SOCIODEMIC AND CULTURAL FACTORS IN THE TRANSMISSION OF HIV/AIDS AMONG SCHOOL AND COLLEGE GOING YOUTH IN CENTRAL DIVISION OF GARISSA DISTRICT, KENYA.

HUSSEIN NOOR ABDIILE (HND, KMTC, NAIROBI)

A thesis submitted in partial fulfillment for the award of the degree of Masters of Public Health and Epidemiology of Kenyatta University

DEPARTMENT OF ZOOLOGY
KENYATTA UNIVERSITY
P.O BOX 43844 – 00100 GPO
NAIROBI, KENYA.

SEPTEMBER, 2003
DECLARATION

This thesis is my original work and has not been presented for a degree in any other university.

Hussein Noor Abdille

Signature ........................................ Date 02/10/2003

We as the university supervisors confirm that the candidate carried out the work reported in this thesis under our supervision.

Dr. Sammy Shimenga Kubasu
Department of Zoology,
Kenyatta University
Signed........................................ Date 02/10/2003

Dr. Isaac Mwanzo
Department of Zoology,
Kenyatta University
Signed........................................ Date 02/10/2003
DEDICATION

This thesis is dedicated to my entire family members and loved ones whose efforts and patience enable me to go through successfully.
# TABLE OF CONTENTS

Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>1</td>
</tr>
<tr>
<td>Declaration</td>
<td>ii</td>
</tr>
<tr>
<td>Dedication</td>
<td>iii</td>
</tr>
<tr>
<td>Table of contents</td>
<td>ix</td>
</tr>
<tr>
<td>List of tables</td>
<td>vii</td>
</tr>
<tr>
<td>List of figures</td>
<td>x</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>xi</td>
</tr>
<tr>
<td>Acronyms</td>
<td>xii</td>
</tr>
<tr>
<td>Abstract</td>
<td>xiii</td>
</tr>
<tr>
<td>CHAPTER ONE</td>
<td>1</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>1.1 General introduction</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER TWO</td>
<td>4</td>
</tr>
<tr>
<td>LITERATURE REVIEW</td>
<td>4</td>
</tr>
<tr>
<td>2.1.0 Epidemiology of HIV/AIDS</td>
<td>4</td>
</tr>
<tr>
<td>2.1.1 Mode of transmission</td>
<td>6</td>
</tr>
<tr>
<td>2.1.1.1 Sexual contact</td>
<td>6</td>
</tr>
<tr>
<td>2.1.1.2 Blood transfusion</td>
<td>7</td>
</tr>
<tr>
<td>2.1.1.3 Prenatal transmission</td>
<td>7</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>2.1.2 Incubation period</td>
<td>8</td>
</tr>
<tr>
<td>2.1.3 Clinical manifestation</td>
<td>8</td>
</tr>
<tr>
<td>2.1.4 Treatment and vaccine development</td>
<td>9</td>
</tr>
<tr>
<td>2.1.5 Prevention and control strategies</td>
<td>9</td>
</tr>
<tr>
<td>2.2 Risk factors</td>
<td>10</td>
</tr>
<tr>
<td>2.2.1 Early sexual experience</td>
<td>10</td>
</tr>
<tr>
<td>2.2.2 HIV/AIDS education and information</td>
<td>12</td>
</tr>
<tr>
<td>2.2.3 Knowledge, attitude and practices</td>
<td>15</td>
</tr>
<tr>
<td>2.2.4 Condom use</td>
<td>16</td>
</tr>
<tr>
<td>2.2.5 Substance abuse</td>
<td>18</td>
</tr>
<tr>
<td>2.3 Rationale of the study</td>
<td>20</td>
</tr>
<tr>
<td>2.3.1 Statement of the problem</td>
<td>20</td>
</tr>
<tr>
<td>2.3.2 Research questions</td>
<td>22</td>
</tr>
<tr>
<td>2.3.3 Justification of the study</td>
<td>22</td>
</tr>
<tr>
<td>2.4 Hypothesis</td>
<td>23</td>
</tr>
<tr>
<td>2.5 Objectives of the study</td>
<td>23</td>
</tr>
<tr>
<td>2.5.1 General objective</td>
<td>23</td>
</tr>
<tr>
<td>2.5.2 Specific objectives</td>
<td>23</td>
</tr>
<tr>
<td><strong>CHAPTER THREE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MATERIALS AND METHODS</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 Study area</td>
<td>25</td>
</tr>
<tr>
<td>3.2 Study population</td>
<td>27</td>
</tr>
<tr>
<td>3.2.1 Inclusion criteria</td>
<td>27</td>
</tr>
</tbody>
</table>
4.5.2 Involvement of youth in HIV/AIDS prevention programmes

CHAPTER FIVE

DISCUSSION

5.1 Knowledge, practice and perception

5.2 Sexual experience and relationships

5.3 Economic factors

5.4 Condom use

5.5 HIV/AIDS information and education

5.6 HIV/AIDS prevention and control interventions

5.7 Substance abuse

CHAPTER SIX

CONCLUSION, RECOMMENDATIONS AND SUGGESTIONS FOR FUTURE WORK

6.1 Conclusion

6.2 Recommendations

6.3 Suggestions for future work

REFERENCES

APPENDIX I

APPENDIX II

APPENDIX III
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:</td>
<td>Distribution of study respondents by school / colleges</td>
<td>31</td>
</tr>
<tr>
<td>2:</td>
<td>Knowledge on incubation period</td>
<td>34</td>
</tr>
<tr>
<td>3:</td>
<td>Perception on HIV/AIDS treatment</td>
<td>38</td>
</tr>
<tr>
<td>4:</td>
<td>Relationship between perception on treatment and age groups</td>
<td>39</td>
</tr>
<tr>
<td>5:</td>
<td>Cultural practices predisposing individuals to HIV/AIDS</td>
<td>40</td>
</tr>
<tr>
<td>6:</td>
<td>Reasons for engaging in sex</td>
<td>43</td>
</tr>
<tr>
<td>7:</td>
<td>Problems that deter youth from accessing condoms</td>
<td>44</td>
</tr>
<tr>
<td>8:</td>
<td>Reasons given for condom ineffectiveness</td>
<td>47</td>
</tr>
<tr>
<td>9:</td>
<td>Commonly used drugs by the youth</td>
<td>50</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

<table>
<thead>
<tr>
<th>Fig</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fig 1</td>
<td>Map of the study area</td>
<td>26</td>
</tr>
<tr>
<td>Fig 2</td>
<td>Knowledge on mode of transmission</td>
<td>35</td>
</tr>
<tr>
<td>Fig 3</td>
<td>Sources of condoms in the community</td>
<td>45</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

I am deeply indebted to my supervisors, Dr. Sammy S. Kubasu and Dr. Isaac Mwanzo both of Zoology Department of Kenyatta University, for their guidance and encouragement during the course of this work. My deepest appreciation goes to the many individuals who assisted in one way or another during data collection. Special thanks to the headmistress, Umul Salama Secondary School, Mrs. Ebla Haji. I would also like to thank Mr. Abdi Farah and Mr. Abdi Yunis both of Gasissa Secondary School and Mr. William Ochieng, a tutor at Garissa Teachers Training College for their assistance. I also wish to thank the principals, heads, teachers and students of the schools and colleges, which participated in the study. I also wish to express my gratitude to Messrs. Mohamed Bu’ul and Qureysh Hassan for the assistance in the data collection, the Medical Officer of Heath, Garissa District, Dr. Hashim Warfa and the district public health staff for their assistance. I would wish to thank my family members and friends, whose financial and moral support enabled me to conduct the study.

Last but not least, I must appreciate the input and assistance which I received from my colleagues especially Mr. Mohamed Shariff, Sahara Sheikh and Mr. Abdihakim Mohamed. Above all, praise is to Allah, the Almighty, on whose Grace everything was achieved.
<table>
<thead>
<tr>
<th>#</th>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>2</td>
<td>CACC</td>
<td>Constituency AIDS Control Committee</td>
</tr>
<tr>
<td>3</td>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>4</td>
<td>CBWG</td>
<td>Community Based Women Groups</td>
</tr>
<tr>
<td>5</td>
<td>CBS</td>
<td>Central Bureau of Statistics</td>
</tr>
<tr>
<td>6</td>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>7</td>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>8</td>
<td>KANCO</td>
<td>Kenya AIDS NGOs Consortium</td>
</tr>
<tr>
<td>9</td>
<td>KDHS</td>
<td>Kenya Demographic Health Survey</td>
</tr>
<tr>
<td>10</td>
<td>NCPD</td>
<td>National Council of Population and Development</td>
</tr>
<tr>
<td>11</td>
<td>NGO</td>
<td>Non Governmental Organizations</td>
</tr>
<tr>
<td>12</td>
<td>PHEAD</td>
<td>Preventive Health Education Against Drug Abuse</td>
</tr>
<tr>
<td>13</td>
<td>RoK</td>
<td>Republic of Kenya</td>
</tr>
<tr>
<td>14</td>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>15</td>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
The UNAIDS/WHO estimate that about 42 million people worldwide were infected with HIV/AIDS by the end of the year 2002 with more than half believed to have acquired the disease between the age of 15 and 24 years. About 29.6 million of the world’s total HIV/AIDS cases are found in sub-saharan Africa where the disease is becoming the leading cause of mortality. In Kenya, it is estimated that 2.5 million people were living with HIV/AIDS by the end of the year 2001. For long, the youth have been regarded as one of the most vulnerable members of our society. Physical, psychological and social attributes of adolescence make young people particularly vulnerable to HIV/AIDS and other transmitted infections. Therefore, there is need to understand the level at which the above factors contribute to this vulnerability.

The main objective of the study was to establish the socio economic and behavioral factors that influence the transmission of HIV/AIDS among school and college going youth. The work was carried out among secondary school and colleges in Central Division in Garissa District, Kenya. A total of 389 students aged between 15 and 24 years were interviewed. Data was obtained using structured questionnaires and focus group discussions. It was then anlysed using Statistical Package for Social Science (SPSS) version 10. In this package, Chi square was use to establish relationships between independent and dependent variables.
The results of the study indicate the existence of disparities especially in the knowledge possessed by the students. For instance, many young people still believe that HIV/AIDS can be transmitted in ways unrelated to known facts such as shaking hands (28%) and sharing utensils (38.6%). Besides, there are those who believe that the disease is curable. About 31.6% of the respondents have had sexual intercourse. This indicates that 42.2% of the boys and 20.5% of the girls are sexually active. There was significant relationship between involvement in sex and age group ($\chi^2 = 9.366$, df=1; $p<0.05$) which indicated that more students aged between 20 and 24 years involved themselves in sex more than those aged 15 and 19 years. On individual perception towards vulnerability, 50.4% believed that they are not vulnerable to HIV/AIDS, which reflects a disturbing sense of vulnerability that many young people have. On the involvement of drugs the study revealed that 23.1% of the boys and 6.3% of the girls use drugs.

From the above trends in the study, it was concluded that there is lack of proper dissemination of adequate HIV/AIDS information as well as limited involvement of the youth in the prevention and control of HIV/AIDS in the community. It is imperative therefore, that the youth be empowered and efforts made to encourage youth-friendly approaches in dealing with HIV/AIDS. Besides, formulated disease control policies should be culturally sensitive to accommodate socio-cultural factors specific to certain communities.
Acquired Immune Deficiency Syndrome (AIDS) is the end stage of HIV infection (Merge and Sunanda, 1993). The virus causes AIDS by destroying the pertinent white blood cells thus affecting the body’s immune system (Last, 1998). Studies have shown that the devastation of the disease is unmatched globally with no known cure in place at the moment (WHO, 2000). Besides, there is a rising incidence of HIV/AIDS despite global efforts (Elizabeth et al., 2003). The UNAIDS and WHO (2003) estimate that 42 million people worldwide were infected with HIV/AIDS by the end of the year 2002 with more than half believed to have acquired the disease between the ages of 15 and 24 years. About 70% of the world’s total HIV/AIDS patients are to be found in Sub Saharan Africa, a region where the disease is becoming the leading cause of mortality (UNAIDS, 2003). Today, nearly 15 million young people are living with HIV/AIDS around the globe (UNAIDS/WHO, 2003). The top fifteen countries with the highest prevalence worldwide are all in the Sub Saharan Africa, Kenya being one of them and accounts for 6% of the world’s total HIV/AIDS infection (Johnston, 2000).

It is estimated that over 2.5 million Kenyans were living with HIV/AIDS by the end of 2001 and another 1.6 million have died since the epidemic was first reported in the country in 1984 (UNAIDS, 2002). The national average prevalence rate stands at 13 - 14% with the urban areas
having a higher prevalence rate of between 17 and 18% (RoK, 2000). The notions that the rural areas are not as much as affected are misleading as trends have indicated otherwise. For instance, between 1990 and 1993, HIV infection rates in the urban areas were almost twice those reported in the rural areas. However, the gap is diminishing as the prevalence rates in 2000 stood at 17% in the urban areas as compared to 12.4% in rural areas indicating that the HIV infection in the rural areas is increasing at a higher rate than in urban areas (RoK, 2001). Thus, there is need to establish socio-economic and behavioural factors that predispose rural communities to HIV/AIDS especially among the vulnerable groups such as the youth.

Adolescence is a sensitive stage in life of the youth during which they undergo sexual, social and emotional changes. More often than not, they do not comprehend or are overwhelmed by these changes (Tabifor, 2000). Hence, the youth tend to engage in risky sexual behaviors with little awareness of the dangers involved. They lack the judgment that comes with experience and thus cannot appreciate the consequences of their actions culminating in HIV infection (UNAIDS, 2003). Risky sexual behaviors often are part of a larger pattern of adolescent behaviors including alcohol and drugs use (Tuju, 1996). The work reported here studied the magnitude of these behaviours.

Premarital sexual activity is common in many parts of the world (Tabifor, 2000). The breakdown of traditional systems, urbanization and the influence of mass media are just some of the factors contributing to increased sexual activities (RoK/NCPD, 1998). Heterosexual relations and HIV have become synonymous with more than 80% of HIV infection worldwide acquired through
sexual contact (RoK, 2000). HIV/AIDS today is widely seen as a social crisis as well as a problem of individual behavior (UNAIDS, 2003). This contributes to the vulnerability of the youth since they are in a state of adventure. Many young people are socially inexperienced and dependent on others especially their peers (UNAIDS, 2003). Yet peers often influence them in ways that increase their risks (Nyembele et al., 2001).

Despite its toll, HIV/AIDS remains elusive to many young people and adults alike. This is evidenced by the fact that more than 70% of young people in Kenya engage in risky sexual behaviors with 80% believing that they are invulnerable to HIV/AIDS (RoK, 2000). This is coupled with early sexual experience, low condom utilization and rampant drug abuse (RoK/NCPD, 1998; Kwamanga et al., 2003). Therefore, it is imperative to establish the reasons for the high level of invulnerability as well as use of condoms, drugs and other risk behaviours, so as to contribute to HIV/AIDS control and prevention.
Chapter Two

LITERATURE REVIEW

2.1.0 Epidemiology of HIV/AIDS

During the period 1983-1984, researchers isolated a newly recognized virus known as the Human Immunodeficiency Syndrome (HIV) and identified it as a cause of AIDS. It was determined that HIV is a member of the class of infectious agents known as retroviruses (Last, 1998). AIDS is the late stage of HIV infections (RoK, 2001). The latter destroys the immune system and when the immune system becomes unable to protect the body against common, otherwise unthreatening diseases, AIDS may be diagnosed (RoK, 2001). HIV infection is caused by two strains of human immunodeficiency syndrome; HIV-1 and HIV-2 with the former having at least nine different subtypes each predominating in different parts of the world although there is increased dispersion. HIV-2, which is less infectious, progresses more slowly and is found primarily in West Africa (Merge and Sunanda, 1993).

Once introduced into the human body, HIV attacks mainly a subset of immune system cells, which bear a molecule called CD4 (Last, 1998). Precisely the virus binds to two type of CD4 bearing cell, CD4+ T-cells, and to lesser extent macrophages. These cells perform various tasks critical to the normal functioning of the immune systems. CD4+ T-cells organize the overall immune response by secreting chemicals to help other immune cell function properly (WHO, 1994). Like
other viral infections, HIV infections can be characterized as a battle between the immune system and the invading virus. This process can be examined in three general stages:

a. **Primary (or acute) HIV infection stage**

This stage begins at the time of infection and lasts until the body initial immune response gains some measures of control over viral replication usually within two weeks of infection (WHO, 2000). During this period the CD4+ T-cell count drops dramatically and between 30% and 70% of people experience flu-like symptom which usually disappears within three weeks as the CD4+ T-cell count rebounds (Last, 1998).

b. **A symptomatic stage**

This is the second stage and accounts for about 80% of the time infection to death (RoK, 2001). Only at the beginning of the second stage do antibodies to HIV become detectable in the bloodstream. Since most HIV test work by detecting these antibodies, it is usually not possible prior to this stage to determine if a person is actually infected (WHO 1994).

Most of the HIV-infected people remain clinically healthy at this stage largely due to the intense but invisible struggle by the immune system against the virus (WHO, 1993). As the infection progresses, HIV destroys huge number of CD4+ cells each day with the bone marrow compensating these by speeding up production of new cells but at a rate that cannot sufficiently keep up with the loss (WHO, 1993). Gradually, CD4+ T-cell count decline by about 50-70 cell every year. When the total CD4+ Tcell count diminishes to around 200 per cubic millimeter of
blood, the rate of decline accelerates and the individual becomes susceptible to opportunistic infection and other illness. This marks the beginning of the final stage (Last 1998).

c. Clinical AIDS

This stage is also commonly referred to as full-blown AIDS (WHO, 1993). In this stage opportunistic infections set in due to the susceptibility of the individual resulting from lowered immune defence system (WHO, 1994; Last, 1998). Most of the illnesses that strike people with HIV/AIDS are communicable in nature. Others are common infections that become unusually severe in people with AIDS like sinuses or pneumonia while others are normally rare diseases that would not have taken hold at all had the person been HIV negative (Last, 1998). Some AIDS associated infections can be treated with conventional antibiotics, particularly at the early stages of clinical AIDS (WHO, 1993). As the immune system continues to deteriorate, however treatment becomes increasingly difficult and the number and variety of illness equally increase leading to death (WHO, 1993; Last, 1998).

2.1.1 Mode of Transmission

HIV/AIDS can be transmitted from one infected person to another through the following ways:

2.1.1.1 Sexual Contact

This involves the direct sexual intercourse between two individuals when either of the partners is infected. It is the commonest mode of transmission and particularly in Sub Saharan Africa (Mureh and Kiarie, 2001; RoK, 2000). Any unprotected penetrative sex whether vaginal, anal or oral can transmit the virus (Merger and Sunanda, 1993). Heterosexual sex accounts for more than 70-80%
worldwide of all HIV / AIDS transmission (RoK, 2001). Oral sex is associated with lower risk but other sexually transmitted diseases such as gonorrhoea, genital ulcers, and syphilis increase the risk of transmission (Mureh and Kiarie 2001; WHO 1993). Although uncommon in most African cultures, homosexual contacts account for 5-10% of all HIV infections (RoK, 2001). The risk of HIV transmission through sexual contacts is influenced by a number of factors. These include, the number of sexual partners, level of virus in the body, sexual orientation, gender and age among others (Mureh and Kiarie, 2001).

2.1.1.2 Blood transfusion
This is basically the transfusion of infected blood to an uninfected patient (RoK, 2000). It is estimated that 5% - 10% of full HIV infections in developing countries are acquired via blood transfusion (WHO, 1993; WHO, 1994). The probability of becoming infected through transfusion is estimated at over 90% (Mureh and Kiarie 2001). In contrast, the risk through single act of sexual intercourse ranges between 0.1% to 1% (Mureh and Kiarie 2001). A high proportion of blood transfusion is given to children with severe anemia and women with hemorrhage complication during pregnancy (WHO, 1993; RoK, 2000; Mureh and Kiarie, 2001).

2.1.1.3 Prenatal transmission
This is the infection from the mother during pregnancy, at the time of birth or through breast milk. About 30-40% of children born to infected mothers will themselves be infected (RoK, 2001). Given the high prevalence of HIV/AIDS among women of child-bearing age, the frequency of
mother-to-child transmission is increasing and is a major cause of morbidity and mortality among children (WHO, 2000; last, 1998; RoK, 2001).

2.1.2 Incubation period

A person does not develop AIDS as soon as he/she is infected with HIV, usually, there is a lengthy incubation period averaging 7-8 years during which the person may not show symptoms of infection (WHO, 1993). The person may be unaware of his/her status and therefore continue to spread the infection to others. For children, the incubation period is much shorter. Most children affected at birth develop AIDS and die within 2 years (Merger and Sunanda, 1993).

2.1.3 Clinical manifestation

The signs and symptoms of HIV/AIDS are varied and complex and include those of opportunistic infections as well as those caused by HIV itself (Last, 1998). Soon after becoming infected with HIV, some people develop the following: fever, enlarged lymph glands, skin rash and cough (WHO, 1994). The early response to infection is followed by a long symptom free interval, which may last for many years. As the immune system weakens, more signs and symptoms may develop. These include: Persistent diarrhoea, severe weight loss, fatigue, skin lesions and loss of appetite (WHO, 1993).

2.1.4 Treatment and vaccine development

AIDS has no cure (WHO, 1993). However, there are several drugs that are approved for the treatment of people with HIV infections or AIDS but their effectiveness are limited to embattling opportunistic infections that arise because of weakened immune system (RoK, 2000). They do not cure the HIV infection or prevent AIDS. Research on vaccines are going on in many laboratories around the world with few trails already in progress (WHO, 2000). However, there is no breakthrough yet. The drugs used for treatment of opportunistic infections include zidovudine, protease inhibitors and non-nucleoside analogues (WHO, 1993). They are usually quite expensive and beyond the reach of many infected people and affected (WHO, 1993).

2.1.5 Prevention and control strategies

HIV/AIDS is basically prevented and controlled through three major ways namely, abstinence from sex, faithful relationship with one partner and finally use of condom during sexual intercourse (Tuju, 1996; RoK, 2000). Abstinence from sex is naturally considered the most effective means amongst the three (RoK, 2000; Obiero et al., 2000). However, this practice is fast disappearing as societies continue to be sexually permissive (Tuju, 1996). Many young people consider abstinence as restrictive and difficult to practice. But when all is said and done, it remains apparently the most effective means of guarding oneself against HIV/AIDS (RoK, 2000).

The second in the line of defenses is a mutually faithful sexual relationship (Tuju, 1996). However, due to many social factors such as poverty, it is increasingly becoming difficult to maintain fidelity in such relationships (Tuju, 1996). Multiple sexual partners usually contribute to
higher risks of infection (Tuju, 1996; RoK, 2000). In the event of an individual failing to abstain from sex altogether or having an exclusive faithful relationship, he/she is bound to use condoms during sex to prevent against contracting HIV/AIDS (RoK, 2000). However, the condom has been met with resistance as its promotion has contributed to the increase in sexual activities among the youth (Barnett and Blaikie 1994). Thus, its availability and acceptance in most communities has been challenged (Tuju, 1996). This stems largely from religious and cultural factors (Barbara, 1998). Besides, the mode of transmission can also be curtailed to reduce risk (RoK, 2000). For instance, blood screening ensures the safety of blood before transfusion. Furthermore, expectant mothers should be screened for HIV/AIDS during their visit to the antenatal clinic to ascertain their status. This helps plan for mitigation to save the unborn child from contracting the virus (RoK, 2000; RoK, 2001).

2.2 Risk factors

2.2.1 Early sexual experience

A large number of the youth engage in sex at an age when they cannot fully realize the consequences of their action resulting in unwanted pregnancies, abortions and sexually transmitted disease including HIV/AIDS. This is complicated further by high frequency of changing sexual partners (AMREF, 1999; Obiero et al., 2000). Abstinence, a virtue promoted by moralists, seems to be disappearing and proving elusive as sexual activity increases among the adolescents (Mutasha et al., 2001; Onyango, 1999). Sexual debut among Kenyan youth is much earlier than their counterparts in other countries in Africa (Johnston, 2000; UNAIDS, 2003). According to the National Aids control council (2000), the maiden age for first sexual intercourse is 12 years for
girls and 13 years for boys (RoK, 2000). Young people are getting into intimacy with older men and women as the pressure for sex continue to be exerted by regular partners and peer regardless of the danger (Erulkar, 1999; Population council 1999). A study conducted among unmarried adolescents aged between 10-24 years in Central Kenya indicated that the maiden age for first sexual experience is 14.5 years for girls and 16 years for boys (Erulkar, 1999). The same study also revealed that 55% of the boys and 44% of girls had a romantic relationship with an opposite sex. This increases with age (Erulkar, 1998).

In another study conducted in Kisumu, it was found that 57% of unmarried girls aged between 15-19 years and 72% of boys in the same age group are sexually active (Chege, 1999). The situation is not different in other parts of the country. A study of four rural districts in Kenya (Kilifi, Kiambu, Siaya and Bungoma) reported that 75% of adolescent girls had their first sexual experience before the age of 16 (Illinigumugabo et al., 1995). Similar findings were also revealed in studies conducted among 10 to 24 year olds in Nyamira district, Kenya (Obiero et al.,2000). Another study conducted in Machakos district among church going youth revealed that more than half are sexually active with only 30.5% abstaining from sex completely (Wambua et al., 2001). Studies conducted in other parts of the world have also shown similar trends (Motashi et al., 2001; Robert et al., 2003). In Siaya and some parts of Western Kenya, the situation is exacerbated by the belief among older men that schoolgirls are HIV negative (Onyango, 1999). In most cases, young girls are infected by older men whom they engage in sexual relationship in return for financial reward (Tuju, 1996).
Due to the economic handicap, most parents are not able to provide requirements for their young daughters and sons demanded by them due to social and peer pressure as this is above their means (Tuju, 1996). The inability of parents to provide such requirement has made young girls to opt for the much older, and financially secure men (Erulkar 1999). With the advent of HIV/AIDS, the ultimate prices such girls pay for this reward is their lives (Merger and Sunanda, 1993).

A study by AMREF (1999), revealed that peer pressure, curiosity and the urge for pleasure are the factors cited by the young for engaging in early sex. Studies conducted in other parts among adolescents have revealed similar findings. (Motash et al., 2001; Nyembelea et al., 2001). Although most cultures condemn pre-marital sex, there are certain communities in Kenya, where premarital sex among young girls is encouraged as it is believed that it might prepare them for marriage (Tuju, 1996).

Although young people engage in sex early in their teens, meaningful approaches have not been put forward to reduce chances of infection. Educating the young people and trying to understand the reasons for engaging in unsafe sex in this era of HIV/AIDS needs thought. This study proposes youth friendly approaches that can curtail the spread of HIV/AIDS among this vulnerable group.

2.2.2 HIV/AIDS education and information

Despite the recognition of the need for education and communication to prevent HIV/AIDS, young people today still have limited opportunities to learn about the virus and topical issues on sex are not normally discussed with ease like any other subject. Ignorance on the part of the youth, the
inability of the parents, teachers and other stakeholder in the community to communicate properly and accurately to young people has made them engage in sexual adventures (Tabi for, 2000). While the importance of education in the fight against HIV/AIDS is widely recognized, many countries including Kenya either do not have AIDS education in their schools curriculum (Cleland and Ferry, 1998) or have only recently established the same. Even where they are taught, HIV/AIDS syllabus are totally inadequate to the needs of the young people as safer sex is not adequately covered and sometimes misunderstood (Population Communication Africa, 2002).

Traditional values and sexual taboos that once regulated sexual behavior among unmarried youth have been undermined. Similarly, traditional ways of educating the young people about sex have diminished or disappeared altogether. Hence the information available to young people is piecemeal. Even in schools, the information to advise to refrain from premarital sex without giving explanation as to why and how this can affect the pupils is limited. This has led to an information gap and inquisitive young people continue to solicit more information elsewhere (Onyango, 1999; Barbara, 1998; Tuju, 1996).

In the absence of reliable guidelines and information on sexuality from adults, many young people are determined to find out for themselves any information on sexuality. What they cannot find out from their own experience, they learn from peers, yet peers do not always give the most appropriate advice. Instead they mainly peddle rumors, myths and lies on sexuality (Nyembelea et al., 2001). Even when young people know something about HIV/AIDS, their knowledge is often shallow. For instance, studies have revealed that many adolescents still think that HIV/AIDS can
be transmitted in ways unrelated to known risks such as mosquito bites, sharing of eating utensils or drinking glasses (RoK, 2001). Peer education is essential in educating young people, as this will facilitate sharing of knowledge among peer members. It is important to get young people to participate actively in matters related to their reproductive health including education on information (Nyembele et al., 2001).

The role of parents in fight against HIV/AIDS among the youth has long been recognized. However, most parents believe that such discussion will encourage sexual experimentation (Tabifor, 2000). Even with such beliefs, the parents cannot afford to remain silent and watch the youth pay dearly for their failure to provide adequate and reliable information on youth sexuality. It is suggested that parents should strive to correctly answer questions on sexuality as their children grow and become more inquisitive. This is one of the challenges of living in the current changing times and the parents must accept the unfolding reality (Tabifor, 2000).

The situation is not different either in health programmes where campaigns are limited in terms of the information they discuss and disseminate. Information, Education and Communication (IEC) materials are general and do not address the need of adolescent and the youth but focus mainly on adults (RoK, 2000). Counseling which is an integral part in helping address and clarify changes in adolescence is not accessible to most of the youth (Wambua, 1998). Besides, the service providers usually lack youth friendly approaches that otherwise would have attracted them (Wambua, 1998). More often than not, adults are the beneficiaries of such services (Wambua, 1998). Hence, studies have noted that improving adolescents reproductive health is an important step in promoting good
health of the youth in particular and our country in general (Tuju, 1996). It is imperative that adequate and reliable information be made available for the youth in whichever way necessary to save the most vulnerable members of our community. Carrying out research and identifying the shortcoming on the view of the young people can provide useful information. This will help develop measures to improve dissemination of HIV/AIDS information to the youth.

2.2.3 Knowledge, attitude and practices
Awareness of HIV/AIDS is a necessary condition for behavior change and avoidance of risky sexual behaviors (RoK, 2000). However, many young people are unaware of what constitutes risky sexual behaviors that could expose them to HIV/AIDS infection (RoK, 2000). The few who understand such behaviour believe that they are invulnerable themselves reflecting a disturbing sense of vulnerability that many young people have today. Knowledge about the nature and transmission of HIV/AIDS is well over 90% among Kenyan youths (RoK, 2001). But perception towards chances of contracting the virus is disturbingly poor (Johnson, 2000). About 80% of young people of both sexes believe that they are not at risk at all (Johnston, 2000; RoK/NCPD, 1998). For instance, studies conducted in Machakos District in Kenya revealed that only 10.3% of the youth thought that there is high chance that they could be infected. 19.9% perceived of some chance of infection while against a background of low condom use, 52.4% said there was no chances of infection at all (AMREF, 1999).

More than 70% of young people continue to engage in risky sexual behavior (RoK/NCPD, 1998). Adolescents who deny such risks can ignore AIDS prevention messages, dismiss their relevance or
think they do not bear responsibility for protection. Thus, sexual behavior of peer groups especially among older adolescents has an effect on young people’s perception towards sexuality (Erulkar, 1999). When adolescents believe that their peers think that unprotected sex is not risky then they are more likely to have unprotected sex themselves (Erulkar, 1999; AMREF, 1999).

This study intended to unveil the reasons why young people continue to engage in risky sexual behavior despite the toll HIV/AIDS is having amongst young people. It is discouraging that the youth continue to perceive themselves as being invulnerable to HIV/AIDS and the underlying reasons can only be understood by carrying out studies of this nature.

2.2.4 Condom use

The use of condom is generally considered one of the most effective tools in the fight against HIV/AIDS (Tuju, 1996). However, the device has generated controversies and is seen by many as a morally and emotionally loaded term with connotation of illicit sex (Cleland and Ferry, 1998). For instance, religion and cultural values often discourage and prohibit the use of condom claiming that it is tantamount to accepting sexual promiscuity (Tuju, 1996). The Catholic and Islam faithful have been the most vocal in opposing the use of condoms (Tuju, 1996). For many abstinence may sound difficult and restrictive because an increasingly sexual permissive society has made it look so (Tuju, 1996). Despite these, condom remains the only alternative to save the youth from the epidemic. However, there are many obstacles to young people in obtaining condoms due to ignorance, disapproving parents, cost and poor attitudes of service providers (Wambua, 1998).
Whereas many young people recognize the importance of using condoms in preventing HIV/AIDS, very few of them know where to get it and therefore majority are not accessible to this important device (AMREF, 1999). A study conducted in Kisumu revealed that 18.8% and 33.9% of young people between 15 and 19 years and 20 and 24 years respectively know that condoms are obtained from retail outlet. An even smaller number of 18% and 15% from the same age groups respectively know that the device can be bought from shops (RoK/NCPD, 1998).

Another study conducted in Nyamira district among young people aged 15 to 25 years indicated low condom utilization (Nyagevu et al., 2001). This was associated with lack of information, complexity in terms of its use and inaccessibility of condoms. This trend is explained by the fact that most youths lack access to relevant information coupled with the cost involved in the purchase of condoms (RoK/NCPD, 1998). Where they are available for free in government institutions like hospitals, health centers and dispensaries, only few can gather the courage to ask for them. So strong is the stigma attached to its use that only a few can openly demand for it (Tuju, 1996).

The use of condom among the youth has further been complicated by the perception attached to its use, not in terms of its effectiveness, but in masking the "originality" of sexual intercourse. Many people say that using condom makes sex less enjoyable (Nyagevu et al., 2001; Tuju 1996). Even those who use condoms, do so in order to avoid unwanted pregnancies. But the advice is not selective and serves the dual purpose of not only avoiding unwanted pregnancies, but also against HIV infection (Tuju, 1996).

In a society where abstinence is now regarded as ancient (Tuju, 1996), promotion of condom use among the young people is the only alternative to prevent the HIV/AIDS scourge among the most
vulnerable group. Understanding the challenges that deter the youth from using or accessing condoms can only achieve this. This study unravels this and comes up with measures to promote the use and accessibility of condoms to the young people.

2.2.5 Substance abuse

There is scanty information on actual drug use and abuse in Kenya. For many adolescents, taking drugs, alcohol and sex are “rites of passage” (Erulkar, 1999). Besides institution of learning, the use of drugs and other addictive substance is on the rise especially among young people in urban areas (Mwenda et al., 2003; Cami and Farris, 2003). The use of drugs is directly associated with the inability of young people to make right decisions pertaining to their sexuality (Tuju, 1996). The high incidence of sexual activity among the youth has been related to drug abuse (Tuju, 1996).

Studies have shown that the use of drugs is associated with behaviour change and memory lapse (Cami and Farris, 2003). Besides, change in personality trait and mental disorders are the major conditioning factors in drug addiction (Cami and Farris, 2003). Drugs also contain a lot of chemicals that have different effects on the body mechanism (Mwenda et al., 2003).

A population based survey conducted among unmarried adolescents aged between 10-24 years in Nyeri and Nyandarua Districts of Central Kenya revealed that drug use was common among adolescents especially boys (Erulkar, 1999). The same study revealed that 38% of boys and 6% of girls smoke cigarettes, 38% boys and 14% of girls drink alcohol and 7% boys and 17% girls smoke marijuana (Erulkar, 1999). However, the magnitude of drug use may be different in major urban towns and cities in the country, where hard drugs such as mandrax, cocaine and heroine are
available to the youth (Erulkar, 1999). A study conducted among secondary school students in Nairobi also revealed similar findings with 58.6% of the boys and 17.9% of the girls involved in drugs (Kwamanga et al., 2003). The same study also revealed that kiosks, general shops and cigarette stalls are the major source of drugs to the young people. In Nigeria, studies on substance use among secondary school in rural and urban communities have also indicated similar findings (Fatoye and Mwakinyo, 2002). Studies have also revealed that youth engaged in drug use are likely than others of their age to have multiple sex partners (Chege, 1999). The social forums demanded of the drug users compound the problem. It is at such social places as cinemas, bars and discotheques that unsuspecting youth are introduced to hard drugs by established drug abusers culminating in further risks (Chege, 1999). Many young people are involved in drugs due to peer pressure and the easy availability of the same (Kwamanga et al., 2003). For long, non-conformity to traditional values and delinquency among the young people has been associated with drug abuse (PHEAD, 1994).

The use and sharing needles among intravenous drug abusers is common route of transmitting the HIV virus among these groups (RoK, 2001; Population Communication Africa, 1999). Most of the drugs and substances influence the users' ability to make right decisions within a short time of use and some even in small quantities (Tuju, 1996). The most commonly used drugs among young people in Kenya include alcohol, mandrax, marijuana (bhang), miraa and glue (Erulkar, 1999; PHEAD 1994)). It is now evident that the use of drugs increases sexual promiscuity among the youth (RoK/ NCPD, 1998).
Whereas it is now evident that drugs are common among the youth including those in learning institutions (Erulkar, 1999), little has been done to determine their sources and how to curtail the supply of such drugs to young people. This study identifies such sources and proposes how the youth can be protected from addictive drugs.

2.3 Rationale of the study

2.3.1 Statement of the problem

HIV/AIDS among the youth has reached alarming proportion. Out of over 60 million commulative infections worldwide in the past 20 years, half were acquired between the age of 15 and 24. Today nearly 12 million of the world’s total of 40 million people living with HIV/AIDS belong to this group (UNAIDS, 2002). The UNAIDS (2002) estimates that more that 5 million people became infected in 2001 alone with 3 million deaths in the same year. Besides, it is further estimated there 60% of new HIV/AIDS infection among women and 40% among men in the next five to six years will occur among those under 20 years of age (RoK/NCPD, 1998).

HIV/AIDS among the youth in Kenya in almost entirely a sexually transmitted infection with 90% of the infection acquired through sexual intercourse (RoK, 2001). Nearly 80% of young people in Kenya become sexually active before 20 years of age (Population Council; 1999, Chege, 1999). Casual and unplanned sexual intercourse continue to determine their sexual reality (Erulkar, 1999). This is worsened by a poor sense of vulnerability that many young people have as well as low utilization of condom. The use of drugs have also been associated with inability of young people to make rational decisions culminating in risks that they regret when they sober up (Tuju, 1996).
Studies have shown that drugs such as alcohol, tobacco, prescription drugs, bhang and heroin are commonly used by young people in learning institutions (Fatoye and Mwakinyo, 2002; Kwashanga et al., 2003).

With the collapse of social bonds and traditions that used to shape young people’s behavior due to urbanization and new attitudes towards sexuality, many young people are more sexually active but without adequate information (Wambua, 1998). Sex education in school curriculum is inadequate and misunderstood (Population Communication Africa, 2002). Several young people have fallen victims of this information gap leading to early sexual experience with multiple sexual partners (Tuju, 1996). Societies often compound young people’s risk by making it difficult for them to learn about HIV/AIDS and reproductive health (Erulkar, 1999).

AIDS is now largely a disease of deprivation with the economic background of individuals playing a major role. Powerful association have been noted between health and absolute lack of economic resource (Paula and Sofia, 2003). For many poor people, the health damaging effects of the economy has implications on their vulnerability to HIV/AIDS (Paula and Sofia, 2003). In a climate of deprivation, young people especially young women are particularly at risk as they are more likely to have sexual experience than those from better family environment. (Tuju, 1996). The study area has a fast rising HIV/AIDS which rose from 7% in 1996 to 11% in 2001 (RoK, 2002b). The district has a very low awareness of the pandemic due to illiteracy and denial of the disease and some prevention measures (RoK, 2002b).
Therefore, it was important to carry out such a study to be able to understand further the social, economic and cultural factors that influence transmission of HIV among the youth.

2.3.2 Research questions

1. What are the socio-economic and behavioral factors that influence the youth to engage in early sex?
2. What is the relationship between knowledge and attitudes about HIV/AIDS and perception of vulnerability?
3. What behavioral factors influence vulnerability to HIV/AIDS infection among the youths?
4. Are the youth adequately involved in the prevention and control of HIV/AIDS?

2.3.3 Justification of the study

Although HIV/AIDS has already caused the death of millions of young people, the pandemic still remains elusive to adults and to young people alike. There seems to be a misconception among the adolescents that the disease actually attacks grown-ups only. This is largely due to the fact that people who testify about positive sero- status are mostly adults and the public only focuses on their current status. This has led to the assumption that people who get infected are older, have sex with prostitutes, or are simply unfortunate, prompting the young to engage in unsafe sex.

Whereas adolescence increase vulnerability to HIV/AIDS, the risk of the disease may be particularly hard for young people to grasp. Since HIV/AIDS has long incubation period, a person’s risky behavior does not have immediate apparent consequences. Thus, many young
people may overlook the fact that majority of people with HIV/AIDS today may actually have contracted the disease as early as their teens. Most of the studies already conducted mainly focus on the knowledge of existence of HIV/AIDS and the mode of transmission. Rarely do they question the knowledge about the incubation period of the disease, a fact that could as well obscure the possible time that one was infected hence the notion of invulnerability among the youth. Therefore, establishing the correct perception of the youth, as this study did, will assist in formulating education and information materials that are suitable to the needs of the youth.

2.4. Hypothesis

Socio-economic and behavioral factors do not determine vulnerability to HIV/AIDS among the youth.

2.5 Objectives of the study

2.5.1 General objective

To establish the socio-economic and behavioral factors that influence transmission of HIV/AIDS among school and college going youth.

2.5.2 Specific objectives

a) To identify the socio-economic and behavioral factors that influence the youth to engage in early sex.

b) To investigate the relationship between knowledge and attitude on HIV/AIDS on one hand, and perception of vulnerability to infection on the other hand.
c) To establish the extent of condom use, substance abuse and risky sexual behavior that influence vulnerability to HIV/AIDS infection.

d) To establish the involvement of the youth in the prevention and control of HIV/AIDS.
CHAPTER THREE

MATERIALS AND METHODS

3.1 Study area

The study was carried out in selected secondary schools and colleges in Central Division of Garissa District, in Kenya. The District is one of the four forming the vast North Eastern province. It borders the Republic of Somali to the East, Wajir District to the North, Tana River to the West and Lamu to the South (Fig 1).

The District is semi arid except for the western part, which borders the River Tana. It depends entirely on unreliable and erratic rainfall. According to the last population census, the District has a population of 395,000 people (RoK, 2002a). The central Division has the largest population of about 70,000 people. Besides, the district harbors three major refugee camps with a population of about 130,000 (RoK, 2002a). The inhabitants of the district are entirely pastoralists except for those farming along the river. With the persistent droughts, most residents have been reduced to dependency on food handouts from the Kenya Government and Non Government Organizations. This is coupled with insecurity that stems largely from the neighboring country.

Health services in the District are not adequate with the Provincial General Hospital being the only referral institution. Besides, it is the only facility where HIV/AIDS testing is conducted. With the absence of mobile testing and voluntary counseling and testing centers, many people have no access to these services. Due to the cultural stigma attached to HIV/AIDS, many people showing the signs of disease may never seek hospital treatment nor report the same.
Fig. 1: Map of the study area
The Division has the highest concentration of secondary schools and colleges in the district. In fact, the only two girls’ schools in the district are in the division. Whereas the secondary schools have a large number of local students, the colleges are more cosmopolitan.

3.2 Study population

3.2.1 Inclusion criteria
The study was carried out among selected secondary schools and colleges in central division, Garissa District. The work covered students of both sexes under the age bracket of 15 to 24 years and not married. Only students who gave consent to participate in the study were involved irrespective of their religion and ethnic background.

3.2.2 Exclusion criteria
All the students in the sampled secondary schools and colleges not falling under the required age bracket and/or are married were excluded from the study. Students who did not give consent to participate were also exempted from the study.

3.3 Ethical consideration
Approval to do the study and visit the schools and colleges to participate was obtained from the Ministry of Education Science and Technology. At the district level, permission was sought from the local District Commissioner and the District Education Officer, who in effect informed the respective schools and colleges heads of the intended study.
The purpose of the study was communicated to the students who were informed that participation was voluntary and subject to their consent. The sampled students were at liberty to withdraw from the study as some of them did, without being victimized. Making the giving of names optional ensured confidentiality of the information given by the participants. This way, information or responses obtained could not be related to specific participants.

3.4 Sample size and sampling methods

The study was carried out in secondary schools and colleges with a proposed sample size of 400 respondents. The sample size was obtained by using the formula as given by Fisher et al., (1998) (Hickey, 1986). This was divided equally between schools and colleges thus 200 respondents for secondary and colleges respectively. A total of 389 respondents were interviewed (Table I) while 11 participants withdrew during the actual process of the interview, citing various reasons.

Four secondary schools and three colleges were randomly selected to participate in the study. This was done by giving numbers to all secondary schools and colleges in the division and then picking the desired number. These were: Garissa Secondary School, County High School, NEP Girls Secondary School, Umul-Salama Secondary School, NEP Technical College, Garissa Medical Training Center and Garissa Teachers College. Since some of the schools and colleges had a higher enrollment than others, proportional to size was the first method of sampling used. This was done commensurate to the enrolment of respective institutions so as to make sure that schools and colleges with higher enrolment had more students participating in the study. The respondents
were divided into two strata of different age groups of 15 to 19 years and 20 to 24 years. Cluster sampling (Hickey, 1986) was then used to identify specific classes within different schools and colleges to participate in the study. Finally, simple random sampling was used to identify specific students from the classes earlier identified in the cluster sampling to participate in the study using random numbers. The selected respondents were then subjected to interview and participated in focus group discussions.

3.5 Data collection

Various methods of data collection were used in the study to obtain the desired information from the participants. Before the actual process of data collection begun, three research assistants were recruited to assist in the process. The recruitment was based on their experience on data collection. The same were subjected to a one day training seminar and eventually participated in the actual fieldwork. The selected students were subjected to interview using structured questionnaires that were pre-coded. The interviews were carried out in their respective schools and colleges. Key informants were also interviewed, but unlike the students, their participation was based on either their role on HIV/AIDS prevention in the community and/or school and their contact with the students. The interviews with the key informants were conducted in their respective offices after obtaining appointments. A total of twelve key informants drawn from different departments and professions were involved.

Finally, focus group discussions (Hickey, 1986) were conducted to generate interactive response from the different people who participated in the study. Two such discussions were held with
group members of 14 and 15 respectively and participants drawn from different schools and colleges, and other professions. During both sessions, the discussions were radio taped.

3.6 Data analysis

At the end of the study, the pre-coded data was analyzed using the software Statistical Package for Social Sciences (SPSS) version 10 (Taylor, 2001). This is a statistical package with different statistical methods for data analysis that can be used in line with the kind of data available or the variables to be analyzed. For this study, dependent and independent variables were compared using Chi square. This was used to establish relationships between such variables as knowledge, involvement in drugs and sexual experience against educational level and age groups. Where necessary, means were also calculated. In the text, graphs and tables are used to present results in summary.
<table>
<thead>
<tr>
<th>School/ college</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Garissa Secondary School</td>
<td>52</td>
</tr>
<tr>
<td>County High School</td>
<td>46</td>
</tr>
<tr>
<td>Umulsalama Secondary School</td>
<td>53</td>
</tr>
<tr>
<td>NEP Girls Secondary School</td>
<td>46</td>
</tr>
<tr>
<td>Garissa Medical Training Centre</td>
<td>45</td>
</tr>
<tr>
<td>NEP Technical College</td>
<td>16</td>
</tr>
<tr>
<td>Garissa Teachers Training College</td>
<td>131</td>
</tr>
<tr>
<td>TOTAL</td>
<td>389</td>
</tr>
</tbody>
</table>
CHAPTER 4

RESULTS

4.1 Demographic characteristic
A total of 389 respondents were involved in the study. This constituted 199 (51.2%) male and 190 (48.8%) female participants. About 56% of the participants were aged between 15-19 years while 44% were aged between 20-24 years. Since the study was carried out among schools and college going youth, 197 participants were drawn from the former and the remaining 192 from colleges (Table I). The results of the study indicate that 65.6% of the respondents receive less than Kshs. 1000 as monthly pocket money from their parents. Only 2.8% receive above Kshs. 4000 with 6.2% between Kshs. 3000 and 4000 and the remaining 25.4% between Kshs. 1000 and 2000. The result also indicate that 64.3% of the respondents were Muslim while the remaining 35.7% were Christians.

4.2 Knowledge, practice, behaviour and perception
There exist disparities on knowledge about the nature and transmission of HIV/AIDS, as well as perception towards vulnerability especially among different age groups and education level. Virtually all the respondents have heard of HIV/AIDS but only 55% consider the disease as a major health problem in the community. Majority (71%) has heard of the disease through their teachers, 11.1% through friends, 10% through mosques/ churches and only 3.9% through their parents. The remaining 41% have heard the disease through the mass media.
4.2.1 Knowledge on transmission and incubation period of HIV/AIDS

As shown in Fig 2, a large number of the youth still believe that HIV/AIDS can be transmitted in ways unrelated to known risks such as shaking hands (28%) and sharing utensils (38.8%). Sexual intercourse was mentioned by the majority of the respondents (98.7%) as the main source of infection. Other modes of transmission mentioned included blood transfusion (69.7%), mother to child transmission (47.8%) and unsterilised instruments (72.2%).

The study findings indicated that 220 (56.6%) of the respondents interviewed mentioned that they do not know the incubation period of the disease. Only 49 (12.6%) mentioned the likely incubation period of 7-8 years and a fraction 17.2% thought the incubation period to be 1-3 years (Table 2).

4.2.2 Knowledge on prevention and treatment of HIV/AIDS

Some 98.2% of respondents mentioned abstinence from sex as a preventive measure. Perhaps to emphasise their attachment to religion, 78.9% mentioned adhering to one’s religion as preventive measure. The least number of respondents (53.5%) mentioned the use of condom. Other preventive measures mentioned were; being faithful to one partner (74.5%) and screening of blood before transfusion (64.8%). It is disturbing to note that the results indicated some 11.5% (55) of the respondents believe there is treatment for HIV/AIDS. 7.7% mentioned that traditional/herbal medicine can treat the virus, while spiritual healing and camel’s urine and milk were mentioned by 9.0% and 7.2% respectively (Table 3).
Table 2. : Knowledge on incubation period

<table>
<thead>
<tr>
<th>Incubation period</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 yrs</td>
<td>67</td>
<td>17.2</td>
</tr>
<tr>
<td>4-6 yrs</td>
<td>53</td>
<td>13.6</td>
</tr>
<tr>
<td>7-8 yrs</td>
<td>49</td>
<td>12.6</td>
</tr>
<tr>
<td>Don’t know</td>
<td>220</td>
<td>56.6</td>
</tr>
<tr>
<td>Total</td>
<td>389</td>
<td>100</td>
</tr>
</tbody>
</table>
Sexual intercourse

Blood transfusion

Mother to child

Un sterilized instruments

Sharing utensils

Shaking hands

Deep kisses

Percentage

0 10 20 30 40 50 60 70 80 90 100

Figure 2: Knowledge on mode of transmission
As shown in Table 4, there was a significant relationship between age groups and perceptions on the existence of treatment for HIV/AIDS. It is amazing to note that more students aged between 15-19 years believed that there is no cure as compared to those aged between 20 – 24 years. There was equally a relationship in terms of educational level ($\chi^2 = 1.105; df=1; p<0.05$), where more students in the colleges mentioned the existence of treatments for HIV/AIDS as compared to fewer students in the secondary school.

4.2.3 Cultural practices predisposing individuals to HIV/AIDS

On the community’s predisposing cultural practices, 44.5% of the respondents could not mention any. However the remaining 55.5% of the respondents were able to name some of the cultural practices which they believe are associated with the spread of the HIV/AIDS. As shown in table 5, the common practices mentioned are wife inheritance (38.3%), circumcision (40.9%), polygamy (32.4), traditional dental extraction (18.8%) and traditional plays (14.4%). The latter refers to plays usually conducted during the night and mostly involved unmarried people. However, these plays are more common among the actual pastoral families than those settled in urban or peri-urban centres.

The results indicate that there was a significant relationship between knowledge on cultural practice predisposing to HIV/AIDS and level of education ($\chi^2 = 49.249; df=1; p<0.001$). This indicates that more students in the colleges were able to identify such cultural practices as compared to those in secondary school. This means knowledge on such practices increases with
level of education. However there was no significant difference in terms of age groups ($\chi^2 = 7.129; \text{df}=1; p=0.68$) and gender ($\chi^2 = 6.244; \text{df}=1; p=>0.05$).

4.2.4 Behaviour change and perception on vulnerability

Some 46.5% of the respondents interviewed mentioned prostitutes are likely to get infected with HIV/AIDS than anyone else. However, 43% mentioned that anyone could get infected while only 6.9% thought that young people are vulnerable. Adults and married couples were also mentioned as been vulnerable by 1.8% and 1.3% respectively. On individual perception, 50.4 believe that they are not vulnerable to infection compared to 49.0% who believe they can contract the diseases. Despite the poor sense of vulnerability that the majority have, 58.8% mentioned that they intend to make behavioural changes in the future compared to 41.2% who stated that they do not intend to make such changes. The behavioural changes mentioned are abstaining from sex (45.5%), avoiding relationship which might lead to sex (34.7%), marrying as soon as possible (30.8%), remaining faithful to one partner (36.2%) and finally, avoiding drugs (33.2%).

The findings indicate that perception on one’s vulnerability increases with the educational level. Chi-square test revealed that there was a significant difference between the two as more students in the colleges believed they are vulnerable to infection than those in secondary schools ($\chi^2 = 7.229, \text{df}=1, p<0.05$).
<table>
<thead>
<tr>
<th>Treatment</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No treatment</td>
<td>345</td>
<td>88.7</td>
</tr>
<tr>
<td>Herbal medicine</td>
<td>30</td>
<td>7.7</td>
</tr>
<tr>
<td>Spiritual healing</td>
<td>35</td>
<td>9</td>
</tr>
<tr>
<td>Camel milk and urine</td>
<td>28</td>
<td>7.2</td>
</tr>
</tbody>
</table>
Table 4: Relationship between perception on treatment and age groups

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19 years</td>
<td>18</td>
<td>200</td>
<td>218</td>
</tr>
<tr>
<td>20-24 years</td>
<td>26</td>
<td>145</td>
<td>171</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>345</td>
<td>389</td>
</tr>
</tbody>
</table>

$\chi^2 = 4.611; df=1; p<0.05$
Table 5: Cultural Practices predisposing individuals to HIV/AIDS

<table>
<thead>
<tr>
<th>Cultural practices</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife inheritance</td>
<td>149</td>
<td>38.3</td>
</tr>
<tr>
<td>Circumcision</td>
<td>159</td>
<td>40.9</td>
</tr>
<tr>
<td>Polygamy</td>
<td>126</td>
<td>32.4</td>
</tr>
<tr>
<td>Traditional dental extraction</td>
<td>73</td>
<td>18.8</td>
</tr>
<tr>
<td>Traditional plays</td>
<td>56</td>
<td>14.4</td>
</tr>
</tbody>
</table>

N= 389
4.2.5 Sexual experience and relationship

The results of the study indicate that 42.2% of the boys and 20.5% of the girls are sexually active. This accounts for some 31.6% of the total respondents. This means that the majority of the respondents (68.4%) have maintained complete abstinence. The mean age for first sexual involvement is 14.5 years. Various factors were mentioned by those involved in sex as driving factor to commit the act. Peer pressure was the major factor as was mentioned by 45.5% of those engaged in sex. Curiosity (26%) and leisure (23.8%) followed respectively. Other factors, though mentioned by few, were financial gains (3.25%) and gifts (1.8%) (Table 6).

About 47% of the respondents had multiple friends of opposite sex, out of which 40% had had sexual partners. The mean average of sexual partners was 1.33. Out of the 73 (18.8%) respondents who engage in sex with their partners 43 (58.9%) used condoms while the remaining 30 (41.1%) did not. The latter group mentioned various reasons why they did not use condoms. These included prevention of pregnancies and HIV/AIDS (73.3%), condoms obscure the leisure sex is supposed to provide (83.3%) and that condoms are not accessible (63.3%). About 25.6% (11), all girls, mentioned that their boyfriends detests the use of condoms.

Involvement in sex increased with age. This was revealed by the chi-square analysis, which indicate that more students aged between 20-24 years involve in sex than those aged between 15 – 19 years. The findings point out that there is a significant relationship between involvement in sex
and age groups ($\chi^2 = 9.366; \text{df}=1; p<0.05$). Significant relationship was also revealed between gender and involvement in sex ($\chi^2 = 20.14; \text{df}=1; p<0.01$). This indicates that male students are more sexually active than female.

4.3 Condom use

4.3.1 Sources and accessibility of condoms

As shown in Fig 3, shops, hospitals, kiosks, private chemists/ pharmacies were mentioned as sources of condoms in the community. However, 26.2% of the respondents stated that they did not know of any source.

The accessibility of condoms to young people despite its availability still remain a problem. About 47.6% of the respondents indicated that condoms are not easily accessible to the majority of young people and a further 61.7% indicated that there were problems that deter accessibility to condoms. The respondents mentioned various factors as contributing to the inaccessibility. This includes religion and cultural factors (48.1%), few number of shops selling condoms (11.5%), ignorance among young people on where to get condoms (37.3%) among others (Table 7).
Table 6: Reasons for engaging in sex

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer pressure</td>
<td>56</td>
<td>45.5</td>
</tr>
<tr>
<td>Leisure</td>
<td>29</td>
<td>23.6</td>
</tr>
<tr>
<td>Financial gains</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td>Gifts</td>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>Curiosity</td>
<td>32</td>
<td>26</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>123</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Table 7: Problems that deter youth from accessing condoms

<table>
<thead>
<tr>
<th>Problems</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial constraints</td>
<td>176</td>
<td>45.2</td>
</tr>
<tr>
<td>Religious and cultural barriers</td>
<td>187</td>
<td>48.1</td>
</tr>
<tr>
<td>Inaccessibility to condoms</td>
<td>144</td>
<td>37</td>
</tr>
<tr>
<td>Seller/providers attitude</td>
<td>143</td>
<td>36.8</td>
</tr>
<tr>
<td>Ignorance</td>
<td>145</td>
<td>37.3</td>
</tr>
</tbody>
</table>

N=398
Fig. 3: Sources of Condoms

[Bar chart showing the percentage of responses for different sources of condoms]

- Don't know: 26.2%
- Shops: 38.6%
- Hospital: 50.1%
- Kiosks: 38.7%
- Chemists/pharmacies: 26.7%
4.3.2 Perception on condoms effectiveness

The results of the study indicated that 75% of the respondents believe that condoms are not effective in preventing its users from contracting the virus. Among the 97 respondents who reported that condoms can protect against HIV/AIDS, (73%) mentioned that it reduces chances of infection to HIV virus. Some 75 of these respondents stated that condoms protect against other forms of STIs, thus reducing chances of contracting HIV/ Virus.

The respondents gave various reasons for condom ineffectiveness. Among these is that condoms are not 100% effective and can burst during sexual act. Others noted that condoms are of poor quality and that they have holes through which the virus could pass through (Table 8).

Perception on condom effectiveness changed with age. From the analysis it was revealed that there is significant relationship between such perception and age groups ($\chi^2 =13.153; \text{df}=1; p<0.01$). Most of the students aged between 20-24 years believe that condoms can protect against HIV/AIDS compared to a fewer number of students aged between 15-19 years.

About 58.6% of the students interviewed believe that the financial ability of the young people affects their use of condoms. Whereas the 41.4% who believed otherwise indicated that condoms are provided free at hospitals (62.5%) and sold at cheap prices at kiosks and shops (70.1%), the rest believe that financial ability affects condom use among the youth. They mentioned that free condoms are rare (65.5%) and that young people who involve in unprotected sex do not have money to buy condoms (59.3%).
Table 8: Reasons given for condom ineffectiveness in preventing HIV/AIDS

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not 100% effective</td>
<td>233</td>
<td>59.9</td>
</tr>
<tr>
<td>Too big for young people (Size)</td>
<td>73</td>
<td>18.8</td>
</tr>
<tr>
<td>Poor quality</td>
<td>165</td>
<td>42.4</td>
</tr>
<tr>
<td>Burst during sexual intercourse</td>
<td>192</td>
<td>49.4</td>
</tr>
<tr>
<td>Has pores</td>
<td>191</td>
<td>49.1</td>
</tr>
</tbody>
</table>

N=389
4.4 Drug and drug involvement

4.4.1 Common drugs and sources

Common drugs available to young people as was indicated by those interviewed are miraa (89.2%), alcohol (71%), bhang (73.5%), cigarettes (65.8%), prescription drugs (50.1%) and heroin (29.5%).

42.7% of the respondents mentioned teachers as one of the sources of drugs to students. Other sources of such drugs are friends (82.5%), kiosks (58.1%), hospitals / clinics (55.8%), private chemists and pharmacies (50%) and street hawkers (46.5%).

4.4.2 Involvement in drugs and its effect on the youth

Out of the 389 respondents interviewed, only 58 (14.9%) were involved in drugs. This includes 23.1% of the boys and 6.3% of the girls in the study. Out of this, 48 (82.7%) were introduced to drugs by their friends and the remaining number by their teachers. The result of this study indicates that the mean age for introduction to drugs is 16 years.

As shown on table 9, those involved in drugs use a variety of substances and at times a combination of more than one drug.

The respondents gave various effects of drugs to young people. 71.5% stated that drugs affect the performance in terms of education of its users while 61.7% mentioned the inability to make rational decision among drug users as one of its effects. Other effects of drugs mentioned were
dropping out of school (57.6%), increased immorality (59.9%), indiscipline (59.1%), behaviour change (40.6%) and general health impairments (53.7%).

The involvement in drugs increases with the educational level. This is evidenced by the chi-square results, which indicated relationship between the two. More students in colleges involve in drugs as compared to those in secondary schools. Alternatively, a bigger number of students in Secondary School abstain from drugs as opposed to their fellow students in the colleges ($\chi^2=8.722$, df=1, $p<0.05$). However, the results also indicate no relationship between age groups and drugs ($\chi^2=3.477$, df=1, $p>0.05$) and monthly income (pocket money) and drugs use ($\chi^2=2.611$, df=3, $p=4.56$). The results also revealed a relationship between gender and involvement of drugs ($\chi^2=29.115$, df=1; $p<0.01$). This indicated that more male students than female were involved in drugs.

### 4.4.3 Economic background and the involvement of drugs

Majority (69.2%) of the respondents indicated that the economic background of individuals determine their involvement in drugs. Another 54.5% stated that youth from rich families are more likely to be involved in drugs. Some 41.9% pointed out that young people from poor families are likely to be involved in drugs to relieve family pressure and / or frustration. However, out the 30.8% that remained, 18.8% indicated that youth involve in drugs irrespective of their family backgrounds. The remaining (20.1%) respondents indicated that friends always provided drugs thus no relationship with one’s family financial background.
Table 9: Commonly used drugs

<table>
<thead>
<tr>
<th>Drugs used</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miraa and prescription drugs</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>Miraa only</td>
<td>19</td>
<td>32.8</td>
</tr>
<tr>
<td>Alcohol only</td>
<td>8</td>
<td>13.8</td>
</tr>
<tr>
<td>Miraa, cigarette and bhang</td>
<td>5</td>
<td>8.6</td>
</tr>
<tr>
<td>Alcohol and cigarettes</td>
<td>5</td>
<td>8.6</td>
</tr>
<tr>
<td>Miraa and cigarettes</td>
<td>6</td>
<td>10.3</td>
</tr>
<tr>
<td>Alcohol, cigarettes and bhang/miraa</td>
<td>4</td>
<td>6.9</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100</td>
</tr>
</tbody>
</table>
4.5 HIV/AIDS prevention and control strategies

4.5.1 Knowledge on existing intervention strategies

Majority (62.5%) of the respondents said they do not know of any existing HIV/AIDS intervention strategy. However, the remaining 37.5% who said they know of such interventions could only mention three. These were abstinence for sex (34%), being faithful to one partner (60%) and use of condoms (28.5%).

4.5.2 Involvement of youth in the prevention and control of HIV/AIDS

Majority (76.8%) of the respondents did not belong to any organisation dealing with HIV/AIDS either in their institution and/or communities. However, 17% belong to health or HIV/AIDS clubs in their respective institutions and a further 2.8% in both such clubs and CBO in their community. Some 4.1% of the respondents are members of such organisations in their communities only. About 58% believe that young people are not adequately involved in the fight against HIV/AIDS and proposed ways in which the same can be improved. These include active involvement of young people in HIV/AIDS control committees, promotion of peer education and the involvement of religious clubs in institutions in the HIV/AIDS prevention. The remaining 42% indicated that although a few youth are involved in the prevention and control of HIV/AIDS, their participation is peripheral. They stated that they are involved only as members (26%) and sometimes in peer education (26.7%). However, very few of them are involved in the latter.
The results indicate that there is a significant relationship between involvement with HIV/AIDS prevention and control groups or organizations and educational levels ($\chi^2=37.301; \text{df}=1; p<0.001$). It is revealed that students in colleges are mostly involved in organisations / groups dealing with HIV/AIDS either in their respective institutions and/or community based organisations. On the contrary, a very small number of secondary students are involved in such community-based organisations. Perhaps this stems from the fact that not a single secondary school, among those participating in the study, had a health or HIV/AIDS club. There was an equally significant relationship between involvement in such organisations and age groups ($\chi^2 = 22.105; \text{df}=1; p<0.001$). Students aged between 20-24 years are mostly involved in HIV/AIDS prevention as compared to those aged between 15-19 years. This shows that such involvement with HIV/AIDS organisation increase with age.
CHAPTER FIVE

DISCUSSION

HIV/AIDS among the youth is a real concern to policy makers especially in the prevention and control of the situation. However, there exists enormous disparity between actual facts about HIV/AIDS and the knowledge on the same by vulnerable groups (Tuju, 1996). It is imperative to reduce this gap in order to tackle the disease. This begins by understanding the scope of knowledge possessed by the young people as well as how best this can be improved in an atmosphere that suits and values young people’s perception and behaviour vis a vis their cultural settings. It is important to note that young people from different cultural settings have different concepts towards vulnerability as well as sexual behaviour. This is largely because their cultural and more importantly, religious background plays a major role in shaping their lifestyle as well as perception towards sex and other behaviour.

In the prevention and control of HIV/AIDS, policies towards youth often reflect adult views of what young people should and should not be doing, not what young people should do. For the prevention and control of HIV/AIDS to succeed among the youth, they must be given a chance to play an integral part as resource persons central to their cultural surroundings. At the moment, their involvement is peripheral and limited only to being members of organisations dealing with the prevention and control of HIV/AIDS without regard to their crucial role in suggesting youth friendly approaches.
5.1 Knowledge, practice and perception

Knowledge about HIV/AIDS plays an important role in the prevention and control of the disease as well as behaviour change. It is important note that there exist disparities in many aspects of the disease (Tuju, 1996). The results of this study revealed that whereas the entire respondents have heard of the disease, a fairly high percentage (55%) believe that it is a major health problem in the community compared to the majority (87%) who believe that it is a global disaster. However, during the focus group discussion, participants acknowledged that the disease is gradually becoming a health concern in a community that was long viewed as safe and therefore the need to address the same.

The knowledge on the disease transmission, especially among the youth has always been limited (Tuju, 1998). Many young people still believe that HIV/AIDS can be transmitted in ways unrelated to known facts (Tuju, 1998). The results of this study is not exceptional, with a good percentage (38.8%) believing that shaking hands can transmit the disease from an infected individual to another. Another 26% believe that sharing utensils can equally transmit the virus. However, majority (98.7%) mentioned sexual intercourse as the main mode of transmission. According to the WHO (1993), sexual intercourse is the single most leading mode of transmission with more than 80% of the worlds total HIV/AIDS cases contacted through sexual contact.
The long incubation period of the disease probably plays a role among young people’s understanding of their vulnerability. A fairly high number (56%) of the respondents interviewed mentioned that they do not know the incubation period of the disease. In fact, a fairly small proportion of only 12.8% mentioned the correct period of 7-8 years (WHO, 1993), with 17.2% stating that it is between 1-3 years. The incubation period of the disease has always obscured the probable time one was likely affected. This has led to the misconception that the disease actually attacks grown-ups only or rather prostitutes as was mentioned during the focus group discussion. Asked whether this affected their perception on their vulnerability, the participants acknowledged this limitation and stated that many expect the signs and symptoms of the disease to appear as soon as one is exposed to the virus. This perception is perhaps attributed to the fact that most people who testify about their status actually do so when adults (Tuju, 1998). This misunderstanding has prompted young people to engage in unsafe sexual behaviour hoping to change when they grow up, which is sometimes too late. More than half of the people living with AIDS today may actually have contracted the disease in their teens. This problem was attributed to lack of enough knowledge on the nature and transmission of the disease during the focus group discussion.

According to one participant, HIV/AIDS education emphasizes on condom promotion and sex issues forgetting the equally important issues of transmission and incubation period, which are crucial in behaviour changes. The head of one of the local Community Based Organizations (CBO) acknowledged this but quickly added that very few members of his organisation actually understood the incubation period themselves. He attributed this to selective activities of trainers. This point emphasises further the gap in terms of knowledge on HIV/AIDS. If members of
organisations dealing with HIV/AIDS are lacking information about the disease, one is left to wonder how much they can communicate to their target groups. A teacher in one of the secondary schools blamed the district HIV/AIDS co-ordinator and other NGOs dealing with the disease for training illiterate people. He claimed that most local CBOs are led by unqualified or semiliterate individuals who could not only fail to address the target group, but are likely to misinform them. Cabrera et al., (1996) acknowledges that most of the small community based groups suffer from lack of technical skills and are often led by semi literate people. This may well have contributed to the larger failure to communicate properly to the people. Cultural backgrounds of communities equally play an important role in shaping peoples understanding in matters pertaining their environment. Although there are various cultural practices that facilitate the spread of HIV/AIDS, very few members of such communities will accept any association between their practice and HIV/AIDS (Tuju, 1996).

According to the results of this study, a good proportion (44.5%) of the respondents could not mention any of their own cultural practices that can be associated with the spread of the disease. However, the remaining proportion (55.5%) gave a number of such practices. These include wife inheritance, circumcision, polygamy and traditional dental extraction. It is imperative to recognise that some of these cultural practices have attachment to people’s religious beliefs. This makes them hard to discard. Among the Muslim community, who are the majority in the study group, polygamy is enshrined in their Islamic teachings. There has been long standing debate that some of these cultural practices do not directly spread the infection and that it is wrong to term them so.
Issues such as polygamy and wife inheritance are difficult to discard considering their social benefits that shroud such marriages. According to Tuju (1998), the association between polygamy and HIV/AIDS remains elusive, as long as members of a polygamous family remain within the parameters of their marriage and they are considered not at risk of contracting HIV/AIDS as well other STIs. The argument has always been that these practices do not directly cause the disease and that it is wrong to talk against them.

According to one participant in the focus group discussions, it is unprotected sex and not the mere act of polygamy or inheriting wives that cause the disease. He continued that communities with such practices should be educated about being faithful to their partners without disregarding their cultural and religious lifestyles. Participants argued that the mere association of such practices to a disease regarded to be for the immoral makes people view HIV/AIDS control programmes as culture insensitive. It is important to make such communities understand that in case of unfaithfulness a polygamous family stands higher chances of risk of infection. This stems largely from the multiple wives involved. The same applies to wife inheritance in regard to its social purpose.

However, it is important to understand that not only do cultures have certain practices which might aid the transmission of HIV/AIDS, but they also corrupt people’s perception on other issues. For instance, 11.3% of the respondents believe that the disease can be cured. This perhaps emphasises on how much cultural belief can mislead. About 7.7% of the respondents mentioned that herbal medicine could cure the disease. The camel is revered among the Cushites who place great value
to its milk. It is therefore not surprising that 7.2% of the respondents believe that camel’s milk and urine can cure the disease. Whereas there is no scientific proof to these allegations, it requires an enormous task of education to change these perceptions. An even bigger number of participants (9%) believe that spiritual healing can cure. In a community where such beliefs exist among its members it is even a bigger challenge to convince them that these cultural beliefs do not hold water. Even among the educated, such beliefs are strong. A religious teacher in one of the secondary schools clearly stated that camel’s urine and milk do cure HIV/AIDS. This perhaps emphasis the lack of adequate knowledge on HIV/AIDS treatment. Efforts must be made, using various media channels, to change this attitude through disseminating correct information.

It is clear from the current study that the mass media plays a crucial role in disseminating wrong information. During the FGD, participants pointed out that they had read advertisement in newspapers where traditional herbalist claim to cure HIV/AIDS. It is such advertisements, which no one has come out to challenge, that perhaps, influenced the participants beliefs that herbal medicine cures HIV/AIDS.

There are regulatory bodies dealing with health issues that should have vetted such advertisements. The participants pointed out that such advertisements make no reference to curing only the opportunistic diseases but rather the real HIV/AIDS. They suggested that a ministry of health statement should accompany such advertisements, otherwise they stand to mislead people.

5.2 Sexual experience and relationships
Many studies have revealed that a large number of young people engage in sex at an age when they cannot fully appreciate the consequences of their action (Erulkar, 1998). According to the NCPD / CSBS (1999) and Johnston (2000) sexual debut among Kenyan youth is much earlier than their counterparts in other countries in Africa. However, results from the current study show that majority (68.4%) of the participants had never engaged in sexual intercourse, while only 31.6% had involved themselves in the act. This finding is quite exceptional from others conducted in other parts of the country. For instance, in Kisumu, 57% of unmarried girls aged between 15 – 19 years and 72% of the boys in the same age group are sexually active (Chege, 1998). A study on four rural districts in Kenya has also revealed similar findings (Illiningumagabo et al., 1998).

The mean age for first sexual is 14.5 years. This is higher than the national mean age which is 12 years for girls and 13 years for boys (RoK, 2001). Asked what prompted them to engage in sex, 45.5% of the 123 participants who had had sex mentioned peer pressure. Other factors mentioned include curiosity (26%) and leisure (25.6%). This is in line with the findings by an AMREF (1999) which revealed that peer pressure, curiosity and the urge for pleasure in that order are the factors cited by young people for engaging in sex. According to one participant in the discussion, peer pressure exerts an enormous amount of pressure on young people to “prove their manhood”. He asserted that “peers will demand that you prove what you are made of”. It is such demand that entice young people to engage in sex.

The results from this study revealed that 47% of the respondents are involved in a relationship with opposite sex. Out of this 18.8% engage in romantic relationship. Studies conducted in other parts
of the country have revealed similar findings. For instance, a study conducted among adolescence aged between 10-24 years in Central Kenya show that 55% of the boys and 44% of the girls had romantic relationships with opposite sex (Erulkar, 1998). The same pointed out that many young people are involved in multiple sexual relationships. The findings of the study was not exceptional either with those involved in relationship having more than one sexual friend. Multiple sexual relationships increase chances of infection (Mureh and Kiarie, 2001). Participants in the FGD pointed out that it is difficult for young people to limit themselves to one sexual partner. Although they acknowledge the risk involved, they said that peers entice one to have multiple sexual partners. Asked why they cannot remain faithful to one partner, the participants stated that it is difficult to remain faithful since one cannot ascertain how faithful the other partner is. This impinges upon trust, which is difficult to create especially among the young people.

Many studies have shown that perception towards vulnerability among the youth is disturbingly poor (Johnson, 2000; AMREF, 1999). Results from the current study indicate that half of the respondents believe that they are not vulnerable to HIV/AIDS. This is similar to the findings by AMREF (1999). In studies conducted in Machakos, AMREF found out that 52.4% of the youth share similar feelings. In Kenya majority of young people (80%) believe that they are not vulnerable to the disease (RoK/ NCPD, 1998). Many people view HIV/AIDS as a disease that strikes the other (Tuju, 1996). Results from the current study show that 46.5% believe that prostitutes are the ones vulnerable to the infection and 43.4% indicated that anybody can contract the disease. It is important to note that majority of those who indicated the latter are aged between 20 – 24 years. This is in contrast to those aged between 15-19 years from whom the majority
mentioned prostitutes as the vulnerable group. This implies that there is a relationship in terms of perception, as regards who are vulnerable, between different age groups.

It is clear that most of the respondents attach great importance to their religion and economic status. Some 20.7% mentioned that they are pious and thus stand no chance of contracting the disease. Another 25.7% pointed out that Muslims with strong faith do not get infected. During the FGD, participants urged that the mere involvement in premarital sex or infidelity in marriage, is immoral in nature. This makes those involved vulnerable not only to HIV/AIDS but equally to other STIs. However, it is important to address this issue as the mere part of belonging to a certain religion or sect is not by itself a barrier. It requires that people practice the teachings of their respective religion. Only then can they talk of religion as a barrier. For the others who feel vulnerable to the disease, they mentioned that they could not use condoms for their fear that it may not be effective in the prevention of HIV/AIDS (25.7%). This is perhaps due to the myths and rumours that taint condom use. During the FGD, participants mentioned that perceptions on condoms effectiveness have created fear even among its users. But the condom remains far much protective than being involved in unprotected sex. This device therefore needs to be emphasised in the fight against HIV/AIDS. The fear of vulnerability to others stems from unfaithful relationships (31.1%). As Tuju (1996) stated, most of the young people are involved in multiple sexual partners, which makes faithfulness difficult to practice. The participants mentioned that since there are no legal bindings in premarital relationships, infidelity is rampant.
From this study, it is clear that the youth's perception towards their vulnerability to HIV/AIDS is poor. This might promote their involvement in risky sexual behaviour that may further predispose them. It is therefore necessary that efforts must be geared towards health education to dispel the poor sense of invulnerability. The use of peer education is crucial in setting “role model” behaviour. Besides, religious leaders, youth groups and women groups should actively be involved.

5.3 Economic factors

Although financial gains and gifts are factors mentioned by a few number of respondents of 0.5% and 2.1% respectively, young people believe that their economic background play a crucial role in determining their involvement in sex. Young girls in an effort to satisfy their social and peer demands are likely to involve themselves with the more financially secure male colleagues and most cases much older men. Due to the crippling effects of poverty, many parents are not able to satisfy such demands and young girls are left at the mercy of their more financially secure and older men. The results of the study revealed that 65.5% of the respondents are given less that Kshs. 1000 as their monthly pocket allowance by their parents or guardians. This amount is meagre and is unlikely to meet the social demands of the students let alone their educational requirements. This statistics clearly translates to vulnerability especially among young girls. Female students in institutions whose students are involved in practical activities outside their institutions without payments are exposed and can easily fall prey to the economically stable men. A female participant from a teaching college said during the discussion, that in event of coming back late from their teaching practice and missing out their meals, female students are likely to fall
victims to fellow male students who will provide them with meals or arrange for the provision of
the same under such circumstances.

5.4 Condom use

The use of condoms is perhaps the most controversial aspect in the fight against HIV/AIDS. Its
use impinges upon people expression of their sexuality, on gender selection and their cultural and
religious belief. For long, the use of condoms has been associated with prostitutes and religious
leaders argue that its promotion is equivalent to the promotion of immorality (Tuju, 1996). Despite
these obstacles, condoms are still used and seen to play an integral part in the prevention and
control of HIV/AIDS. However, to many including young people, abstaining from sex is rightly
considered a better option than the use of condoms as the latter has been surrounded with myths
and rumours (Barnett and Blaikie, 1994). In the current study, majority (98%) of the respondents
mentioned abstaining from sex as an effective method compared to 53.5% who mentioned the use
of condoms. Out of 74 respondents who engaged in sex, 59.5% use condoms. A study carried out
by AMREF (1999) in Machakos equally reveals that there is a low condom use among young
people.

The dual purpose of condoms has obscured the real reasons why most people use the device. The
effectiveness of condoms in preventing pregnancies has always promoted its use among those
involved in premarital sex with intention to avoid pregnancies. However, the availability of other
methods of family planning means that its use in preventing pregnancies can be limited. There is
no doubt that even with such intentions, it still serves the purpose of protecting against HIV/AIDS. This was clear from this study where 20 respondents out of the remaining 30 who had sexual partners indicated that they use other methods of family planning rather than condoms which could obscure the leisure of sex. This indicates that the primary purpose of using condoms among the young people, as mentioned during the focus group discussion by the participants, is to avoid pregnancies and not HIV/AIDS. With the availability of other family planning methods such as pills and injections, the use of condoms is evidently discarded rather than, what one participant in the FGD said, interfering with the pleasure of sex.

One of the most difficult things about the use of condom among the youth is the question of trust in relationships and its dependent upon co-operation especially the male partner (Barnett and Blaikie, 1994). The findings that out of the 26 girls involved in sex, eleven did not use condom simply because their male partners detested its use, gives weight to this statement. This means that despite efforts to persuade people to use condoms it is the individual decision that will totally determine its use. It came out clear during the discussions that many young people, faced with the decision of either loosing trust in their relationship by using condoms or not, will rather opt for the latter. As one female participant puts it, they (young girls) would rather use family planning pills to avoid pregnancies than decline their male partners request of not using condoms. In her own words, "I wont let my steady relationship break up due to condom. If my boyfriend declines to use it, so be it. I will only make sure I use pills to avoid conceiving".
Perhaps the most important difficulty with condom use has to do with religious and cultural objections as well as poverty. These factors do not only affect its use but also its acceptance and availability (Tuju, 1996). This study’s revelation that 41% of the respondent could not mention any source of condoms tells a lot about its availability. Government institutions like hospitals and dispensaries seem to be the most prominent and known source of condoms. The availability of the same in the retail outlets has been limited by the religious and cultural set up of the community. Whereas half of the participants mentioned hospitals as a source, only few stated that the device is available in shops, kiosks or private clinics / pharmacies. In an area that is predominantly occupied by Muslims, it is difficult to obtain the device from the retail outlets. Only few shops, mainly owned by non-local people, sell condoms. However, even for such merchants, the device is not stocked publicly like other items and is sold with utmost secrecy. Although 26.7% of the respondents mentioned that private chemists and pharmacies sell condoms, a spot check revealed that actually none of them sold them. It became clear during the discussion that condoms are closely associated with health facilities and this could only have been an assumption. According to a chairman of a local CBO, owners of private health facilities do not want to be associated with promoting immorality, as many would attach this to the selling of condoms. Thus their decision not to stock them. With possible sources of condoms aside, 52.5% of the respondents stated that the device is not accessible to young people. In line with Wambua, (1999), respondents mentioned religion, culture, ignorance among the youth on where to get condoms and attitude of service providers as some of the contributing factors. This has prompted young people to engage in unprotected sex.
The effectiveness of condoms in preventing the virus has been as controversial as the device itself. The results from this study indicate that 70% of the respondents believe that condoms are not effective at all. Perhaps it is due to this poor perception about its effectiveness that is making condom promotion difficult to succeed. Most of the respondents mentioned that condoms are not 100% effective and therefore cannot be relied upon to prevent the virus. For long, there has been rumours and myth about condoms that not only prejudiced perception towards it’s effectiveness, but also it’s acceptance (Barnett and Blaikie, 1994). A participant stated that most people in his community believe that condoms are laced with the HIV virus and therefore deliberately aimed at reducing the African population. It is perhaps this sort of myth that has prompted another female participant in a discussion ask; “Can anyone explain why more people are contracting HIV/AIDS despite the increase in the use of condoms?” She continued that this was an indication of condom’s failure in preventing the virus and therefore its promotion should cease. This is just an insight of how myths and rumours about condoms have strengthened people’s resistance to its use. Such myths and rumours can be easily addressed through proper health education. However, health workers only emphasis on the use of condoms without addressing the possible challenges.

As Barnett and Blaikie (1994) argue, the effectiveness of condoms depends not only on its use but rather its ‘proper use’ and “consistency”. Nonetheless, condom packets are not accompanied with any instructions for the immediate users. Assertions such as poor quality of condoms and it’s potential to burst during the sexual act could be as a result of improper use. Participants mentioned that health/social workers are more concerned with condom promotion and subsequent availability and failing to address pertinent question that arise out of its use. They added that it is this failure
that has allowed people to generate rumours and myths and thus there is an urgent need to tackle the problem.

Religious objections coupled with cultural attitudes towards condoms may make them difficult to accept. This factors are important and must be considered (Tuju, 1996; Bernett and Blaike, 1994). Results from this study indicate that religious and cultural factors determine condom acceptance and accessibility. Many religions and cultures condemn pre-marital sex and the promotion and use of condoms are seen as an extension of immorality. It is for this reason that communities with strong attachment to the culture and religion are opposed not only to its use but also its availability.

A member of a local CBO acknowledged that it is time to accept the reality that condoms are faced with enormous challenges and there is need to embrace other alternatives that build on communities cultural demands. Such alternatives should be based on specific needs of specific communities. A religious teacher in one of the institutions said that although abstinence and faithfulness to one partner are considered more effective, although stakeholders in the HIV/AIDS prevention control programmes seem to emphasise more on condom promotion. Thus, many people view their stand as interested mainly in promoting condom use and subsequently promoting sex rather than abstinence. Condoms and their promotion remain a challenge in programmes dealing with HIV/AIDS prevention. The acceptance and use of condoms in most societies remain elusive (Tuju, 1996). It is important to acknowledge that religion and cultural factors remain a strong point in spearheading resistance to condoms. This makes it imperative that such religious and cultural obstacles are addressed by policy makers to make their ideas culture sensitive.
5.5 HIV/AIDS information and education

Health promotion is important in the prevention of HIV/AIDS transmission and there are numerous groups to be reached with appropriate HIV information and education. Education and communication programmes must go beyond merely offering information about the disease to fostering risk avoidance skills such as delaying of sexual debut and more important, abstinence from sex. Although the youth are the most vulnerable group in the transmission of HIV/AIDS, their involvement in dissemination of HIV/AIDS information has been far from satisfactory.

Equally important is the manner in which the youth access such information. Although parents are supposed to play a crucial role in educating their adolescents about their sexuality, their contribution to this end is not sufficiently convincing (Tuju, 1996). Results from this study revealed that only 4.1% of the respondents have actually heard of HIV/AIDS through their parents. It is important to note that teachers play a crucial role in the dissemination of HIV/AIDS information. This is evident by the fact that 71% of the respondents got to know the disease through their teachers. There is a general feeling that parents believe discussing issues of sexuality with their children is encouraging promiscuity. It was not surprising that only a handful can discuss such issues with their adolescents. However there is need for these attitude to change. The failure of the parents to carry out their parental responsibilities could have left the youth with the little option in their moral obligations. More often than not, youth get such information from their peers. That is why 11.9% of the respondents have heard of the disease through their friends. But
as Tuju (1996) stated, information from peers is usually about rumors, myths and lies and will probably confuse the teenagers more.

For proper communication on HIV/AIDS information, dissemination of such information must transcend beyond specific professions and age groups. Programmes dealing with such issues must be more accommodative than they actually are at the moment. Religious leaders, women groups, the youth, teachers and parents must all be involved. The involvement of some of these groups, however, is either overlooked or limited to peripheral issues without much regard to their ability to deliver information to specific groups. Whereas the youth are regarded as the most vulnerable group to HIV/AIDS (WHO, 2000) their involvement in the fight against the disease has not been at the expected magnitude. In this study, 58% of the respondents mentioned that the youth are not adequately involved in the fight against the disease. The remaining portion clearly stated that their involvement is limited to being mere members of organizations dealing with the disease as well as participate in public function that are few. It is important to note that only 37.5% of the students involved in the study belong to any organization dealing with HIV/AIDS either in their institutions or community. Out of the seven institutions participating to the study only one had a health club. Perhaps this emphasizes how much the stakeholders such as the District AIDS / STI coordinator, CACC and other CBOs have overlooked the role of institutions and by extension the youth, in their programmes.

Most young people are keenly sensitive to peer opinion especially the older adolescents. Studies have shown that sexual behavior of friends often influence young people’s own sexual behavior.
Involvement of young people in the dissemination of HIV/AIDS information is imperative. To emphasize this, out of the 242 respondents who mentioned that young people are not involved in HIV/AIDS invention, 54% indicated that peer education among youth in and out of school should be promoted. During the focus group discussion, participants pointed out that peer education would help establish acceptable behavior among the youth. They added that young people would see their peers as positive role models for behavior changes. This has also been proposed by Tabifor (2000) and Nyembelela et al., 2001).

Peer education must focus on reducing specific risks to behavior changes that play a crucial role in the transmission of HIV/AIDS. However, as Tabifor (2000) stated, such teachings must be appropriate to students’ age, sexual experience and culture. For peer education to be effective, training of peer education is essential as mentioned by about half (53%) of the respondents. This should essentially be coupled with follow-up seminars to reinforce knowledge belief and skills. The students mentioned that current training on HIV/AIDS conducted by the local stakeholders focuses on older people who have no understanding of the youth’s current behavior and environmental settings. A top official in the fight against AIDS in the district acknowledged these shortcomings. In his words, perhaps they have been “training much older people who will never communicate to young people on reproductive health”. He was, however, concerned with the high turn over of training as students trained as peer educators graduate from schools and colleges. This was quickly dispelled by the participants who reiterated that during their stay in their respective colleges and schools, trained peer educators can always transfer their knowledge and skills to their fellow students given the co-operation and resources.
As Cabrera et al., (1996) and Elizabeth et al., (2003) argued, the fight against HIV/AIDS in any one community is incomplete without the involvement of women groups and religious leaders. They play an important role in changing people’s perception and behaviour based on gender and religion. Community based women groups can actively participate in educating young girls in and out of schools. Civil Society Organizations have an important role to play because of their ability to access and work closely with people in the communities and institutions (KANCO, 2001). Programs on youth and adolescents are important areas where women groups could make contribution. In a culture where reproductive health cannot be discussed among opposite sex, traditional sex educators such as aunts, elderly women and traditional birth attendants can be trained on HIV/AIDS to teach the same to young girls. Women groups, if trained and given the resources, can be called upon to incorporate HIV education in the programmes. They can then be relied on to educate young girls in and out of school who are likely to shy away from male educators. This preference came out clearly during one of the discussions when young girls stated that they were more comfortable discussing reproductive health with fellow females than males.

Special emphasis should be made on religious leaders, as they are the key figure in the informal cultural network in many societies. Studies have shown that religious leaders can take lead in changing the social and cultural factors that influence people’s sexual habits (Elizabeth et al., 2003). The participants acknowledged that they could access people with relevant culture specific information in relation to sexual behaviour and HIV/AIDS. They added that as informal community leaders, and guardians of religion and social norms, religious leaders can be trained to
channel educational messages to their local population. At the moment, the involvement of religious leaders in disseminating HIV/AIDS information can be said to be negligible. This can be deduced from the fact that only a very small proportion (10%) of the respondents mentioned that they first heard of HIV/AIDS in either mosques or churches. This is perhaps due to the failure of HIV/AIDS stakeholders to recognise the crucial role religious leaders can play in educating the public. It must be accepted that religious leaders, women groups and the youth themselves should be integral to the success of educating the public on HIV/AIDS. Their involvement must be considered a priority and resources geared towards achieving the same.

5.6 HIV/AIDS prevention and control

Currently, it is accepted world-wide that abstinence from sex is the first and the most effective way to prevent HIV/AIDS (WHO, 2000). The findings of this study point out a similar concept with 98% of the respondents mentioning abstinence as first line of defence. Many African cultures consider abstinence before marriage a virtue. More often than not, a bride’s failure to be a virgin results in immediate divorce or lowering of price dowry (Tuju, 1996). Even with such a price attached the culture of abstinence is fast disappearing. To many, especially among the young people, abstinence may sound difficult and restrictive because an increasingly sexually permissive society has more it looks so (Merge and Sunanda, 1993). However, during the focus group discussion, participants agreed that it is possible to change such culture with a spirited effort from all concerned. They pointed out religious leaders and women group as particularly vital in promoting abstinence. Human beings can practice abstinence given how much one gains by
practising the same. A female secondary school student said that abstinence should not be seen as restrictive and hindrance to greater achievements but rather as a weapon that gives freedom, vitality and brighter future. As Wambua et al., (2001) argued, teaching abstinence skills especially to those who are not sexually active yet should be strengthened. However, the participants pointed out that the promotion of condom, especially among the young people, makes abstinence hard to maintain. They argued that the mere availability of condoms to the minors could encourage them to indulge in sex. It is essential that the promotion of condoms should be age specific but the young people should be allowed to access it.

As revealed in the findings of this study, a mutually faithful relationship is the second most effective after abstinence. This was mentioned by a high proportion (74.3%) of the respondents. However, due to socio-cultural factors, mutual faithfulness is not always prevailing. Except to some extent, married couples where a sense of legal attachment exists, it is even more difficult to maintain a faithful extra or pre-marital relationship. It is difficult for young people to avoid multiple sexual relationships due to the pressure exerted by their peers (Obiero et al., 2001; Wambua et al., 2001). The demand by peers to show how many beautiful girls that they can command is difficult for many to reconcile with. More often that not studies have shown that young people are involved in multiple sexual relationships (Erulkar, 1999; Wambua et al., 2001)). There is no doubt that it is difficult to maintain faithfulness in such a relationship. The assertion by a young female participant is testimony to this. She said “How can I remain faithful to my boyfriend when I can’t ascertain how faithful he is to our relationship?”
In the event of both abstinence and mutual faithfulness failing, it is advisable for people involved in sexual relationships to use condoms to prevent contracting HIV/AIDS. This is the third line of defence as was pointed out by a good proportion (53.5%) of the participants. Although it has been met with a lot of challenges especially from the religious leaders, it remains an alternative for those unable to abstain. The term “condom” has been depicted to be synonymous with illicit sex.

It is estimated that 5% - 10% of all HIV/AIDS infections in developing countries are acquired through blood transfusion (WHO, 2000). The risk of transmission through blood transfusion is highest in malaria endemic regions where the need for transfusion is high, especially among children. To combat such risks, it is imperative that blood be screened for HIV virus before transfusion. In Kenya most blood is screened to ensure the safety of the recipient. A high proportion of the respondent in this study (64.8%) indicated the need for proper blood screening. Such screening needs expensive devices and expertise, which the Government must provide as a priority.

Although 47.8% of the respondents had knowledge of possible mother to child transmission, not a single one gave a possible preventive measure to reduce such chances of infection. The WHO (2000) estimates that about 40% of babies born to infected mothers will themselves be infected. The other 60%, though not likely to be infected, are at risk of becoming orphans when their parents die of AIDS. Now that HIV/AIDS has become a global health risk, it is imperative to ensure the health of the unborn babies. In Kenya expectant mothers are screened for HIV/AIDS to confirm
their status (RoK, 2000). This can be followed by advice to use family panning to avoid further pregnancies and counselling.

The lack of knowledge on the mitigation among young people can be attributed to the lack of adequate knowledge on HIV/AIDS. This stems from the failure to disseminate proper information to the young and the public at large. Whereas it is universally acknowledged that the youth are the most vulnerable members of our society, their involvement in the fight against HIV/AIDS has been limited. Armed with adequate knowledge, the youth can be resourceful in curbing the spread of the disease. Cabrera et al., (1996) state that although organised prevention and control efforts have been implemented at the national, district and community levels, it has become painfully apparent that organised efforts have only to a limited extent become effective at grassroots levels in terms of changing behaviour and attitude. A well-defined gap exists between national structure on one side and the tangible problems facing the most vulnerable group of the population. To be able to reduce this gap, it is important to involve these vulnerable groups in programmes meant to achieve behaviour change. However, this has been lacking. Only 41.9% of the respondents in the current study believed that young people are involved in the prevention and control of HIV/AIDS. However, they were quick to add that their involvement is peripheral and only limited in participation. It became clear during the group discussion that the involvement of the youth is always limited to merely being members of organisations. They are never considered as resourceful to such programmes and are left out in the decision-making organs. This makes the acceptance of such programmes among the youth so difficult. This is perhaps emphasised by the fact that a mere 23.7% of the respondents in this study is actually involved in such programmes.
Out of this, 17% are involved in health or HIV/AIDS clubs in their institutions while 4.1% were involved in CBOs. Of the seven institutions which participated in the study, only one (Teachers Training College) had an HIV/AIDS clubs. In all the other institutions there are no club dealing with HIV/AIDS issues. These perhaps indicate how much the youth’s involvement in dissemination of HIV/AIDS information has been overlooked.

To be able to improve the representation of the youth, the participants suggested various ways to enhance the same. The participants stated that many programmes dealing with HIV/AIDS work in isolation and their efforts, highly valuable as they are to the local people, suffer from lack of coordination with the relevant target groups. This results in underachievement. There is need to empower the youth and encourage truly led youth groups which will not only have an inner understanding of problems facing the youth but will also be able to communicate better with them. This can be achieved by training the youth on HIV/AIDS, and promoting peer education. Respondents in this study argued that such organisations lack interests and should rather be focussed on development of culture specific and more importantly youth friendly approaches. This view is shared by Cabrera et al., (1996) who point out that current approaches used in HIV/AIDS programmes are vertical, culture insensitive, and stereotypical in nature. There is need to transform these approaches to a more horizontal format that is accommodative of local people. This may assist in changing behaviour and perception of the people. For these to be achieved, the task of preventing and controlling HIV/AIDS should not be limited to health workers and a few “adult led” youth groups with little understanding of the youth. The task should rather involve religious leaders, women groups and the youth besides the professionals. The youth in and out of
school should be a priority. Whereas the youth is institutions can be reached by the formation of health or HIV/AIDS clubs in such institutions, the youth out of school can be encouraged to form youth associations and should be trained properly. At the moment there are very few institutions with such clubs and an equally few CBOs which can access the youth. However as Cabrera et al., (1996) points out, most of the small community based groups suffer from lack of administration and technical skills. There is need to train those involved to equip them with reliable and adequate information. More importantly, as participants stated, such groups must be able to focus on problems facing the youth and embrace behaviour change. Most of the CBOs are either led by semi-literate adults or were formed with ill motives.

The involvement of religions leaders and women groups is crucial in the fight against HIV/AIDS (Elizabeth et al., 2003; KANCO, 2001). Programmes for youth and adolescents are areas where these groups can make crucial contributions. During the FGD, it was suggested that women groups could communicate better with young girls in and out of school than men dominated groups. This can easily be facilitated by religious and cultural set ups which provide barriers and restrictions in communication about sexuality especially among opposite sex. With these cultural and religious barriers, women groups organisation with notable presence of young girls as their members, stand a better chance of success than other groups in targeting young girls in and out of school. Even for peer education within and without institutions, it is essential that young girls be trained to perform and disseminate information among other girls.
To be able to address and involve the youth properly, programmes must be responsive not only to the socio-cultural demands and settings but must also be accommodative of the youth themselves. As Elizabeth et al., (2003) argued, many countries are failing in their efforts to control HIV/AIDS because they are not paying attention to who is affected and how. There is need to tackle structures that support risky behaviours especially among vulnerable groups. This can only be achieved by involving vulnerable groups such as the youth in HIV/AIDS programmes for they have better understanding of these structures. Different communities have different cultures, which makes them dynamic. To be able to alleviate the plight of the local population, programmes should sufficiently be culture specific. The use of the same strategies across the board without regard to different cultural settings has perhaps limited the success against HIV/AIDS prevention. Policies must be flexible to accommodate and cater for the diverse cultural differences that exist in our country. Such diversity will require the formation of strategies or intervention, which will suit specific regions or communities. This will assist in addressing communities’ culture specific behaviours and problems. Communities are likely to be receptive of ideas that build on their own culture and religion.

5.7 Substance abuse

The use of drugs has been associated with the inability of young people to make rational decisions in terms of their sexuality (Tuju, 1996). The use of drugs and other addictive substances among the young people is on the increase. Where as some of the drugs are easily available in the streets and business premises, others are banned or have age restrictions, but still find their way to young people.
According to the findings of this study, the most common drugs available to the youth are miraa (89.2%), cigarette (73.5%), alcohol (71%) and heroine (29.9%). This agrees well with studies conducted by Erulkar (1999), in central Kenya.

Only 14.9% of the respondents are involved in drugs with miraa, alcohol, cigarette and prescription drugs, been the most common. However, most of these drugs are used in combination. For instance miraa and prescription drugs such as valium are used together. So is alcohol and cigarettes. It is important to note that the involvement of drugs among the respondents is exceptional from studies conducted in other parts of the country which revealed a bigger number of minor using drugs (Erulkar, 1999).

For long, the use of drugs has been associated with poor judgement on sexuality among the youth (Tuju, 1996). This is evidently supported by 61.7% of the respondents who mentioned that drugs affect decision making. According to one participant of the FGD, use of drugs such as marijuana, alcohol, miraa and prescriptions drugs have effect in one’s ability to make rational decision pertaining to his/ her sexuality. Other participants mentioned that drugs not only enhance immorality among the user but also affect the non- users who become victims of their indiscipline and behaviour change. Respondents who are non-drug users mentioned that they have affected their colleagues involved in drugs by fighting and intimidation. A female participant in the focus group discussion revealed that her male colleagues had intimidated her whenever they have used drugs.
To be able to limit the damage caused by drugs, it is important to understand the sources of such drugs and curtail their access to the youth especially those in institutions. The participants mentioned that friends, kiosks, government hospitals / clinics, private chemists, street hawkers and teachers in that order are common sources of drugs to the youth. Government Hospitals / clinics and private chemists have been mentioned during the FGD as “dishing out” prescription drugs like any other. Prescription drugs such a valium with many street names such as ‘C-line’ and “Jamaica” are commonly used by miraa chewers. However these drugs are only available in health institutions and their availability to chewers despite restriction has been attributed to leniency by the authorities. A participant in the discussion pointed out that miraa chewers buy such drugs from the private chemists without medical prescription. He added that since their concern is monetary gain, they readily avail such drugs on demand by the chewers. Teachers have also been mentioned as being source of drugs to students at their institutions. However, during the discussion, participants mentioned that this practice is common in primary schools.

It is imperative that availability of drugs to the youth be restricted as much as possible. Where as age restrictions can be imposed on the sale of certain drugs as currently is for the use of alcohol, health workers should be reprimanded for encouraging drag abuse by selling or providing prescription drugs. Health education on the effects of drugs should be given not only to the users but to the entire community. Use of religious leader, CBOs, women groups and other professions must be encouraged to enlighten people.
CHAPTER SIX

CONCLUSION, RECOMMENDATIONS AND SUGGESTIONS FOR FUTURE WORK

6.1 Conclusion

a) There is a substantial gap in the knowledge possessed by the young people due to lack of proper education and communication.

b) Peer education programs are lacking among the youth both in and out of schools and colleges.

c) Perception about vulnerability and the use of condoms as a preventive measure is poor.

d) Drugs and other addictive substances are easily available to the youth in schools and colleges.

e) Involvement of the youth in HIV/AIDS prevention programmes is limited in both education institutions and in the community.

f) Religious leaders and CBWG who would have had impact in changing behaviour of the youth are not adequately involved in programmes dealing with HIV/AIDS.

g) Financial background of the youth has implication on the involvement in drugs, sex and use of condoms.
6.2 RECOMMENDATIONS

a) Promotion of peer education

There is a substantial gap in knowledge about HIV/AIDS among the youth. Most young people are keenly sensitive to peer opinion especially older adolescents. Perception of what peers think often have a greater influence on their sexual and other risky behaviour than the opinion of parents and other adults. This makes peer education imperative. It can be used to set standards for acceptable behaviour among certain peer groups. Peer educators should be trained and follow-up sessions conducted to reinforce knowledge, beliefs and skills. Peer education can be crucial in reaching out to the youth both in and out of schools and colleges who feel alienated by the adult led programmes. Inter-institutional education forums should also be encouraged.

b) Empowering the youth

It has been realised that the involvement of the youth in the fight against HIV/AIDS is peripheral. Recognised as the most vulnerable members of our society, the youth must adequately be represented and involved in programs dealing with HIV/AIDS. Formation of youth groups responsive to the social demands of the youth must be encouraged. Members of such youth groups should adequately be trained to perfect behaviour change among the young people. Adult led CBOs have little understanding of the problems facing the young people and are likely to induce little behaviour change, if any. Institutions must be assisted and encouraged to form clubs or associations to deal with the scourge.
c) Promotion of the involvement of religious leaders and women groups

Emphasis should be placed on these two groups, as they are key in the informal cultural networks in many societies. Religious leaders are considered informal community leaders and guardians of religious and social norms and rules. They should be trained and be involved in HIV/AIDS prevention programmes to channel educational message to their local populations. Programmes dealing with adolescents and youth are important areas where CBWG can make contributions. They can actively participate in educating young girls both in and out of school on reproductive health. Such groups are important in communities where gender mixing is limited by cultural or religious values.

d) Addressing cultural and social norms

Current strategies have been criticised as been vertical, culture insensitive and stereotypical. Interests should focus on the development of innovative and culture specific and social support.

e) Enforce restrictions in selling drugs to minors

Young people and the general public should all be educated on the dangers of drugs through intensive health education. Restrictions must be imposed and rightly implemented especially on the easily available drugs such as miraa, alcohol, cigarettes and prescription drugs. The latter is easily available over the counter in both hospitals and private health facilities. These should be addressed and restrictions imposed on the selling or prescription of such drugs.
6.3 SUGGESTIONS FOR FUTURE WORK

1) Evaluation of the effectiveness of CBOs and government bodies dealing with HIV/AIDS in the Garissa District is essential.

2) The role of religious leaders and women groups in the prevention and control of HIV/AIDS in Garissa District is an area that needs further research.
REFERENCES


APPENDIX I:

QUESTIONNAIRE ON SOCIO-ECONOMIC AND CULTURAL FACTORS IN THE TRANSMISSION OF HIV/AIDS AMONG SCHOOL AND COLLEGE GOING YOUTH IN CENTRAL DIVISION, GARISSA DISTRICT

Date: ____________________________

1. Name (Optional) ____________________________________________________________

2. Age ________________________________________________________________

3. Sex: Male □ Female □

4. Religion: ________________________________________________________________
   a) Islam
   b) Christian
   c) Others (specify) _________________________________________________________

5. Occupation of parent/guardian:
   a) Salaried □
   b) Businessman/women □
   c) Farmer □
   d) Other (specify) _________________________________________________________

6. School / College ____________________________

7. Form/Year: ____________________________
8. How much is your monthly pocket money?
   a) Kshs. Less than 1,000
   b) Kshs. 1,000 – 2,000
   c) Kshs. 3,000 – 4,000
   d) Kshs. 4,000 and above

9. What are the most serious disease or health problems facing the world today?

10. What are the most serious diseases or health problems facing your community today?

(If the responses given in 1 and 2 above do not include HIV/AIDS, then ask question 11)

11. Have you ever heard of HIV/AIDS? Yes □ No □

   If yes, how did you get to know of this condition?
   • Through teachers
   • Through parents
   • Through friends
   • Through mosques/churches
   • Others (Specify)

12. Do you believe that HIV/AIDS is real? Yes □ No □
If yes, what are the main modes of transmission?

13. How long is the incubation period of HIV virus?
   a) 1 – 3 years
   b) 4 – 6 years
   c) 7 – 8 years
   d) Don’t know

14. What are the preventive measures that one can take to avoid contracting HIV/AIDS?

15. Does HIV/AIDS have any cure? Yes □  No □
   If yes, what is the treatment?

16. Have you ever known a HIV/AIDS infected person? Yes □  No □
   If yes, what was your relationship with the infected person?
17. Would you have given any assistance to a HIV/AIDS infected person?

   Yes ☐   No ☐

If yes, what kind of assistance would you have provided?

18. Do you know of any cultural practices that might predispose one to HIV/AIDS in this community?  Yes ☐   No ☐

If yes, what are some of these cultural practices?

19. How has your community/family been affected by HIV/AIDS?
20. Who do you think gets infected with HIV/AIDS?

- Prostitutes
- Adults
- Married couples
- Young people
- Other (specify) ______________________

21. Do you feel at risk of contracting HIV/AIDS?

Yes ☐ No ☐

Explain your answer in question 21.

________________________________________________________________________
________________________________________________________________________

22. Do you intend to make any behavioural changes in the future? Yes ☐ No ☐

If yes, what kind of changes?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

23. Have you ever had sexual intercourse? Yes ☐ No ☐

If yes, how old were you?

_________
24. Why did you involve in sexual intercourse in the first time?

- Peer pressure
- Leisure
- Financial gains
- Gifts
- Curiosity
- Others (specify) 

25. Do you have a boyfriend/girlfriend at the moment? Yes [ ] No [ ]

If yes, how many boyfriend(s)/girlfriend(s) do you have? 

26. How many sexual partners do you have? 

27. Do you engage in sexual intercourse with your partner(s)? Yes [ ] No [ ]

If yes, how long ago did you have sex last? 

28. Do you and your partner(s) use protective device when having sexual intercourse? Yes [ ] No [ ]

If yes, what type of protective device do you and your partner(s) use?

If No, why not?
29. What are the sources of condoms in this community?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

30. Are condoms easily accessible to young people? Yes ☐ No ☐
   Explain your answer ____________________________
   ____________________________
   ____________________________

31. Do you believe that condoms can protect one against HIV/AIDS infection?
   Yes ☐ No ☐
   Explain your answer. ____________________________
   ____________________________
   ____________________________

32. Does the financial ability of the youth affect their use of condoms?
   Yes ☐ No ☐
   Explain your answer in question (32).
   ____________________________
   ____________________________
   ____________________________
33. Are there any problems that deter the youth from obtaining condoms?
   Yes [ ]  No [ ]

   If yes, which are these problems?

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

34. How do you think these problem(s) can be solved?

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

35. What are the common addictive drugs available to the young people?

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

36. How do young people access such addictive drugs?

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

37. Do you use any such drug(s) yourself? Yes [ ]  No [ ]

   If yes which one(s)?

   ____________________________________________________________
38. Who introduced you to drugs? ____________________________

39. How old were you when you first took drugs? ____________

40. How do drugs affect the young people?

________________________________________________________________________

________________________________________________________________________

41. How do they affect you personally?

________________________________________________________________________

________________________________________________________________________

42. Do the economic background of the youth determine their involvement in drug abuse?
   Yes [ ] No [ ]

Explain your answer.

________________________________________________________________________

________________________________________________________________________

43. Are you a member of any organisation that is involved in the prevention of HIV/AIDS in your institution and/or community?
   Yes [ ] No [ ]
If yes which organisation(s)?


44. Do you know of any existing interventions / approaches in the prevention of HIV/AIDS?

Yes ☐ No ☐

If yes, which are these interventions / approaches?


45. Are the youth involved in the prevention of HIV/AIDS in your community?

Yes ☐ No ☐

If yes, how are they involved and how suitable are these approaches to the youth?


If no, how best do you think can the youth be involved in such approaches?


APPENDIX II:

A GUIDE FOR FOCUS GROUP DISCUSSION

• Is HIV/AIDS a serious problem in this community?

• What are some of the risky behaviours that can predispose the youth to HIV/AIDS infection?

• What are the factors that influence the youth to engage in early sex?

• How can the perception about vulnerability of the youth to HIV/AIDS be changed?

• How can information and education of HIV/AIDS be communicated to the youth?

• What are the common addictive drugs used by the youth in this community and how do they access such drugs?

• How can the supply of such drugs to the youth be curtailed?

• Are condoms effective in the prevention of HIV/AIDS?

• What are the existing approaches in the prevention of HIV/AIDS?

• How are the youth involved in such approaches and to what extents?

• How can the youth be involved more in the prevention of HIV/AIDS?

• What are the economic factors that predispose the youth to HIV/AIDS infection?

• How do these factors affect the youth?
SAMPLE SIZE DETERMINATION

Sample size was determined using the formula as used by Fisher et al, (1998).

\[
n = \frac{Z^2pqD}{d^2}
\]

Where:  
- \( n \) = Sample size  
- \( Z \) = Standard normal deviate (1.96) which corresponds to 95% Confidence interval.  
- \( P \) = Proportion of the target population estimated to have a particular Characteristic  
- \( q \) = 1 - \( P \)  
- \( d \) = Degree of accuracy  
- \( D \) = Design effect = 1

Thus,

\[
n = \frac{1.96^2 \times 0.5 \times 0.5}{0.05^2} = 384 \approx 400
\]

The sample size has been rounded to 400 so as to cover respondents who may have declined to participate in the study during the course of data collection.