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## The Role of Interpersonal Communication in Influencing Behavioral Responses to HIV and AIDS among Students in Secondary Schools in Nairobi County

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### **Abstract:**

*The basic question that this study set out to answer was why there are disparities between knowledge of HIV and AIDS and behavior change among the youth in Kenya. The overall objective of this study was to investigate how young people use interpersonal communication to perceive and anchor their self-protection from possible risks of HIV infection.*

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

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

*The study found that the youth used interpersonal communication to engage in discourses that generate meanings, interpretations and understanding of HIV and AIDS with their peers. The interpersonal discourses generated from a common stock of lay knowledge from which the youth made decisions about their behavioral responses to HIV and AIDS. The study concluded that the HIV and AIDS preventive behaviors are not only the outcome of an individual decision but are "rational" decisions stemming from a blending of lay discourses juxtaposed with limited bio-medical knowledge. Therefore, interpersonal exchange is important in mediating mass media campaigns' influences on people's attitudes and beliefs.*

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

**Key words:** *Interpersonal communication, youth, HIV risks, self-protection*

### **1. Introduction**

The United Nations Population Fund's report (2008) showed that 5.4 million young people worldwide were estimated to be living with HIV by the end of 2007. In 2007 alone, there were 2.7 million new HIV infections while two million HIV-related deaths were reported worldwide. Today, it is estimated that about half of all new infections worldwide are among young people aged 15 to 19 years (UNGASS, 2011). This age group also has the highest rates (over 500, 000 infections daily) of infection of sexually transmitted infections excluding HIV (UNAIDS, 2010) due to their physical, social, psychological and economic vulnerabilities. Every day, 6000 young people become infected with HIV – more than five people every single minute. Often, these young people may not perceive themselves to be at risk (UNAIDS, 2010).

The United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Declaration of Commitment on HIV and AIDS (July 2002) set the target of reducing HIV prevalence by 25 percent among 15 – 24-year olds by 2010 globally (UNESCO, 2002). According to the 2010 report on the global AIDS epidemic released by the joint United Nations Program of HIV and AIDS (UNAIDS), young people aged 15 – 19 accounted for about 40 percent of new infections. Young people are particularly vulnerable to HIV infection for many reasons, including age, biological and psychosocial development, lack of

comprehension to self-risk, social norms that make it difficult for them to learn about HIV and AIDS and reproductive health, and peer pressure which easily influences them in ways that can increase their risk (UNAIDS, 2010).

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

### *1.1. Prevalence of HIV and AIDS in Kenya*

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

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

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

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

### *1.2. Prevalence of HIV and AIDS among the youth in Kenya*

The trends in HIV prevalence among the youth aged 15 – 19 years was captured by the 2003 Kenya Demographic Health Survey report, the 2007 Kenya AIDS Indicator Survey report and the 2008/09 KDHS report. According to the three national surveys, HIV prevalence in 2003 KDHS report was 1.6 percent, 2.3 percent in KAIS 2007 report, and 1.7 percent in the 2008-09 KDHS report. This trend showed that HIV infection levels increased between the years 2003 and 2009-09 among this age group.

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

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

Studies have, however, found that though there were high levels of HIV and AIDS knowledge among students, there was still lack of observable behavior change amongst them (Likoye, 2004; Ochieng, 2005; Nyinya, 2007; Ongunya et al., 2009). The HIV and AIDS education program had not enabled the youth to acquire the readiness and ability to adopt lifestyles that were compatible with prevention attitude and practice in relation to HIV and AIDS prevention (Likoye, 2004). The knowledge which was envisaged by the current HIV and AIDS program in schools therefore had not brought about positive behavior change to the students (Ongunya, et al., 2009).

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

## **2. Problem Statement**

The Kenya National HIV and AIDS Communication Strategy for Youth (NACC, 2008), shows that the majority of the youth have heard about HIV and AIDS but many of them do not believe themselves to be at risk. Further, the youth lack

adequate decision – making skills or the ability to adopt safer sexual behaviors. Information alone has not led to behavior change among young people. There is need therefore for greater attention to be focused on addressing the contextual realities faced by young people with regards to the decisions they make about their sexual behavior.

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

In spite of high levels of awareness of HIV and AIDS among the youth, there is no dramatic change in their sexual behavior (Likoye, 2004; Ochieng, 2005; Nyinya, 2007; Ongunya et al., 2009). Scholars have found that high levels of knowledge of HIV and AIDS among students have not always translated into behavior change. Instead, more and more young people continue to engage in risky sexual practices that might lead to high rates of infection of STIs and HIV. This is the knowledge – behavior gap in HIV and AIDS communication that this study sought to investigate in the context of the role of interpersonal communication.

### *2.1. Study Objective*

The purpose of this study was to investigate how young people use interpersonal communication to perceive and anchor their self-protection from possible risks of HIV infection

### *2.2. Literature Review*

#### 2.2.1. The context of HIV and AIDS Communication among the youth in Kenya

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

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

HIV and AIDS communication among the youth requires a move away from debates about whether HIV is a health-related problem or a development problem. As observed by Kiai (2009), one of the opportunities lost in addressing HIV and AIDS was the early perception of HIV as a health problem rather than a development one. This resulted in a focus that neglected the other facets of the pandemic, namely, economic, political, social and cultural (Panos Institute, 2004). Behaviour change can be usually an outcome of social change and requires addressing social issues such as norms and values, stigma and discrimination, power relations and repressive domination within a specific cultural, political and economic context (Lie, 2008).

#### 2.2.2. Perceptions of HIV risks among the youth

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

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

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

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

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

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

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

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

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

### 2.2.3. HIV and AIDS knowledge and the Youth's Self Protection

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

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

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

Ongunya et al. (2009) suggest that whereas students believed they had begun exhibiting the expected change of behavior, teachers felt that this was inadequate in enabling them to prevent and control the spread of HIV among the youth. This meant that there seemed to exist a gap between the objectives and actual HIV and AIDS education program delivery and behavioral changes among the youth in secondary schools.

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

## **3. Theoretical Framework**

### *3.1. The Social Constructionist Theory*

Berger and Luckmann's (1990) social constructionism has its roots in phenomenology. The scholars argue that all knowledge, including the most basic, taken-for-granted common sense knowledge of everyday reality, is derived from and maintained by social interactions.

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

Social construction theory explores an evolving set of meanings that are continuously created from people's interactions. The development of concepts is a social phenomenon, a fluid process that can only evolve within a cradle of communication (Hoffman, 1990). It is only through interaction of the socio-cultural processes with the intrapersonal self (ideas, beliefs, history) that the construction of knowledge is nurtured. Persons are constructors of knowledge in their lives assisted by the prevalent discourses in their societies and cultures, and their own life experiences.

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

According to the social constructionist approach, the world becomes intelligible to us in the way it does only because of the ideas and beliefs we have about it (Bury, 1986). Social constructionists argue that it is human beings who give meanings to diseases (Berger and Luckmann, 1984) so much so that one disease can be experienced differently across and between individuals and communities. The definition of a sign or symptom as illness depends on cultural values, social norms and culturally shared rules of interpretation. Diseases are socially constructed products of cultural and social arrangements (Turner, 1990). Social constructionist theory was used in this study to explain and understand how the youth construct reality and knowledge around the HIV and AIDS communication and how such constructed knowledge informs their behavioral response.

#### 4. Research Methodology

##### 4.1. Research Design

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

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

##### 4.2. Sample Size and Sampling Procedures

###### 4.2.1. Sample Size

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

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

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

Where:

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

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

N = the estimate of the population size

The sample size therefore was:

$$nf = \frac{384}{1 + (384 / 2163)} = \frac{384}{1.18} = 325$$

#### 4.2.2. Sampling Procedures

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

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

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

Where:

x = the study proportion

y = the total population of the school

z = the intended respondents in each class

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

The researcher then selected a random number between 1 and this value to give the first respondent of the sample. This number would also act as a starting point for the selection of the rest of respondents (Mulusa, 1990). From this point, every kth entry on the class list was selected using this sampling interval until the selection was completed. This sampling procedure was applied in all the five schools.

#### 4.3. Data Collection Procedures

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

The quantitative data were necessary to guarantee a generalization of the results. Complementary qualitative data were collected to ensure consistency with the survey research or comparison. In other words, the qualitative data were needed to provide plausible explanations for quantitative data (Cresswell, 2009). Using both the structured questionnaire and the interview schedule to collect data also served as a mutually validating procedure. According to Campbell et al (1999), while the survey is useful for measuring the incidence of a specified behavior, it is often unsatisfactory for full investigation of motivations, beliefs and values that may have a major influence on behavior. Alternative approaches, including key informant interviews and focus group discussions can complement large-scale survey methods. This is consistent with the assertion of Lincoln & Guba (2000) that double measure of the same construct enables the researcher to get more accurate data and thus reduce measurement errors. Hence, the mixed methods approach was used to increase the trustworthiness of the conclusions made from this study.

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

#### 4.3.1. Survey

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

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

#### 4.3.2. Focus Group Discussions

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

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

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

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

#### 4.3.3. Key Informant Interviews

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

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

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

The researcher started by establishing a rapport with each informant. He then provided information on the issues to be covered during the interview. These included the youth's knowledge and understanding of HIV and AIDS, their (youth) HIV risk perceptions, the youth's self protection against HIV infection, and whether HIV and AIDS messages influenced their behaviors. The emphasis here was on understanding the youth's perspectives and descriptions (according to the informants) of the context in which events and actions took place.

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

#### 4.4. Data Analysis Procedures and Presentation

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

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

## 5. Findings

### 5.1. Perceptions of HIV and AIDS Risk among the Youth

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

The results in Table 1 below show that 60.9 percent of the respondents did not perceive themselves to be at risk of HIV infection. Another 35.9 percent said they perceived themselves to be at risk of HIV infection. Lack of risk perception is corroborated by Tsasis & Nirupama (2008) who suggested that one's inability to accept reality of risks was caused by the society in which they lived. Thus, understanding the way perception of risk is shaped and constructed is crucial in identifying why it has been difficult to mitigate the spread of HIV and AIDS (Tsasis & Nirupama, 2008).

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

Table 1: Risk perception of HIV infection

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

- Q: Do you perceive yourself to be at risk of HIV infection?
- P3: Oh no.... why should I be? I am not at risk.
- Q: Why?
- P3: Coz my friends are not at risk either.
- P8: For me, I use protection, though not always.
- P5: We trust each other. We zero graze. No away matches for us
- P6: Infection happens to others.... SisitukoPoa (we are okay)

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

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

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

- P3: I am a man, you know....
- Q: And so?
- P3: I need to deliver bwana! A man has got to be a man, yeah?
- P4: So, there is no room for these risks you talkabout, do you get?

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

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

Table 2: Sexual partners

As the table 2 above shows, 80.3 percent of the respondents agreed that they had sexual partners, while 18.5 percent of the respondents said they did not have sexual partners. As noted earlier in Table 4.5, 57.1 percent of the respondents said they were not at risk of HIV infection because they did not engage themselves in sexual relations. This disparity was explained during the focus group discussions.



- Q: Do you or your colleagues in this school have sexual partners?
- P1: Of course! I thought you knew.
- P2: It would be a lie for anyone to tell you that they did not have a sexual partner.
- Q: So, you guys engage in sexual relations, don't you?
- P5: Certainly yes, many times. The pressure is irresistible.
- P3: And everyone is doing it after all, why not us?
- P4: By the way, if I don't have sex with my girlfriend, someone else will do it. Do you know that?
- Q: Don't you fear getting infected with HIV?
- P6: If you die, you die. Period! You know, one has to live their lives. After all, life is not a rehearsal, or it is?
- P4: If anyone tells you they are not having sex, they are lying. Maybe one or two virgins who are yet to start? Otherwise, to us it is fun. No fear of infection. Maybe the fun and the experience overshadow the risk perception, I think.

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

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

Table 4.11: Influence from colleagues to have sex

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

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

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

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

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

Table 4.12: Knowledge of the Consequences of Unprotected Sex

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

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

- P1: Unprotected sex can bring about sexually transmitted diseases, like syphilis or gonorrhoea or even both.
- P2: Yes, and it can lead also to unwanted pregnancies. And who wants to be a mother or daddy anyway?
- P3: There is also the possibility of contracting the HIV virus.
- Q: How can you protect yourself from these consequences?
- P4: By abstaining from sexual relations
- P5: One can use condoms during sexual contacts
- P6 Or remain faithful to one sexual partner
- P7: Some of us visit VCT centers for advice onHow to practice safe sex
- P8: As a girl, if I have sex without protection I can use a pill to protect me from possible pregnancy

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

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

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

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

The nurse further observed that there were many misconceptions about HIV and AIDS amongst students, particularly the female ones.

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

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

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

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

- P3: It happens mostly during weekends or school holidays. Also, when we have extracurricular activities, some of us seize such moments to engage in illicit sex. As long as your friends do it, you can't escape it.
- P5: Yes. This is also a practice that is common with out-of-school teenagers in most towns today

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

## 5.2. Summary of Findings

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

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

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

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

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

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

## 6. Recommendations

Based on the findings of this study, the following policy recommendations are made. There is need for edutainment programs. The success of entertainment-education in mixing production soap opera formats with subject matter based on the realities, needs and passions of audiences facing HIV and AIDS are evident in South Africa, India, Tanzania and other countries (Singhal & Rogers, 2006).

As much as possible, edutainment approaches should be closely integrated with various youth activities and with the interpersonal communication processes where all those participating constructs meaning.

There is need to involve the youth in the design and dissemination of HIV and AIDS messages. Furthermore, because of lack of engagement of the youth in health communication messages, retention of knowledge is minimal and this leads to lack of acceptance of the message. It is important to listen to what young people think and believe in order to ensure acceptable and appropriate interventions.

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

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