

**DETERMINANTS OF YOUTH PARTICIPATION IN  
PREVENTION OF HIV AND AIDS IN SECONDARY SCHOOLS  
IN SUBA DISTRICT, HOMABAY COUNTY, KENYA**

BY

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A research project report submitted in partial fulfillment of the requirements for the award of the  
degree of Master of Arts in Project Planning and Management

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**DECLARATION**

This research project report is my own work and it has not been submitted for any degree award in any other university.

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## **DEDICATION**

This Research Project paper is dedicated to my mother Florence Magak for her inspiration in my life.

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## **LIST OF ABBREVIATIONS AND ACRONYMS**

<b>AIDS</b>	Acquired Deficiency Syndrome
<b>HBM</b>	Health Behavior Model
<b>HIV</b>	Human Immunodeficiency Virus
<b>HBC</b>	Homa- Bay County
<b>IDU</b>	Injecting Drug Users
<b>KAIS</b>	Kenya AIDS Indicator Survey
<b>HECP</b>	HIV Education Curriculum and Prevention
<b>KNBS</b>	Kenya National Bureau of Statistics
<b>MOH</b>	Ministry of Health
<b>MOE</b>	Modes of Exposure
<b>MOT</b>	Modes of Transmission
<b>MSM</b>	Men having Sex with Men
<b>NACC</b>	National AIDS Control Council
<b>NASCOP</b>	National AIDS and STIs Control Programme
<b>PEP</b>	Post Exposure Prophylaxis
<b>STI</b>	Sexually Transmitted Infections
<b>SW</b>	Sex Workers
<b>VCT</b>	Voluntary Counseling and Testing
<b>WHO</b>	World Health Organization

## ABSTRACT

Knowledge, attitudes and sexual behavior change towards HIV/AIDS remains a primary goal of HIV prevention efforts. HIV and AIDS is one of the leading health problems in Kenya where nearly 7.1% of the population had been infected by the disease in 2011. Suba District in Homabay County is having the highest (26%) prevalence of HIV. Thus, the purpose of this study was to determine the factors that influence the participation of the youth in prevention of HIV/AIDS in Suba District. The objective of the study was to assess how the knowledge on HIV/AIDS, social conditions, attitudes and the sexual behaviors of secondary school students influence their participation in the prevention of HIV/AIDS. The literature reviewed indicated that the knowledge or information that high school students have about HIV and AIDS is not accurate since they still have misconceptions about the diseases. Students engage in sex from the age of 11 years. This exposes them to the risk of acquiring HIV due to the inaccurate knowledge that they have about prevention of the disease. Social conditions such as poverty also prevent students from accessing VCTs and condoms, which they require to prevent the spread of the disease. Negative attitudes towards people living with HIV and AIDS hinder prevention of the disease by encouraging stigmatization. The study used a descriptive research design. The target population was students in rural secondary schools in Suba District. The data was collected from a sample of 371 students who were selected through a stratified sampling technique. The data was collected using questionnaires with structured and unstructured questions. Data analysis was conducted through descriptive statistics. The study found that 100% of the students had heard about HIV and AIDS. At least 80% of the students were aware of the major modes of HIV transmission, which include unprotected sex, sharing sharp objects, and blood transfusion. The study found that 44.7% of the students strongly agreed that if a member of their family was HIV positive, the information should remain secret. Moreover, 63.1% of the students strongly agreed that condom use education should be introduced in their schools. The study found that 63.1% of the students had had sex at least once in their lifetime and 56% of them used a condom in their last sexual intercourse. Moreover, 81.1% of the students had gone for HIV tests. 53.8% of the students stated that having unprotected sex was the main adverse social condition that exposed them to the risk of acquiring HIV. In addition, 27.1% were likely to acquire HIV/AIDS because of risky leisure activities such as drinking alcohol. The study concluded that the students lack accurate information/ knowledge on HIV/AIDS. The quality of information about the disease among students should be improved to prevent the spread of the disease. Students' sexual behaviors and social conditions also expose them to the risk of acquiring HIV/AIDS. Thus, students should be encouraged to use condoms and refrain from risky leisure activities such as drug abuse. The government in collaboration with the community should address the stigma associated with HIV and AIDS to enhance its prevention.

## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background of the Study

HIV and AIDS has in the past decades had devastating effects on the youthful population, especially, secondary school going students by causing deaths and stigmatization. Prevention of HIV/ AIDS is critical for creating a healthy and productive population. According to WHO (2014), 95% of the world population should have accurate knowledge about HIV and AIDS to prevent new infections. However, in low and middle-income countries only 24% and 36% of young women and men respectively have accurate knowledge about the disease. Lack of adequate knowledge prevents individuals from taking preventive measures such as using condoms to avoid acquiring HIV and AIDS.

A positive attitude towards HIV/ AIDS and the people living with it is required to enhance prevention. A positive attitude eliminates stigma and discrimination, thereby allowing individuals to go for HIV tests and seek medication. In the contrary, the negative attitude associated with the disease when it emerged in early 1980s still exists today. This is reflected in the stigma, fear, and discrimination that HIV/ AIDS patients face today. Individuals believe that HIV/ AIDS is a life threatening condition associated with death. They also associate the disease with behaviors that people disapprove such as homosexuality, drug use, sex work, and infidelity. The resulting increase in fear, discrimination, and stigmatization prevent individuals from going for HIV tests, disclosing their HIV status, and taking antiretroviral drugs (Cameron, 2010). Reluctance to go for HIV test means that individuals are diagnosed late, making treatment less effective and increasing the likelihood of transmitting the disease.

According to (Murtala, 2009), safe sexual behaviors should be adopted to prevent the spread of HIV/ AIDS. This includes avoiding unprotected sex, anal sex, and having multiple sexual partners. Risky sexual behavior is still an obstacle to prevention of HIV/ AIDS since only 51% of individuals

aged 15-49 years use condoms in Sub-Saharan Africa, Middle East, and Latin America (UNAIDS 2014). Globally, risky behaviors such as anal sex, oral sex, and having multiple sex partners are still common in most countries.

CDC 2010 notes that poverty is one of the major social conditions that promote the spread of HIV and AIDS in urban and rural communities. Poor people might not be able to access condoms, information about HIV/ AIDS, and antiretroviral drugs due to limited financial resources. HIV patients who are not able to meet basic housing needs often find difficulties in maintaining regular care and adherence to medication. This increases their viral load and chances of transmitting the disease to others. Family rejection is another social condition that prevents the spread of HIV/ AIDS. According to UNAIDS (2014), lesbians, gays, and bisexuals who are rejected by their families or caregivers are 3.4 times more likely to engage in risky sexual behaviors.

According to UNAIDS (2012), globally 34 million people were living with HIV at the end of 2011. An estimated 0.8% of adults aged 15-49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide (Capacity Building International, 2009). The number of people infected by HIV and AIDS in Sub-Saharan Africa is five times higher than in South, Southeast, and East Asia.

According to UNAIDS (2012) worldwide number of people newly infected by the disease continues to fall. However, the rate of decline varies across regions and countries with the Caribbean and Sub-Saharan Africa having recorded the highest decline rates of 42% and 25% between 2001 and 2011 (UNAIDS 2012). However, the number of new infections in the Middle East and North Africa has increased by over 35% between 2001 and 2011. Similarly, the infection rate has been increasing steadily in Eastern Europe and Central Asia since 2007 (UNAIDS 2012).

Overall, developed countries such as the US and Japan have the least prevalence of HIV and AIDS, whereas developing countries in Africa and the Middle East are the most affected. Developed countries have low prevalence rates because of access to advance and affordable health care services that have helped to control the spread of the virus. In most African countries, the prevalence is high due to poor health care systems and lack of access to medication such as ARVs and services such as HIV testing and counseling. Cultural practices such as wife inheritance have also increased the rate of infection in Africa.

In the East African region, the prevalence of HIV/ AIDS has either decreased or remained stable in most countries in the last five years. In Kenya, the national infection rate has declined from 10% in the late 1990s to approximately 5% in 2011 (NACC & NASCOP, 2012). The decline is attributed in part to the increase in the use of condoms among the sexually active youths and adults (Peltzer & Promtussananon, 2005). In Uganda, the national HIV prevalence declined from 18.5% in 1992 to 5% in 2000 (Uganda AIDS Commission, 2012). The remarkable decline was achieved through a strong political leadership that encouraged sexual behavior change among the youth to control the spread of the virus. Other causes of the decline included open discussions to share knowledge about HIV/ AIDS, as well as, a strong decentralized multi-sectoral and community response to the epidemic. By 2005, the prevalence rate had stabilized at around 6.4%. However, it rose to 6.7% in 2012 partly because of the government's decision to promote abstinence only rather than safe sex as a prevention measure.

In Tanzania, the prevalence is high among the old age groups and women who have limited access to medication and information about the disease. Overall, Tanzania's national prevalence rate is nearly 6.5% as at 2011 (NACC & NASCOP, 2012). Rwanda has a low prevalence of only 3%, with women having a higher infection rate than men as at 2010. Over 60% of the adult population has satisfactory knowledge about HIV transmission and prevention in Rwanda (NASCOP, 2012). In



addition, the number of people going for HIV tests increased by 38% in 2010, thereby allowing the infected persons to seek medication in time. Somalia has the lowest prevalence rate of nearly 2%. However, knowledge of HIV transmission is poor and condom use is uncommon.

### **HIV/ AIDS among the Youth in KENYA**

The youth in secondary schools (15-19 years) are among the most vulnerable groups because of their risky sexual behaviors, attitudes towards prevention of HIV/ AIDS, and inadequate knowledge about the disease (NACC, 2005). This can be shown in the below table: -

**Table 1**

*HIV Prevalence among the Youth in Kenya*

Age Group	Male			Female		
	Year			Year		
	2003	2007	2009	2003	2007	2009
15-19	0.4%	1%	0.7%	3%	3.5%	2.7%
20-24	2.4%	1.9%	1.5%	9%	7.4%	6.4%
25-29	7.3%	7.3%	6.5%	12.9%	10.2%	10.4%

Kenya Demographic and Health Survey, 2009(KDHS, 2009)

According to the 2007 KAIS, at least 2.3% of the youth in school were infected with the prevalence among the female being 3.5% while that for the male youth being 1%. The report further indicates that there is a wide regional variation in HIV prevalence with Nyanza province having the highest infection rate at 14.9 percent (NAS COP, 2009). The other regions included Nairobi (8.8%), Coast (8.1%), Rift Valley (6.3%), Western (5.4%), Eastern (4.6%), Central (3.6%) and North Eastern (0.81%).

Suba District has the highest prevalence in Nyanza province at 26.3 percent with the teenage infection rate at 10.8 percent (NASCO, 2006). Among the 15-19 years old, 70 percent are sexually active and the first sexual intercourse occurs before the age of 15 years among the girls. HIV and AIDS is mainly transmitted through sexual intercourse in the district (UNAIDS, 2003). The prevalence level in the district is almost triple the national infection rate for the same age group. Thus, urgent intervention is needed to reduce the infection rate in the district.

### **Knowledge of the Youth about HIV/ AIDS**

The HIV/AIDS pandemic has led to increased public awareness on the importance of the health of the youth since they are the most vulnerable in terms of transmission and impact (WHO, 2004). Knowledge about HIV/AIDS does not always lead to less risky behavior. This is because it is very difficult to change sexual behavior once it becomes a habit (UNICEF, 2006). Successful prevention programs among young people are those that equip the youth with the knowledge, skills, and attitudes that will keep them safe from infection before they become sexually active. Since 2003, the government of Kenya in recognition of the vulnerability of the youth has integrated HIV/AIDS programs into existing education curricula.

The Government of Kenya established a national curriculum on HIV/AIDS education that teaches basic medical facts about the illness such its transmission, prevention, and care for people living with it to reach children in schools. It stresses abstinence as the most effective way to prevent pregnancies and HIV/ AIDS infection. However, it does not teach the importance of using condoms to prevent the disease.

### **Attitude of the Youth towards HIV/ AIDS**

Stigma is the main attitude problem that prevents the youth from participating in the prevention of HIV/ AIDS. Stigma refers to a situation in which individuals living with HIV/ AIDS are considered irresponsible or immoral. Negative attitudes increase marginalization and prejudice against

individuals living with HIV/ AIDS. The attitudes allow members of the community to excuse themselves from the responsibility of providing care to those living with the disease. Stigma encourages secrecy and denial, which prevents the youth from seeking counseling, medication, support services, and test for HIV/ AIDS (UNICEF, 2006). In most African countries, people are still insensitive to the plight of HIV positive youth. Consequently, HIV positive youth opt not to disclose their HIV status for fear of being ostracized by the community. Discrimination against HIV positive youth could lead to dropping out of school; lose of friendship, and lack of social support.

### **Sexual Behavior of the Youth and HIV/ AIDS Prevention**

Sexual behavior change remains a primary goal of HIV prevention efforts. It is influenced by factors such as individual desires; social and cultural relationships; and environmental and economic dynamics (Njau, Mtweye, Barongo, Manongi, Chungulu, & Mwampeta, 2006). The youth do not believe that HIV is a threat to them, while others do not know how to protect themselves from infection (WHO, 2004). Sexual relations typically occur before adolescents have gained experience and skills in self-protection, acquired adequate information about sexually transmitted infections (STIs) or have had access to health services and supplies such as condoms.

Young people's sexual relations are often unplanned, sporadic and, sometimes, the result of pressure or force. This means that the youth are not aware of the risks and vulnerabilities associated with HIV infection. Therefore, lack of knowledge is one of the major factors that make the youth vulnerable to HIV infection.

### **Social Conditions of the Youth and HIV/ AIDS Prevention**

The youth from poor families are less likely to have adequate information about HIV and AIDS due to limited access to mass media channels such as TV, radio, and newspapers (NACC, 2005). In marginalized communities in Northern Kenya, female children hardly get the opportunity to attend schools to acquire knowledge about the transmission and prevention of HIV/ AIDS (Hussein,

2005). Moreover, poverty limits access to condoms and healthcare services among the youth. Sexual abuse is another social condition that exposes the youth to the risk of acquiring HIV/ AIDS. Female youths who are forced to have sex with older men are less likely to demand the use of condoms due to fear. In addition, cultural practices such as female genital mutilation and traditional circumcision where surgical equipment such as knives are shared without being sterilized expose the youth to the risk of acquiring HIV/ AIDS (Mbozi, 2008). This study sought to establish the determinants of youth participation in the prevention of HIV and AIDS in Suba District.

## **1.2 Statement of the Problem**

HIV/ AIDS remain one of the major health challenges that Kenya is trying to deal with. Suba is one of the districts with the highest HIV prevalence in Kenya. The infection rate in the district is 26.3%, which is almost double the prevalence level in Nyanza province. About 70% of 15-19 years olds are sexually active and the first sexual intercourse occurs before the age of 15 years among the girls (Capacity Building International, 2009). The fact that HIV and AIDS is mainly transmitted through sexual intercourse is well documented. In this regard, majority of the youth in school are at risk of being infected with HIV/ AIDS since they are sexually active.

At least 95% of the youth should have accurate knowledge about HIV and AIDS to prevent the spread of the disease. In Kenya, the government has embarked on improving the knowledge of the youth by introducing HIV/ AIDS education programmes in schools. This has increased the general awareness about HIV and AIDS among the youth. However, the information that the youth have is not accurate since they still hold myths and misconceptions about the disease. Lack of adequate and accurate knowledge prevents the youth from taking preventive measures such as using condoms to avoid acquiring or spreading HIV/ AIDS.

The community is expected to develop a positive attitude towards the youth living with HIV/ AIDS to prevent the spread of the disease. Accepting HIV positive youth is expected to eliminate stigma and discrimination, thereby allowing the youth to seek HIV tests and medication. However, stigma, fear, and discrimination continue to limit the participation of the youth in the prevention of HIV/ AIDS in Kenya. Negative attitudes towards the youth living with HIV/ AIDS increase fear, discrimination, and stigmatization, which in turn prevent the youth from going for HIV tests, disclosing their HIV status, and taking antiretroviral drugs. This promotes the spread of the disease.

The youth are expected to adopt safe sexual behavior to reduce their vulnerability to HIV/ AIDS. The government through its HIV/ AIDS awareness campaign programmes continues to sensitize the public including the youth to avoid risky behaviors such as having unprotected sex. Nonetheless, the youth still engage in risky sexual behaviors due to social and economic conditions such as poverty.

Social conditions such as poverty, gender inequality, and sexual violence should be addressed to prevent the spread of the disease. Gender inequality limits women's ability to negotiate for safe sex with their partners. Similarly, sexual violence such as rape or forceful sex can lead to transmission of the disease since the victims might not be able to demand for the use of condoms. Poor youth are at risk of acquiring HIV/ AIDS since their limited financial resources prevent them from accessing supplies such as condoms, visiting VCTs, and accessing medication.

Pending the discovery of an effective vaccine, therapy, or curative treatment, reduction of risk-taking behavior is the only way through which the spread of HIV/AIDS pandemic can be arrested. In particular, the spread of the disease among the youth in school can be prevented if they avoid risky behaviors such as having unprotected sex. Access to adequate and accurate knowledge about HIV/ AIDS can also enhance prevention. The youth are likely to participate in the prevention of HIV/ AIDS if they have a positive attitude towards the disease. It is against this background that

this study sought to establish how the knowledge, attitudes, social conditions, and sexual behaviors of the youth in Suba District determine their participation in the prevention of HIV/ AIDs.

### **1.3 Purpose of the Study**

The purpose of this study was to assess the determinants of youth participation in the prevention of HIV and AIDS.

### **1.4 Objectives of the Study**

The study was guided by the following objectives

1. To assess the level at which the knowledge of youth on HIV/ AIDS determine their participation in the prevention of HIV and AIDS in SubaDistrict, Homabay County.
2. To establish the extent to which the attitudes of youth determine their participation in the prevention of HIV and AIDS inSubaDistrict, Homabay County.
3. To examine how the sexual behavior of youth determine their participation in the prevention of HIV and AIDS in SubaDistrict, Homabay County.
4. To examine the extent to which the social conditions of youth determine their participation in the prevention of HIV and AIDS in Suba District, Homabay County.

### **1.5 Research Questions**

The research answered the following questions:

1. What is the level of knowledge of youth on HIV/ AIDS that determines their participation in the prevention of HIV and AIDS in SubaDistrict, Homabay County?
2. To what extent does the attitude of the youth determine their participation in the prevention of HIV and AIDS in Suba District, Homabay County?
3. How does the sexual behavior of the youth determine their participation in the prevention of HIV and AIDS in Suba District, Homabay County?

4. To what extent do the social conditions of the youth in Suba District determine their participation in the prevention of HIV and AIDS in the Suba District, Homabay County?

### **1.6 Significance of the Study**

The high prevalence of HIV and AIDS in Suba district, estimated at 26.3%, creates a need for intense prevention efforts in the District and other regions with comparable infection rates (Kenya National Bureau of Statistics, 2010). National surveys are usually very expensive to carry out. Consequently, the lowest level that data can be collected and analyzed is up to the regional level (Capacity Building International, 2009). This means that in Kenya data can only be analyzed up to the provincial level. Therefore, we hope that this study provided valuable insights that may guide the target population in the process of preventing HIV and AIDS. Schools have been a hard to reach population due to the strict policy guidelines issued by the Ministry of Education. Abstinence is the only prevention measure that can be taught in schools, despite the fact that majority of the population becomes sexually active by the age of 18 years. Thus, the findings of this study, hopefully, may help the government through the ministry of education to adjust its policy concerning HIV and AIDS education in schools. Finally, studies that target the student population are scanty, and the existing ones are inconclusive. Thus, this study contributed to the process of designing policies and programs that are geared towards the prevention of HIV and AIDS.

### **1.7 Basic Assumptions of the Study**

The study was based on the assumption that students enrolled in day public secondary schools in Suba District were purely residents of the rural set up. This assumption is based on the fact that the targeted schools were located in rural areas in the district.

### **1.8 Limitations of the study**

The main limitation of the study was that some respondents were reluctant to provide information about their sexual behavior. In this regard, the study used anonymous questionnaires to encourage the respondents to provide all the required information.

### **1.9 Delimitations of the Study**

The study focused on the determinants of youth participation in prevention HIV and AIDS prevention in Suba District in Homa-Bay County. It was conducted in July 2014 using a survey research design and a sample of 371 participants selected from the secondary schools in the district. Suba District was chosen because it has the highest prevalence rate in the country. In this case, it was necessary to pay special attention to Suba District to understand the determinants of youth participation in the prevention of the disease in the district. Secondary School students were chosen as the target group because of the ease of accessing them within a short time.

### **1.10 Definitions of Significant Terms used in the Study**

**Knowledge of youth:** Is defined as a justified true belief. For one to have knowledge, three conditions must be fulfilled namely, the belief condition, the truth condition and the grounds/ justification condition.

**Attitude of youth:** Can be defined as learned, relatively enduring dispositions to respond in a consistently favorable or unfavorable ways to certain people, groups, ideas, or situations. They may change and predict behavior. Therefore, attitude includes the affect (psychological arousal), behavior, and cognition (thoughts).

**Experience of youth:** is defined as the content of direct observation or participation in an event. Both psychological and emotional properties are integrated into this ongoing personal-environment to give experience meaning and value and to enhance its quality. For it to occur there has to be a physical presence, which consists of three things: perceptual, intentional, and cognitive components.



**Youth:** Secondary school going person(s) aged between 14 and 21 years

**Youth Participation:** Refers to the youth taking an active role in the prevention of HIV.

**Prevention of HIV:** Refers to ensuring that there is controlled HIV incidence among the secondary school youth

**Determinants of Youth Participation:** Factors that would influence the decision by the youth in taking active role in the prevention of HIV

**Social Conditions:** Refers to factors that would make the youth vulnerable to HIV infection.

**Sexual Behavior:** Refers to any activity that may occur in solitary, between two persons, or in groups that induces sexual arousal. Sexual behavior includes a variety of activities, which include kissing, sexual intercourse, and masturbation among others.

**Abstinence:** Is the act of postponing sexual intercourse until marriage

**Behavior Change:** Adoption of activities or strategies such as abstinence, having one sex partner, condom use among others to prevent the spread of HIV/ AIDS.

**Safe Sex:** Refers to sexual activity in which individuals take measures to protect themselves from sexually transmitted diseases such as HIV/ AIDS.

### **1.11 Organization of the study**

This study is organized into five chapters. Chapter one covers the introduction to the study, which includes the background , the problem statement, purpose, objectives, research questions, significance, basic assumptions, limitations and the scope of the study. Chapter two is the literature review which highlights knowledge, attitudes, practice, experience, and sexual behavior, social conditions, as well as, how these lead to the prevention of HIV and AIDS. Chapter three deals with the research methodology, which includes the study design, study population, sampling techniques, data collection instruments and techniques of data analysis. Chapter four provides the results of data analysis, whereas chapter five presents the discussion of the results, recommendations and conclusions.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter discusses the literature related to the determinants of youth participation in the prevention of HIV and AIDS. It particularly focuses on the knowledge about HIV and AIDS among the youth; attitudes of youth towards prevention of HIV and AIDS; the sexual behavior of the youth and how it affects their participation in prevention of HIV and AIDS; and how the social conditions of the youth affect their participation in prevention of HIV/ AIDS.

#### **2.2 Knowledge of Youth about HIV/ AIDS and Prevention of the Disease**

AIDS is the leading cause of death among adolescents in Africa and the second highest globally with 2.1 million adolescents living with HIV in 2013 globally. A greater percentage of this number (83%) resides in sub-Saharan Africa with 250,000 new infections in 2013. There were 9720 adolescents and young people who died of AIDS in Kenya in 2013. (UNAIDS, 2014). The youth are the most vulnerable since this is the stage at which they are curious and want test things. Knowledge and awareness would therefore be very important at this stage (WHO, 2004).

Knowledge can be defined as a justified true belief. For it to occur three conditions must be fulfilled namely, belief, truth, and grounds condition. Belief is the psychological state of mind or conviction. Truth is the conviction that something is true, while the grounds condition refers to justification. It is only when these three conditions are fulfilled that it can be said that knowledge has taken place (Schelfer, 1965). The following will be discussed under this theme; knowledge and information sources, and HIV curriculum in schools and the prevention of HIV and AIDS.

##### **2.2.1 Knowledge, information Sources of Youth and Prevention of HIV and AIDS**

Knowledge of HIV and AIDS is essential for making behavioral choices that reduce the threat of acquiring and transmitting the infection (NASCO, 2009). In the last 10 years, educational

campaigns in Kenya have focused on disseminating information about the disease in terms of its acquisition and prevention. According to Kenya National Bureau of Statistics (2010), about 99% of Kenyans had heard about HIV and AIDS by 2010. 98.7% of adolescents who are the in school had knowledge about HIV and AIDS. There was a marginal difference in terms of the knowledge at the rural and urban areas, standing at 99 percent and 99.5 percent respectively. However, the results show that the knowledge of all key HIV prevention methods was lower among women and men aged 15-19 years than among people aged 20 years and above. Despite the high knowledge on HIV and AIDS, the prevalence in Nyanza is still very high.

In a study by Ndegwa (2002), 100% of both teachers and students in Nairobi were found to be aware of HIV and AIDS. Majority of the students know the symptoms of HIV and AIDS and have seen or even taken care of AIDS patients. On the other hand, only 50% of the students had knowledge of preventive measures for HIV and AIDs. The study further revealed that teachers were involved in the activities geared towards HIV prevention like counseling, teaching in class and in general discussions with students. This means that if the teachers were well equipped with information on HIV and AIDS, they would play an important role in the prevention of the disease among students. Nonetheless, only 12.9% of teachers often teach about HIV/AIDS (Ndegwa, 2002). This implies that teachers are not well empowered as disseminators of the information about HIV/AIDS prevention methods to students.

In a study on the knowledge of HIV and AIDS among secondary school students in Calabar, Nigeria, Oyo-Ita, Ikpeme, Etokidem, Offor, Okokon and Etuk (2005) found that only 68.8 percent of the adolescents knew that HIV and AIDS is caused by a virus. 31.2 percent of the adolescents did not know the etiological agents of HIV and AIDS, stating that it is caused by bacteria or worms or did not know at all. The majority (90%) knew that HIV/AIDS is transmitted through sexual intercourse. Only 13.4 percent of the adolescents knew that HIV carriers might look normal.

Majority (89.5%) did not know the features of AIDS. Only 48.4 percent of the adolescents knew that avoidance of sex, keeping one sexual partner, use of condom, and screening of blood transfusion before use could prevent HIV transmission. Abstinence from sex was the common mode of preventing HIV and AIDS among the adolescents. The main sources of information on HIV and AIDS for the adolescents in this region included television (53.3%); radio (43.8%); health talks and clinics (36.9%); and newspapers and magazines (35%). Only 2.2% of the adolescents obtained information on HIV/AIDs from their parents. Therefore, the study concluded that although the awareness on HIV and AIDS was high among the secondary school adolescents, parents, teachers, and health workers should be more involved in educating the youth on this dreaded disease.

Murtala (2009) in his study on HIV and AIDS awareness among senior secondary school students in Katsina, Nigeria, found that 97.5% of the students were aware of the existence of the disease. 52.5% of the students believed that there was cure for the disease, while 58% of them believed that the disease could jeopardize a person's dreams if they got it. The majority of the students (96%) were aware of the fact that the disease kills. However, only 66% of them claimed to know of any infected person that had died of the disease. 65 percent of the students were also willing to be tested for the disease. The results also revealed that sexual intercourse (96.7%); use of needles and syringes on human body (82.5%); and blood transfusions (86.7%) are the major means by which the disease is transmitted. On the other hand, the students gave low scores to factors such as sharing toilets, kissing/hugging and mosquito bites as important means of transmitting the disease. The study also established that the student's reliable means of obtaining correct information on HIV and AIDS were television, posters, and radio. The most preferred source of information was road shows and public lectures.

In a study on HIV and AIDS related knowledge, attitudes and practice among students of Municipal Corporation School in Pune, India, Pankaj, Pore and Patils (2012), found that 63.7 percent of the students were aware of HIV and AIDS. Regarding the modes of transmission of the disease, 61.8 percent of the students were aware of unsafe sex as a mode of transmission. Television was the main source of information (54.9%) followed by friends. Very few students mentioned family as a source of information, whereas schools or teachers were not mentioned as a source of information on HIV and AIDS by any of the students. Obare et al (2010) reaffirms this finding by asserting that most adolescents who are HIV positive talk to service providers and counselors more than parents or guardians about sexual or reproductive health matters. However, with respect to general issues they report talking to service providers and parents in equal measures.

A study by Ladhani (2005) on awareness and prevention of HIV and AIDS among urban upper primary school in Kisumu revealed that most students (97%) were aware of the disease. However, only 48.6 percent of the respondents perceived themselves to be at risk of contracting HIV (Ladhani, 2005). A similar study by Ochieng (2005) revealed that there was a misconception that a person with HIV always looked unhealthy. The symptoms of HIV and AIDS are documented in HIV and AIDS materials (Ochieng, 2005). Reading the materials can help to eliminate the misconceptions about the disease. Ongunya, Indoshi and Agak (2009) in his evaluation of HIV and AIDS programs in secondary schools in Siaya revealed that students did not have time to read extra materials on HIV and AIDS apart from what they were either taught in classroom or by invited guests. The reason for this was that the secondary school education had too much workload. Therefore, learners only concentrated on examinable materials to improve their grades. Thus, there is a gap between the objectives of HIV/AIDS programs and the actual outcomes.

Hussein (2005), in his study of socio-economic and cultural factors in the transmission of HIV and AIDS among the school and college going youth in Garisa District refutes the claim that there is

high knowledge about the disease among learners. He observed that many young people were unaware of what constituted risky sexual behavior that could expose them to HIV infection. The few learners who had knowledge about the disease believed that they were invulnerable (Hussein, 2005). A similar view was advanced by Johnston (2000) who noted that even though knowledge about the nature and transmission of the disease is over 90% among Kenyan youth, the perceptions about the chances of contracting the virus are very poor. Generally, young people already know something about sex and HIV/AIDS. However, the information could be inadequate and wrong or incomplete.

### **2.2.2 Knowledge, HIV Education Curriculum and Prevention of HIV among Youth in Suba District, Homa Bay County.**

The government of Kenya introduced an integrated HIV and AIDS education in the year 2000 (Kenya Institute of Education, 2000). The objectives of the program include the acquisition of knowledge and the necessary skills about HIV/AIDS and other sexually transmitted diseases; development of life skills that will lead to an AIDS and sexually transmitted diseases free life; to identify sources of information on HIV and related issues; and making decisions about personal and social behavior in order to reduce the risk of HIV and other sexually transmitted infections. Hussein (2005), in his study of socio-economic and cultural factors in the transmission of HIV and AIDS among the school and college going youth in Garisa District refutes the claim that there is high knowledge about the disease among learners. He observed that many young people were unaware of what constituted risky sexual behavior that could expose them to HIV infection. The few learners who had knowledge about the disease believed that they were invulnerable (Hussein, 2005). A similar view was advanced by Johnston (2000) who noted that even though knowledge about the nature and transmission of the disease is over 90% among Kenyan youth, the perceptions about the chances of contracting the virus are very poor. Generally, young people already know something about sex and HIV/AIDS. However, the information could be inadequate and wrong or incomplete.

According to Ongunya et al (2009), the content of the HIV/AIDS education program has not been reviewed since its introduction in 2000 in response to emerging issues concerning the disease. For instance, materials on VCT services are clearly missing from the content of the program. Additionally, the program lacks practical orientation and only concentrates on delivering superficial knowledge because it is taught as a contemporary theme in secondary education curriculum. This finding suggests that a gap exists between the objectives and the actual HIV and AIDS education program delivery and behavior change in schools. This disconnect may be emanating from the presentation of the knowledge itself or lack of proper focus. The youth in school are exposed to HIV and AIDS education knowledge in the form of contemporary themes, which they expect to memorize during examinations and not to influence them to change their behavior.

### **2.3 Attitudes of Youth and Prevention of HIV and AIDS**

Attitudes towards VCT, attitudes towards condoms and condom and attitudes towards persons living with HIV and AIDS will be discussed under this theme. Eiser (1988) describes attitude as a form of experience that (a) refers to specific objects, events, people or issues, and (b) is primarily evaluative. He further says that people express their attitudes by describing the objects of their experience in evaluative terms. Additionally, people do not typically treat their attitudes as just a matter of opinion, but regards them as truth at least until someone can introduce new facts or arguments to change their minds (Eiser, 1988). Fishben and Ajzen (1975) describe attitudes as learned, relatively enduring dispositions to respond in a consistently favorable or unfavorable ways to certain people, groups, ideas, or situations. This definition implies that attitudes are learned, they may change, and they may predict behavior (Fishbein & Azjen, 1975).

### **2.3.1 Attitudes of the Youth towards Condom Use**

Ochieng et al (2011), notes that wider delivery of effective behavior change strategies is central to reversing the global HIV epidemic. In her study of HIV prevalence and condom use among secondary school students in Kisumu district in Nyanza province, she finds that more than half of the students reported early onset of sexual activity with the majority indicating that they initiated sexual intercourse between the ages of 11-15 years.

She further states that condoms are an integral part of HIV prevention and care programs. Thus, their promotion must be accelerated. Latex condoms are effective barriers to HIV and other STIs when used in every act of intercourse. This protection is most evident in HIV discordant couples. Condom knowledge and attitude ranked low in the study population. For example, there was a negative attitude towards the protective role of condoms in preventing HIV transmission. Even though the majority of students had seen a condom and believed that they were effective in protecting against pregnancy, only 22.9% thought that condoms were effective in protecting against HIV/AIDS. Similar results have been reported by Toroitich (2004) who found that 43.8% of students believe that condoms could slip off the man and disappear inside the woman's body.

Other studies have shown that condom breakage rates were less than 2%. Most of the breakage and slippage was likely due to incorrect use rather than poor condom quality. Factors such as using oil-based lubricants, age, exposure to heat or sunlight, could weaken latex, causing the condom to break. Majority of students agree that condoms cannot be used more than once, and did not agree that if a girl suggested using a condom to her partner, it would mean that she did not trust him. Misconceptions about HIV/AIDS and the protective role of condoms in preventing its spread are potentially dangerous since they may lead young people to avoid condoms during sexual intercourse. Misconceptions about condoms also exist. More male than female students believe that condoms reduce sexual pleasure. Even though condoms play a protective role in the fight against



HIV/AIDS, their use among students is low and inconsistent, reflecting the fact that for adolescents, condom use may not be an effective tool for protecting them against HIV/AIDS. Shops and chemists are the main sources of condoms. Only 16.6% of students indicated that they had never had sex without using a condom. However, the number of students who are not aware of correct condom usage is not known. In Tanzania, many youths have experienced sex at a relatively young age and often do not use a condom at first sexual intercourse (Njau, Mtweye, Barongo, Manongi, Chungulu, & Mwampeta, 2006). More male than female students had multiple sexual partners. However, it is not clear if this disparity is due to male exaggeration and female reticence in reporting sexual activity or not (Kiragu, 1991).

Ochieng (2011) notes that there is knowledge gap among secondary school adolescents on sex education, HIV/AIDS and the protective role of condoms. Moreover, they have myths and misconceptions on condoms and HIV/AIDS, which should be dispelled. Ndegwa (2002) established that most students abstain from sex. This is because they associate HIV and AIDS with loose morals. Their attitude is that only those with loose morals contract HIV. However, HIV can be contracted through other ways other than sexual intercourse. A study in Alabama established that parents could help their teenagers form positive attitudes towards condom use through discussions before their first sexual intercourse. The timing of the discussion is also very critical (Miller, 1998).

Ravai et al (2002) in his study on condom use among teenagers aged 14-20 years in Zimbabwe established that condom use was not popular in this age group. The females thought that condoms reduce pleasure. Furthermore, they believed that using condoms implied mistrust and that if one used a condom, then she would be viewed as a prostitute. Males, on the other hand, reported that condoms should only be used when engaging in casual sex.

### **2.3.2 Attitudes of the Youth towards VCT Services**

Voluntary counseling and testing for HIV has become a major component of the expanded responses to the HIV/AIDS pandemic. Early testing for HIV/AIDS offers many benefits for young people, but in many countries, it is still rare. In Kenya, existing counseling and testing centers are situated mainly in urban and semi-urban areas. The increasing demand for VCT services can be attributed to several factors. First, individuals have a right to know their sero-status in order to protect themselves and others from infection. Second, early detection may help individuals to access sources of support and variety of treatments for opportunistic infections associated with HIV and AIDS (Kiragu, 2001; Population Council and UNFPA, 2002). VCT can result in a reduction in risk taking tendencies and promote behavior change.

Where services are still poor as in Kenya, people may believe that the risks of knowing and disclosing their sero-status outweigh the benefits (Kiragu, 2001). Lack of clear linkages between VCT, treatment and care also acts as a deterrent to voluntary testing. Many people including the young do not seek VCT services until they develop symptoms of AIDS. Among the youth, barriers to VCT include lack of information; perception of low risk; lack of privacy and confidentiality; and costs and laws that require parental consent (Kiragu, 2001). Men and women seek voluntary counseling and testing services for different reasons. Men do so to reassure themselves or their partners that they are uninfected, while women do so only if they suspect that they may be infected (Population Council and UNFPA, 2002). However, the reasons why the young people may seek VCT services are still unknown in African countries.

Muganda and Otieno (2003) in their study of the uptake of voluntary counseling and testing services in Kenya noted that most of the secondary school adolescents still did not believe that they have enough information on VCT. Many of the young people believed that the best way to pass VCT information is through the electronic media (TV and Radio). Posters and billboards ranked

very low (Muganda & Otieno, 2003). This has obvious implication on IEC media to young people in school. The young people in school are more inclined to receiving much of the information that they may believe from electronic mass media. However, behavior change communication is much more effective through interpersonal communication rather than intrapersonal communication. Most of the secondary school students do not know the services offered at VCT centers (Muganda & Otieno, 2003).

Despite the advertising of VCT programs, many students are not sure of what to expect. Most of them believe that only testing services are offered at VCT centers. There is a general assumption that young people have adequate knowledge, which should influence positive values and attitudes. The fact that behavior change is happening at such a slow pace should raise serious doubts about the quality, appropriateness, and presentation of information to the youth. What is emerging is that, although knowledge is high, only about half of the young people are willing to use VCT services. Several factors may be contributing to this trend, key among them being lack of access to VCT services. Only about 46% of the students in the survey conducted by Muganda and Otieno (2003) had a VCT center near them. Thus, even if they were interested in using VCT services, access is hindered by the lack of VCT centers.

The stigma associated with HIV/AIDS may be a key factor that reduces the uptake of VCT services among the students. The challenge now is to link awareness creation with service delivery. Most VCT services are located in public health facilities. Additionally, there is a general lack of confidence in reproductive health services provided in public health facilities. This has clearly been extended to VCT services. Plans to roll out more VCT centers across the country must consider this. VCT services in most areas are currently located in the district hospitals. Most of the youth recommend that VCT centers be located in private places such as youth centers. It has also been

widely suggested that the centers be located in areas that the youths frequent such as churches, villages, hospitals, schools and market places.

### **2.3.3 Attitudes of the Youth towards PLHIV**

Stigma and discrimination in a population can adversely affect both people's willingness to be tested and their adherence to antiretroviral therapy. Reduction of stigma and discrimination in a population is, thus, an important indicator of the success of programmes targeting HIV and AIDS prevention and control (KNBS 2010). In a survey by the KNBS, respondents who had heard of HIV and AIDS were asked if they would be willing to take care of a family member who is suffering from AIDS in their own households; if they would be willing to buy fresh vegetables from a market vendor who had the AIDS virus; if they thought a female teacher who had the AIDS Virus, but not sick should be allowed to continue teaching; and if they would want to keep a family member's HIV status secret. Among the secondary school going youth, 27.1 percent expressed accepting attitudes on all the four indicators. Urban women are more likely than their rural counterparts to have accepting attitudes on all the four measures towards people affected by HIV and AIDS.

Kasonde (1996) established that 95 percent of the youth feel that HIV and AIDS is on the increase because the people who are HIV positive are busy spreading the HIV virus by having multiple partners. Ndegwa et al (2002), on the other hand, established that most people associate HIV and AIDS with loose morals.

## **2.4 The Sexual Behavior of the Youth and Prevention of HIV/AIDS**

Under this theme, the following will be discussed as sub themes; condom use and the prevention of among the youth and the uptake of Voluntary Counseling and Testing services (VCT) among the youth.

### **2.4.1 Condom Use and Prevention of HIV/AIDS**

Kabiru (2005) in her study of sexual relationships among high school students in Kenya found that approximately 50% of males and 11% of females have had sexual intercourse at least once in their lifetime. For both males and females, the proportion of sexually experienced respondents increased with increasing grade level. A higher percentage of students in provincial schools than in national schools reported that they were sexually experienced. Regarding school type, the highest proportion of sexually experienced female respondents was among those attending mixed day and single gender boarding schools, while in males it was among those attending mixed day and boarding schools. The proportion of sexually experienced respondents decreased with increasing socio-economic status. Among males, over 90% of those who stated that they did not belong to any religious organization were sexually experienced. Similar proportions of males and females reported condom use at last intercourse. The main difference between male and female respondents was the number of sexual partners reported. Approximately 60% of sexually experienced females reported that they had one sexual partner compared to 35% for males. 8% of the sexually experienced females and 26% of males stated that they have had five or more sexual partners over their lifetime. Another important difference between males and females was the age of first sexual partners. The average age of the first sexual partner among female respondents was 17.7 years compared to 13.4 years among male respondents.

Kabiru (2005) also noted some of the risky behaviors that students engage in. These included going to a disco clubs, going to youth parties, smoking cigarettes, drinking beer, drinking illicit brews, smoking marijuana, and using other drugs. Some of the drugs reported by students included cocaine, heroin, mandrax, khat, and kuber. 23% of females and 13% of males stated that they had never engaged in any of these activities, while one female and six males stated that they often engaged in all the seven risky behaviors. The results indicated that close to 50% of females and 60% of males engage in at least one of the behaviors sometimes or often.

Kakai, Ochieng and Abok (2011), in their study of condom use among secondary school students in Kisumu district, noted that 64.1% of boys and 41% of girls had had sexual intercourse. Majority of the students (49.8%) initiated sexual intercourse at the age of 11-15 years. Further analysis revealed that boys were twice more likely to initiate intercourse at the age of 6-10 years than girls. More boys (76.5%) than girls (54.8%) reported multiple sexual partners and over 75% of the students had engaged in sex without a condom. Even though the majority (97.4%) had seen a condom and believed that they were effective in protecting against pregnancy, only 22.9% of the students thought condoms were effective in protecting against HIV/AIDS. In this study, 8.8% of students reported that they had experienced a condom that slipped or broke during intercourse. Majority (77.1%) of the respondents agreed that condoms could not be used more than once.

On the issue of trust, 57.6% of the respondents did not agree that if a girl suggested using a condom meant that she did not trust her partner. Condom use at first sex was low (22.9%) among male and female students, but it doubled (40%) last time they had sex. The most popular sources of condoms at last sex were shops and chemists (31.2%), followed by their sexual partners (10.2%) and health care facilities (7.3%). The health care facilities included hospitals, health centers, dispensaries, and VCT centers. It was noted that girls (16.4%) were more likely than boys (9.8%) to acquire their condoms from their partners. On the other hand, boys (9.8%) were more likely than girls (2.7%) to acquire their condoms from health care facilities. Up to 51.2% of the respondents did not use condoms at last sex, especially, among boys (55.3%).

#### **2.4.2 Uptake of VCT Services and the Prevention of HIV/AIDS**

VCT services mainly target asymptomatic individuals. By informing clients of their HIV sero-status and creating personalized HIV prevention plans, VCT centers can provide the support necessary to change risky sexual behaviors and prevent the transmission of HIV (Voluntary HIV-Counseling & Testing Efficacy Study Group, 2000). Since their implementation, VCT programs have

demonstrated their ability to promote safe sexual behaviors, as well as, to provide care and support services among adults (Matovu et al, 2005). In spite of this progress, up to 80% of Kenyans aged 15 to 54 still do not know their HIV status (NASCOP, 2005).

Perception of the VCT process itself is instrumental in eventual uptake of VCT services. Factors that influence uptake of VCT services may be based on past experience with being tested for HIV, second-hand information about the testing process, the experiences of acquaintances and friends, as well as, other factors that increase or reduce the perceived difficulty of attending a VCT clinic (Kakoko, Astrom, Lugoe, & Lie, 2006).

In a study by Pikard (2009) on HIV voluntary counseling and testing among Kenyan youths aged 13-15 years in Nairobi and Nakuru, found that most students in the rural parts of Nakuru did not use the static VCTs. This is because they did not have transport to get to those VCT centers. This was converse for the students in the urban areas of Nairobi (Pikard, 2009). 21% of the students said that they were not willing to go to the VCT centers due to stigma. The number was higher in the rural areas at 51%.

Abebe and Mitikie (2007) in a study of the perception of high school students about voluntary HIV counseling and testing in Ethiopia, note that about half of the respondents thought that going for HIV test was very important. Regarding preference of professionals as counselors, 52% of the students preferred trained VCT counselors, followed by physicians (25.2%), HIV patients (10.5%) and religious leaders (5.8%). The majority (60%) of the respondents showed preference to confidential testing, followed by anonymous ways of testing (24.4%). As a way of receiving HIV test result, the majority (57.2%) preferred face-to-face, while 30.9% preferred to receive the results in secret envelopes. Regarding their practice towards VCT, 18.5% had used VCT service. Among these, males and females accounted for 10.8% and 7.7%, respectively. 82.5% of the respondents

(students) explained that they were willing to undergo VCT. The main reason for not being willing to undergo VCT included fear or anxiety following possible positive result (45.5%) and due to fear of stigma and discrimination by the society at 19.6 percent.

## **2.5 The Social Conditions of Youth and Prevention of HIV and AIDS**

Social conditions heavily influence the degree of vulnerability experienced by individuals and groups. In particular, women's disproportionate vulnerability to HIV is intrinsically linked with the many social, legal, economic, cultural, and educational opportunities experienced by women and girls. (NACC & NASCOP, 2012).

Nearly every country struggles with the legacy of unequal gender norms, and Kenya is no exception. There are some encouraging trends for example the ratio of girls to boys in primary and secondary schools in 2008 was 96:100 (World Bank, 2010). Despite the laudable signs, the country's women and girls continue to experience inequality that reduces their opportunities and intensifies their vulnerability to HIV infection. When all forms of violence are taken into account 41.2 percent of Kenyan women aged 15-49 years report having been victimized by intimate partner violence and the majority do not report the incidents (Tegang et al., 2007). A study by World Bank concluded that sexual violence could represent the single greatest contributing factor to new HIV infections in Kenya, which includes even the secondary school going youth (Fraser et al., 2008). Traditional cultural practices also often reflect and reinforce gender inequality and women's disempowerment. These practices include FGM, which is widespread in some parts of the country and marrying off girls at a very early age (KNBS, 2010).

The stigma associated with HIV has long undermined the HIV prevention and treatment efforts (UNAIDS, 2008). HIV related stigma inhibits open discussions of the epidemic and fear of discrimination or disapproval may deter individuals from seeking the services they need. In some instances, individuals may actually avoid taking steps to protect themselves 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.

## **2.6 Theoretical Framework**

In this section, the theories that underpin our study of the determinants of the participation of students in rural secondary schools in the prevention of HIV/AIDS will be discussed. The theories under consideration are the health belief model and the social cognitive theory. These theories will be used to illustrate the link between the prevention of HIV/AIDS and students' attitudes, knowledge, perceptions and practices.

The health behavioral model explains health behaviors by predicting the attitudes and beliefs of individuals (Janz & Becker, 1984). The fundamental concept of this model is that human behavior depends on two factors. The first factor is the significance that a person attaches to a particular goal. The second factor is the person's prediction of the probability that a particular course of action will lead to the achievement of the goal. The first factor can be interpreted as the value that high school students place on the goal of preventing HIV/AIDS in their community. The second factor, on the other hand, can be conceptualized as the students' estimation of the possibility of preventing HIV/AIDS by taking specific measures. According to the HBM, an individual will take a particular action to protect or improve his health under three conditions. First, a person will engage in a health-related action if he believes that an undesirable health state can be prevented. Second, a person will take a recommended action if he or she anticipates positive health outcomes after taking the action. Finally, an individual will take a recommended health action if he believes that he can successfully do so. These conditions are the fundamental assumptions that underpinned our application of the HBM in this study. Concisely, we assumed that high school students would participate in the prevention of HIV/AIDS if they believe that the disease can be prevented. According to the second condition, we assumed that students would participate in the prevention of HIV/AIDS by taking recommended actions if they believe that their participation will facilitate a

reduction of the prevalence of the disease in Suba District. Finally, condition three implies that students will participate in the prevention of HIV/AIDS if they believe that they have the capacity to do so.

On the other hand the Social Cognitive theory hypothesize a “multifaceted causal structure in which self-efficacy beliefs operate in concert with cognized goals, outcome expectations, and perceived environmental impediments and facilitators in the regulation of human motivation, action and well-being” (Bandura, 1998). The theory explains the socio-structural and personal determinants of health. Thus, we can use it to explain the determinants of students’ participation in the prevention of HIV/AIDS in terms of four dimension namely self-efficacy, outcome expectations, normative influences, and cognized goals.

Self-efficacy refers to “beliefs in one’s capabilities to organize and to execute the courses of action required in producing given levels of attainments” (Bandura, 1998). Self-efficacy encompasses an individual’s ability to regulate his motivation, thought process, behavior patterns, and environmental conditions. Students’ beliefs concerning their capacity to learn will determine their ability to acquire the knowledge and skills that are central to their participation in the prevention of HIV/AIDS. People’s beliefs concerning their capabilities determine the extent to which they can utilize their skills and knowledge to solve a problem. Consequently, students are likely to be resilient and to persevere for a long time in order to overcome the barriers associated with the prevention of the disease in their community if they believe that they have the capacity to do so.

Students’ participation in the prevention of HIV and AIDS can also be influenced by their outcome expectations. The expected positive outcomes are incentives, whereas the anticipated negative outcomes are disincentives to take actions that lead to the prevention of the disease (Bandura, 1989, pp. 1-60). Students are likely to participate in the prevention of the disease if they expect positive outcomes. Normative influences control people’s actions through social sanctions and self-

sanctions. Norms control behavior through the expected social consequences. Social norms define the standards of behavior that will guide students to participate in the prevention of the disease.

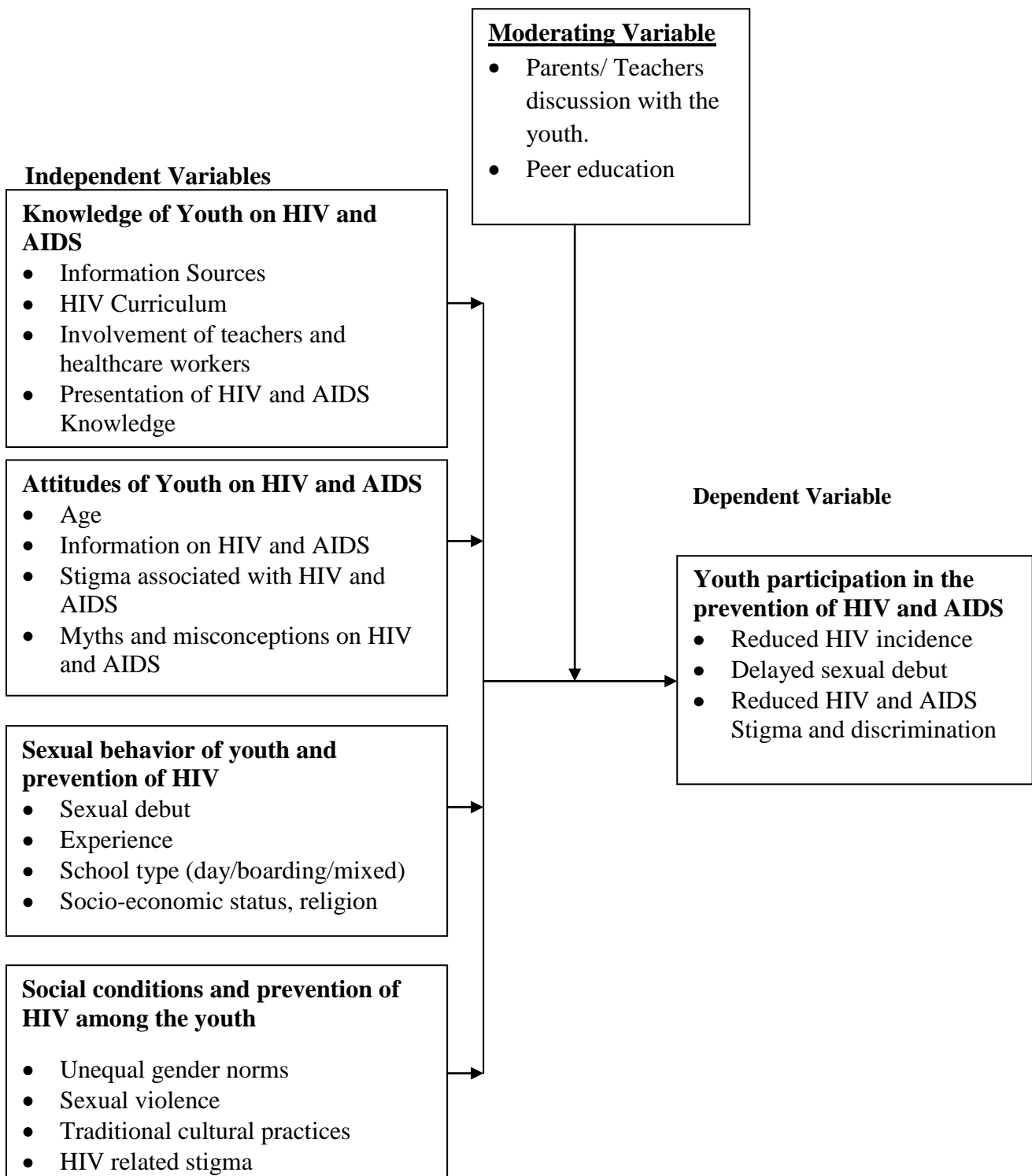
## **2.7 Conceptual Framework**

The study postulated that the participation of secondary school students in prevention of HIV/AIDS is determined by four factors (dependent variables) as shown in figure 1. First, the knowledge that secondary school students have about HIV/ AIDS was expected to influence their capacity to prevent the spread of the disease. In this case, the premise was that having adequate knowledge about the disease will enable students to engage in responsible sexual behaviors or take preventive measures to avoid contracting or spreading the disease. Second, the participation of secondary school students in prevention of HIV/ AIDS is likely to be influenced by the students' attitudes towards the disease and the available prevention methods. For instance, a positive attitude towards testing for HIV would improve the uptake of VCT services and abstinence, thereby reducing the spread of the disease.

Third, sexual behaviors determine students' exposure to the risk of contracting HIV/ AIDS. In particular, students are likely to prevent the spread of the disease if they refrain from risky sexual behaviors such as unprotected sex or having multiple sexual partners and vice versa. Finally, social conditions such as poverty, stigma, and gender are also likely to influence secondary students' participation in prevention of HIV/ AIDS. For instance, stigma can prevent students from going for HIV tests or providing care or support to their friends or family members who have been infected with the disease.

**Figure 1**

**Conceptual framework**



## 2.8 Summary of the Literature Reviewed

*Table 2: Summary of literature reviewed*

SNo.	Researcher	Focus	Findings	Gap
1.	KNBS 2010	Knowledge, attitudes and practices towards HIV and AIDS	<p>Knowledge on HIV and AIDS in Kenya was high, standing at 98.7 percent among the adolescents with a marginal difference between the rural and urban areas.</p> <p>The knowledge of all key HIV prevention methods was lower among women and men aged 15-19 than among people aged 20 and above.</p>	Despite the high knowledge in the region, prevalence and incidence were still high.
2.	Ndegwa, N(2002)	Knowledge, attitudes and practices towards HIV and AIDS among students and teachers.	<p>100 percent of both teachers and students were aware of HIV and AIDS.</p> <p>Only 50 percent of the students had knowledge of preventive measure of HIV and AIDS</p> <p>Teachers were involved in activities geared towards HIV prevention.</p>	Only 12.9 percent of the teachers taught about HIV and AIDS. Most teachers were therefore not well equipped/empowered as disseminators of the information about HIV and AIDS.
3.	Murtala (2009)	HIV awareness among secondary school students	Awareness among the students was very high at 97.5 percent.	More than half of the students (52.5) percent believed that HIV had cure.
4.	Ochieng, M (2005)	Reproductive and sexual health behavior of	Reading materials on HIV and AIDS could help eliminate	Students do not have time to read extra materials on HIV and

		adolescents	misconceptions about the disease	AIDS apart from what they were taught in classroom or from invited guests.
5.	Hussein (2000)		The young people generally knew something about HIV and AIDS and that the knowledge on nature and modes of transmission was high.	The information could be wrong, inadequate or incomplete.
6.	Onguya et al (2009)	HIV and AIDS education curriculum	The curriculum gave the students the overview of HIV and AIDS.	The content of the curriculum had not been reviewed in a long time to respond to emerging issues.  The program lacked practical orientation and only concentrated on delivering superficial knowledge.
7.	Kakai, Ochieng and Abok (2011)	Knowledge, attitude and practice of condom use among youth.	There is knowledge gap among youth on sex education, HIV and AIDS and the protective role of condoms.	The youth have myths and misconceptions on HIV and AIDS that should be dispelled.
8.	Kiragu (2001)	Youth and HIV and AIDS	Where VCT services are poor in Kenya, people still believe that the risk of knowing ones status outweighs the benefits	Lack of clear linkages between VCT, treatment and care.  Lack of information.
9.	Muganda and Otieno (2003)	Knowledge, attitudes and practice of youth towards VCT	The knowledge of VCT is high but only 50 percent of the youth have positive attitudes towards VCT.	Most youth did not know the services offered at the VCT centers.

10.	KNBS (2010)	Attitudes towards persons living with HIV	The survey found that 27.1 percent of the youth expressed accepting attitudes towards people infected and affected by HIV and AIDS.	Most of the youth associated HIV and AIDS with loose morals.
11.	Kabiru (2005)	Sexual relationship among high school students	The study found that the average age of the first sexual partner among females was 17 and for males being 13.4 years.	The curriculum stresses only abstinence for youth.
12.	Kakai, Ochieng and Abok (2011)	Knowledge, attitude and practice of condom use among youth.	The study noted that at the age of 11-15 years the youths had already initiated sexual intercourse, had multiple partners and over 75 percent of the youth engaging in sex without a condom.	The youth thought that condoms were ineffective in protection against HIV.  Stigma in obtaining condoms from health centers or even from the vendors.
13.	Pikard (2009)	HIV Counseling and testing among the youth	Most students in the rural areas did not use static VCT due to lack of transport to get to the VCT centers	Stigma and fear of knowing ones status.

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## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter describes the methodology that was used to conduct the study. These include the research design, target population, sample size, sample selection, research instruments, data collection procedures, data analysis techniques, and ethical issues in research.

#### **3.2 Research Design**

This study adopted descriptive survey research design. The study is concerned with the determinants of youth participation in the prevention of HIV and AIDS. Concisely, it assessed the relationship between knowledge, attitudes, sexual behavior, and social conditions of the youth in the prevention of new HIV infections. These issues can be best investigated through the descriptive survey research design. This design involves studying the populations by selecting samples to discover and to analyze occurrences in order to provide quantitative descriptions of the aspects of the problem (Mugenda & Mugenda, 2003). The design was suitable because it enabled the researcher to collect data rapidly and to understand the population from just a portion of it. Standardization was used to ensure that similar data is collected from the target group and interpreted comparatively (Mugenda & Mugenda, 2003). The weakness of the design is that an inflexible data collection tool had to be used. Concisely, the data collection tool remained unchanged throughout the study. However, this weakness is insignificant compared to the contributions that the study has made.

#### **3.3 Target Population**

The study was conducted in Suba District in Nyanza Region. The District was identified because it is one of the regions with the highest infection rates in the Province and in the Country (Ministry of Planning, 2008). The target population was the rural secondary school youth in the District. This includes students in the rural secondary day schools from form one to form four. Suba District has



two Constituencies, Mbita and Gwassi, which have a total of 49 schools with 6869 boys and 3912 girls. Hence, the target population consisted of 10311 students in total. This is tabulated in table 2 and 3: -

**Table 3: Secondary school enrollment in Suba District**

Constituency	No. Of secondary schools		Enrollment				Totals
	Day	Boarding	Day (boys)	Board (boys)	Day (girls)	Board (girls)	
Gwassi	14	7	1453	1022	817	690	3823
Mbita	20	8	2238	1886	1434	771	6488
<b>Totals</b>	<b>34</b>	<b>15</b>	<b>3691</b>	<b>2908</b>	<b>2251</b>	<b>1461</b>	<b>10311</b>

**Table 4: Day Schools in Suba District by Divisions**

Constituency	Division	No. of Day Schools
Gwassi	Gwassi	7
	Central	7
Mbita	Lambwe	2
	Mbita East	7
	Mbita West	4
	Mfangano	7

*(Source: Ministry of Education, Suba District 2015)*

### 3.4 Sample size and Sampling Procedures

This section will describe how the sample size was determined; sampling techniques; and the selection of the respondents for the study.

### 3.4.1 Sample Size

In order to obtain the desired sample size, the following formula was used: -

$$n = \frac{z^2 pq}{d^2}$$

Where

- n – is the desired sample size for the target population less than 10000
- Z – The standard normal deviate at the required confidence level (95%) for the study
- d – The level of statistical significance
- p – The proportion in the target population estimated to have characteristics being measured
- q- 1-p

Therefore:  $n = \frac{1.96^2 \times 0.5 \times 0.5}{0.5^2}$   
= 384 Samples

The estimated sample size was obtained using the following formula:

$$n_s = \frac{n}{1 + \frac{n}{N}}$$

Where

- $n_s$  – The estimated sample size for the study
- n- The desired sample size
- N- The estimate of the population size

(Source: Mugenda and Mugenda, 2003)

In this case

- N = 10311
- n = 384
- $n_s = 384 / (1 + 384 / 10311)$   
= 370.2  
= 371 (134 girls and 237 boys)

### **3.4.2 Sampling Techniques**

This section explains the sampling techniques that were used to obtain the samples for the study. This study employed purposive sampling, stratified sampling, and simple random sampling techniques.

In purposive sampling, the researcher decides whom to include in the sample. In this case, the researcher was interested only in day secondary schools in Suba District. This is because the researcher was interested in students residing in the rural areas of the District. The assumption was that the students in the rural day secondary schools are residents of rural areas. Since the District does not have one-sex day secondary schools, only mixed day secondary schools were included, in this case 34 schools.

Simple random sampling is a technique that selects a sample without bias from the accessible population in order to select a representative sample. It ensures that each member of the target population has an equal and independent chance of being included in the sample (Osoo&Onen, 2004). The researcher used this technique in the selection of a sample of 10 rural day secondary schools in Suba District from the population of 34. Two schools were sampled randomly from each of the six divisions other than Mbita East and Lambwe divisions where one school was sampled. The students were given random numbers after which simple random sampling was employed to get the respondents for the study.

The study also employed stratified sampling. This technique identifies sub-groups in the population and their proportion. Respondents are then selected from each sub-group to form a sample. The purpose of this technique was to group the population into homogeneous subsets i.e. boys and girls. The proportion of boys to girls was about 2:1 i.e. 6869 divided by 3712. This was to ensure equitable representation of the population in the sample.

At the school level, the researcher first obtained the school's enrollment register (Form 1-Form 4) from the school's head. This was disaggregated by gender. To obtain the number of respondents in a specific school, the total number of students in that particular school was divided by the total number of students in the target population (10311) and multiplied by the sample size that is 371. The figure that was obtained was the total number of respondents in that school. A class/form with a high enrolment got more respondents and vice versa. The proportion of boys to girls per school was also used to obtain the number of boys and girls who were interviewed. Based on the number of boys and girls in a selected school, numbers were assigned to each student using the class register and a simple random sampling was conducted to get the respondents in each class.

### **3.5 Research Instruments**

Data for this study was obtained from primary and secondary sources, as well as, oral interviews and intensive literature search. The primary data was collected using a set of questionnaires. The questionnaires were designed based on the nature of the data that was to be collected, available time, literature reviewed from related studies, as well as, the objectives of the study. The researcher was mainly concerned with the knowledge, attitudes, sexual behavior, and social conditions regarding the prevention of HIV infection. The best methods for collecting this data are questionnaires and interviews (Touliatos & Compton, 1988).

The researcher used a semi-structured questionnaire. This means that the tool had both open and close-ended questions. This enabled the researcher to balance between quantitative and qualitative of data, as well as, to collect more information. This balance was useful in the explanation of the area of study.

The questionnaire was divided into five areas: part A, which had demographic profile with questions about age, education level, religion and sex; part B, which had questions pertaining to

HIV and AIDS knowledge; part C, which had questions pertaining to attitudes on HIV and AIDS; part D, which had questions pertaining to HIV and AIDS sexual behavior; and lastly part E, which focused on recommendations for enhancing HIV and AIDS Programs as well as the social conditions.

Questionnaires were used since this study was mainly concerned with variables that cannot be directly observed such as knowledge, attitudes, experience, and expectations of the respondents. Such information is best collected through questionnaires. The sample size was also quite large (371) and given the time constraints, the questionnaire was the ideal tool for collecting data. The target population was also unlikely to have difficulties in responding to the questionnaires.

### **3.5.1 Validity of the Instrument**

Validity is the accuracy and meaningfulness of inferences, which are based on the research results. It is the degree to which the results obtained from the analysis of data accurately represent the phenomenon under study (Mugenda & Mugenda, 2003). Therefore, to ensure content validity, the tool was given to professionals/experts in the HIV and AIDS field to assess the concept that it was trying to measure and to determine whether the questionnaire items accurately represented the topic of the study. The piloting of the instrument also enabled the researcher to improve on the content validity of the tool.

### **3.5.2 Pilot Testing**

Pilot testing can be described as a small-scale trial run of a particular component, in this case, the questionnaire. It involves the use of a small number of respondents to test the appropriateness of the questions and their comprehension. The pretest sample is usually between 1% and 10%. Therefore, the main purpose of pilot testing is to identify potential problems with the methods, logistics, and the questionnaire (Mugenda & Mugenda, 2003).

Two secondary schools were selected within Gwasssi Division and the researcher requested the school administrators to provide the list of students per gender. Ten percent of the sample size i.e. 10% of 371, which is approximately 37 students, was selected based on the ration of boys to girls. Six research assistants who had been trained on interviewing skills, research ethical considerations, and on the questionnaire itself interviewed the students. After the first set of interviews, the questionnaires were studied in order to iron out difficulties and or, challenges before the next set of interviews.

The pilot test data was used to determine the reaction of respondents to the different aspects of the study, which included timing, acceptability of the questions, and willingness of the respondents to cooperate. It was also helpful in discovering errors in the instrument. This included the reliability of the instrument, time taken/needed to conduct the interviews and if there was, need to adjust the tool. It also helped in assessing the sampling procedures, as well as, the training of the research assistants.

### **3.5.3 Reliability of the Instrument**

Reliability is a measure of the degree to which a research instrument yields consistent results or data after repeated trials (Mugenda & Mugenda, 2003). It is influenced by random errors. As random errors increase, reliability decreases and vice versa.

In order to ensure reliability of the instrument, the researcher considered the consistency with which the answers were generated. This was established at the piloting stage where the ease of interpreting and answering the questions was determined. The inconsistencies that were noted in interpreting the questions were addressed by rephrasing the questions and instructions to make them clearer to the respondents. This helped to improve the consistency of the answers provided by the respondents. Randomization was also used in the selection of participants from the population to avoid bias by improving the representativeness of the sample.

### **3.6 Data Collection Procedure**

The data collection process began with a formal acquisition of a permit from the National Council of Science and Technology to conduct the research. A letter of introduction for the researcher was also obtained from The University of Nairobi's campus administrator. These documents were presented to the Ministry of Education in Suba District in order to obtain clearance and support during the data collection process.

The second step in the data collection process involved training six research assistants for two days so that they could understand the study's objectives and to master the research tool, as well as, to understand the ethical considerations and to plan approaches to data collection. The research assistants were recruited from the district where the study was conducted. The third step involved conducting a pilot test to verify the validity of the questionnaires. The results of the pilot test were used to correct the questionnaires to enhance the quality of data collected.

The fourth step was fieldwork in which quantitative and qualitative data was collected in the month of July 2014. The data was collected by six trained research assistants under the supervision of the researcher using questionnaires that had both closed and open-ended questions. The respondents were expected to respond to the closed ended questions by making choice(s) to the list that was provided in the questionnaires. On the other hand, the respondents were expected to give personal opinion(s) for the open-ended questions in the questionnaires. The research assistants administered questionnaires through interviews to students in one school at a time. The help of research assistants was required because the researcher could not administer the questionnaires to all the 371 respondents by himself due to time constraint.

### **3.7 Data Analysis Techniques**

Quantitative analysis technique and inferential were used to analyze the data. Descriptive statistics, which is part of quantitative analysis technique, summarized data on the objectives of the study to enable the researcher to describe the measurements using a few statistics. On the other hand, inferential analysis was used to draw conclusions concerning the relationships and differences found in the research results.

Descriptive statistics provided simple summaries about the sample and measures. Together with simple graphical analysis, they formed the basis of quantitative analysis of data. Inferential analysis, on the other hand, enabled the researcher to use sample statistics to draw conclusions about the population, i.e. students from rural secondary schools in Suba district. Frequency tables cross tabulations and correlations were generated and formed the backdrop of research's findings and recommendations.

The researcher grouped data from open-ended items and interviews under broad themes and converted them into frequency counts. Data from the closed ended questions were assigned numerical values to facilitate analysis. This was then keyed into SPSS spreadsheets for analysis. The data was analyzed at a level of significance of 5%. This value was chosen because the sample size was adopted from figures calculated on the basis 0.95 level of significance.

### **3.8 Ethical Considerations**

The main ethical issues in this study included informed consenting, privacy, confidentiality, and anonymity.

**Informed Consent-** it implies informing the respondents about the procedures of the study in which they will be participating. The respondents were provided with information on the purpose of the research, expected duration of participation, the procedure to be followed, unforeseen



discomforts, as well as, the extent of privacy and confidentiality. Once this was done, the respondents were expected to voluntarily participate in the exercise.

**Privacy and confidentiality-** To ensure privacy and confidentiality, the respondents were interviewed one at a time in a private room that was provided by the school administration.

**Anonymity-** for anonymity purposes, the researcher did not ask for the respondents' names in the questionnaires. Thus, numbers were used to represent the respondents.

## **CHAPETR FOUR**

### **DATA ANALYSIS, PRESENTATION, INTERPRETATIONS, AND DISCUSSION**

#### **4.1 Introduction**

The results of data analysis will be presented in this section. The results cover the knowledge about HIV/AIDS among secondary school students; attitudes of secondary school students towards prevention of HIV/ AIDS; the sexual behavior of school students and how it affects their participation in prevention of HIV/ AIDS; and how the social conditions of secondary school students affect their participation in prevention of HIV/ AIDS.

#### **4.2 Background Information of the Respondents**

Background analysis of respondents' characteristics is important as it depicts a concise understanding of HIV and AIDS issues in Suba District. Some demographic data captured oscillates around distribution of respondents by age group, religion, gender/sex and class/form. These parameters were deemed important in the survey because data on HIV and AIDS are largely influenced by the demographics of the youths and therefore the recommendations proposed should be formulated around the demographic data captured. The respondents were asked to provide their background information, which included their demographic data such as age, gender, and religion. Table 4 shows that majority (61.2%) of the respondents were male students. 149 students or 52.3% of the sample were Protestants, whereas the rest belonged to other denominations such as Catholic and the Orthodox Church. 230 students or 62% of the sample were in the age group of 16 to 18 years. However, 13 students did not indicate their age. Form two and three had the highest number of respondents, which stood at 114 (30.7%) and 106 (28.6%) respectively.

**Table 5: Respondents' demographic data**

<b>Demographic characteristic</b>		<b>Frequency (n)</b>	<b>Percentage (%)</b>
Sex/ gender	Male	227	61.2
	Female	144	38.8
	<b>Total</b>	<b>371</b>	<b>100</b>
Religion/ denomination	Catholic	149	40.2
	Protestant	194	52.3
	Muslim	0	0
	Orthodox	5	1.3
	Traditionalist	22	5.9
	Pagan	1	0.3
	<b>Total</b>	<b>371</b>	<b>100</b>
Age group	13-15	90	24.2
	16-18	230	62
	19-21	38	10.2
	Not indicated	13	3.5
	<b>Total</b>	<b>371</b>	<b>100</b>
Class/ Form	Form one	67	18.1
	Form two	114	30.7
	Form three	106	28.6
	Form four	84	22.6
	<b>Total</b>	<b>371</b>	<b>100</b>

Gender distribution determines youth participation in prevention of HIV and AIDS due to the socio-economic and biological vulnerability of females as opposed to males. Gender bias is deeply rooted in cultural and traditional values, which discriminate against the female gender. Gender inequality is a salient socio-cultural issue that puts women at a lower bargaining power in the decision-making process pertaining to HIV and AIDS. Respondents were therefore asked to state their gender and table 4 states the gender distribution within the district.

Religious affiliation is an important characteristic as it has significant influence on the determinants of youth participation in prevention of HIV and AIDS. Table 4 captures the data on religious affiliation. From the table, the Protestants constituted the majority at 52.3 percent followed by Catholics at 40.2 percent, traditionalists at 5.9 percent, orthodox at 1.3 percent, pagan at 0.3 percent and no Muslims. HIV and AIDS programs should therefore incorporate religious leaders and gatekeepers and exploit the existing good will to disseminate pertinent information on HIV and AIDS. Catholics for example have a strong stance on condom use and this may call for other means of prevention other than the condom.

Age distribution is important in the study as different age groups have unique characteristics pertaining to HIV and AIDS. According to KAIS 2007 report, different age groups have diverse HIV and AIDS needs and challenges hence the need to formulate intervention strategies based on the different age groups. Table 4 depicts that most of the respondents were in 16-18 age group at 62 percent followed by 13-15 at 24.2 percent and 19-22 at 3.5 percent. From table 4 age group 13-18 forms the majority of the respondents at 86.2 percent. A number of the youth at this age are in between form 1 and form three. This is the age at which most sexual debuts occur and therefore a need to put more emphasis on safe sex practices.

#### **4.3 Knowledge of Youth about HIV/ AIDS and Prevention of the Disease**

Knowledge about HIV and AIDS among the youth was important since it was expected to influence their ability to identify and take various precautionary measures to prevent the spread of HIV and AIDS. For instance, students are likely to avoid contracting the disease if they have adequate knowledge on how it is transmitted. Similarly, students are likely to use condoms if they are aware that it can help to prevent the spread of HIV/ AIDS. Therefore, students were asked if they had ever heard about HIV and AIDS. All the students (371) had heard about HIV and AIDS.

### 4.3.1 Knowledge and Perceptions of Youth on HIV and AIDS

The knowledge and perceptions of HIV and AIDS were measured by asking the respondents whether they had ever heard of HIV and AIDS. The data from the survey revealed that 100 percent had heard about the disease. This indicated that the level of HIV and AIDS awareness was very high among the youth and this therefore provides a major opportunity for formulating diverse interventions on HIV response. Out of the 371 youths/respondents who participated in the study, 371 were aware of the existence of HIV and which represented 100 percent. This finding is comparable to that of Murtala (2009) who found that 97.5% of secondary students in Katsina, Nigeria had heard about HIV and AIDS. The finding means that there is a general high awareness about HIV/ AIDS among secondary school going youth in Suba District. However, the finding does not reveal the quality of information or what the students know about the disease, as well as, how they got the information.

### 4.3.2 Source of Information about HIV and AIDS for Secondary School Students

The youth were asked to state their sources of information about HIV and AIDS. Knowing the main sources of information about the disease was important because it is likely to help health policy makers, the community, and schools to use the right communication channels to inform the youth about HIV and AIDS. Table 6 shows that students obtained information about the disease from multiple sources.

**Table 6: Sources of information about HIV/AIDS by the youth**

Source	Frequency (n= 371)	Percentage (%)
Schools	251	67.7
Youth clubs	237	63.9
Health centre	231	62.3
Mass media	229	61.7
IEC materials	190	51.2
Community health workers	188	50.7
Church/ Mosque	125	33.7
NGOs	73	19.7
Reproductive health motivators	27	7.3
PET group	24	6.5

Table 6 reveals that the most important sources for information about HIV and AIDS among students were schools, youth clubs, health centres, mass media, and IEC materials. These sources are important because they were used by over 50% of the students. Oyo-Ita et al (2005) also found that the main sources of information about HIV among the youth in Calabar, Nigeria were clinics/ health centers, health talks given in youth clubs, and the mass media that included television, radio, and newspapers. Schools are expected to be the main source of information about the disease among students because the government of Kenya introduced HIV/ AIDS syllabus in the secondary school curriculum in 2000. This means that students have to be taught about the disease in their schools. However, schools are not necessarily the best source of information about the disease. For instance, Ladhani (2005) found that secondary school students in Siaya County did not have time to read the extra materials about HIV provided by their teachers because of work overload. Thus, they did not receive the information or knowledge about HIV/ AIDS that they were expected to acquire in school. Ogunya et al (2009) contend that HIV/ AIDS education programs in Kenya have not been reviewed since their introduction in 2000. This means that the HIV/ AIDS syllabus might not provide relevant information to enable the youth to participate effectively in the fight against the disease. This suggests that students might not acquire adequate information or knowledge about the disease in their schools.

Youth clubs are important sources of information because they encourage open talk among peers about HIV and AIDS. In this respect, secondary school students in Sub District are likely to acquire adequate information about the disease if the discussions in their youth clubs are led by experts or people who have accurate and enough information about HIV and AIDS. The high utilization rate of health centres as a source of information about HIV is consistent with the perspective of Obare et al (2010), who found that the youth in Kenya prefer to talk to health care service providers and counselors about sexually transmitted disease and reproductive matters. The finding also suggest

that counseling services in health centres is highly accessible in Suba District since over 50% of the respondents could access information about HIV from them.

The high utilization rate (61.7%) of mass media as a source of information reflects increased access to various media channels such as radio, televisions, newspapers, and mobile phones with FM radio capabilities. In this respect, the youth are expected to access information about the disease through mass media and IEC materials such as posters because the Ministry of Health often carryout campaigns against HIV and AIDS through them (NAS COP, 2009).

### 4.3.3 Modes of HIV Transmission among the Youth

Modes of transmission are important indicators of measuring the level of awareness about HIV infection. Table 6 contains data on the knowledge base of respondents in regards to modes of HIV transmission. Students were asked to state the modes of HIV transmission that they were aware of to test the quality and depth of knowledge they had about the disease. Students’ responses to this question are presented in table 7.

**Table 7: The youth’s knowledge on Modes of HIV transmission**

<b>Mode of transmission</b>	<b>Frequency (n =371)</b>	<b>Percentage (%)</b>
Unprotected sex	337	90.8
Sharing sharp objects	323	87.1
Blood transfusion	303	81.7
Deep kissing	233	62.8
Wounds/ cuts	149	40.2
Sharing toothbrushes	126	34.0
MTC	112	30.2
Blood contact	85	22.9

Table 7 shows that at least 80% of the students were aware that unprotected sex and sharing sharp objects could lead to transmission of HIV/ AIDS. This result is consistent with that of Murtala (2009) who found that at least 80% of secondary students in Katsina, Nigeria knew that sexual intercourse, use of needles/ syringes on human body, and blood transfusion are major means by which HIV is transmitted.

The study also revealed that 81.1% of the students were aware that blood transfusion can lead to HIV/ AIDS transmission. Moreover, 62.8% of the students knew that HIV/ AIDS can be acquired through deep kissing. Only 40.2% of the respondents knew that they could acquire the disease by coming into contact with the wounds of an infected person. These findings are supported by those of Murtala (2009) who found that 86.7% of secondary school students in Katsina, Nigeria were aware that HIV/ AIDS could be transmitted through blood transfusion. The research also found that only 8% of the students in Nigeria knew that HIV/ AIDS could be transmitted through kissing.

Table 7 shows that less than 35% of the students knew that sharing toothbrushes, MTC, and coming into contact with blood of an infected person can lead to transmission of the disease. This means that students lack perfect information about the modes of HIV/ AIDS transmission. Moreover, the finding suggests that the students are at risk of being infected since ignorance of some modes of transmission could lead to increased infection rates. This perspective is supported by the findings of Hussein (2005) who concluded that school and collage going youth in Garisa District were at risk of contracting HIV because they were unaware of the risky sexual behaviors that could lead to transmission of the disease.

#### **4.3.4 Strategies of HIV Prevention among the Youth**

HIV and AIDS prevention strategy is very important in the sense that it is possible to gauge whether the youth know different ways of protecting themselves from contracting the HIV virus.



Students were asked to identify the various strategies for preventing HIV/ AIDS that they were aware of. The responses to this question are summarized in table 8.

**Table 8: HIV prevention strategies adopted by the youth**

<b>Strategy</b>	<b>Frequency (n =371)</b>	<b>Percentage (%)</b>
Abstinence	341	91.9
Condom use	330	88.9
Not sharing sharp objects	243	65.5
Faithfulness to one uninfected partner	221	56.9
VCT (Testing for HIV)	162	43.7
Counseling	132	35.6
Blood screening	72	19.4
Not sharing toothbrushes	72	19.4
PMTCT	49	13.2
Avoiding harmful cultural practices	34	9.2
Installing moral values	33	8.9
BCC	24	6.5
No response	11	3
Do not know	0	0

The main HIV/ AIDS prevention methods that the students knew included abstinence, using condoms, not sharing sharp objects, and being faithful to one uninfected sexual partner. These strategies or prevention methods were known by majority (at least 50%) of the students.

Less than 50% of the students were aware that knowing one’s HIV status and obtaining counseling services from VCTs was a way of preventing the disease. Conceptually, students who are aware of their HIV status are likely to take measures to avoid contracting or spreading the disease if they obtain appropriate counseling and guidance services (Ndegwa, 2002). Less than 20% of the students were aware that blood screening before transfusion, PMTCT, and avoiding sharing toothbrushes could lead to transmission of the disease.

Table 8 shows that less than 10% of the students knew that refraining from harmful cultural practices such as wife inheritance and female genital mutilation (FGM) are effective methods of

preventing HIV and AIDS infection. In addition, BCC and instilling moral values were considered effective strategies for preventing the disease by less than 10% of the students.

There is a huge information asymmetry concerning the methods of HIV prevention among students in Sub District. This suggests that poor knowledge about HIV prevention methods among the youth could be one of the major causes of the high prevalence of the disease in Sub District. Oyo-Ita et al (2005) also found that students in Calabar Nigeria had very poor knowledge of HIV prevention methods. In their study, only 48% of the students were aware that keeping one sexual partner, using condoms, blood screening, and abstinence could help to prevent HIV/ AIDS. According to Uganda AIDS Commission (2012), the imperfect knowledge about HIV prevention methods is explained by the fact that health care policy makers often over emphasize the importance of the major prevention methods such as protected sex at the expense of other equally important measures such as avoiding getting into contact with the blood of an infected person. The youth tend to remember only the prevention methods that they regularly hear about in schools and the mass media.

#### **4.3.5 Statements about HIV and AIDS**

In addition to knowing about effective ways to avoid contracting HIV, it was also useful to be able to identify incorrect beliefs about the disease to eliminate misconceptions. Common misconceptions about AIDS include the idea that all HIV-infected people always appear ill and the belief that the virus can be transmitted through sharing of clothes. The respondents were asked about these misconceptions including different ways of protecting oneself and the findings are presented in table 9.

**Table 9: Statements about HIV/ AIDS by the youth**

<b>Statement</b>	<b>True (%)</b>	<b>False (%)</b>	<b>No response (%)</b>	<b>Total (%)</b>
An individual can protect him/herself from HIV infection by abstinence	93.5	3.5	3.0	100.0
An individual can protect him/herself from HIV infection by being faithful to one partner	85.7	11.1	3.2	100.0
Proper use of condom can protect one from HIV infection	87.9	8.6	3.5	100.0
An individual who looks healthy can also be infected with HIV	83.0	14.0	3.0	100.0
Sharing of clothes can also transmit HIV	9.4	87.6	3.0	100.0
Sharing of sharp objects can also transmit HIV	90.0	0.5	9.4	100.0
Unprotected sex is the main mode of HIV infection	93.0	4.0	3.0	100.0
Some cultural beliefs and practices enhance HIV infection	66.3	30.2	3.5	100.0
There is a linkage between STI and HIV	84.1	11.9	4.0	100.0

Table 9 indicates that over 80% of the students knew that abstinence, being faithful to one partner and proper use of condom could protect an individual from HIV infection. This finding is supported by that of Pankaj et al. (2012) who found that at least 84% of secondary students in Pune, India were aware that HIV infection could be avoided by engaging in safe sex practices such as abstinence and using condom. According to Pankaj et al. (2012), students are likely to participate effectively in HIV prevention if they know the major methods of transmission and prevention of the disease.

The students were also aware of the various HIV/ AIDS modes of transmission. 90% of the students knew that sharing sharp objects could lead to HIV transmission. Over 85% of the students were aware of the fact that the disease cannot be easily transmitted through sharing clothes. At least 80% of the students knew that a person who looks healthy could be infected with the disease. Ochieng et al. (2011) also found that over 70% of secondary school students in Kisumu had adequate knowledge of the main HIV prevention methods.

The study revealed that 93% of the students knew that unprotected sex is the main mode of HIV transmission. 84.1% of the students also knew that there is a link between STI and HIV. This knowledge is important because individuals with STIs are more susceptible to HIV infection than those who are not suffering from any STI. However, only 66.3% of the students considered cultural practices and beliefs such as wife inheritance as factors that enhance the spread of HIV/ AIDS.

Overall, table 9 confirms the earlier findings, which suggested that the youth lack accurate knowledge about the disease. For instance, 30.2% of the students do not believe that risky cultural practices such as FGM promote the spread of HIV/ AIDS. Similarly, 11.1% of the students believe that being faithful to one sexual partner cannot prevent the spread of HIV and AIDS. This means that the students can be tempted to have multiple sexual partners thereby enhancing instead of preventing the spread of the disease. Ochieng (2005) in his study of reproductive and sexual health behavior in Kisumu County also found that the youth had misconceptions on how HIV is transmitted and prevented. One of the possible explanations to the inconsistency of the knowledge that the youth have is misinterpretation of information coupled with believing in the myths about the disease. Specifically, if students fail to understand what they are taught about HIV/ AIDS, then they are likely to have misconceptions about it (Hussein, 2005).

#### **4.3.6 Cultural Practices and the Spread of HIV and AIDS among the Youth**

The researcher also sought to establish whether the youth would clearly identify some of the cultural practices that would enhance the spread of the HIV virus. This was important in the designing of HIV programs for the youth. The results were as show in table 10.

**Table 10: The youth's knowledge on cultural practices that enhance the spread of HIV/ AIDS**

<b>Cultural practice</b>	<b>Frequency (n =371)</b>	<b>Percentage (%)</b>
Wife inheritance	162	43.7
Polygamy	100	27.0
Traditional male initiation	80	21.6
Sharing sharp objects	77	20.8
Blood sucking	56	15.1
Female circumcision (FGM)	53	14.3
Scarification	33	8.9
Removal of teeth	26	7.0

Table 10 shows that the students in secondary schools in Suba District have very little knowledge of the cultural practices that enhance the spread of HIV despite the fact that they reside in rural areas where cultural practices such as wife inheritance and polygamy are common. The practices listed in table 9 have the potential of facilitating the spread of HIV/ AIDS. However, none of them could be identified by at least 50% of the students as a risk factor. Wife inheritance was identified by 43.7% of the students as a cultural practice that enhance HIV infection. This means that it is the main practice, which students associate with HIV infection in the district. Other major cultural practices that were identified by the students were polygamy, which encourages sex with multiple partners, sharing sharp objects, and traditional male initiation that can cause HIV infection through sharing of equipment such as circumcision knives.

Blood sucking, FGM, sacrificing, and removal of teeth were identified by less than 20% of the students as cultural practices that could lead to HIV/ AIDS infection. This suggests that the students consider the aforementioned practices as minor modes of HIV transmission. One of the possible explanations of this finding is that most of the cultural practices listed in table 9 might not be widespread in Suba District. Thus, the youth have little knowledge about them, including how they can lead to HIV infection. According to Mbozi(2008), the students are less likely to associate

cultural practices such as polygamy and wife inheritance with the spread of HIV and AIDS if they hold these practices in high esteem by considering them as an integral part of their culture.

#### 4.4 Attitudes of the Youth and their Participation in HIV Prevention

Stigma and discrimination in a population can adversely affect both people’s willingness to be tested and their adherence to antiretroviral therapy. Reduction of stigma and discrimination among the youth is, thus, an important indicator of the success of programmes targeting HIV and AIDS prevention and control.

##### 4.4.1 Maintaining Secrecy about Family Member Infected with HIV

In the event that a family member was infected with HIV/ AIDS, students were asked if they wanted the information to remain secret or not. The students responded to this question as shown in table 11.

**Table 11: Level of secrecy by the youth about a family member’s infection with HIV**

<b>Response</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Strongly agree	166	44.7
Agree	128	34.5
Neutral	51	13.8
Disagree	14	3.8
Strongly disagree	12	3.2
No response	0	0
<b>Total</b>	<b>371</b>	<b>100</b>

Table 11 shows that 44.7% of the students strongly agreed that the information about the positive HIV status of a member of their family should remain secret. Moreover, 34.5% agreed that the information should remain secret. 13.8% of the students were neutral, which means that they neither agreed nor disagreed that the information should be shared. The finding indicates that stigma against HIV/ AIDS patients is still a problem in Suba District. Cameron (2010) in his study of the responses adopted to reduce HIV noted that stigma against HIV/AIDS patients is still a problem both in developed countries such as Brazil and developing countries such as Zimbabwe,

Zambia, and Botswana. Attawell, Pulertwitz, and Brown (2002) contend that stigma against HIV patients arises from the fear of contagion and the disease itself. These fears are exacerbated by shame, guilt, and low self-esteem.

Only 3.8% of the students disagreed that the information about the HIV positive status of a member of their family should remain a secret. Similarly, 3.2% of the students strongly disagreed. Students in Suba District are likely to avoid sharing information about the HIV status of their family members to avoid shame or embarrassment. According to Cameron (2010), stigma is a negative attitude that worsens the conditions of HIV patients. Stigma can lead to job loss, school expulsion, violence, and denial of health services among HIV patients. It also enhance the spread of the disease because people living in fear are less likely to adopt preventive behavior, go for testing, and access care and adhere to treatment.

#### 4.4.2 Sharing a Desk with an Infected Classmate

Students were asked if they would agree to share a desk with a classmate who has been infected with HIV. Table 12 presents the students responses to this question.

**Table 12: Ability of the youthsharing a desk with an infected classmate**

<b>Response</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Strongly agree	191	51.4
Agree	57	15.4
Neutral	11	3.0
Disagree	59	15.9
Strongly disagree	42	11.3
No response	11	3.0
<b>Total</b>	<b>371</b>	<b>100</b>

Table 12 shows that majority of the students (51.4%) strongly agreed to share a desk with an infected classmate. Another 15.4% agreed to share their desks with an infected classmate. 3% of the students were neutral, which means that they could not take a stance on whether to or not to share a

desk with an infected classmate. The finding means that discrimination against HIV patients in the school setting is not a major problem in rural secondary schools in Suba District. According to NCHSR (2012), health care providers and the community can only provide care and support to HIV patients if they have a positive attitude towards them. This implies that students in Suba District are likely to provide emotional support to their infected colleagues or to encourage them to seek medication.

Table 12 also shows that 15.9% of the students disagreed to share a desk with an infected classmate. Another 11.3% strongly disagreed. The implication of this finding is that the students who have a negative attitude towards their colleagues who are HIV positive are likely to practice discrimination and stigmatization. This would limit their ability to participate in the prevention of HIV/ AIDS.

#### **4.4.3 Willingness to buy vegetables from an infected vendor by the Youth**

The students were also asked if they would buy vegetables from a HIV infected vendor to determine their attitudes towards HIV patients in the community. The students' responses to this question are presented in table 13.

**Table 13: Willingness by the youths to buy vegetables from an infected vendor**

<b>Response</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Strongly agree	217	58.5
Agree	77	20.8
Neutral	12	3.2
Disagree	14	3.8
Strongly disagree	51	13.7
No response	0	0
<b>Total</b>	<b>371</b>	<b>100</b>



The results in table 13 show that 58.5% strongly agreed, whereas 20.8% of the students agreed that they could buy vegetables from an infected vendor. This indicates that majority of the students have a positive attitude towards infected members of their community such as vegetable vendors. Thus, they are likely to avoid discriminating against them.

#### 4.4.4 Introduction of Condom Use in Schools

In order to determine students' attitude towards HIV prevention methods, they were asked if they should be taught about condom use in school. The responses are presented in table 14.

**Table 14: Opinion of the youths on introduction of condom use education**

<b>Response</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Strongly agree	234	63.1
Agree	37	10
Neutral	12	3.2
Disagree	12	3.2
Strongly disagree	76	20.5
No response	0	0
<b>Total</b>	<b>371</b>	<b>100</b>

The results in table 14 shows that 63.1% of the students strongly agreed that condom use education should be introduced in their schools. 10% agreed whereas 3.2% were neutral. This means that majority of the students are willing to learn about using condoms to prevent the spread of HIV/AIDS or to avoid contracting the disease. Effective use of condom is likely to reduce the chance of acquiring HIV by up to 60%. Thus, the level of the infection in Suba District is likely to reduce if the youth use condoms correctly whenever they have sex.

Nevertheless, nearly 20.5% of the students oppose the introduction of condom use education in their schools. 3.2% of the students also disagree with the introduction of the education. In their study of condom use in Zimbabwe, Ravai et al (2002) found that majority of the youth aged

between 14 and 20 years did not use condoms regularly during sex. They did not use condoms because the females thought that it reduces pleasure and implied mistrust among sexual partners. In this context, resistance to condom use education can be a result of the negative attitudes that students have towards using condoms.

#### **4.5 Sexual Behavior and HIV/ AIDS Prevention**

##### **4.5.1 Sexual Intercourse among the Youth and their Participation in HIV Prevention**

The students were asked if they had ever had a sexual intercourse. The study found that 63.1% of the students had had an intercourse. This means that majority of the students are sexually active. In this respect, they are at risk of contracting HIV/ AIDS if they do not engage in safe sex by using condom or being faithful to one uninfected sexual partner.

##### **4.5.2 Sexual Partner in the last Intercourse among the Youth**

In order to understand the sex pattern among the students, they were asked who their sexual partner was in the last intercourse. The responses are presented in table 15.

**Table 15: Sexual partner by the youth in the last sexual intercourse**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
Spouse	11	3.0
lover/ friend	235	63.3
Someone I just met	12	3.2
No response	113	30.5
<b>Total</b>	<b>371</b>	<b>100.0</b>

Table 15 reveals that 113 students (30.5%) were unwilling to disclose who their sexual partners were in their last sexual intercourse. This suggests that sex is still a topic that students are not comfortable to discuss openly. Thus, they might not be confident to seek help when they encounter sexually transmitted diseases. 3.2% of the students had sex with someone they just met. This means

that the students are at risk of acquiring HIV since they are not likely to know the HIV status of a person they just met.

Majority of the students (63.3%) had sex with their lovers/ friends. The students who had sex with their spouses were 3%. Brown, Jejeebhoy, Shah, and Yount (2001) in their study of sexual behavior among the youth in developing countries found that sexual relationships among the youth are often transitory in nature. This means that the students are likely to have multiple sexual partners if their relationships with their lovers or friends are only temporary. In this respect, they are likely to spread HIV/ AIDS instead of preventing the disease.

#### **4.5.3 Encounter with STIs among the Youth**

The respondents were asked if they had encountered an STI to understand the implications of their sexual activities. The study found that nearly 82% of the students had not been infected by a sexually transmitted infection (STI). Only 6.7% had been infected by an STI, whereas 11.1% did not indicate whether they had been infected or not. The result suggests that the prevalence of STIs among secondary school students is low.

#### **4.5.4 STIs Encountered by the Youth and HIV Prevention**

Since 25 students indicated that they had encountered STIs, they were asked the disease that they had been infected with. The responses are presented in table 16.

**Table 16: STIs encountered by youths by type**

<b>Response</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Gonorrhea	24	96
Syphilis	23	92
Herpes	12	48
Hepatitis	12	48
Chlamydia	12	48
Cancroids	11	44
HIV	3	12

Table 16 indicates that 24 out of the 25 (96%) students who had encountered STIs had been infected with gonorrhoea. In addition, 23 students had suffered from syphilis. Herpes, hepatitis, and Chlamydia were the third most prevalent STI since each of them affected 48% of the students. According to CDC (2010), individuals who are infected with STIs are at least four times more likely than uninfected individuals to be infected with HIV if they are exposed to the virus through sexual contact. Moreover, if an HIV infected person is also infected with another STI, he or she is more likely to transmit HIV through sexual contact than other HIV infected individuals. This means that more students in Sub District will be exposed to the risk of acquiring HIV if the prevalence of other STIs increases.

Cancroids had infected 44% of the students who had STIs. HIV, on the other hand, had infected only 12% of the students. This confirms the earlier findings by Kenya National Bureau of Statistics (2010), which showed that Suba District has one of the highest prevalence of HIV/ AIDS among the youth. The disease is likely to spread if the infected youth are not equipped with the knowledge that they need to avoid transmitting the disease to others.

#### 4.5.5 Measures taken in the Treatment of STIs

The respondents were asked about the measures they took to treat their STIs to understand their ability to access help when sick. The students' responses are presented in table 17.

**Table 17: Measures taken by the youth to treat STIs**

<b>Response</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Sought medical treatment	6	24
Sought traditional treatment	0	0
Sought religious intervention	0	0
Bought drugs from chemist	3	12
Bought drugs from shops/ kiosks	5	20
None	11	44
<b>Total</b>	<b>25</b>	<b>100</b>

The results in table 17 reveals that only 24% of the students infected with STIs sought medical attention. None of the students sought traditional treatment or religious intervention to cure their STIs. The results suggest that medication is either not available or students are not willing to use them due to fear of stigmatization. They further suggest that traditional treatment and religious intervention are not considered as effective ways of curing STIs among the youth in the district.

The study found that 32% of the students resorted to self-medication to cure their STIs. This is demonstrated by the fact that 12% and 20% of the students bought drugs from chemists and shops respectively to treat themselves. Self-medication might not be effective since students lack the expertise to diagnose the symptoms of various STIs. 44% of the students did not take any measure to treat their diseases. This means that they were likely to transmit the diseases to their sexual partners through unprotected sex.

#### 4.5.6 Condom Use among the Youth

In order to determine if the respondents were engaging in safe sexual behavior, they were asked if they had used a condom in their last sexual intercourse. Table 18 presents the students' responses to this question.

**Table 18: Condom use experience by the youths**

Ever used condom	Response	Frequency	Percentage (%)
	Yes	252	67.9
	No	69	18.6
	No response	50	13.5
	<b>Total</b>	<b>371</b>	<b>100</b>
Used condom in last intercourse	Yes	210	56.6
	No	55	14.8
	No response	106	28.6
	<b>Total</b>	<b>371</b>	<b>100.0</b>

According to the results in table 18, only 67.9% of the students had ever used a condom. In addition, only 56.6% of them used a condom in their last sexual intercourse. 18.6% of the students had not used a condom, whereas 14.8% did not use a condom in their last intercourse. The implication of the finding is that the youth are at risk of acquiring HIV/ AIDs since they are sexually active but condom use among them is less than 100%. Kakai, Ochieng, and Abok (2011) in their study of sexual behavior among the youth found that 97.4% of students in high schools in Kisumu District had seen and heard about condoms. However, only 22.9% of them believed that condoms were effective in preventing HIV and AIDS. In this context, some students in Sub District were likely to have failed to use condoms because they did not believe that they would help them to avoid HIV/ AIDS.

#### 4.5.7 Reasons for Condom Use by the Youth

The respondents who had used a condom were asked why they used it in their last intercourse. Their responses are presented in table 19.

**Table 19: Reasons for condom use by the youths**

<b>Response</b>	<b>Frequency (n =210)</b>	<b>Percentage</b>
To prevent unwanted pregnancy	110	52.4
To prevent HIV	88	41.9
My partner is promiscuous	10	4.8
No response	2	0.9
I had an STI	0	0
My partner/ spouse has an STI	0	0
Total	210	100

The main reason for using a condom was to prevent unwanted pregnancy followed by HIVinfection. These reasons were cited by at least 40% of the students. Another 4.8% of the

students used condoms because they believed that their sex partners were promiscuous. This means that the students are more concerned about unwanted pregnancy than being infected with HIV/STIs. This further means that the students are likely to engage in unprotected sex if they have an alternative contraceptive such as an oral pill or injection.

None of the students used a condom because they or their sex partner had an STI, whereas 0.9% of the students did not state their reasons for using condoms. The finding suggests that the youth are not concerned about protecting themselves from STIs in order to prevent the spread of HIV/ AIDS.

#### 4.5.8 Reasons for Condom Non-use

The 55 students who did not use condoms were asked to state the reasons why they did not use them. The responses are presented in table 20.

**Table 20: Reasons for not using condoms by the youths**

<b>Response</b>	<b>Frequency (n=55)</b>	<b>Percentage (%)</b>
Have one faithful partner	42	76.4
Unavailability of condoms	26	47.3
One tested HIV negative	24	43.6
Against my religious belief	13	23.6
I trust my partner	13	23.6
To enhance conception	12	21.8
Condoms do not prevent HIV infection	11	20
I do not like condom	11	20
Unaware of sources of condom	1	1.8
Against cultural beliefs	1	1.8
Partner detests condoms	1	1.8
Spouse/ partner does not exhibit signs of HIV	0	0
Coerced into sex	0	0

The students had multiple reasons for not using condoms. The major reasons included having one faithful partner and unavailability of condoms. These reasons were cited by at least 47% of the

students. According to Kakai, Ochieng, and Abok (2011), unavailability of condoms underscores the fact that the youth in rural areas are marginalized in terms of limited access to healthcare facilities and shops/ chemists, which are the main sources of condom.

Having tested HIV negative was cited by 43.6% of the students as a reason for not using condoms. This shows that students have misconceptions about condom use. Individuals who have tested HIV negative are expected to continue rather than to stop using condoms in order to maintain their negative status. Trusting one's sex partner and religious belief were each cited by 23.6% of the students as reasons for not using condoms during sex.

Condoms were not used by 21.8% of the students to enhance conception. 20% of the students did not use condoms because they believe that condoms do not prevent HIV infection. Similarly, 20% of the students did not use condoms because they disliked them. Lack of awareness concerning sources of condoms was cited by only 1.8% of the students. These findings show that students have imperfect knowledge concerning the effectiveness of condom use in HIV prevention. They are likely to acquire the disease by failing to use condoms.

Failing to use condoms because of cultural belief and partners who detest condom were each cited by 1.8% of the students. However, none of the students failed to use condoms because of being coerced into sex or their partner did not exhibit signs of HIV. According to Ravai et al (2002), cultural and religious beliefs that discourage condom use are risk factors because the students are likely to be infected with HIV/ AIDS as they have unprotected sex.

#### **4.5.9 Condom Source for the Youths**

Respondents were also asked to state their sources of condoms. The responses to this question are presented in table 21.



**Table 21: Sources of condom for the youth**

Source	Frequency	Percentage (%)
Shop/ kiosk	102	27.5
Government health facility	88	23.7
NGO health facility	49	13.2
VCT centers	42	11.3
Private health facility	39	10.5
Youth centre	34	9.2
Mission health facility	26	7.0
Camp dispenser	25	6.7
Friends/ relatives	15	4.0
RHMs	0	0
No response	80	21.6

The finding indicates that students depend on several sources of condoms. Shops/kiosk and government health facilities were the main sources of condom since they were used by over 20% of the students. NGO health facilities were used by 13.2% of the students to obtain condoms. According to Atere et al (201), affordability and accessibility were major determinants of condom use among the youth in Lagos Nigeria. Frequent condom use was high among those who had a regular income and lived close to shops/ chemists where they could purchase the condoms and vice versa. In this regard, dependence on shops/ kiosks as the main source of condom in Sub District is likely to reflect the fact that these sources are more convenient to students in terms of accessibility. However, depending on shops is a risk factor because students do not have a regular source of income. Thus, they might not access condoms if they lack money to purchase them. Students are also likely to depend on government health facilities and VCT centres since most of them provide

free condoms. However, students in rural areas are disadvantaged since government hospitals and VCT centres are not easily accessible (Kabiru, 2005).

VCT centers and private health facilities were used by 11.3% and 10.5% of the students respectively. Youth centers and mission health facilities were used by 9.2% and 7% of the students respectively. Students are less likely to obtain condoms from mission and private health facilities because the high costs, which often arise because of the profit motives of the facilities.

Camp dispensers, friends/ relatives were sources of condoms to only 6.7% and 4% of the students respectively. Fear/ shame is one of the reasons that are likely to discourage students from obtaining condoms from their friends or relatives. None of the students obtained condoms from RHMs. Nearly, 21.6% of the students did not indicate their sources of condoms.

#### 4.5.10 HIV Testing

The study found that 301 out of 371 students (81.1%) had gone for HIV test. However, 48 students (12.9%) had not gone for the test, whereas the remaining 22 students (5.9%) did not indicate whether they had gone for the test. In this respect, the students were asked to mention the factors that motivated them to go for the tests. The responses are presented in table 22.

**Table 22: Reasons for having a HIV test by the youths**

<b>Response</b>	<b>Frequency (n =301)</b>	<b>Percentage (%)</b>
To know status	222	73.8
Radio/ TV adverts	56	18.6
Advised by friends/ relatives	38	12.6
Advise by health facility	37	12.3
Counseling	34	11.3
Donating blood	27	9.0
Exhibited signs of HIV/ AIDS	15	5
IEC materials	11	3.7
Getting married	0	0.0
Pregnancy	0	0.0

Table 22 shows that knowing one's HIV status was the main reason for going for HIV tests since it was cited by 73.8% of the students. This finding means that majority of the students have overcome the fear of knowing their HIV status. Consequently, they are likely to seek medical attention in the event that they are HIV positive (Cameron, 2010). The finding also reveals that mass media campaigns that promote HIV tests have not been very effective in Sub District. This perspective is supported by the fact that only 18.6% of the students were motivated by Radio/ TV adverts to go for HIV tests.

Counseling also promoted HIV tests among the students. 12.6% of the students went for the test after being advised by their friends/ relatives, whereas 12.3% of them took the test after being advised in a health facility. Counseling accounted for 11.3% of the students who went for the test, whereas donating blood accounted for 9%. The implication of these findings is that appropriate counseling can motivate the youth to go for HIV test. As a result, they would be able to take precautionary measures to prevent the spread of the disease.

According to table 21, 5% of the students went for HIV tests because they had exhibited the signs of HIV/ AIDS. Although this proportion is small, it indicates that the students have knowledge about the symptoms of HIV/ AIDS and they are willing to seek timely medication. Pregnancy and getting married were not considered as important reasons for going for the tests.

#### **4.5.11 Facility Used for HIV Testing by the Youth**

The students were also asked to state the places where they went for the HIV tests. The responses are presented in table 23.

**Table 23: Centers where the youth took the HIV test**

<b>Test centre</b>	<b>Frequency (n =301)</b>	<b>Percentage (%)</b>
VCT centre	202	67.1
Government health facility	107	35.5
Mobile clinic	78	25.9
NGO health facilities	40	13.3
Mission health facilities	27	9.0
Private health facilities	15	5.0

Table 23 shows that the main centers for HIV tests were VCT centres, government health facilities, and mobile clinics. According to Abebe and Mitikie (2007), high school students in Ethiopia preferred to obtain HIV testing and counseling services from trained counselors and physicians. In this context, the students in Sub District perhaps preferred to obtain the tests in VCT centres and government facilities because they have trained professionals who are likely to give quality services. In addition, VCT centres and government health facilities normally provide free HIV tests. Hence, affordability is also likely to be a reason for the preference of VCT centres and government facilities. Mobile clinics, on the other hand, are likely to be used by students because they enhance accessibility to HIV test services.

NGO health facilities provided HIV tests to only 13.3% of the students. Mission health facilities and private hospitals, on the other hand, provided the tests to 9% and 5% of the students respectively. Few students are likely to visit mission and private health facilities for VCT tests due to their limited availability in the district. In addition, the high cost of accessing services in private health facility is likely to discourage the youth from visiting them for HIV tests.

#### 4.5.12 Reasons for not taking HIV Test among the Youths

The youths who had not gone for HIV test were asked to state the reasons that prevented them from going for the services. Their responses are presented in table 24.

**Table 24: Reasons for the youths not taking a HIV test**

<b>Response</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Fear of stigma	12	25
I assume am negative	12	25
I fear knowing my HIV status	11	22.9
I trust my partner	10	20.8
Am virgin	2	4.2
Am sexually inactive	1	2.1
<b>Total</b>	<b>48</b>	<b>100</b>

Table 24 shows that stigma, assumption of a negative status, and fear of knowing one's HIV status are the main barriers to uptake of HIV test services. According to the NCHSR (2012), the fight against HIV/ AIDS cannot be won if people fear knowing their status and the stigma associated with the disease. Specifically, the students in Sub District cannot participate in the prevention of HIV/ AIDS if they fear to know their HIV status. For instance, an infected student is likely to spread the disease if he fails to know his/ her status in order to take measures to stop the spread of the disease.

Having trust in one's sex partner accounted for 20.8% of the students who did not go for HIV tests. Being virgin and sexually inactive accounted for less than 5% of the students who had not gone for HIV tests. Having trust in one's sex partner is a risk factor because students are not likely to have

accurate information about their partners' sexual activities. Thus, they need to verify their HIV status regularly to prevent the spread of the disease.

The study found that 274 out of 371 students (73.9%) had visited a VCT. However, 74 students had not visited VCTs, whereas the remaining 23 did not indicate whether they have been to a VCT.

#### 4.5.13 Likes and Dislikes with Regards to VCTs by the Youth

In order to understand the factors that motivated students to visit VCTs, they were asked to list the things they liked and those they did not like in VCTs. The responses are presented in table 25.

**Table 25: The likes and dislikes by the youth with regard VCTs**

Responses		Frequency n= 274	Percentage (%)
Things liked	Good counseling services	167	61
	Information given is easy to understand	85	31.
	Friendly staff	70	25.5
	Quick dispatch of results	63	23.0
	No response	2	0.7
Things not liked	Fear of other people knowing my results	92	33.6
	Anxiety of waiting for results	86	31.4
	Inaccessibility	31	11.3
	Poor counseling skills	12	4.4
	Tests results take too long to be dispatched	9	3.3
	Lack of privacy	7	2.6
	Exorbitant/ high charges	3	1.1
	Unfriendly staff	3	1.1
	No pre-test counseling	2	0.7

The results in table 25 show that the friendliness of staff and the quality of the services provided at VCTs are important to the students. This suggests that more students are likely to attend VCTs if the quality of the services is improved. The uptake of VCT services is also likely to increase if the information given is easy to understand and the results are dispatched quickly.

Fear of other people knowing one's results and anxiety of knowing results were the main things that students did not like in VCTs. Inaccessible and poor counseling skills were also a concern among

students. The results suggest that students are concerned about the privacy over their HIV status information since they do not want others to know their test results. This means that fear and stigma are still barriers to voluntary HIV tests. This perspective is supported by the findings of Abebe and Mitikie (2007) who found that 60% of students in Ethiopia were willing to visit VCTs only if confidential test was offered.

High charges and unfriendly staff were each cited by 1.1% of the students as things that were not liked in VCTs. This could be explained by the fact that students accessed VCT services in government health facilities that provide free services. Lack of pre-test counseling was cited by only 0.7% of the students. According to Kiragu (2001) people tend to believe that the risk of knowing ones status outweighs the benefits in cases where VCT services are poor. This limits the participation of the youth in the fight against HIV.

#### 4.5.14 Reasons for Not Visiting VCTs by the Youths

The students who had not visited VCTs were asked about the reasons that prevented them from visiting the centers. Their responses are presented in table 26.

**Table 26: Reasons for not visiting VCTs by the youths**

<b>Response</b>	<b>Frequency (n= 74)</b>	<b>Percentage (%)</b>
Fear of knowing status	45	60.8
Fear of stigma	35	47.3
I know am negative	33	44.6
VCT inaccessibility (far)	11	14.9
Exorbitant prices	1	1.4
No response	4	5.4

The results in table 26 clearly confirms that fear of knowing one’s HIV status and the stigma associated with the disease are the main factors that prevent students from visiting VCTs. Moreover, 44.6% of the students did not visit VCTs because they knew they were HIV negative. According to Abebe and Mitikie (2007), students are likely to visit VCTs if they perceive

themselves to be vulnerable to HIV/ AIDS. Students who are HIV negative might not perceive themselves as vulnerable to the disease. Thus, they are not likely to go for regular HIV tests.

The results show that 14.9% of the students did not go for HIV tests because accessing VCTs was difficult due to long distance. Exorbitant prices accounted for only 1.4% of the students who did not visit VCTs, whereas 5.4% of the students did not state their reasons for not visiting VCTs. Overall, the results means that fear and stigma are major factors that prevent students in Sub District from participating the prevention of HIV and AIDS.

#### **4.6 Social Conditions of the Youth and HIV/ AIDS Prevention among the Youth**

The students were asked if they had ever encountered a social factor/ condition that exposed them to the risk of contracting HIV/ AIDS. 247 out of 371 students (66.6%) had encountered at least one social factor/ condition that exposed them to the risk of being infected with HIV. However, 64 students (17.3%) had not encountered any adverse social factor/ condition, whereas 60 students (16.2%) did not indicate whether they had encountered any adverse social condition.

##### **4.6.1 Social Conditions Encountered by the Youths**

The youths who had encountered the adverse social conditions were asked to list them. The factors identified by the students are presented in table 27.

**Table 27: Social conditions encountered by the youths**

<b>Response</b>	<b>Frequency (n = 247)</b>	<b>Percentage (%)</b>
Unprotected sex	133	53.8
Delay/ lack of post exposure prophylaxis	72	29.1
Risky leisure activities	67	27.1
Lack of access to information on HIV	46	18.6
Peer pressure	38	15.4
Cultural practices	35	14.2
Poverty	26	10.5
Orphanage	26	10.5
Sexual violence	0	0



Unprotected sex is the main social condition that exposes the students to the risk of acquiring HIV / AIDS. Lack of post exposure prophylaxis is another adverse social condition that increases the students' chances of acquiring the disease. This finding means that at least 29.1% of the students are not able to get short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure to the virus either through sexual intercourse or through any other mode of transmission.

The results reveals that risky leisure activities such as drinking beer/ illicit brews, smoking cigarettes, going to disco clubs, and attending youth parties among students in Sub District is a course of concern. In particular, Kabiru (2005) asserts that the aforementioned leisure activities expose the youth to the risk of contracting HIV because they promote irresponsible sexual behavior. For instance, the youth are likely to have unprotected sex with a person they just met when they are drunk. Cultural practices such as teeth removal and peer pressure are also risky social factor/ condition that expose the students to HIV infection. For instance, the youth are likely to engage in unsafe sexual behaviors or risky leisure activities due to peer pressure. As a result, they might be infected with HIV/ AIDS.

Poverty and orphanage were each mentioned by 10.5% of the students as social risk factors. Poverty limits the amount of financial resources that students can use to access medication when infected by STI and HIV/ AIDS. Poverty and orphanage are also likely to lead to risky behaviors such as sex work and drug abuse, which in turn make the students more vulnerable to HIV/ AIDS.

## **CHAPTER FIVE**

### **SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS**

#### **5.1 Introduction**

This chapter will present a summary of the major findings of the study. The conclusions of the study will also be presented in this chapter. In addition, recommendations for improving the participation of secondary school students in prevention of HIV will be made. The chapter will also highlight the study's contribution to the body of knowledge and the areas for further research.

#### **5.2 Summary of Findings**

The study found that 100% of the students had heard about HIV and AIDS. The main sources of information about the disease included schools, youth clubs, health centers, and the mass media. These sources of information were used by at least 60% of the 371 students who participated in the study. At least 80% of the students were aware of the major modes of HIV transmission, which include unprotected sex, sharing sharp objects, and blood transfusion. In addition, 91.9% of the students were aware that abstinence helps in preventing HIV infection. However, less than 20% of the students were aware that blood screening before transfusion, avoiding sharing toothbrushes, and instilling moral values could prevent HIV/ AIDS. Condom use was identified by 88.9% of the students as a means of preventing the spread of HIV/ AIDS. Other prevention measures that were identified by at least 50% of the students included being faithful to one uninfected sexual partner and not sharing sharp objects. However, only 43.7% of the students knew that wife inheritance could lead to HIV infection. Moreover, only 14.3% of the students were aware that female genital mutilation (FGM) can lead to HIV infection.

The study found that 44.7% of the students strongly agreed that if a member of their family was HIV positive, the information should remain secret. Similarly, 34.5% of the students agreed that the information should be treated as a secret. According to the findings of the study, 51.4% of the

students strongly agreed that they were willing to share a desk with a classmate who is infected with HIV/ AIDS. In addition, 58.5% of the students strongly agreed that they would buy vegetables from an HIV/ AIDS infected vendor. Similarly, 20.8% of the students agreed that they would buy vegetables from an infected vendor. Majority of the students (63.1%) strongly agreed that condom use education should be introduced in their schools. However, 20.5% of the students strongly disagreed that the use of condom should not be taught in schools.

The study found that 63.1% of the students had had sex at least once in their lifetime. Majority of the sexually active students (63.3%) had sex with their friends/ lovers in their last sexual intercourse. Although majority of the students were sexually active, only 6.7% of them had been infected with a sexually transmitted infection (STI). 96% of the students who had encountered STIs had been infected with gonorrhoea, whereas 92% of them had been infected with syphilis. Furthermore, 12% of the students had been infected with HIV/ AIDS. Only 24% of the students who were infected with STIs sought medical treatment from health facilities. However, 12% of the infected students bought drugs from chemists, whereas another 20% bought drugs from shops/ kiosks to treat themselves.

The study found that 67.9% of the students had ever used a condom. Moreover, 56% of the students used a condom in their last sexual intercourse. The main reason for using a condom (cited by 52.4% of students) was to prevent unwanted pregnancies. Using condoms as a means of preventing HIV/ STIs was cited by only 41.9% of the students. The main reason for not using a condom was that the students had faithful sexual partners. This reason was given by 76.4% of the students who did not use condoms. Another important reason given by 47.3% of the students was unavailability of condoms. However, 20% of the students did not use condoms because they believed that condoms do not prevent HIV/ AIDS. The students obtained condoms from multiple sources. However, the

leading sources were shops/ kiosks and government health facilities, which were used by 27.5% and 23.7% of the students respectively.

The study revealed that 81.15% of the students had gone for HIV tests. 73.8% of the students who had gone for HIV tests went for the tests because they wanted to know their HIV status. In addition, 67.1% of the students who had been tested went for the tests in VCT centers, whereas 35.5% of them went for the tests in government health facilities. Among the students who had not gone for HIV tests, 25% stated that they avoided the test because of the fear of the stigma associated with HIV. Another 25% of the students avoided the test because they assumed to be HIV negative, whereas 22.9% avoided the test because of the fear of knowing their status. Overall, 73.9% of the students had visited a VCT. The main things that students liked in VCTs included good counseling services and ease of understanding the information given.

The study revealed that 66.6% of the students had encountered a social condition that exposed them to the risk of acquiring HIV. 53.8% of the students stated that having unprotected sex was the main adverse social condition that exposed them to the risk of acquiring HIV. In addition, 29.1% of the students were likely to acquire HIV because of lack of post exposure prophylaxis. Risky leisure activities such as drinking alcohol and smoking had been encountered by 27.1% of the students. However, poverty and peer pressure were considered adverse social conditions by only 10.5% and 15.4% of the students respectively.

### **5.3 Conclusions**

The study shows that there is high awareness about HIV/ AIDs in general. However, the quality of knowledge that students have about the disease is not perfect. Majority of the students have basic knowledge about the major modes of HIV transmission, as well as, the main methods of preventing the disease. However, majority of the students have inadequate knowledge about the cultural practices that can lead to HIV infection. In addition, they lack knowledge of important measures for

preventing HIV/ AIDS such as blood screening before transfusion. In this respect, the quality of knowledge that students have is not adequate to enable them to participate effectively in prevention of HIV/ AIDS.

The students have a positive attitude towards their colleagues and members of the society who are infected with HIV and AIDS. Moreover, majority of them believe that the use of condom should be taught in schools. Majority of the students are not willing to share information about their relatives who are HIV positive. This implies that fear, stigma, and discrimination against HIV patients in the community are barriers that prevent students from participating in prevention of HIV/ AIDS.

The study shows that majority of the students are sexually active and most of them are using condoms. However, the main reason for using condoms was to prevent unwanted pregnancies rather than HIV/ STIs. Therefore, the students are at risk of being infected with HIV since they are likely to abandon using condoms if they find alternative contraceptives. The prevalence of STIs including HIV among the students is low. However, STIs are still a threat to students' participation in prevention of HIV because they increase the likelihood of acquiring the disease and most of those who are already infected hardly seek medical treatment. Although the uptake of HIV test is high, stigma and the fear of knowing one's status still prevent some students from going for the tests as a way of participating in the prevention of HIV/ AIDS.

Adverse social conditions also prevent secondary school students from participating in the prevention of HIV/ AIDS. The social conditions that expose the students to the risk of acquiring the disease include having unprotected sex, lack of access to treatment after potential exposure to HIV, and having unprotected sex.

## **5.4 Recommendations**

The following policy recommendations should be considered by the school administrators and the government to enhance prevention of HIV/AIDS among school going youth. First, the study revealed that students did not have perfect or accurate information or knowledge about HIV/ AIDS. This problem should be solved by improving the quality of information about HIV and AIDS. This should involve consolidating accurate information about the disease and disseminating it through appropriate means such as formal class lessons, youth clubs, and health centers. This will help in eliminating the myths and use of incorrect information that is likely to expose students to higher risk of infection.

Second, the study found that risky sexual behavior such as having unprotected sex is a problem that limits students' participation in prevention of HIV/ AIDS. In order to solve this problem, school administrators, parents, and the government should promote responsible behaviors among students. Since majority of the students are already sexually active, the use of condoms should be promoted. In this respect, the use of condoms should be encouraged as a means of preventing HIV/AIDS rather than just avoiding unwanted pregnancies. Additionally, abstinence should be promoted among the youth.

Third, riskyleisure activities such as drug abuse are also challenges that prevent the youth from participating in the fight against HIV/ AIDS. Risky leisure activities should be discouraged since they expose the youth to the risk of contracting HIV/ AIDS. In this case, counseling services should be provided to the youth to discourage them from participating in risky activities such as having unprotected sex due to peer pressure or drug abuse.

Fourth, fear and stigma prevent the youth from participating in the fight against HIV/ AIDS. Health policy makers/ the government should collaborate with the community to address the fear and stigma associated with HIV/ AIDS. This will improve the participation of secondary school students in prevention of HIV/ AIDS through going for voluntary counseling and testing, seeking medication, and living positively in the event that one is infected with the disease. In addition, access to medication for STIs should be improved to enable the infected youth to avoid spreading or acquiring HIV. Similarly, access to post exposure prophylaxis should be improved to enable students avoid acquiring the disease.

### 5.7 Contribution to the Body of Knowledge

The table below shows a summary of how the study will contribute to the body of knowledge: -

**Table 28: Body of knowledge contribution**

No.	Objective	Contribution to body of knowledge
1.	To assess the level at which the knowledge of the youth on HIV and AIDS determine their participation in prevention of HIV and AIDS in Suba District, Homabay County.	The findings in this objective bring out the fact that the knowledge of youth on HIV and AIDS is quite high but this does not relate directly to lower prevalence levels. This would therefore inform the Development Partners and Government in developing policies and or programmes that would address this gap.
2.	To establish the extent to which the attitudes of the youth determine their participation in the prevention of HIV and AIDS in Suba District, HomabayCounty.	It was noted that stigma and discrimination towards HIV and AIDS was still high among the youth. Addressing stigma and discrimination reduces HIV incidence because the youth are able to access HIV and AIDS services freely. This would also inform the Government in policy development to address the issues of stigma in schools.

- |    |  |   |
|----|--|---|
| 3. | To examine how the sexual behavior of the youth determine their participation in the prevention of HIV and AIDS in Suba District, Homabay County.                  | The findings in this study show that majority of the youth were sexually active and had an early sexual debut, were using condoms and some of them had been infected by STIs. The youth also had only abstinence being advocated as the only way of HIV prevention. This brings to the fore importance of the introduction of other means of HIV prevention other than abstinence only among the youth in school. |
| 4. | To examine the extent to which the social conditions of the youth determine their participation in the prevention of HIV and AIDS in Suba District, Homabay County | The social conditions prevented the students from participating I activities geared towards prevention of HIV and AIDS among the youth. This brings forth the importance of developing policies that would empower the youth by the Government.   |

### **5.8 Areas for Further Research**

This study focused only on the knowledge and attitudes of secondary school youth, as well as, their sexual behavior and social conditions. Thus, in future the following areas should be considered for further researcher. To begin with, future studies can use a larger sample size by including the youth who are not in school in Sub District. Future studies can also explore how variables such as mental health, social norms, social networks, and sexual abuse influence the participation of the youth in prevention of HIV/ AIDS.



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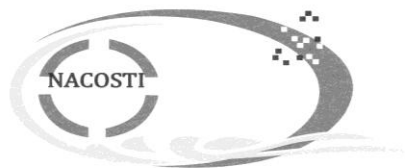
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## APPENDICES

### Appendix I: Research Authorization



## NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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Ref: No.

Date:

9<sup>th</sup> April, 2014

NACOSTI/P/14/2576/789

Otieno Gevonce Ooyi  
University of Nairobi  
P.O.Box 30197-00100  
NAIROBI.

### RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on *“Determinants of participation of rural secondary school youth towards prevention of HIV and AIDS in Suba District, Homabay County, Kenya,”* I am pleased to inform you that you have been authorized to undertake research in **Homabay County** for a period ending **30<sup>th</sup> May, 2014**.

You are advised to report to **the County Commissioner and the County Director of Education, Homabay County** before embarking on the research project.

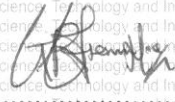
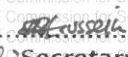
On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

  
SAID HUSSEIN  
FOR: SECRETARY/CEO

Copy to:

The County Commissioner  
The County Director of Education  
Homabay County.

## Appendix II: Research Clearance Permit

<b>THIS IS TO CERTIFY THAT:</b>	<b>Permit No. : NACOSTI/P/14/2576/789</b>
<b>MR. OTIENO GEVONCE OOI</b>	<b>Date Of Issue : 9th April, 2014</b>
<b>of UNIVERSITY OF NAIROBI,</b>	<b>Fee Received :ksh 1,000.00</b>
<b>17659-20100 Nakuru, has been</b>	
<b>permitted to conduct research in</b>	
<b>Homabay County</b>	
<b>on the topic: DETERMINANTS OF</b>	
<b>PARTICIPATION OF RURAL SECONDARY</b>	
<b>SCHOOL YOUTH TOWARDS PREVENTION</b>	
<b>OF HIV AND AIDS IN SUBA DISTRICT,</b>	
<b>HOMABAY COUNTY, KENYA</b>	
<b>for the period ending:</b>	
<b>30th May, 2014</b>	
	
<b>Applicant's</b>	<b>Secretary</b>
<b>Signature</b>	<b>National Commission for Science, Technology &amp; Innovation</b>



**Appendix III: Letter of Consent to Collect Data**

**MINISTRY OF EDUCATION SCIENCE AND TECHNOLOGY  
STATE DEPARTMENT OF EDUCATION**



Telephone : 059-22380

*SUB-COUNTY DIRECTOR OF EDUCATION OFFICE*

Fax : 059-21286

*SUBA SUB- COUNTY*

When replying please quote:

*P.O. BOX 71,  
MAGUNGA.*

**REF: NO. SBA/ CIRC/VOL 1/73/18**

email:

DATE: 6<sup>TH</sup> MAY, 2014.

TO:.

ALL PRINCIPALS

SECONDARY SCHOOLS

SUBA DISTRICT.

RE: RESEARCH AUTHORIZATION FOR GEVONCE OOIYI OTIENO –REG: L50/70264/2007

Reference is made to national council for science and technology letter dated 31/1/2014 in regards to carry out research on “*Determinants of participations of rural secondary school youth toward prevention of HIV/ AIDS in Suba District, Homa-bay county in Kenya*”.

Therefore the office do grant you opportunity to liase with school administration to conduct your research.

Upon completion of the exercise there is need for the report on the activities in this office.

*DISTRICT EDUCATION OFFICER  
SUBA DISTRICT  
P.O. BOX 71 MAGUNGA*

*AMOTH M. O.*

SUB-COUNTY DIRECTOR OF EDUCATION

SUBA.

**Appendix IV: Questionnaire**

# QUESTIONNAIRE

**INTRODUCTIONS**

Name of the Interviewer.....

Date of Interview .....

Supervisor's Signature .....

Questionnaire Number.....

**SECTION 1: SOCIO DEMOGRAPHIC PROFILE**

SERIAL NO.	QUESTIONS	CODING CATEGORIES	GO TO
1.	Sex	1. Male 2. Female	
2.	What is your religion	1. Catholic 2. Protestant 3. Muslim 4. Orthodox 5. Traditionalist 6. Pagan	
3.	What is your age in years?		
4.	What class/form are you in?	1. Form One 2. Form Two 3. Form Three 4. Form Four	
<b>KNOWLEDGE TO HIV/AIDS</b>			
5.	Have you ever heard of HIV or AIDS?	1. Yes 2. No	
6.	If Yes, state the source of information <b>(MULTIPLE RESPONSES ALLOWED)</b>	1. Mass media 2. IEC materials (posters, pamphlets) 3. Church/mosque 4. Health centre 5. Community Health Worker 6. Reproductive Health Motivator 7. PET Group 8. NGO 9. Youth Clubs 10. School	
7.	If yes, what are the modes of HIV transmission <b>(MULTIPLE RESPONSES ALLOWED)</b>	1. Mother to Child Transmission 2. Sharing sharp objects 3. Blood transfusion 4. Unprotected sex 5. Sharing of toothbrushes 6. Wounds/cuts	

		<p>7. Deep kissing</p> <p>8. Blood contact</p> <p>99. No response</p>																					
8.	<p>State the various strategies of HIV prevention that you are aware of.</p> <p><b>(MULTIPLE RESPONSES ALLOWED)</b></p>	<p>1. Voluntary Counseling and Testing (VCT)</p> <p>2. Counseling</p> <p>3. BCC</p> <p>4. Condom usage</p> <p>5. Abstinence</p> <p>6. Being faithful to one uninfected and faithful partner</p> <p>7. Prevention of Mother to Child (PMCTC)</p> <p>8. Not sharing sharp objects</p> <p>9. Refraining from harmful cultural practices</p> <p>10. Blood screening</p> <p>11. Instilling moral/religious values</p> <p>12. Not sharing tooth brushes</p> <p>13. 88. Don't Know/not sure</p> <p>99. No response</p>																					
9.	<p>Please state which of the following statements is true about HIV/AIDS/STIs</p> <p>1. An individual can protect him/herself from HIV infection by abstinence</p> <p>2. An individual can protect him/herself from HIV infection by being faithful to one uninfected partner</p> <p>3. Proper use of condoms can protect oneself from HIV infection</p> <p>4. An individual who looks healthy can also be infected with HIV</p> <p>5. Sharing of clothes can transmit HIV</p> <p>6. Sharing of sharp objects can transmit HIV</p> <p>7. There is a linkage between STI and HIV infection</p> <p>8. HIV testing is the most appropriate way of determining HIV status</p> <p>9. Unprotected sex is the main mode of HIV infection</p> <p>10. Some cultural beliefs and practices enhance HIV infection</p>	<p><b>(Circle as appropriate for each statement)</b></p> <table border="0"><tr><td>1. True</td><td>2. False</td></tr><tr><td>1. True</td><td>2. False</td></tr><tr><td>1. True</td><td>2. False</td></tr><tr><td>1. True</td><td>2. False</td></tr><tr><td>1. True</td><td>2. False</td></tr><tr><td>1. True</td><td>2. False</td></tr><tr><td>1. True</td><td>2. False</td></tr><tr><td>1. True</td><td>2. False</td></tr><tr><td>1. True</td><td>2. False</td></tr><tr><td>1. True</td><td>2. False</td></tr></table>	1. True	2. False	1. True	2. False	1. True	2. False	1. True	2. False	1. True	2. False	1. True	2. False	1. True	2. False	1. True	2. False	1. True	2. False	1. True	2. False	
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1. True	2. False																						
10.	<p>If the answer to Question 10 above is true, state some of the</p>	<p>1. Wife inheritance</p>																					

	cultural practices that enhance HIV infection	<ul style="list-style-type: none"> <li>2. Female circumcision</li> <li>3. Traditional male initiation</li> <li>4. Polygamy</li> <li>5. Scarification</li> <li>6. Removal of teeth</li> <li>7. Blood sucking</li> <li>8. Sharing sharp objects</li> </ul>	
11.	Have you ever encountered any factor that might expose you to HIV infection?	<ul style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> <li>3. 99. No response</li> </ul>	
12.	If yes, What were the risk factors? <b>(MULTIPLE RESPONSES ALLOWED)</b>	<ul style="list-style-type: none"> <li>1. Sexual violence</li> <li>2. Delay/lack of post exposure prophylaxis</li> <li>3. Poverty</li> <li>4. Peer Pressure (Explain)</li> <li>5. Lack of access to information</li> <li>6. Cultural practices</li> <li>7. Unprotected sex</li> <li>8. Orphanage</li> <li>9. Risk leisure activities</li> <li>99. No response</li> </ul>	
<b>ATTITUDES PERTAINING TO HIV AND AIDS</b>			
13.	In a scale of 1-5 with 1 being fully keeping it a secret and 5 fully not keeping it a secret. If a member of your family got infected with the virus that causes AIDS, would you want it to remain a secret or not?	<p><b>(Circle as appropriate)</b></p> <p>1      2      3      4      5</p>	
14.	In a scale of 1-5 with 1 being for not fully sharing and 5 fully sharing. If your classmate has AIDS virus, would you share a desk with him/her?	<p><b>(Circle as appropriate)</b></p> <p>1      2      3      4      5</p>	
15.	In a scale of 1-5 with 1 being extremely unwilling and 5 extremely willing. Would you buy vegetables from a vendor who has AIDS virus?	<p><b>(Circle as appropriate)</b></p> <p>1      2      3      4      5</p>	
16.	In a scale of 1-5 with 1 being extremely against condom education and 5 for condom education, Should the secondary school students be taught be taught about using condoms to	<p><b>(Circle as appropriate)</b></p>	

	avoid the HIV virus?	1      2      3      4      5	
<b>EXPERIENCES AND PRACTICES PERTAINING TO HIV/AIDS/STI</b>			
17.	Have you ever had sexual intercourse?	1. Yes 2. No	
18.	If yes, who was your sexual partner in the last sexual encounter?	1. Spouse 2. Lover/friend 3. Commercial sex worker 4. Someone I just met 99. No response	
19.	If the sexual partner was a commercial sex worker, give reasons for paying for having sex with your partner	1. For sexual pleasure 2. Don't have a spouse	
20.	Have you ever encountered an STI?	1. Yes 2. No	
21.	If Yes, what was the STI?	1. HIV 2. Gonorrhea 3. Syphilis 4. Herpes 5. Hepatitis 6. Candidiasis/thrush 7. Genital warts 8. Chlamydia 9. Chancroid 99. No response	
22.	What measures did you take to treat the STI?	1. Sought medical treatment 2. Sought traditional treatment 3. Sought religious intervention 4. Bought drugs from chemist 5. Bought drugs from shop/kiosk 6. None	
23.	Have you ever used a condom during sexual intercourse?	1. Yes 2. No	
24.	If yes, did you use a condom during the last sexual encounter?	1. Yes 2. No	
25.	If yes, what reasons prompted you to use a condom?	1. My partner is promiscuous 2. To prevent HIV/STI	

		<ul style="list-style-type: none"> <li>3. To prevent unwanted pregnancy</li> <li>4. I had an STI</li> <li>5. My partner/spouse had an STI</li> <li>99. No response</li> </ul>	
26.	If no, what made you not to use a condom?	<ul style="list-style-type: none"> <li>1. It is against my religious belief</li> <li>2. I trust my partner</li> <li>3. I have only one faithful partner</li> <li>4. To enhance conception</li> <li>5. Unavailability of condoms</li> <li>6. Unaware of sources of condom distribution/usage</li> <li>7. I don't like condoms</li> <li>8. Coerced into sex by partner</li> <li>9. Partner detests condoms</li> <li>10. Spouse/partner does not exhibit signs of HIV/STI</li> <li>11. I/my spouse/lover tested HIV negative</li> <li>12. Against my cultural belief</li> <li>13. Condoms don't prevent HIV infection</li> <li>99. No response</li> </ul>	
27.	Where do you normally obtain condoms?	<ul style="list-style-type: none"> <li>1. Mission health facility</li> <li>2. Private health facility</li> <li>3. NGO health facility</li> <li>4. Government health facility</li> <li>5. Shop/kiosk</li> <li>6. Camp dispensers</li> <li>7. Friends/relatives</li> <li>8. Youth centres</li> <li>9. CT centres</li> <li>10. RHMs</li> <li>88. Don't know</li> <li>99. No response</li> </ul>	
28.	Have you ever had a HIV test	<ul style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ul>	
29.	If yes, what motivated you to have the test?	<ul style="list-style-type: none"> <li>1. Radio/TV adverts</li> <li>2. IEC materials (posters, pamphlets etc)</li> <li>3. Exhibited signs of HIV/AIDS</li> <li>4. Counseling</li> <li>5. Advised by health facility</li> </ul>	

		<ul style="list-style-type: none"> <li>6. Getting married</li> <li>7. Donating blood</li> <li>8. Pregnancy</li> <li>9. To know my status</li> <li>10. Advised by friend/relative</li> <li>88. Don't Know</li> <li>99. No response</li> </ul>	
30.	If yes, where did you go for the test?	<ul style="list-style-type: none"> <li>1. CT centre</li> <li>2. Mobile VCT/clinic</li> <li>3. Government health facility</li> <li>4. Mission health facility</li> <li>5. NGO health facility</li> <li>6. Private health facility</li> <li>88. Don't Know</li> <li>99. No response</li> </ul>	
31.	If no, what hindered you from taking the test?	<ul style="list-style-type: none"> <li>1. I am sexually inactive</li> <li>2. I trust my partner</li> <li>3. I fear knowing my HIV status</li> <li>4. I have no idea of HIV testing centre</li> <li>5. Financial instability</li> <li>6. Fear of stigma and discrimination</li> <li>7. I am a virgin</li> <li>8. I assume I am HIV negative</li> <li>9. Its against my religious beliefs</li> <li>88. Don't Know</li> <li>99. No response</li> </ul>	
32.	Have you visited a Counselling and Testingcentre?	<ul style="list-style-type: none"> <li>1. Yes</li> <li>2. <b>No</b></li> </ul>	
33.	If yes, what did you like about the services of the CT?	<ul style="list-style-type: none"> <li>1. Friendly staff</li> <li>2. Quick dispatch of results</li> <li>3. Information given at VCT is easy to understand</li> <li>4. Good counseling services</li> <li>88. Don't Know</li> <li>99. No response</li> </ul>	
34.	If yes, what did you not like about the CT?	<ul style="list-style-type: none"> <li>1. Anxiety of results</li> <li>2. Lack of privacy</li> <li>3. Fear of other people knowing my results</li> </ul>	



		<ul style="list-style-type: none"> <li>4. Exorbitant/high VCT charges</li> <li>5. Inaccessibility of VCT from camp</li> <li>6. Unfriendly staff</li> <li>7. Tests take too long to be dispatched</li> <li>8. Poor counseling skills</li> <li>9. No pre-test counseling</li> <li>88. Don't Know</li> <li>99. No response</li> </ul>	
35.	If no, what are your reasons for not visiting a CT?	<ul style="list-style-type: none"> <li>1. I assume/know I am HIV negative</li> <li>2. Fear that my spouse will abandon me</li> <li>3. Fear of knowing my status</li> <li>4. Fear of stigma and discrimination</li> <li>5. I have no information about VCT</li> <li>6. VCT is inaccessible/too far</li> <li>7. Exorbitant prices</li> </ul>	
<b>RECOMMENDATIONS FOR ENHANCING THE HIV/AIDS PROGRAMMES</b>			
36.	Give suggestions of enhancing HIV and AIDS Programming in secondary schools		
37.	What main HIV/AIDS issues would you like to be addressed in the schools? <b>(Multiple responses allowed)</b>		

38.	1. In your opinion, what is the best strategy of disseminating information on HIV/AIDS/STI?	<ul style="list-style-type: none"> <li>1. Creation of awareness</li> <li>2. Training workshops</li> <li>3. Group discussions</li> <li>4. Audio visual aids</li> <li>5. IEC material</li> <li>6. Mass media</li> <li>7. Print media</li> <li>8. Mass campaigns</li> <li>9. Health facilities</li> <li>10. RHM</li> <li>11. CHW</li> <li>88. Don't know/not sure</li> <li>99. No response</li> </ul>	
39.	In your opinion, what is the best strategy of mobilizing secondary school going youth into HIV/AIDS/STI activities?	<ul style="list-style-type: none"> <li>1. Group discussions</li> <li>2. Printed T-shirts</li> <li>3. Organized groups</li> <li>4. Schools</li> <li>5. AIDS clubs</li> <li>6. Sports activities</li> <li>7. Music/drama</li> <li>8. Notice boards</li> <li>9. Mass media</li> <li>10. Mass campaigns</li> <li>11. Social events</li> <li>88. Don't know/not sure</li> <li>99. No response</li> </ul>	
40.	State <b>4</b> main HIV/AIDS/STI activities that you recommend to be implemented by HIV/AIDS/STI interventions within the secondary school. <b>(Multiple responses allowed)</b>	<ul style="list-style-type: none"> <li>1. Home based care</li> <li>2. Establishment of VCT</li> <li>3. Counseling services</li> <li>4. HIV/AIDS/STI and reproductive health resource centre</li> <li>5. Peer educators</li> <li>6. Condom distribution</li> <li>7. IGAs for PLWHA</li> <li>88. Don't know/not sure</li> <li>99. No response</li> </ul>	

**THANK YOU FOR TAKING YOUR  
TIME TO RESPOND TO THE  
QUESTIONNAIRE**