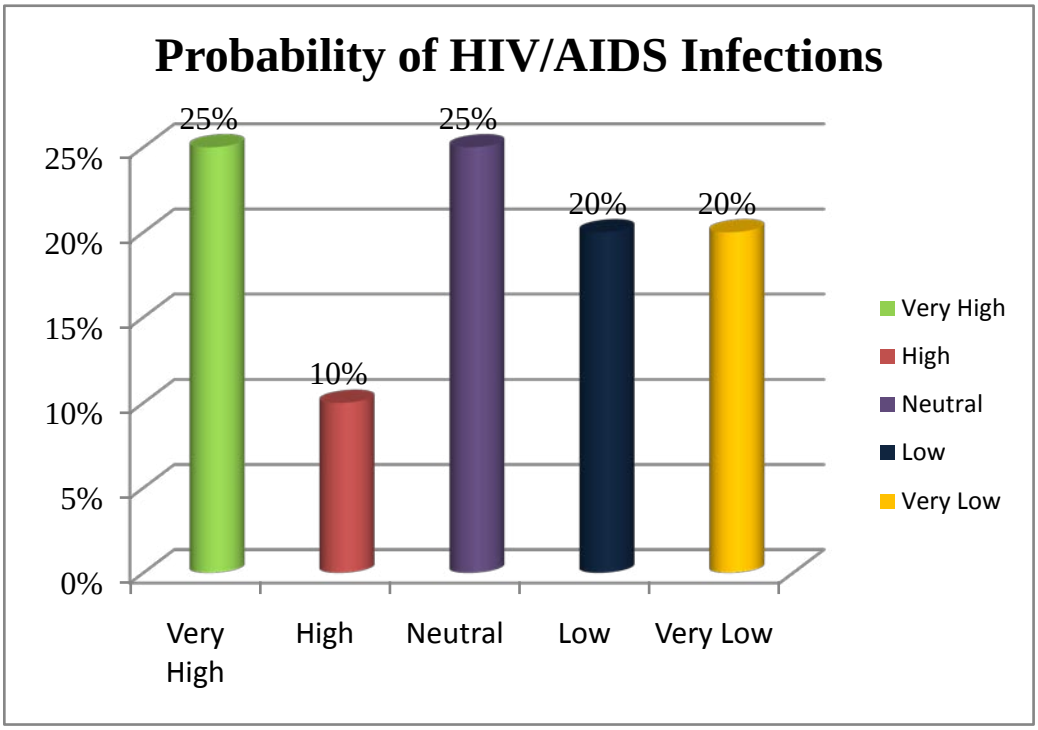
The respondent were evaluated on the probability of they be infected with the virus and the findings were quite interesting. About 24% of them felt that there was a very high chance of infection and another 24% not sure of the probability. There was a very small gap between those who presented a high chance of infection and the 20% who presented a very low probability of infection. The youth who participated in the focus group discussion had mixed views on their susceptibility to getting infected with HIV/AID, about 40% of the participants regarded themselves to be at a very risk of acquiring the , while 10% thought of themselves to be at low risk of getting HIV/AIDS (*See Table 4.3.3 (a)*)

**Table 4.3.3 (a) Probability of HIV/AIDS Infection**

| Response | Frequency | Percentage (%) |
|---|---|---|
| Very High | 10 | 25 |
| High | 4 | 10 |
| Neutral | 10 | 25 |
| Low | 8 | 20 |
| Very Low | 8 | 20 |
| **Total** | **40** | **100** |

The above data is clearly presented in the Figure 4.3.3 (b) below;

**Figure 4.3.3 (b) Probability of HIV/AIDS Infection**




About 51% of the respondents reported to have known someone living with HIV/AIDS and 49% responded to have no knowledge of anyone with the virus. There is no big margin between the two responses. See Table 4.3.3 (c)

**Table 4.3.3 (c) Knowledge of someone with HIV/AIDS**

| Response | Frequency | Percentage (%) |
|---|---|---|
| Yes | 20 | 51 |
| No | 19 | 49 |
| **Total** | **39** | **100** |

Almost all of the respondents (90%) were aware of other sexually transmitted diseases; however a small number 10% had no knowledge of other sexual diseases. This is shown in Table 4.3.3 (d) below;

**Table 4.3.3 (d) Knowledge of other sexually transmitted diseases**

| Response | Frequency | Percentage (%) |
|---|---|---|
| Yes | 37 | 90 |
| No | 4 | 10 |
| **Total** | **41** | **100** |

### 4.3.4 HIV/AIDS Transmission knowledge

All the respondents were in agreement that HIV/AIDS can be transmitted through sexual intercourse and contact with blood of infected person with 100% and 95.2% respectively, although 4.9% of the respondents were not sure if contact with blood of the infected person is a form of HIV/AIDS transmission. Among the respondents a majority had the correct knowledge that HIV/AIDS is not transmitted during casual contact with infected person (i.e. sharing food, cup, glass, handshake, hugging, clothes), kissing and mosquito bite. About 65.8% of the youths had the knowledge that an HIV infected mother could transmit the virus to an unborn child, 44% during pregnancy and 70.7% through breast milk. An interesting finding was the 21.9% who believed wrongly that HIV/AIDS could not be transmitted when having sexual intercourse without using a condom, although 68.3% had correct knowledge that HIV/AIDS could be transmitted when not using a condom. Other form of transmission; sharing needles and use of

unclean medical equipment represented 92.7% and 68.3% respectively of who were in agreement that these practices transmit HIV/AIDS. See table 4.3.4 below.

**Table 4.3.4 HIV transmission knowledge among the youth (N=41). (SA =strongly agree, A= Agree, N= Neutral, D= Disagree, SD= Strongly Disagree)**

| **HIV knowledge**<br>**Can you be infected with HIV/AIDS from:** | **4**<br>**SA** | **3**<br>**A** | **2**<br>**N** | **1**<br>**D** | **0**<br>**SD** | **TOTAL** | |
|---|---|---|---|---|---|---|---|
| | **%** | **%** | **%** | **%** | **%** | **N** | **%** |
| Sexual intercourse | 95.0 | 4.9 | - | - | - | 41 | 100 |
| Contact with blood of infected person | 65.9 | 29.3 | 4.9 | - | - | 41 | 100 |
| Casual contact with infected person ( i.e. sharing food, cup, glass, handshake, hugging, clothes) | - | - | 12.2 | 24.4 | 63.4 | 41 | 100 |
| Not using condoms | 48.8 | 19.5 | 9.8 | 14.6 | 7.3 | 41 | 100 |
| Contact with infected person's toothbrush/shaving material | 36.6 | 29.3 | 14.6 | 9.8 | 9.8 | 41 | 100 |
| During Pregnancy | 22.0 | 22.0 | 19.5 | 19.5 | 17.1 | 41 | 100 |
| During Birth | 31.7 | 34.1 | 19.5 | 9.8 | 4.9 | 41 | 100 |
| Through Breast Milk | 36.6 | 34.1 | 12.2 | 12.2 | 4.9 | 41 | 100 |
| Sharing Needles (drug use), razor blades | 61.0 | 31.7 | 4.9 | 2.4 | - | 41 | 100 |
| Unclean Medical Equipment | 36.6 | 31.7 | 9.8 | 9.8 | 12.2 | 41 | 100 |
| Kissing | 4.9 | 22.0 | 24.4 | 19.5 | 29.3 | 41 | 100 |
| Mosquito/Insect bites | 2.4 | 4.9 | 9.8 | 17.1 | 65.9 | 41 | 100 |

### 4.4 Attitudes towards HIV/AIDS

The respondents mostly expressed empathic attitudes towards people with HIV/AIDS. On the statements, “Students with HIV/AIDS should be treated with the same respect as other students”, 56% answered that they strongly agreed and another 27% agreeing constituting 83% response rate. On the statements, “I am sympathetic towards the misery that students with

HIV/AIDS experience", 31% answered that they strongly agreed and another 42% agreeing constituting 73% response rate. On the statements, "I would like to do something to make life easier for people with HIV/AIDS", 83% answered that they were in agreement with this statement and an interesting finding was none of the respondent disagreed with this statement.
This is well depicted in Table 4.4 (a). Table 4.4 (b) also shows the respondents' answers on statements measuring attitudes towards people with HIV/AIDS. The level of blame was high on the statements measuring question a. About 39% respondents answered that they strongly agree that youths are to blame for acquiring HIV/AIDS compared to 17% who strongly disagreed. The level of blame was not so high on the statements, "most youth who have HIV/AIDS deserve what they get" most respondents answered that they strongly disagree represented by a 27% response rate.

About 63% were against students being removed from school if they are HIV positive and a further 74% were sympathetic towards students who get HIV/AIDS from blood transfusion compared to those who get it from drug abuse. Yet another interesting finding was the 7% who strongly disagreed on the statement, "I have little sympathy for students who get HIV/AIDS from sexual promiscuity", although 52% did show to feel sympathy.

Half the respondents were worried about getting HIV/AIDS from social contact with fellow students. However, 20% strongly disagreed that they would worry about getting HIV/AIDS from fellow students. Fifty six percent of the respondent strongly agreed that sexual partners should tell each other if infected with the virus and another 34% agreeing. On average 90% were in support of the statement, "people with HIV/AIDS should tell their sexual partners that they are infected". Respondents seem to be comfortable discussing HIV/AIDS with someone represented by a 68% response rate. Majority of respondents were neutral when it came to deciding if they had had enough about HIV/AIDS, this was represented by a 29% response rate. (*See Table 4.4(a), below*)

**Table 4.4 (a) Attitudes towards HIV/AIDS Prevention**

(N=41**). (SA =strongly agree, A= Agree, N= Neutral, D= Disagree, SD= Strongly Disagree)**

| **Attitudes towards HIV/AIDS prevention** | **SA** | **A** | **N** | **D** | **SD** | **TOTAL** | |
|---|---|---|---|---|---|---|---|
| | **%** | **%** | **%** | **%** | **%** | **N** | **%** |
| a. Most youth who have HIV/AIDS have only themselves to blame | 39 | 20 | 17 | 7 | 17 | 41 | 100 |
| b. Most youth who have HIV/AIDS deserve what they get | 22 | 17 | 17 | 17 | 27 | 41 | 100 |
| c. Students should be removed from the school if they are HIV positive | 15 | 7 | 15 | 15 | 48 | 41 | 100 |
| d. I feel more sympathetic towards students who get HIV/AIDS from blood transfusion than those who get it from drug abuse | 54 | 20 | 12 | 9 | 5 | 41 | 100 |
| e. I have little sympathy for students who get HIV/AIDS from sexual promiscuity | 22 | 30 | 29 | 12 | 7 | 41 | 100 |
| f. Students with HIV/AIDS should be treated with the same respect as other students | 56 | 27 | 15 | - | 2 | 41 | 100 |
| g. I am worried about getting HIV/AIDS from social contact with a fellow students in school | 24 | 26 | 15 | 15 | 20 | 41 | 100 |
| h. People with HIV/AIDS should tell their sexual partners that they are infected | 56 | 34 | 10 | - | - | 41 | 100 |
| i. I am sympathetic towards the misery that students with HIV/AIDS experience | 31 | 42 | 15 | 5 | 7 | 41 | 100 |
| j. I would like to do something to make life easier for people with HIV/AIDS | 37 | 46 | 15 | 2 | - | 41 | 100 |
| k. I am comfortable discussing with someone HIV/AIDS | 34 | 34 | 20 | 2 | 10 | 41 | 100 |
| l. I have heard enough about HIV/AIDS and I don't want to hear about it anymore. | 15 | 20 | 29 | 15 | 21 | 41 | 100 |

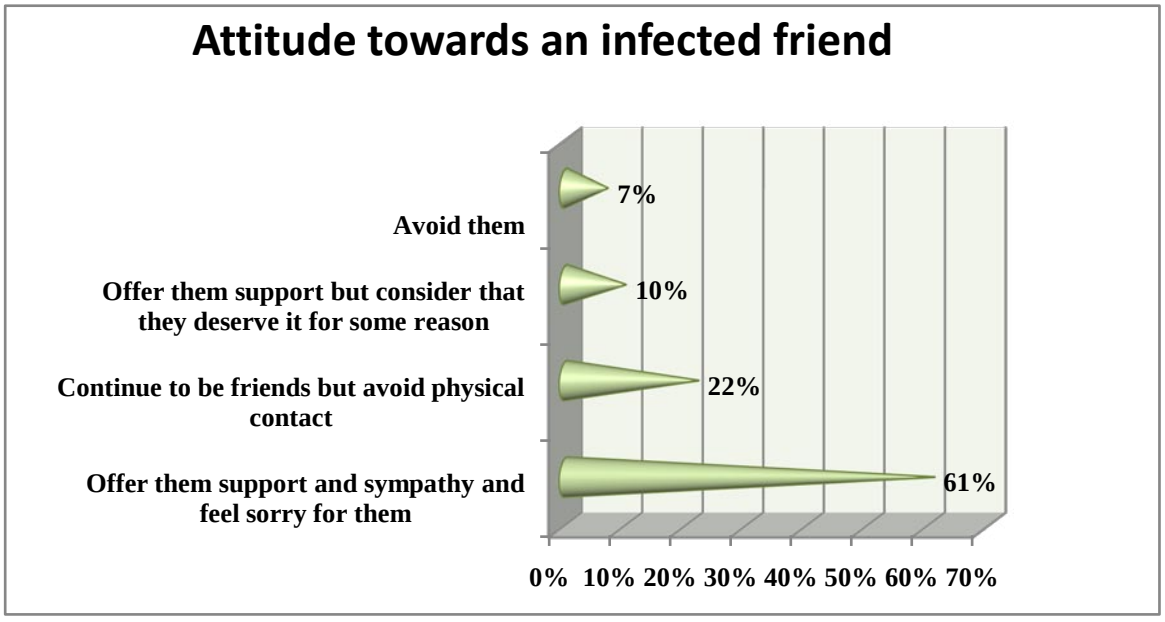
Table 4.4 (b) shows, in general the students depict a positive attitude towards those infected with HIV/AIDS.

**Table 4.4 (b) Attitude towards an infected friend**

| Attitudes | Frequency | Percentage (%) |
|---|---|---|
| Offer them support and sympathy | 25 | 61 |
| Continue to be friends but avoid physical contact | 9 | 22 |
| Offer them support but consider that they deserve it | 4 | 10 |
| Avoid them | 3 | 7 |
| **Total** | **41** | **100** |

The majority of the respondents (61%) would opt to offer support and sympathy and feel sorry if they found out their friend was infected with HIV/AIDS. Another 22% would continue to be friends but avoid physical contact. Few respondents would offer support but consider they deserve it and avoid them; this is represented by a 10% and 7% response rate respectively. This is well depicted in Figure 4.4 below

**Figure 4.4 Attitude towards an infected friend**



### 4.5 HIV/AIDS Prevention Practices

More than half the respondents (56%) had never used a condom with female having the highest number with 64.7 response rate. About 68% represented the number of respondents who did not use a condom the last time they had sex. Use of condom during last sexual intercourse was more common among male than females (41.7% and 17.6% respectively).

A majority of male (79.2%) would use a condom if they could get them for free, while 53% of the female would not. More male than female had had sexual relations during the last year with a regular partner (50% and 41.2% respectively), 8.3% male with more than one partner and 5.9% female. Although a significant number of male (25%) had not had any sexual relation.

About 83% of the respondents had taken a HIV test with another 83% willing to take the test. More male than female had the knowledge about where they could have an HIV test in their community (91.7% and 88.2% respectively). Majority of the respondents (82.9%) had changed their sexual behavior habits because of information gained from HIV/AIDS awareness campaigns or programs. See table 4.5 (a)

**Table 4.5 (a) HIV prevention practices (N=41).**

| HIV prevention practices | Total | | Male | | Female | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| **Have you ever used a condom?** | | | | | | |
| Yes | 18 | 44 | 16 | 66.7 | 6 | 35.3 |
| No | 23 | 56 | 8 | 33.3 | 11 | 64.7 |
| **Did you use a condom the last time you had sex?** | | | | | | |
| Yes | 13 | 32 | 10 | 41.7 | 3 | 17.6 |
| No | 28 | 68 | 14 | 58.3 | 14 | 82.4 |
| **Would you use condom if you get them for free?** | | | | | | |
| Yes | 27 | 66 | 19 | 79.2 | 8 | 47 |
| No | 14 | 34 | 5 | 20.8 | 9 | 53 |
| **In the past year have you;** | | | | | | |
| Had sexual relations only with a regular partner | 19 | 46 | 12 | 50 | 7 | 41.2 |
| Had sexual relations with more than one partner | 3 | 8 | 2 | 8.3 | 1 | 5.9 |
| Had no sexual relation | 19 | 46 | 10 | 41.7 | 9 | 52.9 |
| **Have you ever had an HIV test?** | | | | | | |
| Yes | 34 | 83 | 20 | 83.3 | 14 | 82.4 |
| No | 7 | 17 | 4 | 16.7 | 3 | 17.6 |
| **Would you like to have a HIV test?** | | | | | | |
| Yes | 34 | 83 | 21 | 87.5 | 13 | 76.5 |
| NO | 7 | 17 | 3 | 12.5 | 4 | 23.5 |
| **Do you know where you can have an HIV test in your community?** | | | | | | |
| Yes | 37 | 90 | 22 | 91.7 | 15 | 88.2 |
| No | 4 | 10 | 2 | 8.3 | 2 | 11.8 |
| **Have you changed your sexual behavior habits because of information gained from HIV/AIDS awareness campaigns or programs?** | | | | | | |
| Yes | 34 | 82.9 | 20 | 83.3 | 14 | 82.4 |
| No | 7 | 17.1 | 24 | 16.7 | 3 | 17.6 |

Table 4.5 (b) below shows, about 44% of the respondents reported that the HIV/AIDS program has not been include in their curriculum at all, 32% reported it has been somewhat included and 24% reported it has been sufficiently included in their curriculum.

**Table 4.5(b): Has HIV/AIDS program been included in the curriculum?**

| Response | Frequency | Percentage (%) |
|---|---|---|
| Not at all | 18 | 44 |
| Somewhat | 13 | 32 |
| Sufficiently | 10 | 24 |
| **Total** | **41** | **100** |

Table 4.5 (c) shows the level of knowledge of the respondents in four different levels.
The level of knowledge was categorized into four levels such as Very Good, Good, Fair and Poor.

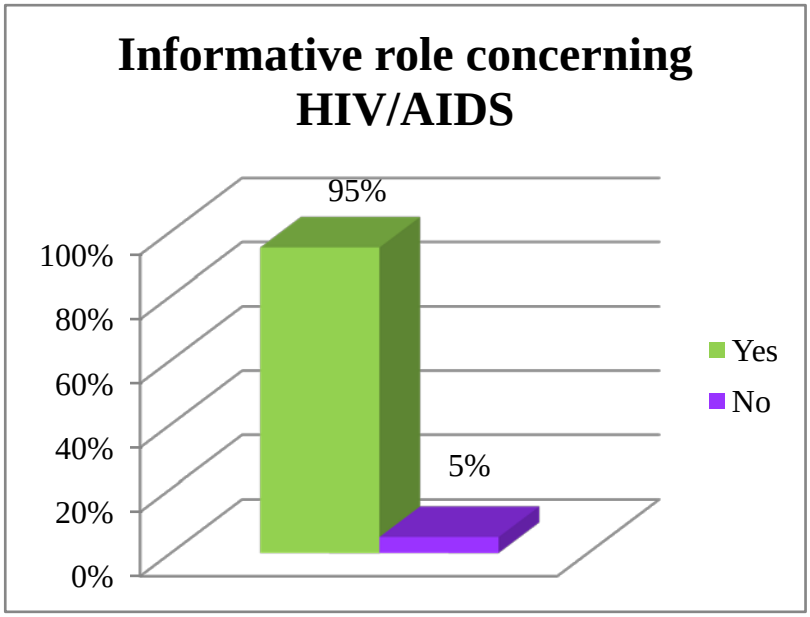
**Table 4.5 (c): How is your theoretical knowledge on HIV/AIDS?**

| Response | Frequency | Percentage (%) |
|---|---|---|
| Fair | 23 | 57 |
| Very Good | 10 | 24 |
| Poor | 5 | 12 |
| Good | 3 | 7 |
| **Total** | **41** | **100** |

57% of the respondents have a fair knowledge of HIV/AIDS, about 24% very good knowledge, around 12% fall within the category of poor and only 7% of the respondents have a good knowledge.

Ninety five percent of the respondents felt the need for the youth to have informative role concerning HIV/AIDS and 5% felt no need of involving the youth (Table 4.5 (d) below)

**Figure 4.5 (d): Should youth have informative role concerning HIV/AIDS?**




The majority of the respondents reported the most suitable person to give information on HIV/AIDS should be a doctor with a 59% response rate. Thirty two percent preferred parents, while another 22% the teachers, 15% preferred their fellow students. Further 7% preferred a different person other than the proposed. See Table 4.5 (e) below.

**Table 4.5 (e): Suitable person to give HIV/AIDS information (N=41)**

| Suitable Person | N | Percentage (%) |
|---|---|---|
| Doctor | 24 | 59 |
| Parents | 13 | 32 |
| Teacher | 9 | 22 |
| Fellow students | 6 | 15 |
| Others | 3 | 7 |

The respondents mostly expressed a need for more HIV/AIDS programs. About 98% reported yes to introduction of more HIV/AIDS programs. However, 2% felt no need of including more HIV/AIDS programs and training in school and institute (Table 4.5(f)).

**Table 4.5 (f): Are more HIV/AIDS programs necessary?**

| **Response** | **Frequency** | **Percentage (%)** |
|---|---|---|
| Yes | 40 | 98 |
| No | 1 | 2 |
| **Total** | **41** | **100** |

# CHAPTER FIVE

# SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATION

## 5.1 Summary of Findings

This chapter draws a summary and conclusion based on the findings which attempted to answer the research questions.

1. **What is the level of knowledge of HIV/AIDS among the youth in Eastleigh?**

Level of Knowledge of HIV/AIDS can be explained on how well the youths are aware of HIV/AIDS, the difference between HIV and AIDS, the symptoms and how HIV/AIDS is transmitted. The study found out that the level of knowledge of the youth on HIV/AIDS was quite good. They have all heard of HIV/AIDS and 60% of the population have received information on HIV/AIDS from various sources television being on the lead, followed by the Internet. All the youth who participated in the Focus group discussions had heard of HIV. Some of them got the information from family members , others from friends but most of them had heard it from radio and television.A few in the group responded to hearing it from friends and in Schools. All the members in the group responded positively to knowing a Youth who had contracted HIV but very few knew of one who had died from the desease.

The respondents were able to identify HIV as a virus not a bacteria, although there was a small percentage who were not sure if it a bacterium or not. Another finding was how the respondents were able to differentiate between HIV and AIDS. About 73% of the respondents stated that someone with HIV does not necessarily means s/he has AIDS and even though that the case, HIV can still lead to AIDS. The symptoms of HIV/AIDS vary, depending on the individual and what stage of the disease they are in. More than half the respondents identified the symptoms correctly with others suggesting more symptoms like coughing, tuberculosis. It was also noted that a healthy-looking person can have the virus.

HIV/AIDS can be transmitted in various ways, the respondents accurately identified sexual intercourse and blood transfusion as a major form of HIV/AIDS transmission; they also identified sharing of needles (drug use) and razor blades. This was a clear indication that majority were aware of ways they can contract the virus. In this study 59% of the men knew that

a mother with HIV could transmit the virus to her unborn child, but only 41% of the women knew about this. Reasons for this lack of KAP of HIV prevention and for the pandemic of the disease could be that there are differences in health care, infrastructure, sexual risk behavior, knowledge about the disease, poverty and political and economic stability around the world (Coovadia & Hadingham, 2005). Multilayered social, political and economic efforts are therefore needed to reduce the HIV risk and vulnerability, where different countries have different opportunities (Gupta et al., 2008). According to the author the misconceptions and lack of KAP of HIV prevention are a major problem, where increased knowledge and understanding of the disease is needed globally.

An interesting finding was more than half the respondents stating HIV/AIDS as a fatal disease and no cure. This shows the misconception the youth must have about the virus. This finding can be explained by the growing problem of HIV/AIDS in Eastleigh with 82.9% reporting it to be a major issue in the county. The youths know how to protect themselves from HIV/AIDS and more than 50% identified ways like abstaining and using condoms and having only one sexual partner. Only a few youth in the focus group discussion considered themselves to be at Risk of contracting HIV. They were confident because some of them were abstainig others were using condoms each time they had sex. Some said that they do not share sharp cutting objects hence reducing the risk of contracting the disease.

Although having sex with a one partner only is not 100% safe, it can minimize the chances of one contracting the virus by being faithful. Therefore the findings concluded that the youths is Eastleigh have vast knowledge of HIV/AIDS though they need more education on how it can be controlled and managed.

**2. What is the attitude of the respondents towards acquiring the HIV/AIDS?**

The researcher took time to measure the respondent feeling towards HIV/AIDS. The respondents mostly expressed empathic attitudes towards people with HIV/AIDS and the men were more empathic compared to the female. In this study more than 30% of the men felt more sympathetic towards students who get HIV/AIDS from blood transfusion than those who get from drug abuse but only 20% of female felt this way. About 83% of the youths were willing to do something to make life easier for people with HIV/AIDS. The majority of the male felt that they would like to

offer support, sympathy and feel sorry for their friend if they found out that he/she was infected. Among the female, more than 30% felt they would avoid an infected friend. There was some level of blame when the youth respondents' answers on statements measuring refraining attitudes towards people with HIV/AIDS were negative. About 39% blamed those who had acquired HIV/AIDS and a number thought that they deserved what they got, though 31% were sympathetic towards the misery that students with HIV/AIDS experienced. In the focus group discussion all the youth responded to positive treatment of the people who had contracted the disease in their community.Others went further to say that the disease is not a death sentence and cannot be contracted by just being friends with the person or buying goods from them.

This study has shown that in general the youth depict a positive attitude towards those infected with HIV/AIDS. Although the great majority of the youths are afraid of getting the disease via contact, only about 22% say that they prefer to keep away from those infected with the disease. Due to the awareness of HIV/AIDS, if they should tell their sexual partners their HIV/AIDS status, a vast majority (70%) of students responded "Yes". The youth overall show a compassionate attitude towards those infected. The youths also indicate a positive and healthy attitude towards those infected with HIV/AIDS, which could be due to accurate knowledge of this disease.

**3. Which are there sexual practices adopted by youth towards HIV/AIDS prevention?**

Inconsistent condom use puts individuals of great risk being infected with HIV/AIDS and is also one of the major risk factors for acquiring the virus (Pinkerton & Abramson, 1997). Among the youths in this study 54% had sexual relations, and it was more common among men to have had sexual relations with more than one partner. More than 50% of the male and female had never used a condom and 69% had not used a condom the last time they had sex and a majority of the women would not use a condom even if they could get them for free. One reason for this could be that many female youth felt less comfortable discussing HIV and issues of condom use, as cultural factors discourage women from discussions of sex (Mullany Maung & Beyrer, 2003; Bradley et al., 2011). The proportion of individuals who used a condom during last sexual intercourse and the number of sexual partners varies widely globally though, where access and information about HIV are different from country to country (Crosby et al., 2012).

The study found that 61% of the youths in Eastleigh considered themselves at risk of HIV

infection even though a 95% agreed that there are ways in which they can protect themselves from getting HIV/AIDS. In this study 83% of the youths had not had an HIV-test but almost 51% of the male and 31% of the female would like to have one. One explanation why relatively few of the youths had done a HIV test when many would like to do it and 90% of the youths knowing where to access HIV test in their community; could be that the society have a negative attitude towards youths engaged in sex, which make many youths reluctant to seek information and treatment from public service providers.

HIV/AIDS topic are yet to be included in their study programs with 43% stating that it hasn't been included in their curriculum yet; this has a great influence on their theoretical knowledge on HIV/AIDS since only 24% of the respondents has a very good theoretical knowledge. About 50% has a fair HIV/AIDS theoretical knowledge with the male constituting the majority which is alarming thus a great need to introduce HIV/AIDS in their curriculum as a compulsory unit. This will contribute greatly to their decision making when it comes to taking precaution when having sex and how one can take care of oneself when infected to avoid further spread of HIV/AIDS. The youth think it will be wise for them to have an informative role concerning HIV/AIDS to the public with more HIV/AIDS programs and training schools/institutes introduced in Eastleigh.

4. **To what extent is HIV/AIDS prevention practices informed by knowledge and attitudes towards HIV/AIDS?**

About 44% of the youth have used a condom which shows some reluctance in using condoms. The association of condoms with promiscuity may be a factor to why the youths are shying away from using the condoms. Often the youth experience gradual movement towards heterosexual relationships which can lead to sexual activity (Missie L Oindo, 2002). Culture fundamentally affects sexuality and fertility by creating values, norms, and expectations about sexual relationships, roles and behaviours. In most traditional cultural set-ups, both pre-marital sex and pregnancy were frowned at and even punished. Despite religiosity featuring as an important determinant of indiscriminate sex in Kenya, traditional cultures have been eroded and the concept of abstinence not fully adopted, further compromising sexual behaviour (Missie L Oindo, 2002). Majority of the youth agreed that HIV/AIDS cannot be cured though measures

like use of ARVs, eating balanced diet and constant clinical checkup would play a major role in managing the virus. The willingness of youths to go for HIV test also depicted a positive attitude towards control and management of the virus.

## 5.2 Conclusion

In the light of above findings we draw the following conclusions:

The research showed that most of the youths both female and male have a good level of knowledge regarding HIV/AIDS, which is to be taken as a good sign; however, the male had overall better results than the female concerning knowledge, attitudes and practices of HIV prevention. A majority of them didn't feel they are at risk of HIV infection but condom use was low among the youths, and misconceptions on HIV transmission were relatively common, especially among the female. In spite of the various seminars, classes and inputs on HIV/AIDS in Kenya, more than 59% of the students still think that they have not heard enough about this disease yet. Although there are clear indications of a rather good knowledge on HIV/AIDS, a lot more can be done and needs to be done, particularly more of educational programs, because about 89% of the respondents, in this study, stated that young people already in high schools should be taught about sex and HIV/AIDS. If more people are aware of the basic information on the root causes of the disease, they would have informed opinions about sexual behaviors and positive attitudes towards HIV/AIDS victims.

In the focus group discusion a few of the youth reported apprehenssion of discussing about HIV/AIDs with their familys hence relied on friends to discuss about issues dealing with the disease. All the responded responded positively to effots being made in the community to to stop the spread of the disease among the youth. Some reported of the efforts of the NGOs in eastleigh distributing free condoms to the Youth, others reported of theater groups that are present for the youth to express their artistic skills, keeping them busy hence reducing idling which could lead them to engage in activities like drug abuse  hence reducing their chances of acquiring HIV/AIDS.

Reponses from key infromant was rather intersting where they all expressed their concern on the Health of the Youth and responded positively to the HIV/AIDS pandemic increasing among the youth in the study area especially now that the pop culture is really embrased by the youth. This

culture encourage alcohol intake and provocative dressing all this things contribute to the youth engaging in unprotected sex hence putting them at risk of contracting HIV/AIDS. Various interventions strategies have been put in place for the youth to prevent the spread of the disease,one of them is Guidance and counselling programmes in schools, courses on HIV/AIDs in colleges and schools and also provision of free condoms to the youth who are already sexually active. The key informant responded negatively to the strategies working in that the youth think of themselves as invisible and that they know more than the older generation hence do not take any advice given to them on matters HIV/AIDS hence putting themselves at risk of contracting HIV/AIDS

Perhaps the most encouraging fact is that the youth overall show a considerate and compassionate attitude towards those infected. The youths also indicate a positive and healthy attitude towards those infected with HIV/AIDS, which could be due to accurate knowledge of this disease.

### 5.3 Recommendations

1. In this study the author investigated knowledge, attitudes and practices concerning HIV/AIDS prevention among the youths in Eastleigh Location, Nairobi County. In the future it would be interesting to investigate and compare what information and recommendations the youths believe they have received from health care givers, and what information and recommendation the health care givers believe they have given to the youths. This could show if there is lack of information from the health care givers or if there are any area concerning KAP of HIV prevention that needs to be improved.
2. It could also be interesting to make a qualitative study to understand more deeply why the female have poorer knowledge on HIV and its transmission compared to the male.
3. The findings of this study clearly indicate that educators must provide more than just accurate information about HIV/AIDS. They must be aware of the differences between female and male's attitudes and behaviors with regard to HIV/AIDS.
4. It is important for future research to focus on: a) the level of knowledge of the staff or other educators on the same issue, in order to ensure that they impart right knowledge and methods which help the youths to realistically assess their risk for HIV/AIDS.
5. Youth should be involved in the intervention design in order to ensure relevance of

programs to them. The success of youth-specific interventions often depends greatly on how the youth relate to their service provider and, in turn, how those providers and institutions succeed in empowering and integrating youth. Similarly, the local governments, development partners, civil society organizations in the region should involve youth as early as possible.

6. Making health services more youth-friendly may lead to an increased use of facilities by young people in Eastleigh. Many young people lack access to services such as condoms and voluntary counseling and testing (VCT). Sensitizing health staff on young peoples' needs is critical to make sure they get the service package they need.
7. Targeted media and social marketing campaigns should be used in communities to improve young people's knowledge about HIV and AIDS. Programs that use a mix of media show significant outcomes on HIV knowledge and skills as well as on condom use. Higher levels of program exposure increase the likelihood of behavior change.
8. Training peers to be positive role models that can positively influence young peoples' behaviors, facilitating access to and creating trust among young people.

**REFERENCES**


Adegbola, O et al 1995, Sexual networking in free town the background of AIDS epidemics. Health Transition Review.

Akol etal 2000, knowledge, attitudes and Sexual Behavior of young people towards HIV/AIDS. Page 1-45.

Akwuwe C. (1999): *HIV/AIDS in African Children*: Major calamity that Deserve Urgent Global Action Journal on HIV prevention. Education for Adolescents and Children Vol(IV) NO.11

Amornkul PN et al (2009). *HIV prevalence and associated risk factors among individuals aged 13-34 years in Rural western Kenya*. PL.S ONE 4:e6470

Auerbach, J. and Coates, T.(2009). *HIV prevention research: accomplishments and challenges for the third decade of AIDS*. American Journal of public Health.

Bankole A (etal) 2004, *Risk and protection, youth and HIV/AIDS in Sub-Saharan Africa*, The Alan Gultma cher institute, New York

Biggar and Aggius, 1987, A Brief History of HIV/AIDS, pages 3-8, *The International Electronic Journal of Health Education*, 2000; Volume 8: pages 86 - 94.

Bradley et al. (2011). Changes in HIV knowledge, and socio-cultural and sexual attitudes in South India from 2003-2009. *BMC Public Health 11*(6), 6-12.

Catania J.A et al (1990) Towards an understanding of risk behavior: An AIDS Risk Reduction Model (ARRM) Health Education and Behaviour Quarterly 17,53-72

Central Bureau of statistics CBS [Kenya], Ministry of Health (MOH) ORC macro: *Kenya Demographic Health Survey 2003* Calveton, Maryland : CBS,MOH, and ORC macro; 2004

Centers for Disease Control and Prevention. (2006). *HIV/AIDS Basics.* USA: Department of Health and Human Services. From:
http://www.cdc.gov/hiv/resources/qa/definitions.htm

Centers for Disease Control and Prevention (CDC) (1995); Morbidity and mortality weekly report (MMWR): *Case control study of HIV sero-conversion in health care workers after percutaneous exposures to HIV infected blood*; France, UK, and US. 44: pages 929-931, CDC, Atlanta , USA

Chu, C. & Selwyn, P. A. (2010). Diagnosis and initial management of acute HIV infection. *American Family Physician 81*(10), 1239-1244.

Coates, T., Richter, L. & Caceres, C. (2008). *Behavioral strategies to reduce HIV transmission:*

*how to make them work better*. The Lancet 372(9639), 669-684.

Coco, A. & Kleinhans, E. (2005). *Prevalence of Primary HIV Infection in Symptomatic Ambulatory Patients.* Annals of Family Medicine 3(5), 400-404.

Cohall, A. et al (2001) Adolescents in the age of AIDS: Myths, Misconception, and misunderstandings, regrading sexually transmitted diseases, J Natl med Assoc. 93(2), 64-65

Cohall, A Et al 2001, HIV/AIDS knowledge, attitudes and opinions among adolescents in the River States of Nigeria, Joint National Medical Association pages 64-69.

Cohen,M., Hellmann, N., Levy, J., DeCock, K. & Lange, J. (2008). *The spread, treatment and prevention of HIV-1: a global pandemic*. The Journal of Clinic Investigation 118(4), 1244-1254.

Coovadia, H. & Hadingham, J. (2005). *HIV/AIDS: global trends, global funds and delivery bottlenecks*. Globalization and health 1(13), 1-10.

Crosby, R., Graham, C., Milhausen, R., Sanders, S. & Yarber, W. (2012). *Preface to condom use to prevent sexually transmitted infections: a global perspective*. Sexual Health 9(1), 150-156.

Eaton et al (2003) unsafe sexual behavior in South African Youth. *Social Science and Medicine* 56(1)

Ford J. Et al (1998) *Factors related to condom uses among four groups of female sex workers in Bali, Indonesia.* AIDS Education and Prevention, 10 (1), 34-35

Friis-Möller, N., Thiébaut, R., Reiss, P., Weber, R., Monforte, A.D., De Wit, S. et al. (2003). *Combination Antiretroviral Therapy and the Risk of Myocardial Infraction.* The New England Journal of Medicine, 349(21), 1993-2004.

Fuller, T.D. & Chamratrithirong, A. (2009). *Knowledge of HIV risk factors among immigrants in Thailand*. Journal of immigrant and minority health 11(2), 83-91.

Giri, P., Shirol, S., & Kasbe, A. (2011). *A comparative study to assess the knowledge and practices regarding sexual health among the migrants and non-migrants in Mumbai city*. International Journal of Collaborative Research on International Medicine & Public Health *3*(5), 341-352.

Gupta, G., Parkhurst, J., Ogden, J., Aggleton, P., & Mahal, A. (2008). *Structural approaches to HIV Prevention.* The Lacet 372(9640), 764-775.

Ho. J. & Hsue, P. (2009). *Cardiovascular manifestations of HIV infections*. Heart 95(14), 1193-1202.

Jackson H. (2002) Aids African, continent in Crisis, SAFAIDS, Harare, Zimbabwe.

Jemmot L.S 2000 Savings our children; strategies to empower African American adolescents to under their risk for HIV infection. J NaH Black Nurses Association pg 4-14.

Kabiru C.W, Orpinas P (2009) Correlates of condom use among male High school students in Nairobi, Kenya. J Sch health 79:425-432.

Kaiser family foundation, (2005) the Global HIV/AIDS Epidemic HIV/AIDS.

Kenya National Bureau of Statistics (KNBS) *Kenya Demographical and Health Survey (2008-2009)*

Kinirons M. J Stewart C (1998). Adolescent Knowledge of common foods and drinks and the importance of the pattern of consumption: a study in an area of high dental needs. Community Dent. Health 15(3) 175-178

Kiragu K (2001) Youth and HIV/AIDS: Can we avoid the catastrophe?

Kirby, D., Laris, L. & Rolleri, L. (2005). Impact of Sex and HIV Education Programs on Sexual Behaviors in Developing and Developed Countries. *Family Health International 2*(2), 5-38.

Lakemedelsverket. (2011). Lakemedelsboken: HIV. Uppsala: Lakemedelsverket. From: http://www.lakemedelsverket.se/lakemedelsbroken

Likoye, Francis (2004) *Knowledge and practice: The implications of Freires, Concept of critical consciousness for HIV/AIDS awareness, Nairobi:* Unpublished M. Ed Thesis, KU.

Maswanya E. et al. Knowledge and attitudes toward AIDS among Female college students in Nagasaki. Health Education Research, 2000, 15:5–11.

Mayer, K. & Beyrer, C. (2007). *HIV Epidemiology Update and Transmission Factors: Risk and Risk Contexts – 16th International AIDS Conference Epidemiology Plenary*. Clinical Infectious Diseases 44(7), 981-987.

Mishra V. Et al. (2009). *Concurrent sexual partnership and HIV infection: Evidence from National population Based surveys*. Calverton, Maryland (USA): Macro international inc.

Mitchelle, J. (1971) Adolescence, some critical issues. Toronto and Montreal. Pinehart and Wiston of Canada Ltd.

Mugenda and Mugenda (2003) *Research methods. Quantitative and qualitative approaches* Acts press: Nairobi.

National AIDS and STI Control Programme (NASCOP) Kenya AIDS Indicates Survey 2007: financial report Nairobi Kenya: Nascop; 2009.

Nyinya F (2007). *Altitude of Teachers and students towards HIV/AIDS Education programme in Secondary School in Kisumu Municipality*. Unpublished Masters Thesis, Maseno University.

Ochieng Am (2005) A study of the reproductive and sexual –health behavior of Adolescents in Kisumu Districts in Relations to HIV/AIDS. Unpublished masters thesis, Maseno University.

Ochola Ayayo et al (1991) first preliminary report on sex practices and the spread of AIDS and other STDs in Kenya, University of Nairobi.

Odu, O, et al (2008). Knowledge's attitude to HIV/AIDS and sexual behavior of students in a tertiary institution of South-Western Nigeria. European Journal of contraception and reproductive Health care, 13(1), 90-96.

Parekh, B., Kalou, M., Alemnji, G., Ou, C-Y., Gershy-Damet, G. & Nkengasong, J. (2010). *Scaling up HIV Rapid Testing in Developing Countries.* American Society for Clinical Patalogy 134(10), 573-584.

Park, L., Siraprapasiri, T., Peerapatanapokin, W., Manne, J., Niccolai, L. & Kunanusont, C. (2010). HIV: Transmission rates in Thailand: Evidence of HIV Prevention and Transmission Decline. *Journal of Acquired Immune Deficiency Syndromes: 54*(4), 430-436.

Pinkerton, S.D. & Abramson, P.R. (1997). Effectiveness of condoms in preventing HIV transmission. *Social Sciences Medicine 44*(5), 1303-1312.

Piot, P., Bartos, M., Laerson, H., Zewdie, D. & Mane, P. (2008). *Coming to terms with complexity: a call to action for HIV prevention.* The Lancet 372(9641), 845-859.

Microsoft Encarta (2007) Encarta dictionaries 1993-2006

Pathfinder Intenational (2009). *Assesment of Kenya sexual networks: Collecting evidence for interventions to reduce HIV/STI risk in Garissa, North Eastern Province and Eastleigh, Nairobi:* Pathfinder international Kenya.

Resenstock I. (1966) *why people use Health services*. Milbank memorial Fund Quarterly New York

Resenstock I. (1974) *why people use Health services*. Milbank memorial Fund Quarterly New York 44:94-124

Ross D, Pick B, Fergroon J.(2006). Preventing HIV/AIDS in yours people: a systematic review of the evidence from developing countries

Shaffer D.N. Et al. (2010) HIV-1 *Incidences Rates and Risk factors in Agricultural workers and dependents in Rural Kenya: a 36-month follow up of the Kericho HIV cohort study*. J 53: 514-521

Shapiro, J. Radecki S, Charchick, A.S. Josephson v. 1999,(Sexual behavior and AIDS) related knowledge among community college students in orange country, California Journal of community health.

Tegang S et at. (2007). APHA II Baselie Behavioural Monitoring Survey Report- Coast Rift Valley 2007.

Tuju R. (1996) AIDS, understanding the challenges, Ace Communication Ltd Nairobi.

UNAIDS (2008) Report on the global AIDS epidemic. Geneva: Joint United Nations programme on HIV/AIDS.

UNAIDS (2009). AIDS epidemic update. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS: UNAIDS *Report on the Globe AIDS Epidemic* -2010 Joint United Nations programmes on HIV-AIDS (UNAIDS).

UNAIDS (2010) Outlook breaking News: Young people are leading the HIV Prevention Revolution, Geneva: Joint United Nations programme on HIV/AIDS.

UNAIDS world AIDS Day Report 2011. (Geneva, UNAIDS, 2011UNGASS 2010: United Nations General Assembly Special Session on HIV and AIDS. County Report –Kenya.

UNAIDS. (2010).UNAIDS country progress report Thailand. USA: UNAIDS. From: https://docs.google.com/gview?url+http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/thailand 2010 country progress report en.pdf https://docs.google.com/gview?url=http://unaids.org/ctrysa/ASITHA_en.pdf
University of California (UCSF) Medical Center. (2012). *HIV Diagnos.* San Francisco: UCSF. From:http://translate.google.se/translate?h1=sv&langpair=en|sv&u=http://ucsfhealth.org/conditions/hiv/diagnosis.html

Walensky, R.P., Paltiel, A.D., Losina, E., Mercincavage, L., Schackman, B., Sax, P. et al. (2006). *The Survival benefits of AIDS treatment in the United States*. The Journal of Infectious Diseases 194(1), 11-19.

Westercamp N. Et al. (2008). *Determinants of consistent condom use vary by partner type among young men in Kisumu, Kenya*: A Multi-level Data analysis AIDs behavior 58 – 1

Wodi B.E. 2005, International Electronic (Journal of Education pages 5-11)

World Health Organization (2011), *HIV/AIDS Prevention and Control*. Geneva: World Health Organization from: http://www.searo.who.int/en/Section10/Section18/Section2009.htm

World Bank (2010). World development indicators 2010. Washington DC: World Buna.

## APPENDICES

### QUESTIONNNAIRE

I am a student at the University of Nairobi, Department of Sociology and Social Work conducting a research on **Knowledge, Attitudes and Practices concerning HIV/AIDS Prevention** among youth in Eastleigh location in Nairobi County for the attainment of a Master Degree in Rural Sociology and community development.

Your responses will be treated with almost confidentiality and will only be used for education purposes.

Kindly put a tick (/) where appropriate.

### SECTION ONE: DEMOGRAPHICS

1. How old are you (in years)?

   ( ) 15-16yrs ( ) 19-20yrs ( ) 23-24yrs

   ( ) 17-18yrs ( ) 21-22yrs

2. What is your gender

   a. Male ( ) b. Female ( )

3. What is the name of your school or Institution? _____

4. What is your level of education?

   a. Form 2 ( )
   b. Form 3 ( )
   c. Form 4 ( )
   d. College ( ). Specify what level _____

5. What is your Religion/ denomination

   a. Christian ( )
   b. Muslim ( )
   c. Other (specify) ( ) _____

**SECTION 2: KNOWLEDGE RELATED TO HIV/AIDS**

6. a) Are you aware of HIV/AIDS

   a. Yes ( ) b. No ( )

7. a) Have you ever received information on HIV/AIDS?

   a. Yes ( ) b. No ( )

   b) If you have received information on HIV/AIDS, how much information about HIV/AIDS do you gain from following sources?

| | | | | |
|---|---|---|---|---|
| a. Television | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| b. Radio | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| c. Newspapers | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| d. Pamphlet/Poster | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| e. Health care workers | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| f. Campaigns | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| g. Religious Leaders | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| h. Friend | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| i. Sexual Partner | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| j. In class at school | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| k. School health education | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| l. Peers | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| m. Family member | No ( ) | Little ( ) | Some ( ) | A lot ( ) |
| n. Internet | No ( ) | Little ( ) | Some ( ) | A lot ( ) |

   c) If others (specify) _____

8. Is HIV a Bacterium?

   a. Yes ( ) b. No ( ) c. Don't Know/Don't Remember ( )

9. Is HIV a Virus?

   a. Yes ( ) b. No ( ) c. Don't Know/Don't Remember ( )

10. Does HIV cause AIDS?

    a. Yes ( ) b. No ( ) c. Don't Know/Don't Remember ( )

11. Is HIV/AIDS a growing problem in this community?

    a. Yes ( ) b. No ( ) c. Don't Know/Don't Remember ( )

12. Is AIDS a fatal disease?

a. Yes ( ) b. No ( ) c. Don't Know ( )

13. a) Is there a cure for AIDS?

a. Yes ( ) b. No ( ) c. Don't Know ( )

b) Explain your answer _____

_____

14. A person can be infected with HIV and not have the disease AIDS

a. Yes ( ) b. No ( ) c. Don't Know/Don't Remember ( )

15. Can a healthy looking person have HIV/AIDS?

a. Yes ( ) b. No ( ) c. Don't Know/Don't Remember ( )

16. a) To what extent do you feel the following practices transmit HIV/AIDS? (*where 4 is Strongly agree, 3 is Agree, 2 is neutral, 1 Disagree and 0 Strongly Disagree* )

| **HIV/AIDS TRANSMISSION** | **4 3 2 1 0** → | | | | |
|---|---|---|---|---|---|
| Sexual intercourse | | | | | |
| Contact with blood of infected person | | | | | |
| Casual contact with infected person ( i.e. sharing food, cup, glass, handshake, hugging, clothes) | | | | | |
| Not using condoms | | | | | |
| Contact with infected person's toothbrush/shaving material | | | | | |
| During Pregnancy | | | | | |
| During Birth | | | | | |
| Through Breast Milk | | | | | |
| Blood transfusion | | | | | |
| Sharing Needles (drug use), razor blades | | | | | |
| Unclean Medical Equipment | | | | | |
| Kissing | | | | | |
| Mosquito/Insect bites | | | | | |

b) If others (specify) _____

17. Which are the symptoms of HIV/AIDS? Kindly tick the relevant ones.

a. Fever ( )

b. Diarrhoea ( )

c. Nausea and Vomiting ( )

d. Weight loss ( )

e. persistent skin rashes ( )

f. Fatigue ( )

g. Others (Specify) _____

18. Can a person do anything to protect him/herself from getting HIV/AIDS?

a. Yes ( ) b. No ( ) c. Don't Know/Don't Remember ( )

19. How can people protect themselves from getting infected with HIV/AIDS?

a. Abstain from sex ( )

b. Non penetrative sex/thigh sex ( )

c. Always use condoms ( )

d. Limit number of sex partners ( )

e. Have only one sex partner ( )

f. Avoid sex workers ( )

g. Have sex with a virgin ( )

h. Use sterilized needles ( )

i. Require partner to take blood test( )

j. Other (specify) _____

k. don't know/don't remember ( )

20. a) Have you ever heard of diseases other than HIV/AIDS that can be transmitted through sexual intercourse?

a. Yes ( ) b. No ( )

b) If yes, specify

_____

21. In your opinion, who are the people likely to be infected with HIV/AIDS?

a. Parents ( )

b. Youth ( )

c. Prostitutes ( )

d. Others (Specify) _____

22. In your own opinion, what is the probability that you may get infected with HIV/AIDS?

a. Very high ( )

b. High ( )

c. Neutral ( )

d. Low ( )

e. Very low ( )

23. Do you know anyone infected with HIV/AIDS?

a. Yes ( ) b. No ( )

**SECTION 3: ATTITUDES OF YOUTHS TOWARDS HIV/AIDS**

24. Most youth who have HIV/AIDS have only themselves to blame

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

25. Most youth who have HIV/AIDS deserve what they get

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

26. Students should be removed from the school if they are HIV positive

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

27. I feel more sympathetic towards students who get HIV/AIDS from blood transfusion than those who get it from drug abuse

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

28. I have little sympathy for students who get HIV/AIDS from sexual promiscuity

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

29. Students with AIDS should be treated with the same respect as other students

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

30. I am worried about getting HIV/AIDS from social contact with a fellow students in school

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

31. People with HIV/AIDS should tell their sexual partners that they are infected

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

32. I am sympathetic towards the misery that students with HIV/AIDS experience

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

33. I would like to do something to make life easier for people with HIV/AIDS

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

34. I am comfortable discussing with someone HIV/AIDS

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

35. I have heard enough about HIV/AIDS and I don't want to hear about it anymore.

a. Strongly Agree ( ) b. Agree ( ) c. Neutral ( ) d. Disagree ( ) e. Strongly Disagree ( )

36. What would you do if you found out that a friend of yours was infected with HIV/AIDS? *Please tick only one response.*

a. Offer them support and sympathy ( )

b. Offer them support but consider that they deserve it for some reason ( )

c. Continue to be friends but avoid physical contact ( )

d. Avoid them ( )

**SECTION 4: PREVENTIVE PRACTICES**

37. Have you ever used a condom?

a. Yes ( ) b. No ( )

38. Did you use a condom the last time you had sex?

a. Yes ( ) b. No ( )

39. Would you use condoms if you get them for free?

a. Yes ( ) b. No ( )

40. In the past year have you: *please tick one response.*

a. Had sexual relations only with a regular partner ( )

b. Had sexual relations with more than one partner ( )

c. Had no sexual relation ( )

41. Have you ever had an HIV test?

a. Yes ( ) b. No ( )

42. Would you like to have an HIV test?

a. Yes ( ) b. No ( )

43. Do you know where you can have an HIV test in your community?

a. Yes ( ) b. No ( )

44. a) Have you changed your sexual behavior habits because of information gained from HIV/AIDS awareness campaigns or programs

a. Yes ( ) b. No ( ) c. Somewhat ( )

b) Please explain your answer _____

45. Has the topic HIV/AIDS been included in your study program?

d. Not at all ( ) b. Somewhat ( ) c. Sufficiently ( )

46. How do you asses your theoretical knowledge in HIV/AIDS to be

e. Poor () b. Fair ( ) c. Good ( ) d. Very Good ( )

47. Do you think that the youth should have an informative role concerning HIV/AIDS to the public?

a. Yes ( ) b. No ( )

48. Who is most suitable to give information about HIV/AIDS?

f. Doctor ( )

g. Teacher ( )

h. Parents ( )

i. Fellow students ( )

j. Others (Specify) _____

49. a) More HIV/AIDS programs and training in schools and institutes are necessary.

a. Yes ( ) b. No ( )

b) Explain your answer _____

_____

_____

50. What do you think would make the HIV/AIDS awareness programs more effective for young people?

_____

_____

_____

_____

***Thank you very much for your time and cooperation.***

**HELLEN WANJIRU WAIRIMU**

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**FOCUS GROUP DISCUSSIONS**

**KNOWLEDGE, ATTITUDES AND PRACTICES CONCERNING HIV/AIDS PREVENTION AMONG YOUTH IN EASTLEIGH LOCATION IN NAIROBI COUNTY**

**FOCUS GROUP DISCUSSION GUIDE FOR THE YOUTH**

**INTRODUCTION**

My Name is Hellen Wanjiru Wairimu, Am a student of The University of Nairobi, Department of Sociology and social work. I am conducting a research for the attainment of a Master's degree in Rural Sociology and community development.

This interview guide is prepared to collect information on HIV/AIDS knowledge, attitude and practice among the youth in Eastleigh location for research purposes. Your honest and genuine answer to the questions will have a great value to the research outcome. I would greatly appreciate your help in responding to these questions.

Thank you.

1. Have you ever heard of HIV/AIDS?
2. Where do you get your information about HIV/AIDS?
3. Do you know of any youth who has contracted or died from HIV/AIDS?
4. Do you consider yourself to be at risk of contracting HIV/AIDS?
5. What efforts are you making to avoid contracting the disease?
6. How do you treat people whom you know that have the disease in your community?
7. Do you discuss about the disease with your friends and family?
8. Are there any efforts made by the community to stop the spread of HIV/AIDS among the youth.

**THANK YOU VERY MUCH FOR YOUR TIME**

**KEY INFORMANT GUIDE**

**INTERVIEW GUIDE**

**KNOWLEDGE, ATTITUDES AND PRACTICES CONCERNING HIV/AIDS PREVENTION AMONG YOUTH IN EASTLEIGH LOCATION IN NAIROBI COUNTY**

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1. What is your occupation?
2. What is your place of work?
3. How did you start involving yourself with HIV/AIDS issues?
4. From your experience, how do you view the HIV/AIDS pandemic in regards to the Youth?
5. What specific issues are the youth grappling with in regards to HIV/AIDS?
6. What intervention strategies do you offer to this young people?
7. Are the strategies working in your opinion?
8. To what extent do the youth consider themselves to be at risk?
9. Are the youths taking initiative to prevent themselves from being infected?
10. Is the knowledge available on HIV/AIDS to the youth enough to enable them to avoid engaging in risky sexual practices?
11. To what extent are the initiatives if any, informed by the attitudes towards HIV/ AIDS?
12. Are institutions of learning assisting in curbing the HIV/AIDS infection among the students?

**THANK YOU VERY MUCH FOR YOUR TIME**