

**FACTORS INFLUENCING PREVENTION OF HIV/AIDS AMONG  
SECONDARY SCHOOLS STUDENTS IN ELDORET EAST  
SUB COUNTY, UASIN GISHU COUNTY KENYA**

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## DECLARATION

### Declaration by the Candidate

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## **DEDICATION**

This thesis is dedicated to my family, friends and relatives who have supported me fully during this course. It's also dedicated to my colleagues at work who stood by me and occasionally assisted me when I had to take a break to work on the thesis. It's dedicated to my parents for instilling in me the values of hard work and integrity and also emphasizing to me the benefits of education

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## ABSTRACT

The purpose of the study was to investigate the factors influencing prevention of HIV/AIDS among students in secondary schools in Eldoret east sub county, Uasin Gishu County Kenya. HIV/AIDS threatens to reverse enrolment and completion rates in secondary schools and therefore there is need to respond to the disease in a visionary and a dynamic way. This calls for development of skills and values and changing attitudes to promote healthy social behavior. The objectives of the study were; to establish personal characteristics influencing HIV/AIDS prevention, assess available resources used in prevention of HIV/AIDS, determine policy measures provided for prevention of HIV/AIDS and finally assess institutional factors influencing implementation of education sector policies towards prevention of HIV/AIDS among students in secondary schools. The theoretical framework adopted was the diffusion of innovation theory advanced by Rogers, which explains that for an idea to be disseminated through a community innovation, communication social system and time are the key elements. The study employed descriptive survey design. The target population was 3500 students, 9 HODs, and 9 principals from the selected area of study. The study adopted stratified, purposive and simple random sampling techniques to select the sample size. The sample size comprise of 359 students, 9 HODs, and 9 principals. The study used Questionnaire, interview schedules and documents analyses to collect data. The data was analyzed by the use descriptive statistics by means of percentages and frequencies. The peer counseling/education programs be mounted and youth are fully involved in the designs of such interventions. Learning institutions have to respond to develop related skills, values and attitudes to promote healthy behavior. Students need to be provided with information on prevention of HIV/AIDS so as to develop meaningful skills to stay unaffected. There is need to encourage students to speak out on issues related to HIV/AIDS establish peer counseling clubs as well as mounting performance of peer counseling clubs. The available resources such as books, pamphlets, films, and DVDs have an effect. Films and videos were hired from film industries. Well-endowed schools have resources while young upcoming schools mostly in the Sub County have scanty resources e.g. magazines, pamphlets, textbooks and video and films. Most teachers lacked HIV/AIDS education materials textbooks, the syllabus, charts and the education policy. This prevented them from gathering enough knowledge and information to pass to students. This undermined its integration in the curriculum. The government of Kenya has the commitment to reverse the spread of HIV/AIDS. Through the office of the president established NACC to provide leadership and strong coordination mechanism for multi-sect oral national response to HIV/AIDS prevention 2005-2009. The ministry should plan for HIV/AIDS education material production for students and teachers. The government and other stakeholders in the war against HIV/AIDS prevention should provide resources to all schools and clear guidelines as to where to source funds to purchase the resources to help in the prevention of HIV/AIDS among students.

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**ABBREVIATIONS AND ACRONYMS**

AIDS	Acquired Immune Deficiency Syndrome
CDC	Centre for Disease Control
G.O.K	Government of Kenya
HIV	Human Immuno Deficiency Virus
IEC	Continuous Education Information
ILO	International Labor Organization
NACC	National AIDS Control Council
RH	Reproductive Health
SRH	Sexual reproductive health
STI's	Sexually Transmitted Infections
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Family Planning Association
UNICEF	United Nations International Child Education Fund
WHO	World Health Organization

## **CHAPTER ONE**

### **INTRODUCTION TO THE STUDY**

#### **1.1 Introduction**

This chapter contains the background of the study, statement of the problem, the purpose of the study, research objectives, research questions, significance of the study, scope and limitation of the study, assumptions of the study, theoretical framework, conceptual framework, and operational definition of terms.

#### **1.2 Background of the Study**

Thirty three million individuals were evaluated to live with the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) before the finish of 2015 all inclusive (UNAIDS, 2008). The appraisals demonstrate that the worldwide HIV/AIDS predominance rate (level of individuals living with the sickness) has leveled off, in spite of the fact that the quantity of individuals living with the malady keeps on expanding (UNAIDS 2011). An expected 2.7 million individuals turned out to be recently contaminated with the HIV in 2015 and 2 million individuals kicked the bucket of AIDS related causes (UNAIDS, 2012). Youngsters less than 25 years old years are assessed to represent the greater part of all new HIV diseases around the world (UNAIDS, 2012).

HIV and AIDS has in the past decades had devastating effects on the youthful population, especially, secondary school going students by causing deaths and stigmatization. Prevention of HIV/AIDS is critical for creating a healthy and productive population. According to WHO (2014), 95% of the world population should have accurate knowledge about HIV and AIDS to prevent new infections.

However, in low and middle-income countries only 24% and 36% of young women and men respectively have accurate knowledge about the disease. Lack of adequate knowledge prevents individuals from taking preventive measures such as using condoms to avoid acquiring HIV and AIDS.

Globally, risky behaviors such as anal sex, oral sex, and having multiple sex partners are still common in most countries. Centre for Disease Control (2010) notes that poverty is one of the major social conditions that promote the spread of HIV and AIDS in urban and rural communities. Poor people might not be able to access condoms, information about HIV/AIDS, and antiretroviral drugs due to limited financial resources. HIV patients who are not able to meet basic housing needs often find difficulties in maintaining regular care and adherence to medication. This increases their viral load and chances of transmitting the disease to others. Family rejection is another social condition that prevents the spread of HIV/AIDS.

Globally HIV/AIDS is a disease which has been, and continues to be primarily a sexually transmitted disease (STD) spread through unprotected sex between heterosexual men and women. Almost 20 million people worldwide have died of the disease and an estimated 36 million are living with the virus which develops into Aids (UNAIDS, 2006). UNAIDS reports that new diagnosis of HIV and AIDS doubled in UK in 2000 to 2004 which is a big challenge especially in a country where any possible means can be used to prevent the spread, on the other hand HIV and AIDS policy is well implement to curb the spread of the pandemic/ scourge (UNAIDS,2008).

Research carried out from a survey of thirty seven successful approaches to AIDS prevention in the United States of America shows that providing unique forums for open discussions and the exchange of health promoting information encourages the

creation of group and norms that support safer sex and the prevention of HIV/AIDS. Furthermore having the students educate one another about HIV also works well. Trained peer counselors can serve as role models in reducing misconceptions about HIV risk among their fellow students and initiating discussion about preventive measures (Walberg, 2002). Youth in Canada and Jamaica face many issues with respect to the risk of contracting HIV, and this takes people into the hearts, experiences, and struggles of those living with ,and affected by HIV/AIDS. In both countries there are challenges in capturing the full picture of HIV among the youth (UNAIDS 2008).

In Caribbean there are inconsistencies' in data collection on and methodology. However the use of aids diagnoses provides qualitative snapshots. Seventy percent of people with AIDS are individuals between the ages of 15-44 and half of these are between the ages 25-34 (WHO 2005). It is estimated that most infections in Caribbean occurs when individuals are in their teens and early twenties, underscoring the need for youth focused education and treatment programming. In Canada tracking HIV prevalence among youth in the Caribbean Diaspora is also difficult as HIV ethnicity reporting only began in 1998.

According to the 2001 census, 73% of people in Caribbean descent live in Ontario, followed 19% in Quebec (UNAIDS, 2010). However these two provinces do not submit ethnicity information with their HIV statistics (Ibid). Governments and Non-governmental organizations in Caribbean and Canada after realizing the high HIV prevalence among youth, invested in the education system to fight the pandemic. They targeted HIV related programs impeded in school sexual health curricular which will access their youth to essential HIV prevention information (UNAIDS, 2010). This prevention information will explode conservative attitudes regarding gender-

roles and sexuality within the Canadian Diaspora. These attitudes often contribute to HIV stigma and impede HIV prevention, education messaging, condom negotiation, testing and access to services for people living with HIV/AIDS.

Furthermore youth living with HIV/AIDS in Caribbean are often stigmatized and face rejection by their families, peers and communities, and may also face barriers in accessing education, employment, health care and social support (UNAIDS, 2010). There are clearly a wide range of social and economic issues that can place youth in Caribbean and Caribbean Diaspora at risk of HIV. Prevention, care and treatment require multi-sect oral collaboration and a youth-centered approach grounded in human rights and development framework. Effective HIV/AIDS prevention education, care and treatment must address the specific risk and vulnerabilities faced from Caribbean and Canada. It must also work to address the negative effects of HIV stigma (AIDS committee of Durham, 2010). Factors influencing HIV risk are rooted in cultural and many social contexts.

In Brazil an integrated response to HIV infection and prevention resulted into significant reduction in HIV stigma and infection among the youth. This reduction is as a result of an increase in knowledge and use of HIV related services, and a significant increase in interpersonal communication about HIV prevention and sexual behavior Public education campaigns and condom promotion has led to increased safer sex practices among young people which have stabilized the country's epidemic (UNAIDS, 2008).

In Pakistan HIV prevalence among the youth was going high until (WHO 2010) the youth peer network implemented a project to provide sexuality education with the target of HIV prevention to youth key population in Lahore. The project was designed to build capacity of local young key population to be peer educators and to convey

HIV prevention messages through theatre shows (UNAID, 2013). The project provided young people with information on HIV prevention and safe sex practices using peer to peer approach , as well as with information on theater based techniques so that young people can not only prevent themselves from HIV infection but can also continue to spread the message of HIV prevention and safe sex practices.

According to UNAIDS (2014), lesbians, gays, and bisexuals who are rejected by their families or caregivers are 3.4 times more likely to engage in risky sexual behaviors. According to UNAIDS (2012), globally 34 million people were living with HIV at the end of 2011. An estimated 0.8% of adults aged 15-49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide (Capacity Building International, 2009). The number of people infected by HIV and AIDS in Sub-Sahara Africa is five times higher than in South, Southeast, and East Asia.

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



Developed countries have low prevalence rates because of access to advance and affordable health care services that have helped to control the spread of the virus.

Sub-Saharan Africa is home of two thirds (68%) of people living with HIV/AIDS or 22.5 million infected people (UNAIDS, 2008). Almost all the nations in the region have their national HIV prevalence rate being greater than 1 %. In several countries, more than 10% of the adults are already estimated to be HIV positive (UNAIDS, 2008). In most African countries, the prevalence is high due to poor health care systems and lack of access to medication such as ARVs and services such as HIV testing and counseling. Cultural practices such as wife inheritance have also increased the rate of infection in Africa. Sub-Saharan Africa is home of 66% (68%) of individuals living with HIV/AIDS or 22.5 million contaminated individuals (UNAIDS, 2012). All the countries in the locale have their national HIV commonness rate being more noteworthy than 1 %. In a few nations, over 10% of the grown-ups are as of now evaluated to be HIV positive (UNAIDS, 2012). In the East African region, the prevalence of HIV/AIDS has either decreased or remained stable in most countries in the last five years.

In South Africa 2000 adolescence are members of girls and boys education movement clubs were established in schools, where they are provide with life skills and information prevent and address HIV/AIDS gender violence, pregnancy and other issues. UN reports that among young people aged 15-30 yrs in south Africa, an estimated 4.6% women and 1.7 % men were living with HIV and AIDS (WHO, 2005). The rate suggest that the existing HIV and AIDS policy implementation has failed to make impact or has not succeeded in scaling down HIV infection and prevalence to significant level.

In Namibia life skills based HIV education is now taught in many (79%) secondary schools, a national campaign was launched on HIV risk and alcohol abuse, and more than 25 million male condoms are distributed free of charge every year (UNAIDS, 2010). levels of knowledge about HIV and condom use have increased rates of sex before the age of 15 and sex with more than one partner in the last 12months have decreased, and HIV prevalence in young women attending antenatal clinic from 18% to14%.

The resulting increase in fear, discrimination, and stigmatization prevent individuals from going for HIV tests, disclosing their HIV status, and taking antiretroviral drugs (Cameron, 2010). Reluctance to go for HIV test means that individuals are diagnosed late, making treatment less effective and increasing the likelihood of transmitting the disease. According to (Murtala, 2009), safe sexual behaviors should be adopted to prevent the spread of HIV/AIDS. This includes avoiding unprotected sex, anal sex, and having multiple sexual partners. Risky sexual behavior is still an obstacle to prevention of HIV/AIDS since only 51% of individuals aged 15-49 years use condoms in Sub-Saharan Africa, Middle East, and Latin America (UNAIDS 2014).

In Tanzania, the prevalence is high among the old age groups and women who have limited access to medication and information about the disease. Overall, Tanzania's national prevalence rate is nearly 6.5% as at 2011(NACC & NASCOP, 2012). Rwanda has a low prevalence of only 3%, with women having a higher infection rate than men as at 2010. Over 60% of the adult population has satisfactory knowledge about HIV transmission and prevention in Rwanda (NASCOP, 2012). In addition, the number of people going for HIV tests increased by 38% in 2010, thereby allowing the infected persons to seek medication in time.

Somalia has the lowest prevalence rate of nearly 2%. However, knowledge of HIV transmission is poor and condom use is uncommon. The youth in secondary schools (15-19 years) are among the most vulnerable groups because of their risky sexual behaviors, attitudes towards prevention of HIV/AIDS, and inadequate knowledge about the disease (NACC, 2005).

In Uganda, the national HIV prevalence declined from 18.5% in 1992 to 5% in 2000 (Uganda AIDS Commission, 2012). The remarkable decline was achieved through a strong political leadership that encouraged sexual behavior change among the youth to control the spread of the virus. Other causes of the decline included open discussions to share knowledge about HIV/AIDS, as well as, a strong decentralized multi-sectoral and community response to the epidemic. By 2005, the prevalence rate had stabilized at around 6.4%. However, it rose to 6.7% in 2012 partly because of the government's decision to promote abstinence only rather than safe sex as a prevention measure. Uganda managed to reduce HIV prevalence through comprehensive use of ABC campaign. Uganda allocated funds, trained teachers on HIV education and sexual behavior change in order to reach the young people before they were sexually active. Uganda boasts to be the first country in Africa to launch VCT services and their people were willing to know their zero-status.

In Kenya, the HIV prevalence rate increased to 7.8% in 2007 from the 6.7% prevalence recorded in the year 2006 (NASCO, 2008). The increase in the percentage of the population living with HIV is because of wider access to antiretroviral drugs. According to the Kenya AIDS Indicator Survey (NASCO, 2008), about 1.4 million Kenyan adults are living with HIV/AIDS. In addition, four out of every five HIV positive Kenyans are unaware of their status and about two

thirds of the country's 37 million people have never been tested for the virus (NASCO, 2008).

The UNAIDS (2007) report indicates that Kenya is one of the countries in Africa where there has been a favorable trend in HIV incidence. This is related to changes in behavior and prevention programmes. However, these intervention programmes still reach only a minority of those in need and a number of prevention targets like the adolescents are not being reached adequately (NASCO, 2005). Young people are particularly vulnerable and are the key to the future course of the HIV pandemic. Data from Kenya and other countries in Africa show that young people are at the greatest risk for HIV infection, and yet they have the best chance of reversing trends in behavior that place them at risk (UNAIDS, 2006). They need to make responsible decisions about sexual behavior and protect themselves from unwanted pregnancies, HIV, and other sexually transmitted infections. It is against this background that this study was conducted to establish factors influencing behavior change for the prevention of HIV/AIDS among students

In Kenya, the HIV prevalence rate expanded to 7.8% of every 2015 from the 6.7% commonness recorded in the year 2006 (NASCO, 2014). The expansion in the level of the populace living with HIV is a result of more extensive access to antiretroviral drugs. As indicated by the Kenya AIDS Indicator Survey (NASCO, 2016), around 1.4 million Kenyan grown-ups are living with HIV/AIDS. What's more, four out of each five HIV constructive Kenyans are ignorant of their status and around 66% of the nation's 37 million individuals have never been tried for the infection (NASCO, 2016). In Kenya, the national infection rate has declined from 10% in the late 1990s to approximately 5% in 2011(NACC &NASCO, 2012). The decline is attributed in

part to the increase in the use of condoms among the sexually active youths and adults (Peltzer & Promtussananon, 2005).

The UNAIDS (2016) report demonstrates that Kenya is one of the nations in Africa where there has been a positive pattern in HIV rate. This is identified with changes in conduct and counteractive action programs. In any case, these mediation programs still achieve just a minority of those in require and various aversion targets like the young people are not being come to enough (NASCOP, 2015). Youngsters are especially helpless and are the way to the future course of the HIV pandemic. According to the 2007 KAIS, at least 2.3% of the youth in school were infected with the prevalence among the female being 3.5% while that for the male youth being 1%. The report further indicates that there is a wide regional variation in HIV prevalence with Nyanza province having the highest infection rate at 14.9 percent (NASCOP, 2009). The other regions included Nairobi (8.8%), Coast (8.1%), Rift Valley (6.3%), Western (5.4%), Eastern (4.6%), Central (3.6%) and North Eastern (0.81%). Among the 15-19 years old, 70 percent are sexually active and the first sexual intercourse occurs before the age of 15 years among the girls. HIV and AIDS is mainly transmitted through sexual intercourse in the district (UNAIDS, 2003). The prevalence level in the district is almost triple the national infection rate for the same age group. Thus, urgent intervention is needed to reduce the infection rate in the district.

Information from Kenya and different nations in Africa demonstrate that youngsters are at the most serious hazard for HIV contamination, but then they have the most obvious opportunity with regards to turning around patterns in conduct that place them in danger (UNAIDS, 2016). They have to settle on mindful choices about sexual conduct and shield themselves from undesirable pregnancies, HIV, and other sexually

transmitted contaminations. It was within this context that the study seeks to investigate Factors which influence prevention of HIV/AIDS among students in public secondary schools in Eldoret East Sub County, Uasin Gishu County, Kenya. It is against this foundation that this investigation led to set up factors impacting avoidance of HIV/AIDS among under studies Eldoret East Sub-County.

### **1.3 Statement of the Problem**

Wider delivery of effective behavior change strategies is central to reversing the global HIV epidemic (Global HIV Prevention Group, 2008). The availability of new biomedical HIV prevention modalities such as vaccines and microbicides is still many years away. Even when these tools finally emerge, human behavior will remain critical as new prevention strategies are unlikely to be hundred percent effective in preventing HIV prevention (Global HIV Prevention Group, 2008).

HIV/AIDS remain one of the major health challenges that Kenya is trying to deal with. Suba is one of the districts with the highest HIV prevalence in Kenya. The infection rate in the district is 26.3%, which is almost double the prevalence level in Nyanza province. About 70% of 15-19 years olds are sexually active and the first sexual intercourse occurs before the age of 15 years among the girls (Capacity Building International, 2009). The fact that HIV and AIDs is mainly transmitted through sexual intercourse is well documented. In this regard, majority of the youth in school are at risk of being infected with HIV/AIDS since they are sexually active. At least 95% of the youth should have accurate knowledge about HIV and AIDS to prevent the spread of the disease. In Kenya, the government has embarked on improving the knowledge of the youth by introducing HIV/AIDS education programmes in schools. This has increased the general awareness about HIV and

AIDS among the youth. However, the information that the youth have is not accurate since they still hold myths and misconceptions about the disease. Lack of adequate and accurate knowledge prevents the youth from taking preventive measures such as using condoms to avoid acquiring or spreading HIV/AIDS.

According to the KDHS (2003), almost 99% of the youth in Kenya (students inclusive) are aware of the presence of HIV/AIDS pandemic but behavior change is slow as most of them still engage in risky sexual behavior as is evidenced by the high number of teenage pregnancies and school dropouts. The concern for youths in secondary schools is even overwhelming in that in Kenya, age at first sexual intercourse is low (14 years) and age at first marriage seems to have been declining (16 years) contributing to observed increase in school dropouts (NASCOP, 2005).

Data is lacking on factors influencing behavior change for HIV/AIDS prevention among students in Kenya (NASCOP, 2007). Consequently, the factors that influence behavior change for HIV/AIDS prevention amongst students are not well understood. For instance, it is not known why high levels of awareness about risky sexual behavior do not translate to the desired behavior change. Although the relative protection by schools remains difficult to measure and guarantee, the physical and psychological changes at adolescence implies that secondary school students are at an extra risk to HIV infection (NASCOP, 2007).

In particular, the spread of the disease among the youth in school can be prevented if they avoid risky behaviors such as having unprotected sex. Access to adequate and accurate knowledge about HIV/AIDS can also enhance prevention. The youth are likely to participate in the prevention of HIV/AIDS if they have a positive attitude towards the disease. Despite the current interventions through adolescent sexual and reproductive health (ASRH) programmes, behavior change among some sub-sections

of Kenya's population such as secondary school students has remained a challenge (UNAIDS, 2006). This could be a serious health problem and the results of this study could encourage students to initiate behavior change and sustain healthy sexual behavior to reduce HIV infection. Thus the need to determine factors influencing HIV/AIDS prevention among secondary school students in Eldoret East Sub County, Uasin Gishu County.

#### **1.4 Purpose of the Study**

The purpose of this study was to establish factors influencing the prevention of HIV and AIDS among students in secondary schools in Eldoret East sub county, Uasin-Gishu County, Kenya. This was achieved through establishing the influence of personal characteristics of students, availability of resources, policy measures and institutional factors in secondary schools.

#### **1.5 Research Objectives**

The following were the objectives of the study;

- i. To find out personal characteristics influencing HIV/AIDS prevention among students in secondary schools
- ii. To establish availability of resources used in teaching of prevention of HIV/AIDS among students in secondary schools
- iii. To identify policy measures used for the prevention of HIV/AIDS among students
- iv. To assess institutional factors influencing implementation of prevention of HIV/AIDS policies among students in secondary schools.



## **1.6 Research Questions**

- i. Do personal characteristics influence HIV/AIDS prevention among students in secondary school?
- ii. Are there available resources that are used in HIV/AIDS prevention among students in secondary schools?
- iii. What policy measures in place for the prevention of HIV/AIDS among students in secondary schools?
- iv. What institutional factors influencing behavior change on HIV/AIDS prevention among students in secondary schools?

## **1.7 Justification for the Study**

At the beginning of this decade, the global community embraced a set of ambitious development goals for the new millennium. Among them was the commitment to halt and begin to reverse the global HIV epidemic by 2015. Behavior change remains the world's primary tool for achieving this goal, clarity is urgently required regarding the optimal means of producing needed behavior changes, hence this study. Youths are a very potential population subset that needs to be understood and therefore studies should focus on promoting desired behavior among this age cohort because of the physiological changes that could drive them to engage in risk behavior for HIV. Available data provides limited information for devising effective HIV/AIDS prevention strategies targeted at the Kenyan adolescents. Youths also form the majority of the population (Government of Kenya, 2002) and, hence, the need for the focus of this study.

Any studies that seek to understand factors behind the observed low change in behavior among the youth are sound from a political, economic and social and human

rights points` of view. The study may provide guidelines on how to promote desired behavior among the youth to prevent HIV/AIDS especially in this era of no known and effective cure for AIDS. Kenya has a mixed epidemic, thus activities are needed at a local level to understand, plan for, coordinate, implement, monitor and evaluate HIV responses. The HIV response in Kenya has been driven mainly from the national level with general and overarching programmes that have not focused on the unique needs of specific most at risk populations with specific messages and approaches. There is growing recognition that scaling up prevention strategies and interventions that have been proven to be most effective may be the most cost effective way to contain escalating treatment costs. Empirical evidence is lacking on behavior change by the youth and others to effectively adhere to abstinence.

The young people ages (13-18years) are a window of hope in the prevention of HIV/AIDS and secondary schools are in the center of promoting values and attitudes that say yes to life and no to premature causal or socially unacceptable sex and sexual experimentation. Therefore a lot of emphasis has been given to secondary schools to give a solution to HIV/AIDS prevalence countrywide. It is against this background that the study seeks to establish factors influencing the prevention of HIV/AIDS among students in secondary schools in Kenya.

### **1.8 Significance of the Study.**

The study findings will form an important platform for implementers and policy makers in using effective strategies for behavior change promotion among the youth in Kenya as a whole. For instance, secondary school curriculum planners will use the research findings to enable them to incorporate and enforce teaching of reproductive health education in secondary schools. The study findings will contribute to the body

of knowledge in the area of HIV/AIDS prevention and control, thus reducing the number of HIV/AIDS infections. The findings of this study will be of great benefit to the government in the area of policy formulation with regard to a healthy youth population. The study will also inform the NGOs in determination of sound intervention measures and curriculum development for peer led initiatives aimed towards safe sex practice among secondary school students.

Through this study, it will be possible first, to add more information on the current database on prevention of HIV/AIDS among students in secondary schools will be noted. If people are able to identify that various factors that influence on prevention of HIV/AIDS, stakeholders will be in a position to handle the problem. This will contribute significantly towards national development and hopefully Kenya can achieve the vision 2030. Lastly, recommendations for further research will serve as reference material for researchers interested in the topic.

### **1.9 Scope of the Study**

The study sought to establish the factors influencing the prevention of HIV and AIDS among students in secondary schools in Eldoret East sub county, Uasin-Gishu County, Kenya. This was achieved by identifying the influence of personal characteristics of students, availability of resources, policy measures and institutional factors in secondary schools. The study was carried out among students in secondary schools in Eldoret East sub county, Uasin Gishu County, Kenya.

### **1.10 Limitations of the Study**

The study was hindered by the following constraints;

Firstly, the study used primary data which range from semi-structure to open-ended questionnaire as mode of data collection; this method has limitation since it give room for irrelevant responses, thereby making analysis of the data very difficult. This was overcome by researcher administering questionnaires herself and helped the participants internalized the whole process.

Secondly, respondent failing to complete part or the whole questionnaire, such as the questions dealing with sexual life and reproductive health thereby, ending up with incomplete questionnaires. Because of the sensitive nature of the information being gathered, the researcher followed strict confidentiality and anonymity protocols for interviews and questionnaires. Protection of confidentiality and anonymity was explained to the respondents before the interview and they consent to be part of the study. Thirdly, some respondents were reluctant to provide information about their sexual behavior. In this regard, the study used anonymous questionnaires to encourage the respondents to provide all the required information.

Finally, the other shortcoming of the questionnaires was the challenge of the respondents misunderstanding the question put forward and failing to provide the required answer. This has effect of lowering the validity of the measuring instrument and in effect the findings of the research are not a true reflection of the reality the researcher seeks to study. The researcher mitigated this by devoting a great deal of time in designing the questionnaire, trying as much as possible to use simple language. The researcher also piloted the questionnaire to respondents in order to identify any ambiguities.

### **1.11 Assumptions of the Study**

The study assumptions were that all the respondents would be available and that they would answer the questions truthfully. The study assumed that sample was a true representative of the population, respondents answered questions completely and correctly. The success of the project depended greatly on the data collected from the field. It was therefore assumed that respondents were willing to respond to the questions given the sensitivity of the topic. Further the researcher assumed that the data provided by the respondents were accurate. The researcher also assumed that the research instruments were valid and that they would measure the desired constructs for achieving the research objectives.

### **1.12 Theoretical Framework**

In this section, the theories that underpinning the study on factors influencing prevention of HIV/AIDS among secondary schools students was discussed. The theories under consideration are the health belief model and Theory of Reasoned Action.

#### **1.12.1 Health Belief Model**

For the purpose of this study, the Health Belief Model (Becker and John, 1984) was applied. According to Becker and John (1974), the Health Belief Model is based on a consideration of multiple consequences both that are health enhancing and those that are health- threatening. It comprises four elements, arguing that people's actions are based on a combination of the subjective sense of vulnerability or susceptibility to illness, perceived severity of the consequences of the illness, perceived benefits or

sense of efficacy from engaging in the recommended behavior before deciding whether or not to trigger changes in health related behavior.

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

Youths constitute the quickest developing populace for new AIDS contaminations (Plessis, 2003). However, current anticipation endeavors are barely engaged and don't satisfactorily address the particular logical requirement for youths (UNAIDS, 2006). As indicated by Becker and John (1974), the Health Belief Model depends on a thought of various results both that are wellbeing upgrading and those that are wellbeing debilitating. It contains four components, contending that individuals' activities depend on a blend of the subjective feeling of powerlessness or defenselessness to disease, saw seriousness of the results of the ailment, saw advantages or feeling of viability from taking part in the prescribed conduct before choosing whether or not to trigger changes in wellbeing related conduct.

The Health Belief Model is one of the first models, which adapted theories from the behavioural sciences to examine health problems (Rosenstock and Becker, 1988). The Health Belief Model assumes that people fear diseases and that the health actions of people are motivated by the degree of fear (perceived threat) and the expected fear (reduction action) as long as that possible reduction outweighs practical and psychological barriers to taking action (net benefits). The Health Belief Model is used to explain what would drive and motivate the secondary school teachers to engage in the process of teaching HIV/AIDS education in secondary schools. This is outlined using the six constructs of the health belief model as explained below;

**a) Perceived susceptibility:** This is the opinion of the teacher on his or her chances as well as that of students being infected or affected with HIV/AIDS. Teachers, together with their relatives, friends, and students within or outside the school, risk being infected or affected by HIV/AIDS. This could drive them to engage in teaching HIV/AIDS education in order to prevent being affected or infected.

**b) Perceived severity:** This is the teacher's opinion on the seriousness of being infected or affected by HIV/AIDS. This would drive teachers to engage in preventing HIV/AIDS through teaching.

**c) Perceived benefits:** This is the teacher's opinion of the effectiveness of teaching HIV/AIDS education to prevent HIV infection as a measure of reducing the effects of HIV/AIDS.

**d) Perceived barrier:** This is the teacher's opinion of the concrete and psychological costs of using HIV/AIDS education to prevent HIV/AIDS as compared to other preventive measures, such for example, as using condoms and antiretroviral.

**e) Cues to action:** These are internal or external events that activate a person's readiness to act and stimulate an observable behaviour. An example of internal events is the teacher's own conscience as an adult which can drive him or her to engage in the process of teaching HIV/AIDS education so as to protect the young people from being infected or affected. External events that can drive teachers to engage in the process of teaching HIV/AIDS education include availability and accessibility of teaching materials and resources, HIV/AIDS Education Policies and frequent inspection.

**f) Self-efficacy** (a concept originally developed by Albert Bandura): This is simply the teacher's confidence in his or her ability to teach HIV/AIDS education successfully.

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals. The HBM was developed in the 1950s as part of an effort by social psychologists in the United States Public Health Service to explain the lack of public participation in health screening and prevention programs (a free and conveniently located



tuberculosis screening project). Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS. This study has employed this theory to gain a better understanding of sexual risk behaviors.

Young people need enough assets and accessible data support to have the capacity to roll out the improvements important to secure themselves. As indicated by the Health Belief Model of conduct change, people must see themselves to be in danger of the wellbeing danger, before they take activities to decrease hazardous practices or to take part in solid option conduct. In this manner, teenagers who report high saw hazard for HIV/AIDS hone more secure sexual practices, while the individuals who see generally safe for contracting HIV/AIDS report honing risky sexual practices. Adolescents need to have enough resources and available information support to be able to make the changes necessary to protect themselves. According to the Health Belief Model of behavior change, individuals must perceive themselves to be at risk of the health threat, before they take actions to reduce risky behaviors or to engage in healthy alternative behavior. Thus, adolescents who report high perceived risk for HIV/AIDS practice safer sexual behaviors, whereas those who perceive low risk for contracting HIV/AIDS report practicing unsafe sexual behaviors.

### **1.12.2 Theory of Reasoned Action**

According to (Fishbein & Ajzen 1975), the theory of reasoned action states that a person's perception of the social norms or beliefs that people important to them hold about a particular behavior can influence behavior change. This theory states that the intention of a person to adopt a recommended behavior is determined by: A person's subjective beliefs, that is, his or her own attitudes towards this behavior and his or her

beliefs about the consequences of the behavior. For example, a young woman who thinks that using contraception as a safe sex practice will have positive results for her will have a positive attitude towards contraceptive use. It also relates to a person's normative beliefs, that is, how a person's view is shaped by the norms and standards of his or her society and by whether people important to him or her approve or disapprove of the behavior. In the context of peer education, this concept is relevant because young people's attitudes are highly influenced by their perception of what their peers do and think. Also, young people may be motivated by the expectations of respected peer educators.

The purpose of the Theory of Reasoned Action in relation to culture is to predict and understand motivational influences on behavior that is not under the individual's volitional control, to identify how and where to target strategies for changing behavior and to explain virtually any human behavior such as why a person buys a new car, votes against a certain candidate, is absent from work or engages in premarital sexual intercourse. This theory provides a framework to study attitudes toward behaviors. According to the theory, the most important determinant of a person's behavior is behavior intent much influenced by their cultural surrounding. The individual's intention to perform a behavior is a combination of attitude toward performing the behavior and subjective norm or cultural custom. The individual's attitude toward the behavior includes; Behavioral belief within the culture, evaluations of behavioral outcome, subjective norm, normative beliefs, and the motivation to comply. If a person perceives that the outcome from performing a behavior is positive, she/he will have a positive attitude forward performing that behavior. The opposite can also be stated if the behavior is thought to be negative. If relevant others see performing the behavior as positive and the individual is motivated to meet the exceptions of relevant

others, then a positive subjective norm is expected. If relevant others see the behavior as negative and the individual wants to meet the expectations of these "others", then the experience is likely to be a negative subjective norm for the individual (Fishbein & Ajzen, 1975).

Theory of Reasoned Action addresses the impacts of cognitive components, such as attitudes, social norms, and intentions, on behaviors (Guo et al., 2007). According to this theory, a person's performance of a specified behavior is determined by his or her behavioral intention to perform the behavior, and behavioral intention is jointly determined by the person's attitude and subjective cultural norms concerning the behavior in question (Malhotra & Galletta, 1999). The Theory of Reasoned Action assumes that most human social behavior is under volitional control and, hence, can be predicted from intentions alone (Ajzen, 2002). This implies that we should be able to predict specific behaviors with considerable accuracy from intentions to engage in the behaviors under consideration (Ajzen & Fishbein, 2000). Behavioral intentions are motivational factors that capture how hard people are willing to try to perform a behavior (Chen et al., 2009). Attitude involves judgment whether the behavior is good or bad and whether the actor is in favor of or against performing it (Leonard et al., 2004).

In conclusion, many theories specify attitudes, beliefs, and/or intentions as proximal determinants of behaviour. As a result, changes in attitudes are viewed as an important goal in many AIDS prevention programmes and intentions to engage in low-risk behaviours are often taken as a sufficient indicator of subsequent behaviour. A theory-based integrated behavioral intervention can improve HIV treatment adherence and reduce HIV transmission risks. HIV treatment as prevention should be bundled with behavioral interventions to maximize effectiveness.

### 1.13 Conceptual Framework

A conceptual framework is made up of the following variables: independent variables, moderating factors and dependent variables. The independent variables are the variables which a study seeks to examine in order to determine their impact on a particular subject matter (Creswell, 2002). Conceptual framework is the conceptualization of the relationships between variables in the study in a graph or diagram form. The researcher conceptualizes the relationships between independent and dependent variables as summarized in Figure 1.1. The independent variable comprises of factors influencing prevention of HIV/AIDS among students in secondary schools and included; personal characteristics of students, availability of resources, policy measures and institutional factors in secondary schools. The dependent variable was the prevention of HIV/AIDS among students. The government policy on HIV/AIDS was the intervening variable.

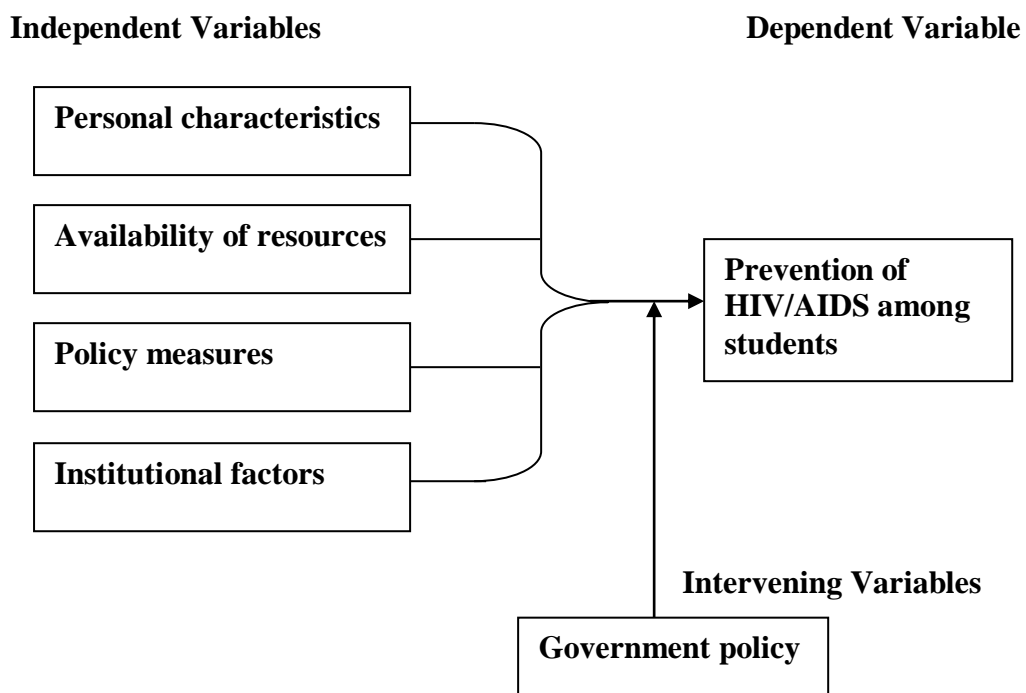


Figure 1: Conceptual framework

The study postulated that the participation of secondary school students in prevention of HIV/AIDS is determined by four factors (independent variables) as shown in figure 1.1. First, the knowledge that secondary school students have about HIV/AIDS was expected to influence their capacity to prevent the spread of the disease. In this case, the premise was that having adequate knowledge about the disease will enable students to engage in responsible sexual behaviors or take preventive measures to avoid contracting or spreading the disease. Second, the participation of secondary school students in prevention of HIV/AIDS is likely to be influenced by the students' attitudes towards the disease and the available prevention methods. For instance, a positive attitude towards testing for HIV would improve the uptake of VCT services and abstinence, thereby reducing the spread of the disease.

Third, the teaching of HIV/AIDS education could be influenced by availability and accessibility of the learning materials and resources. Majority of the teachers could not access HIV/AIDS education materials. However teachers who could access HIV/AIDS teaching materials were more likely to teach it as compared to those who could not access the materials. The study also found that the teaching of HIV/AIDS was not supported by most administrators because it was not examinable. The examinable subjects were given priority when purchasing learning materials and sponsoring their teachers for in service training.

Finally, school principals, being leaders of the school system, are important in the adoption of teaching HIV/AIDS education in secondary school. This is because they may oversee the implementation of teaching HIV/AIDS Education through frequent inspection, to ensure that HIV/AIDS education is taught. They can also help in sourcing and providing teaching and learning materials for HIV/AIDS education. The social conditions such as poverty, stigma, and gender are also likely to influence

secondary students' participation in prevention of HIV/AIDS. For instance, stigma can prevent students from going for HIV tests or providing care or support to their friends or family members who have been infected with the disease.

#### **1.14 Operational Definition of Terms**

**AIDS:** Is a condition that weakens a person's immune system so that he or she no longer has the strength to fight off disease. The term "AIDS" stands for "Acquired Immune Deficiency Syndrome".

**HIV and AIDS** - HIV is an abbreviation to Human Immuno Deficiency Virus; it is a virus that interferes with the immunity of the human body. AIDS, an acronym for Acquired Immuno Deficiency Syndrome, is a condition that results when the HIV virus destroys body defense mechanism to an extent that it considerably weakens when attacked by other pathogen or disease causing organisms.

**HIV prevention:** refers to practices done to prevent the spread of HIV. HIV prevention practices may be done by individuals to protect their own health and the health of those in their community, or may be instituted by governments or other organizations as public health policies.

**HIV/AIDS Education:** is the transmission of knowledge, skill and attitude that helps to assist the learners to develop, adapt, and adopt behaviour that will enable them prevent themselves and others from being infected with HIV.

**HIV:** Is a virus that causes AIDS. The term HIV stands for "Human Immunodeficiency Virus". This virus destroys the human immune (defence) system, rendering the body vulnerable to other infections.

**Institutional factors:** In this study it referred to management support, student involvement, proper communication, value HIV/AIDS, volunteer test, provision of condoms and counseling services.

**Policy factors:** In this study it refers to clear guidelines for interpretation, policy ownership, adequate budgetary allocation, National Aids Control Council and strong stakeholders.

**Resources related factors:** In this study it referred capacity for intervention, financial base, monitoring and evaluation, commitment, adequate data, external linkages, focusing on academic performance, culture, motivation and staffing level.

**Students' personal characteristics;** In this study it referred to sexual intercourse, perception, sexual experience, stereotype, cultural background, religious affiliation, individual lifestyles and don't care attitude.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

The literature was drawn from the different studies in Kenya and outside Kenya and from authorities who have written extensively on the subject. The sources of literature review include books, journals seminar papers, thesis, newspapers, periodicals and magazines.

#### **2.2 Status of HIV/AIDS Epidemic**

At the end of 2007, 33 million people were estimated to be living with the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) globally (UNAIDS, 2008). The estimates indicate that the global HIV/AIDS prevalence rate (percentage of people living with the disease) has leveled off, although the number of people living with the disease continues to increase (UNAIDS, 2008). An estimated 2.7 million people became newly infected with the HIV in 2007 and 2 million people died of AIDS related causes (UNAIDS, 2008).

Young people under the age of 25 years are estimated to account for more than half of all new HIV infections worldwide (UNAIDS, 2008). AIDS is the leading cause of death among adolescents in Africa and the second highest globally with 2.1 million adolescents living with HIV in 2013 globally. A greater percentage of this number (83%) resides in sub-Saharan Africa with 250,000 new infections in 2013. There were 9720 adolescents and young people who died of AIDS in Kenya in 2013 (UNAIDS, 2014). The youth are the most vulnerable since this is the stage at which they are



curious and want test things. Knowledge and awareness would therefore be very important at this stage (WHO, 2004).

The Global Fund to Fight AIDS, Tuberculosis and Malaria was founded in 2002 to attract and disburse additional health resources to those in need. In the last ten years it has helped countries launch unprecedented responses to the three diseases – HIV, Tuberculosis and Malaria with the aim of reaching the Millennium Development Goals by 2015 (The Global Fund To fight AIDS, Tuberculosis and Malaria, 2013). At the end of 2011, an estimated 34 million people were living with HIV worldwide, with two-thirds of them living in sub-Saharan Africa. This reflects the continued large number of new HIV infections and a significant expansion of access to antiretroviral therapy, which has helped reduce AIDS-related deaths, especially in more recent years.

The number of people dying of AIDS-related causes fell to 1.7 million in 2011, down from a peak of 2.2 million in the mid-2000s; in 2012 alone 700,000 AIDS related deaths were averted. However, HIV continues to spread – in 2011, 2.5 million people were newly infected with HIV. Although this number remains sobering, it is also important to note that 25 countries have seen their numbers of new infections drop by 50 percent or more, and that half of the infections averted worldwide were among newborns, demonstrating that it is possible to eliminate new infections in children (The Global Fund to fight AIDS, Tuberculosis and Malaria, 2013).

In countries with generalized epidemics, a combination of behavior changes, including reductions in numbers of sexual partners, increases in condom use, and delayed age of first sex, have reduced new infections in several countries. However, some regions are seeing their rates of infection grow significantly. For example, the

number of new infections in the Middle East and North Africa region has grown by more than 35 percent. And Eastern Europe is seeing infection rates climb, particularly among most-at-risk populations. New tools for prevention are being implemented, as can be seen by large-scale circumcision campaigns, particularly in sub-Saharan Africa. The increase in coverage of antiretroviral treatment will also aid in slowing new infections. Studies have shown that putting a person on treatment as soon as they are diagnosed can reduce the risk of transmission of the virus by up to 90 percent (The Global Fund to fight AIDS, Tuberculosis and Malaria, 2013).

About half of all new H.I.V infections occur among the youth aged between 15-24 years of age (UNAIDS, 2008). In some countries in Africa where AIDS is widespread, early and risky sexual activity increases young people's vulnerability to HIV (UNAIDS, 2007). HIV is concentrated in high risk groups which often includes significant number of young people (UNAIDS, 2007). The impact of HIV/AIDS among adolescents is felt by the society at-large. Students are dying or leaving schools, reducing both the quality and efficiency of the educational system (Tobijar, 2000). Yet, the youth also present a window of opportunity for reversing HIV rates especially when effective prevention programmes can reach them before they engage in risky behavior (UNAIDS, 2007).

Adolescence can be a highly charged developmental period (Appelbaum, 2003). This is because this period is characterized by the psychological needs of young people to individuate from parental attachment and form their own firmer identities (Appelbaum, 2003). This period does however usually involve young people shifting to a collective 15 peer group identity, before moving on to shape their own sense of self. They become attracted to and made vulnerable by the normative social influences of their peers (Applebaum, 2003).

The identity crisis of adolescence includes a crisis of sexuality. The emergence of sexual needs in the face of unsure social and sexual identities can be both confusing and difficult (Applebaum, 2003). The development of depression, withdrawal, often including oppositional deviant and risky behaviors is common among adolescents (Kaupeni *et al.*, 2004). Teenagers often experiment with drugs, alcohol, casual sex and other risky behaviors (Kaupeni *et al.*, 2004). It is for this reason that Applebaum (2003) rightly points out that the behavior of adolescents often places them at increased risk of HIV infection.

In Uganda, AIDS was first identified in 1982 in a fishing village on the western shores of Lake Victoria. Since then, the epidemic has had a devastating effect on the demographic, economic and governance structures of the country. By the late 1980s, the country was experiencing a full-blown epidemic, the virulence of which was exacerbated by social dislocation and insecurity related to economic crisis and war. By 1997, the health system was strained to breaking point in a country where the per capita health expenditure at its best was under \$31. Patients with HIV/AIDS - related illnesses occupied more than 55 per cent of the hospital beds, and by 2000 the occupancy rate had increased to 70 per cent (Tumushabe, 2006).

In 1998, an estimated 1.9 million people were living with HIV/AIDS (UNAIDS 1999). AIDS had overtaken malaria as a leading cause of death among people aged 12–49 years and was responsible for 12 per cent of all deaths. MacAdam (2003) reported that more than 800,000 people in Uganda had lost their lives to the HIV/AIDS epidemic, leaving behind an estimated two million orphans who had lost one or both parents. Extended family systems were hard pressed to care for this vast number of uprooted children. As the epidemic continued to spread and intensify in

Africa and other areas of the world in the early and mid-1990s, prevalence rates in Uganda were reported to be declining, especially starting around 1993.

International and bilateral aid agencies that provide large sums of money for HIV prevention used Uganda as an example to argue that, with sufficient resources and appropriate prevention messages, HIV/AIDS could be controlled. The international community focused on two elements of Uganda's strategy: (i) the important role of the political leadership in speaking publicly about the epidemic at an early stage; and (ii) the government's assumed use of the approach of abstinence, being faithful and condom use (ABC) as a combination that reduced HIV prevalence (Tumushabe, 2006).

Much has been done in Kenya to fight the AIDS epidemic in the last 15 years. Through the Sessional Paper on AIDS in Kenya, the government has established a clear policy framework. The National AIDS Control Council working with AIDS Control units in the Ministry of Health and other ministries is organizing the government response including disseminating information about the epidemic, coordinating research, ensuring safe medical practices and implementing intervention and treatment programmes. A large number of NGOs provide prevention, counseling and care services. Organizations from all parts of the society are participating, including church and community groups and the commercial sector. Political, commercial and community leaders are speaking out about AIDS and are encouraging people to protect themselves (Aids in Kenya, 2001).

Though the HIV prevalence rate has been on the decline in the last few years, the number of people living with HIV and AIDS has been on the increase, and is currently estimated at 1.6 million. This number is projected to increase due to improved survival (reduced mortality due to HIV) attributed to ART program

(National AIDS Control Council, 2014). The National AIDS Control Council (NACC) recognizes the need to shift the characterization of its HIV response from “crisis management” to “strategic and sustainable.” NACC understands the importance of engaging scientists, policymakers, programme managers, and activists in its efforts to take a long-term approach to the epidemic and do what is needed to achieve better outcomes by the year 2030—the year that Kenya aims to achieve its economic, social, and political goals.

With regards to health, the government is looking to maximize its limited resources by identifying and implementing the most efficient and effective HIV programmes. NACC, with the assistance of the Health Policy Project, is conducting quantitative and qualitative analysis using a participatory approach to identify (1) financing options for HIV services, (2) the most effective HIV programmes, and (3) related policy implications. The information will help policymakers to prioritize and implement cost-effective, equitable programmes under Kenya’s next National AIDS Strategic Plan (NACC, 2012).

### **2.2.1 HIV/AIDS Prevention Efforts**

HIV and AIDS is a developmental and human rights problem whose determinants are anchored in a myriad of biological, physical, socio-demographic, economic, cultural, psychological, political and legal factors that drive the epidemic. The complex interactions among these factors acting at individual, community and institutional levels frustrate efforts to find consistent and effective responses to management of the HIV and AIDS epidemic in sub-Saharan Africa. There is a general agreement that engaging partners across all development sectors creates synergy to address HIV and

AIDS issues within a multi-spectral and multilevel approach (Rehle, Shisana and Pilly, 2006).

As the HIV/AIDS epidemic varies between countries, it is critical that countries understand how the epidemic is affecting them specifically to ensure prevention interventions are appropriate and cost-effective. This includes gathering information about HIV infection rates among different population groups within a given country. Ongoing country-level surveillance of the epidemic is essential for countries to plan and adjust their prevention strategies accordingly.

In Nicaragua, a communications for social change strategy to promote HIV stigma reduction, gender equity, and HIV prevention among youth called *Somos Diferentes, Somos Iguales*, resulted in a significant reduction of stigmatizing and gender-inequitable attitudes, an increase in knowledge and use of HIV-related services, and a significant increase in interpersonal communication about HIV prevention and sexual behavior. In Brazil, an integrated response to the epidemic which funds health care systems; promotes racial, gender, ethnic, and sexual orientation equality in access to information and treatment; and includes public education campaigns and condom promotion, has led to increased safer sex practices among young people and has stabilized the country's epidemic (Brazilian Ministry of Health, 2008).

In India, where young people represent a large proportion of the country's population, an estimated 2.27 million people are living with HIV (UNAIDS 2010). In phase II of the country's National AIDS Control Programme, the Adolescent Education Programme (AEP) was launched. The programme aimed to train teachers and peer educators to educate the student community both in and out of school about life skills, HIV prevention and HIV related stigma and discrimination. Under the initiative 112,000 schools were covered and 288,000 teachers were trained (National AIDS

Control Organization 2007). In reality, it is crucial that young people learn about AIDS in areas with a low prevalence so that the prevalence stays low. In 2007 it was reported that a number of states had decided not to implement the Adolescence Education Programme in its present form, rejecting the material that had been supplied (National AIDS Control Organization, 2007). Many young people across India are still not receiving information about HIV/AIDS.

In Namibia, life-skills based HIV education is now taught in 79 percent of secondary schools, a national campaign was launched on HIV risk and alcohol abuse, and more than 25 million male condoms are distributed free of charge every year. Levels of knowledge about HIV and condom use have increased; rates of sex before the age of 15 and sex with more than one partner in the last 12 months have decreased; and HIV prevalence in young women attending antenatal clinics declined from 18 percent in 2003 to 14 percent in 2007[UNAIDS, 2008].

Kenya has witnessed a declining HIV prevalence in recent years – in 1997/98 the prevalence was estimated at 10 percent; by 2009 this figure had lowered by more than a third to 6.3 percent. The decline has been attributed to a number of factors, including a reduction in risky behaviours (UNGASS 2008). Kenya's education sector has taken an active role in the country's response to the AIDS epidemic, having a particularly positive effect on HIV and AIDS awareness and leading to a reduction of risk behavior among young people (Action aid 2003). Kenya has integrated AIDS education into all subjects at school, and introduced a weekly compulsory HIV and AIDS lesson into all primary and secondary curricula. An evaluation of 2000 schools found that AIDS education is effectively promoting healthy behaviours and reducing the risk of infection (Kenya National AIDS Control Council 2009).

In spite of the endeavors made to build up youth-accommodating HIV counteractive action administrations, the greater part of the all new HIV diseases on the planet happen among youngsters under age 25. The way to working effectively with youngsters is to create real grown-up youth organizations ahead of schedule in the arranging of intercessions (UNAIDS, 2006). This is fundamental for creating shared targets and additionally to better comprehend the particular determinants of positive direct change including the enabling variables that can roll out a relentless area for improvement (FHI, 2001). Exceptional advance has been made in advising the general population about HIV/AIDS. Sustenance of these projects and affecting genuine change in conduct and at last decreasing STDs and HIV/AIDS and undesirable pregnancies among the school going youth lamentably keeps on being an issue (Karuru 2004).

In September 2003, the Kenyan government endorsed a bill that would make it a criminal offense to fire or deny work to anybody on the premise of his/her HIV status and would keep back up plans from raising premiums or refusing any assistance to HIV-positive customers. With the death of the HIV/AIDS Prevention and Control Act in December 2006, Kenya now has an approach forbidding HIV screening for general business purposes and guaranteeing that AIDS examine conventions including human subjects are explored and affirmed by a national or nearby moral audit board.

### **2.2.2 Prevention of HIV Transmission through Behavioral and sexual means**

Sexual behavior is private and patterns of sexual behavior are not well understood (Kenyatta University, AIDS Control Unit, 2006). There are also many religious and cultural dilemmas in dealing with HIV as sexually transmitted. Finding ways to alter and change sexual behavior to eliminate the further spread of HIV has proved to be



extremely difficult (Kenyatta University, AIDS Control Unit, 2006). Many adolescents feel invulnerable to HIV infection. For instance, students interviewed in Malawi, South Africa, Tanzania and Kenya, revealed that they did not consider themselves at risk of contracting HIV, while others said that if they became infected, other people would be responsible and not themselves (Macphail and Campbell, 2001).

Since the discovery of HIV, there have been many programs and measures to promote behavioral change towards safer sex. Despite the huge efforts, the number of HIV infections continues to increase dramatically mainly in some developing countries. AIDS is primarily a STD. Safer sex according to them includes every behavior that has the intention of avoiding transmission of HIV. They go on to say that if this condition is not fulfilled, safer sex includes using a condom correctly every time one has anal or vaginal sex. However, the numbers of new diagnoses of HIV especially among the adolescents reflect a large amount of unsafe sex both by HIV positive and negative persons. Although sex has a biological function, it is one of the most socially diverse of human activities (Moloney, 2005). The meaning of sex differs profoundly among societies, cultures, sub-cultures and individuals. Moloney (2005) has classified these factors into three groups namely, factors that are linked to the attributes of the individual, factors within the sexual relationship and factors that derive from the community or culture of which the individual is a part. He too has identified the following factors as influencing the extent to which a person will take steps to protect against infection: a person's perception of his or her own ability to undertake a certain behavior; the perception of the personal risk of HIV infection (it is common for many people to underestimate the dangers posed by personal behavior and the risk of HIV

infection) outcome expectations (the results of adopting a new behavior); Perceived social and community norms.

The basic premise is the assumption that people make decisions about and potentially have control over their behavior. However, Moloney (2005) states that emotional factors may interfere with rational decision-making. This together with feelings of depression, suicidal or other self-destructive tendencies, the erotic arousal of taking risks, internalized homophobia in some men who have sex with men and feelings of guilt in some survivors can all be obstacles to safer sex (Moloney, 2005).

HIV prevention behavior programmes can target individuals, families, communities, entire societies or (ideally) a combination of all these. Well-designed programmes seek to achieve results on multiple levels. They promote accurate individual knowledge and perception of risk and increase individual motivation to avoid risky behavior (the Global HIV Prevention and Working Group, 2008). Prevention programmes also build individual skills needed to use to effectively negotiate risky situations. Within households, HIV prevention programmes aim to decrease the stigma associated with both HIV and sexuality, to promote open discussions about sexuality and drug use and to influence gender roles and norms. At a community level, effective HIV programmes seek to increase the value associated with safer behaviors to support community members reduce their risk, to build solidarity and reciprocity and to reinforce new norms (The Global HIV Prevention and Working Group, 2008).

Human behavior is complex. Widespread behavior changes are challenging to achieve and there are important gaps in knowledge on the effectiveness of HIV prevention (Global HIV Prevention Group, 2008). Yet, research to date clearly documents the impact of numerous behavioral interventions in reducing HIV infection. A study

carried out in Uganda by the Makerere Institute of Social Research (MISR), (2003), indicates that Uganda is internationally considered a leader in responding to HIV/AIDS and many countries are keen to learn the approaches that have been used and if possible replicate them. The study was to establish the social and cultural factors that had impacted on HIV in Uganda and in particular their role in enhancing behavior change. The findings from the study indicated that there was a strong relationship between information, awareness, knowledge, perception and behavior change (Makerere Institute of Social Research (MISR), (2003). HIV prevention efforts targeting young people have traditionally focused on delaying the onset of sexual intercourse, promoting abstinence, decreasing frequency and number of sexual partners, safer sexual practices and condom use and treatment of STIs (FHI, 2001).

Karuru (2004) carried out a study on factors predisposing adolescents to HIV/AIDS in selected secondary schools of Kiambu District, Central Province, Kenya. It was a cross-sectional descriptive study aimed at investigating the factors that predisposed adolescents to high-risk sexual behaviors leading to HIV/AIDS infection. The population consisted of 600 secondary students from three selected Divisions in Kiambu District. The study indicated that the students were aware of the factors that can predispose them to HIV/AIDS. The average number of sexual partners for male students was higher (47.9%) as compared to that of female students (24%). The study recommended that adolescents must learn the facts on reproductive health before they become sexually active and that the information needs to be regularly reinforced and built in both the classroom and beyond.

Ambagwa (2004) carried out a study on knowledge of the relationship between Sexually Transmitted Infections and HIV transmission among secondary school students in Kabartonjo Division, Baringo District, Kenya. It was a descriptive cross-

sectional study, aimed at establishing the student's knowledge of the relationship between STIs and the transmission of HIV. A total of 365 sampled respondents were interviewed. About 50% of them were aware of clinical symptoms of STIs in both males and females. The results further showed that 86% of the students considered STIs to be a serious problem, 39% perceived themselves as being at risk of contracting STIs and 39.7% reported being at risk of contracting HIV. The study concluded that there was need to strategize on information, education and communication targeting adolescents on knowledge of STIs as a measure of curbing the transmission of HIV.

Onyango (2002) carried out a cross-sectional exploratory study aimed at determining the Factors that influence risky sexual behavior among the youth in selected school in Bondo District, Kenya. The schools were selected by purposive sampling, while the study subjects were selected randomly using a table of random numbers. Data was collected using self-administered questionnaires and key informant interviews. The results of the study showed that 94% of the youth who engaged in risky sexual behavior knew that HIV/AIDS was not curable and 60% of them still had multiple sexual partners. The media had a great influence on the youth with 66% of them having copied and performed certain activities picked from the media. The study concluded that there was need to give particular attention to health and sex education to the youth in and out of secondary schools in an attempt to stem the increasing incidence of HIV/AIDS among the youth.

Noor (2003) also conducted a study on the Socio-economic and Cultural factors in the transmission of HIV/AIDS among schools and college going youth in Central Division of Garissa District, Kenya. 389 students aged between 15-24 years were involved. Data was obtained through structured questionnaires and focused group

discussions. The results of the study indicated the existence of disparities especially in knowledge possessed by students. The study concluded that there was 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. The study recommended that the youth be empowered and efforts made to encourage youth-friendly approaches in dealing with HIV/AIDS.

Obiero *et al.*, (2000), conducted a study among unmarried adolescents aged between 10-24 years, in Nyamira District. The study indicated that the maiden age for the first sexual experience among adolescents was 14.5 years for girls and 16 years for boys. The same study revealed that 55% of the boys and 44% of the girls had had a romantic relationship with a member of the opposite sex. According to the study, a large number of the youth engaged in sex at an age when they could not understand the consequences of their actions resulting in unwanted pregnancies, abortions and Sexually Transmitted Infections. The study recommended that educating young people on reproductive health and trying to understand their reasons for engaging in unsafe sex in this era should be considered.

Makerere Institute of Social Research (2003) carried out a study in Uganda to establish the social and cultural factors that have impacted on HIV/AIDS in Uganda and their role in enhancing behavior change. The findings from the study indicated that there was a strong relationship between information, awareness, knowledge, perception and behavior change. According to the study, although knowledge of HIV/AIDS (measured by people's knowledge on how HIV is transmitted and how it can be prevented) was found to be near universal, big gaps were noted especially in areas where access to information was limited. There was also universal willingness and determination to change behavior especially among adolescents and women.

A behavioral surveillance survey (2002) was carried out by the Government of Kenya. It was to monitor and evaluate knowledge in HIV/AIDS attitudes and behavior in populations at particular risk of HIV infection, such as youth and female commercial sex workers. The study established that Kenyans were very knowledgeable about HIV/AIDS and STIs and a substantial proportion reported having many sexual partners. Condoms were not used consistently with higher risk partners. Trust of a partner was the most common reason for not using condoms at last sex. Youths mentioned dislike of condoms as a reason for not using them. This persistent behavior indicates that heightened awareness of HIV/AIDS and STIs had not translated into safer sex.

From the afore-mentioned, it is evident that various studies have been carried out in the field of adolescents and HIV/AIDS. However, most of these studies have focused on knowledge, attitudes, and the use of VCT by the youth. A study carried out by Obiero *et al.*, (2000), indicated that despite adolescents having information and awareness on HIV/AIDS, many were still engaging in risky sexual behavior. Karuru, (2004) looked at factors inclining young people to HIV/AIDS in chose optional schools of Kiambu District, Central Province, Kenya, but did not look at the factors influencing behavior change among the students, hence the need for this study. Another study carried out in Uganda by the Makerere Institute of Social Research in 2003 focused on behavior change of the out- of- school youth. However, this study focused on school going youths where most of the behavior programs have been implemented.

The worry for adolescents in optional schools is overpowering in light of the fact that in Kenya (Osupuko Division comprehensive), age at first sex is low (14 years) and age at first marriage appears to have been declining (16 years) adding to watched

increment in school dropouts (NASCO, 2015). As indicated by the worldwide HIV anticipation working gathering (2003), many investigations have shown that an assortment of techniques can enable people to start conduct change and manage sound conduct to lessen chance.

The requirement for this investigation is upheld by the Global HIV anticipation working gathering (2003), which shows that conduct change and upkeep programs give basic wellbeing data, rouse individuals to lessen dangers and increment a person's aptitudes in arranging more secure sex. It is likewise obvious that in the current years in Kenya, treatment has been over-underlined eclipsing aversion. HIV reactions in Kenya have been driven from the national level with general and larger projects that have not concentrated on the extraordinary needs of particular most in danger populaces like the young in country regions. Empirical evidence is still lacking on behavior change by the youth and others to effectively adhere to abstinence and condom use promotion among the youth in school is difficult, hence the need for this study. The high level of awareness of HIV and AIDS in Kenya has not been matched by comparable behavior change especially among the youth.

Further, as per the KAIS 2008 report, 70% of HIV positive grown-ups are presently living in country territories while the majority of HIV battles are packed in the urban regions thus this examination with the goal that the investigation discoveries could be utilized as a part of giving strategies and rules on the HIV and AIDS reaction in Kenya. Youth speak to the eventual fate of Kenya and need uncommon consideration in HIV counteractive action programs. They report high sexual action and low condom utilize, which puts them at expanded danger of contamination with STIs including HIV. A multi-faceted approach that includes forbearance, loyalty and condom utilize is critically required.

### **2.3 Students' Personal Characteristics and HIV/AIDS prevention**

In 1981 a form of HIV and AIDS was discovered among Homo sexual males in United States of America. Since then, the disease has threatened to wipe out the achievements made in the last half of a century for example reducing infant mortality rate, poverty levels, literacy level, control of communicable diseases including, tuberculosis and improved health care access. The principle cause of worldwide mortality among adults aged 15 to 59 has become HIV/AIDS (WHO, 2005).

One of the main challenges to halting the spread of HIV and AIDS has been cultural norms regarding gender roles which impact sexual behavior. This challenge is particularly relevant for youth, who inherit this view from their cultural environments, act upon these beliefs with often disastrous health consequences, and transmit these views to their own offspring, perpetuating a cycle of gender inequality and related sexual behaviors. Half of the 5 million new cases of HIV infection occur in youth aged between 15 to 24 (UNPF, 2003). The present study argued that addressing the challenge of cultural gender-related beliefs is paramount to combating the spread of HIV and AIDS among youth, which must include interventions that target young men and parents, in addition to young women, who use local cultural traditions that promote female empowerment. Specifically, cultural beliefs related to the engaging in sex, condom use, and sexual coercion will be examined.

Recently, women empowerment has been repeatedly recommended as a main focus of funding in combating HIV and AIDS, particularly through general education, as well as through sexual and reproductive health education and negotiation skills (Global



Campaign for Education, 2005; (Herz & Sperling, 2004; UNPF, 2003). For example, studies in Zambia, Uganda, and Kenya found that educated girls are less likely to become infected with HIV (Herz & Sperling, 2004).

There are a number of recurring gender-related beliefs about behavior surrounding sex that hinder safe sex. For example, in a number of cultures, it is expected for women to be passive, and assertive, discussion about sex and sexually transmitted disease (STD) protection would be viewed as unfeminine and when young women ask questions to parents or teachers about sex, carry condoms, or attempt to discuss sex openly with partners, they are seen as promiscuous (Levinson, Sadigursky, & Erchak, 2004).

Cultural beliefs about masculinity also hinder safe sex. Views that men who have numerous sexual partners are studs and that sex with a virgin protects you from AIDS, and that men have to be quick, decisive, and not talkative, might help spread HIV and AIDS (Levinson *et al.*, 2004 UNPF, 2003). For example, in focus groups with Brazilian adolescent boys, did not engage in discussing safe sex with their partners for fear of being seen as not masculine because they talked rather than took action (Levinson *et al.*, 2004).

In Latin America, Machismo, that is the strong adherence to a rigid masculine role that emphasizes dominance and authoritarianism, is customarily seen as promoting sexual inequities. However, machismo also includes features such as self-respect, dedication to one's family, and the responsibility to protect and provide for the family (Jaes Falicov, 1996; Torres, 1998, as cited in Ferrari, 2002). This could be used to counter the view that men should have multiple partners, and to promote the protection of women. The latter point could take the following format.

Young men would be educated that women are more prone to HIV and AIDS than men due to biological reasons such as the nature of maturing reproductive tracts and the tear-prone quality of the vagina (UNPF, 2003). They would be told that 62% of young women aged 15 to 24 are living with HIV and AIDS worldwide, as compared to only 38% of young men (UN AIDS, 2001 as cited in UNPF, 2003). The role of men would then be defined as that of protecting women against this inherent vulnerability. Redefining masculinity within cultural limits could be promoted by male role models such as sports celebrities. This type of approach would no doubt garner the support of more traditional parents and community leaders. A paramount deterrent to safe sex is young women fearing sexual violence and young men coercing women to have sex, either through pressure or through rape. In particular, high levels of violence against women and girls are unremittingly present in parts of Sub-Saharan Africa (Sachs, 2005).

Girls' first sexual experience is often forced, with as high as 30% of first encounters being coerced in South Africa (UNFP, 2003). Sexual coercion is often condoned by adult men and seen as normal rough sex (UNFP, 2003). Although young women need to be taught to say no to unwanted sex, there is often nothing they can do when a stronger man uses violence. Thus, awareness campaigns need to target young men and promote respect for women, to denounce sexual coercion, and define rape clearly.

Inherent in views that coercion is acceptable is the devaluing of female sexuality that is, female desire and pleasure is seen as unimportant, and female pain is

ignored. Again , values already present in specific cultures can be used to promote a view of the role of men as attending to women 's needs for painless and pleasure-promoting sexual experiences. For example, in China, Confucius' Book of Rites could be used to promote the view that it is men's duty to care for his partner's emotional needs and sexual rights (Wolf, 1997).

Attending to gender-related cultural norms is of paramount importance in preventing the spread of HIV and AIDS. Such an approach is not about being culturally insensitive or imposing Western values, it is about helping communities take the blindfold off when it comes to the reality of sexual behavior and sexually transmitted disease among their adolescent and young adults and finding culturally significant ways of addressing this very important urgency. Despite the fact that the Muslim world is a home to many of the behaviors, such as premarital sex, adultery, prostitution, homosexuality and intravenous drug users which have helped spread HIV and AIDS in other countries and regions around the world, many governments in the Muslim world have been slow to respond to the rapidly spreading disease (Kelly & Eberstadt, 2005).

The rapid spread of HIV and AIDS in countries south of the Sahara over the past decade is no longer a health problem, but a major cause for the ongoing development crisis. Education is one of the many sectors that are being devastated by the spreading of the pandemic in those countries (UNAID, 2000). The pandemic is concentrated in so called Aids belt stretching from East though Central to South Africa where infection rates are now between 20 and 30 percent of the sexually active population.

The bulk of the new AIDS cause is among young people aged 15-25 and females are disproportionately affected (UNESCO, 2002). These countries will experience most severe demographic effects of HIV and AIDS over the next 25-30 years after the epidemic has peaked. Decades of improvements in social welfare are likely to be undermined by the uninhibited progression of the epidemic. AIDS-related mortality has begun to eliminate the gains made in child survival over the past 20 years. Life expectancy will drop to 30 years or less in nine Sub-Saharan countries by 2010 (UNESCO, 2002).

As they mature and become sexually active more young people face serious risks with too little factual information, too little guidance about sexual responsibility, few skills about how to protect themselves from adult coercion and too little access to youth friendly health services (Kelly, 2008).

The primary mode of HIV/AIDS transmission is sexual. Because gender norms shape attitudes towards and information sharing on sex, sexuality, sexual risk taking and fidelity, they play a clear role in determining the course of the epidemic. In some societies, gender norms require females to remain ignorant, passive, subordinate and faithful in sexual relations while simultaneously promoting the notion that men ought to be knowledgeable and experienced. This may prevent both sexes from accessing preventative or curative information and services. A series of vulnerability factors influence the engagement in risky sexual behaviors. Determinants of female vulnerability include poverty, cultural and sexual norms, violence, legal issues that impede women's access to assets, information and services and physiological factors (G.O.K, 2015). Youths both male and female are particularly vulnerable and at risk due to risky behaviors such as unprotected sex, injecting drugs, commercial sex and a

limited empowerment. Limited empowerment, restricted access to and control over resources, assets and opportunities, economic dependence of females on males, and associated power differences between sexes particularly in sexual relations are associated with women's limited control over their own health, the timing, context, and safety of intercourse and vulnerability to gender based violence. In some contexts, female responsibility for care giving reduces girls and women's participation in productive and economic activities (including education) as the epidemic spreads. This in turn constricts women's social and economic opportunities further contributing to the cycle of poverty, lack of empowerment and vulnerability to infection. In some cases, laws and regulatory frame works discriminate against women and reinforce their subordinate status in such spheres as property and inheritance rights, marriage, employment, rape, and sexual harassment and reproductive rights. Physiologically, women are more susceptible to HIV infection than men are.

Transmission during sexual intercourse is almost twice as likely to lead to female infection as to male infection. Gender based cultural practices such as female genital mutilation and widow inheritance may increase the spread of the HIV virus. Stigma and a culture of silence and denial exacerbates the epidemic by preventing diagnosis and care seeking and reducing communication between sexual partners. According to Bennett *et al.*, (2007), adolescence is a period of transition from childhood to adulthood marked by physical, psychological and social maturation. This is due to unplanned sexual intercourse as young people do not plan about having sex because the social environment does not allow them to do so.

Maturing also means developing one's own adult identity as part of a gender specific process. The process of changing from child to adult often takes the form of testing

alternative views, behaviors and norms. As part of this process, adolescents tend to increasingly identify themselves with peer group values or behavior. Risky behavior among adolescents is associated to rebellion against adults, which is a normal part of teenagers acquiring their own identity. The risks may be different among young people in different cultures but often include experimentation with sexual activities, alcohol and drug abuse. Risk taking among adolescents is strongly linked to the fact that the pleasure or importance of the movement may outweigh their ability to foresee or care about long-term consequences of their actions. Because adolescence is a period in which an identity is acquired, it is also a period of uncertainty (Jackson, 2002).

Risky behavior among adolescents is associated to rebellion against adults, which is a normal part of teenagers acquiring their own identity (Jackson, 2002). The risks may be different among young people in different cultures but often include experimentation with sexual activities, alcohol and drug abuse (Jackson, 2002). Risk taking among adolescents is strongly linked to the fact that the pleasure or importance of the movement may outweigh their ability to foresee or care about long-term consequences of their actions. Because adolescence is a period in which an identity is acquired, it is also a period of uncertainty (Jackson, 2002). When young people have a sense of self-efficacy and self-esteem (rather than powerlessness and a sense of self-worthlessness), they are better able to make their own decisions, they have less need to prove themselves to their peers by taking risks (Jackson, 2002).

Despite huge prevention efforts, numerous studies have revealed substantial cases of unsafe sex in the population at large and in different subgroups amongst the youth throughout the world. Kenya Ministry of Health (2005) states that early marriage or what is normally called child marriage is constitutionally illegal but culturally

accepted and tolerated. The age that was reported was 14 years and 19 years (Kenya Ministry of Health, 2005). Many parents would force their daughters to name the sexual partner responsible for the pregnancy so that they would negotiate for marriage. Early marriage has also been attributed to idleness, giving love for money and parent's lack of school fees, which makes them give in to the pressure for marriage (Republic of Kenya, 2005). Behavior Change Communication (BCC) strategies play a vital role in this process and can set the tone for a comprehensive response (FHI, 2001). BCC strategies can function to support all components of a comprehensive prevention and care program and create a cohesive environment for behavior change.

In Kenya evils of HIV infection are alarmingly high among young people, particularly women special efforts are required to protect the youth. It is difficult to change behavior pattern and especially sexual behavior pattern, once it has become a habit. Around the world successful prevention programs among young people are ones, that equip adolescents with the knowledge, skills and attitudes that will keep them safe from infections before they become sexually active (GOK/MOH, 2001). The government has recognized the vulnerability of youth. In the Sessional Paper No. 4 on AIDS in Kenya has committed itself to protecting young people from HIV infection by equipping them with adequate knowledge and skills. Further, the government has stated that as a matter of policy, it has integrated AIDS education programs into existing school curricular. This has forced schools especially secondary schools institutions to implement the policy to mitigate the spread of HIV/AIDS among young people teachers and all workers/service providers.

As a rule, young men meet young ladies on their way to the market or waterway and in the event that they concur, they have sex. It is at this age that the rate of STIs

including HIV/AIDS is at its highest. In most traditional societies, the period of transition from childhood to adulthood was short. Young people often took on the same responsibilities as adults. The change was often abrupt marked by ceremonies of initiation, which included practical instruction on adult behavior and sex education unlike in the modern society (Bennett et al., 2007). This has resulted to a large number of the youth engaging in sex at an age when they cannot fully realize the consequences of their actions resulting in unwanted pregnancies, abortions and STIs. This is complicated further by high frequency of changing sexual partners.

To understand young people's behavior, it is necessary to understand the period of adolescence, the challenges it brings and the changes that come with it. Physical, mental and emotional development occurs at different and uneven rates in adolescents. They become physically mature before they have fully developed mental, emotional or social skills necessary to understand or practice safer sex behavior. As part of maturing process, young people often question established social norms and attitudes. Therefore, it was necessary investigating factors influencing prevention of HIV/AIDS among students in c secondary schools.

#### **2.4 Influence of Resources on HIV/AIDS Prevention**

HIV/AIDS threatens sustainable development, not just in regions that are already seriously affected, but also in those where it is spreading fast right now, such as Asia and Eastern Europe. The latest epidemiological data show that infection rates in many Asian and Eastern Europe countries stand today where they stood in southern African countries 12 years ago, and that they are steadily growing. In the meantime many lessons have been learned. Countries like Senegal, Thailand or Brazil whose governments have openly acknowledged their HIV/AIDS epidemic and implemented



comprehensive, multi-sectoral responses have been able to reverse the fatal trend. Today, there is still a window of hope for many regions if government and development actors in all sectors acknowledge the exceptionality of the HIV/AIDS crisis and devise sector specific responses to it (Fact Sheet, 2003).

The impact of HIV/AIDS on the supply and quality, demand and access of education must be a crucial issue for the development of the community. HIV and AIDS reduce the supply of educational services as a result of teacher attrition and absenteeism. Studies predict teacher shortages in many countries, including Kenya, Malawi, Nigeria, South Africa, Zambia and Zimbabwe. There is little doubt that the epidemic is seriously damaging the quantity and quality of education which in turn is violating the right to basic education (Fact Sheet HIV/AIDS & Education, 2005).

The education system is affected by AIDS in many ways. Children infected with HIV at birth do not live to enroll in school. Many children have to drop out of school when they become orphans or attend to sick family members. Teachers are dying from AIDS and Education is one of the solutions to the problem, School, based programs can help young people understand how to avoid the risks of unsafe sex (UN AIDS, 2004). HIV and AIDS have the potential to create severe economic impact in the world.

It causes reduction in the size and experience of the labor force, increases health care expenditure, raises the cost of labor, and reduces savings and investment. HIV and AIDS is different from most other diseases because it strikes people in the most productive age groups and is essentially 100% fatal. The economic effect of AIDS

will be felt first by individual and their families, and then will ripple outwards to low demand in education and high expenditure for treatment, (GOK/UNICEF 2005). HIV/AIDS will affect the supply of education in the region through deaths of personnel, school closure and reduced budgets for education and reduced capacity of households to contribute for financing education.

Teachers and other education personnel receive higher incomes which enhance greater mobility and consequently place them at greater risk, Furthermore teachers and other education personnel may be posted to areas away from their families, which results in high risk behavior leading to HIV infection (World Bank, 1995). After the initial incubation period of the disease, there will be absenteeism caused by illness, the need to tend to the sick and attending funerals, loss of staff due to increased mortality rate and transfers from or refusals to be posted to heavily affected areas. Sick leave for ministry personnel becomes a financial burden to governments since they are entitled to pay for up to one year, (UNAIDS, 1999).

At school and community level, as extended families grow, available income decreases while more financial resources are needed for illness and death, thus also money is contributed by the community to the school. At the level of the education system, funds may be required for health related personnel costs such as treatment and care of staff, insurance and death benefits. These will be a greater need for training and paying replacements of affected personnel who may still be on the payroll and on implementing an effective AIDS education policy (Kelly, 2008).

At the same time, increased funds will be required for new clients and roles which the education system may need to adopt scholarships for orphans, teacher training in

counseling, new curricular in life skills education and new school based programs in income generation. The Ministry of education however may receive a diminishing proportion of the national budget as demand for resources increases from other sectors (ibid). Kafu (2005) argues that, HIV/AIDS education has not been taken seriously because there are no trained teachers and also there are no instructional material resources which play a significant role in curriculum implementation. Teaching of HIV/AIDS in secondary schools requires that there is preparation and distribution of scientifically accurate, good quality teaching and learning materials on HIV/AIDS. Therefore, it was necessary investigating factors influencing prevention of HIV/AIDS among students in secondary schools.

In Kenya, the Ministry of Education, Science and Technology (MOEST) launched the education sector policy on HIV/AIDS in 2004. The policy provides a framework for the teaching of HIV/AIDS education in learning institutions (MOEST, 2004). However, the adoption of teaching HIV/AIDS education in schools is slow. The study therefore analyses the availability of materials that provide guidelines towards the teaching of HIV/AIDS education. The task of strengthening school system to meet the pressure posed by AIDS and other problems needs to be based on sound evidence of actual conditions in the education sector in order to know how best to apply scarce resources.

Recently a study was undertaken on how ready the education sectors in various parts of the world have responded to the impact of AIDS (Boler and Jellema, 2005). The study used two approaches. The first used a self-assessment questionnaire sent by post to ministries of education in 117 countries, from which 71 replies were received. The second sought input from civil society organizations through workshops that brought

together representatives from non-governmental education networks, teachers unions and ministries of education in 18 countries heavily burdened by AIDS.

A summary report unifying the two approaches revealed mixed results (Inter Agency Task Team on Education (IATT), 2006). For example three quarters of the responding countries and all high prevalence countries reported having established dedicated management structures to coordinate the response of ministry of education to the epidemic. However, 59% of these structures in all countries and 70% in high prevalence countries did not have a dedicated budget calling into question the actual powers and effectiveness of these structures. The introduction of teaching HIV/AIDS education to the already struggling African education system is likely to influence its adoption. Thus, this study examines the adoption of teaching HIV/AIDS education in secondary schools, by analysing the availability of HIV/AIDS education teaching resources for example syllabus and text books.

### **2.5 Policy Measures for the Prevention of HIV/AIDS.**

In the United States, the effectiveness of public education programs that target people at risk for HIV infection was well demonstrated in the gay community of San Francisco, Californian in the 1980s. In 1982 and 1983, 6000 to 8000 people of San Francisco became infected with HIV. The gay community rallied to promote condom use and advocate monogamy through extensive education programs geared for gay men. These public education programs were credited with reducing the number of gay men in San Francisco who became HIV infected. By 1993 the numbers of new infections declined to 1000 and by 1999 fewer than 500 people were infected each year (Bertlet, 2004).

In Jamaica there is no known case of transmission of HIV/AIDS within educational institution, there are students with HIV and aids in school. Children who acquire HIV prenatally will with adequate medical care reach school going age, and with HIV/AIDS infected educators form part of the population of educational institution.

Since the detection of HIV case in Jamaica it is estimated that over 22000 persons are living with HIV/AIDS. The Caribbean region has the second largest HIV/AIDS prevalence rates after sub-Saharan Africa (Piot, 2004).

The new initiative, Focusing Resources on Effective School Health (FRESH) launched at the world education forum in Dakar Senegal (April 2000) jointly held the belief that there is a core group of cost effective activities which when implemented together, provide a sound basis and point of departure for intensified and joint action to make schools more healthy for children, children more able to learn and education for all more likely to be achieved (FRESH, 2000). The education for all initiative was launched in Jomtien, Thailand in march 1990 with respect to the growing HIV/AIDS epidemic, four pillars of the FRESH approaches are clear school health policies on HIV/AIDS, discrimination, healthy school environment, skills based education for the prevention of HIV/AIDS, school based counseling and student clubs for prevention of HIV/AIDS. This calls for a need to provide teachers and other educators with guidance on how to develop and implement an effective school based programs for education on HIV/AIDS prevention (Walberg, 2002).

Public education on HIV/AIDS has also proven effective in Uganda. It was the first African country to embrace aids control measures. The first cases of aids were reported in 1982 and by late 1980s Uganda had one of the highest rates of HIV infection in the world. The Ugandan government was one of the countries to set up partnership with world health organization to create a national aids control program

called AIDS Information center (AIC). The education programs promoting condom use and other methods to prevent HIV/AIDS from spreading further. The AIC promotes its message using innovative drama song and dance programs, particularly effective methods for African communities. AIC established confidential HIV testing services that provide same day results and counseling programs as a result of quick response to the aids epidemics the number of HIV infect people in that country has declined significantly since 1993, during a time when most other African nations faced frightening increases in the incidence of HIV infection (Dowsett, 1993).

Consequently, the Kenyan government saw education as an important tool which may be used to stop the spread of HIV and Aids programs after a slow start. Kenya has made great strides in the fight against HIV /AIDS pandemic. Since the discovery of the first Aids case there has been investment in a variety of interventions including treatment, management care and support (Odi workshop, 2006). There was need for clear policy to support the various interventions soon after the government declared HIV/AIDS a national disaster in 1999. In 2000 the government puts in place multi-sect oral strategy to guide the various stake holders in their participation in the war against the disease. Through these efforts Kenya is one of the few African countries to register a sustained decline in HIV infection rates (from 10% in '90s to 7% in 2003) as a result of the large investment in various interventions against the pandemic (Ibid).

Drawing from the national HIV/AIDS strategy the ministry of education science and technology has taken the initiative to prepare for implementing the ministry-specific HIV/AIDS policy. It has put in place sector-wide support program (KESSP) which has adopted a program for implementing HIV/AIDS policy in schools in Kenya.

The aim is to create HIV/AIDS education awareness and prevention projects (Sessional Paper number 5, 2005). At the school level Kenya has invested in a national HIV/AIDS Curriculum which was launched in 2000 and since then all Secondary Schools were expected to implement the curriculum through infusion method. In 2004 the Kenya Institute of Education revised the National curriculum for secondary schools and all teachers are expected to teach using revised curriculum.

### **2.5.1 Government Policy on HIV/AIDS and the Youth**

The government of Kenya is committed towards eradicating the HIV/AIDS scourge, for instance, on November 14<sup>th</sup> 1999, the government declared H.I.V/A.I.D.S a national disaster (NACC, 2000). In addition, the Sessional Paper No. 4 of 1997 of the Republic of Kenya gives the following guidelines on youth education. The government, in 2001 revised the secondary school curriculum by incorporating STI as an integral subject among the various subjects being taught in the schools (K.I.E, 2001). The topics covered under STI include any one of the following: gonorrhoea, Chlamydia, herpes, candidiasis, trichomoniasis, HIV/AIDS, and syphilis. Students are supposed to understand the other STIs through their own private studies (KIE, 2001). The overall goal of the AIDS education programmes is to prevent the spread of the HIV/AIDS among the youth in and out of school through behavior change.

Kelly (2000) points out that adolescents in secondary schools are predisposed to HIV infection due to the fact that schools provide little help to them on sexual and reproductive health despite the efforts to provide them with knowledge on HIV/AIDS. Little counseling is offered to assist them in understanding their sexual identity and how to cope with its demand. The values of behavioral standards communicated to adolescents through the mass media and society around them weakens their ability to

deal in a mature way with their emerging sexuality as societies continue to be sexually permissive. Similarly, unwillingness of parents to discuss sexual issues with adolescents predisposes them to negative influences in and outside school. Lastly, since adolescents belong to a group, which is most likely to be AIDS free, young boys and girls are subjected to sexual attention from adults who may be infected by the HIV virus (Kelly, 2000).

### **2.5.2 National Policies for HIV Prevention**

Despite an initial reluctance during the 1980's to acknowledge the gravity of the epidemic, Kenya now has political commitment to reverse the spread of HIV and AIDS. The National AIDS Control Council (NACC) was established in 2000 under the Office of the President to provide leadership and a stronger coordination mechanism for a new multi-sectoral national response to HIV/AIDS (NACC, 2009). The NAC has a costed plan for effective HIV management, including HIV prevention, for the period 2005/6-2009/10 and coordinates all HIV and AIDS programmes, policies and interventions in the country, working and liaising with stakeholders from government, civil society, the private sector, external agencies and the corporate world.

In September 2003, the Kenyan government approved a bill that would make it a criminal offence to terminate or deny employment to anyone on the basis of his/her HIV status and would prevent insurers from raising premiums or denying services to HIV-positive clients. With the passing of the HIV/AIDS Prevention and Control Act in December 2006, Kenya now has a policy prohibiting HIV screening for general employment purposes and ensuring that AIDS research protocols involving human subjects are reviewed and approved by a national or local ethical review committee



(NACC, 2009). The country has anti-discrimination laws and regulations that specify protection for vulnerable subpopulations which include children, women and young people. Promotion and protection of human rights is explicitly mentioned in some HIV policies and strategies and there also policies and laws against child marriage, sexual abuse and gender-based violence.

The country has a national policy for free (to users) HIV-prevention services, Antiretroviral Therapy and HIV related care and support interventions. Through the Joint

Annual Performance Review (JAPR) process, the NACC conducts regular national annual reviews to monitor and evaluate the progress in implementing the national strategic plan including whether current practices promote risk behavior or hamper access to HIV prevention services (NACC, 2009). Kenya has a policy or strategy that promotes information, education and communication on HIV to the general population.

The key messages that are explicitly promoted include being sexually abstinent, delaying sexual debut, being faithful, using condoms consistently, engaging in safer sex and involving people with HIV to a greater extent in the national response. The government promotes increased knowledge of HIV status by vigorously promoting counseling and testing. Other policies it promotes include, blood safety, personal hygiene and sanitation, improved methods of waste disposal, HIV-related reproductive and sexual health education for young people and HIV education as part of the curriculum in primary and secondary schools and teacher training colleges (NACC, 2009).

## **2.6 Institutional Related Factors and HIV/AIDS Prevention**

The social concern for students with HIV/AIDS requires timely and focused responses from educational institutions. Appropriate responses, including prevention and intervention strategies might necessitate policies to guide the management of the incidents of HIV/AIDS among students and others in the education sector. The Ministry of Education internationally, regionally and locally recognizes the fact that there is a great deal that can be done to influence the course of the epidemic, is committed to minimizing the social, economic and developmental consequences of HIV/AIDS to the educational system, and to provide leadership to implement an HIV/AIDS policy. The policy should be interpreted to ensure respect for the rights and dignity of students and school personnel with HIV and AIDS as well as other members of the institutions community (UNAIDS, 2004).

The role of educational institutions in imparting knowledge regarding HIV and AIDS has been proven important opportunity in reducing the impact of the epidemic on our society. Development of a policy for schools in a world with AIDS is important, but it will only have desired impact if it is implemented effectively. Schools are key settings for educating children about HIV and AIDS and for halting further spread of the HIV infection. Success in carrying out this function depends upon reaching children and young adults in time to reinforce positive health behaviors and alter the behavior that place people at risk (Walberg, 2002).

Students reach adolescents at ages 13 – 18 years and have excellent resources for delivering effective education; skilled teachers, an interactive educational process that occurs over time, a variety of learning opportunities, materials and methods and the ability to involve parents in their children learning (Ibid). In combating HIV infection

the crucial responsibility of school is to teach young people how to avoid either contracting the infection or transmitting it to others, and to serve as a catalyst for the development of HIV related policies that are based on the most current scientific knowledge about HIV and AIDS. In doing so schools and especially secondary schools have the opportunity to make important improvements in the quality of health education provided to young people worldwide as a step towards improving global health (FRESH, 2000).

HIV/AIDS prevention and anti-discrimination are complex issues which demand specifically experienced educators who have acquired the particular characteristics that allow them to be effective behavior changing agents in schools. Research has found that teachers were initially reluctant to teach HIV/AIDS prevention in a way that encouraged student participation overcame this hurdle during training sessions (Walberg, 2002). Walberg, (2002) reiterated that providing school students with information on HIV and AIDS and its prevention is essential for them to develop meaningful attitudes and learn the necessary skills to help them stay uninfected. He added that in order for HIV/AIDS education to achieve its goals, teaching methods must evolve from the style in which educators lecture their students from the front of the classroom to more participatory teaching methods where students play an active role in the learning process.

Education for HIV/AIDS prevention cannot be taught effectively if fear and uncertainty surrounds the disease. These fears, attitudes, feelings and anxieties may inhibit students learning. To curb these problem interactive strategies in secondary schools can be used to promote students participation. These strategies have proved effective in facilitating learning in all domains as well as in encouraging changes

towards desirable behavior. Hence the need in implementing HIV/AIDS policy in all secondary schools (Telcher, 2002).

Education institution and services play a vital role in teaching employees and students about HIV and AIDS, shaping attitudes to HIV, Aids and people living with HIV, and building skills for reducing risk of HIV, promoting care and opposing stigmatization. Infection rates are increasing in Caribbean region prevalence rates are the second highest among regions worldwide. At the same time the education sector must take account of the fact that the people who are HIV positive can remain capable of normal work for many years, (ILO & UNESCO, 2001). It is therefore critical for education services and institutions as workplace adopt and implement policy or where such a policy exist in the education sector adopt it for use, based on the principles and concepts of the present text. This approach would enhance the education sector response in ways that protect the rights of all employees and students prevent further HIV infections and create caring, safe and supportive learning environment.

Pressure on governments in Sub-Saharan Africa (SSA) to expand secondary education is growing. Increasing numbers of students flowing from expanded primary education to secondary schools makes it inevitable that governments in SSA will turn their attention to expanding and improving secondary education (Alvarez, 2003; Mulkeen *et al.*, 2005; Secondary Education in Africa (SEIA), 2007; World Bank, 2006; World Bank, 2007). The dilemma these countries face is multifaceted. Many countries will need to continue to devote resources to expanding and improving primary education to achieve the goals of Education for All.

A realistic conversation about greater access to secondary education in Sub-Saharan Africa will need to confront the present status of education systems in terms of their capacity to sustain the growth and improvement of primary education, as well as their

existing limitations in terms of capacity and financing to simultaneously expand and improve secondary education.

There is consensus that secondary education is now the fastest growing segment of the education sector (SEIA 2001; UNESCO 2001; Mulkeen *et al.*, 2005; World Bank 2005; Di Gropello 2006; World Bank 2007). In many countries, movement away from seeing primary education as the terminal level of education towards policies that envision widespread completion of junior secondary and upper secondary as the goals of education system development is well underway, but has only recently begun in Sub-Saharan Africa (De Ferranti *et al.*, 2003; World Bank 2005).

Many challenges to expanding secondary are particular to, and particularly pronounced in SSA. Governments in Sub-Saharan Africa and their financial partners are increasingly looking to make secondary education more widely accessible, more relevant, and of higher quality. Secondary school participation rates in SSA have increased from 19% in 1999 to 30% in 2004 (SEIA 2007). However, the region faces many challenges in meeting the goal of further expansion of secondary education. In addition to access and financing issues, secondary education curricula are outdated, irrelevant, or poorly implemented. According to (SEIA, 2007), the content of programs has rarely changed to match countries that are dealing with democratization, HIV/AIDS, and changing labor market demands.

Teacher recruitment, retention, and deployment are insufficient and inefficient. Achieving the goals of universal primary enrollment (UPE) requires increasing the teacher supply by up to four times' the current levels (Lewin, and Cailloids, 2001). According to World Bank simulations based on UNESCO statistics, Sub-Saharan Africa will need more than 1,361,000 new teachers between 2000 and 2015 to meet the demands of primary education (Schwille, 2007). As more countries feel they are

reaching their UPE goals and begin expanding secondary education, the requirements for additional teachers will increase pressure on an already stretched system (training institutions, public expenditures), making the challenge seem insurmountable (Schwille, 2007). While the issues of financing, curriculum, and access are all expounded, how to content with issues of teacher supply as a critical constraint to secondary expansion is barely addressed (Lewin, and Cailloids, 2001; OECD, 2002; OECD, 2004; Mulkeen *et al.*, 2005). Enough trained teachers on teaching HIV/AIDS is a problem in Kenyan schools and the study analyzed the extent to which it could influence the teaching of HIV/AIDS education.

In Sub-Saharan Africa as well as in developing countries in other regions, the projected demand for teachers exceeds the projected supply required for expanding secondary education (World Bank, 2006). The literature generally acknowledges the lack of teachers, but fails to quantify the teacher gap. Among the constraints are the limited number of potential teacher candidates and the lack of space and funding in the teacher training colleges, which together currently prevent countries from producing sufficient numbers of qualified teachers. In addition to limited capacity to produce teachers, governments are also constrained in their ability to assign and keep teachers in remote and otherwise underserved areas. Add to that the fiscal constraint of meeting the higher wage bill implied by a dramatic expansion of the teaching force (De Stefano *et al.*, 2006). The study therefore analyzed the adoption of HIV/AIDS education. Teacher recruitment and retention is one of the most critical factors to ensure students have access to secondary education.

Recent publications and studies highlight the following challenges facing teacher recruitment and retention in secondary education across developing countries (Lewin and Cailloids, 2001; OECD, 2002; Mulkeen *et al.*, 2005; World Bank, 2005; SEIA,

2007; World Bank, 2007): High Attrition, Low salary and poor teaching conditions cause teachers to leave the field within 1–3 years of entering the service. Those teachers posted to rural areas often seek immediate transfer back to urban areas or fail to show-up to teach on a consistent basis. These arise because of low compensation (for example, other professions requiring similar educational qualification offer higher compensation).

Poor working conditions, lack of professional development opportunities, little mobility to better positions, inadequate professional support and supervision, unprofessional treatment of teachers, and lack of incentive systems to stimulate and motivate teachers to remain in the teaching field (Mulkeen *et al.*, 2005; De Stefano *et al.*, 2006; Terway *et al.*, 2007). This study analyzed the factors that influenced the adoption of HIV/AIDS education, in secondary schools.

Bottlenecks in teacher preparation systems: High rates of attrition throughout the education system (continuation to secondary education; lack of space in teaching colleges; failure to pass relevant tests) dramatically constrain the numbers of students successfully advancing through secondary education, thereby reducing the pool of potential teacher candidates for secondary education. Lack of teachers in specific subject areas like mathematics and science: Secondary education teachers require more subject-specific knowledge and few choose or are able to specialize in science and math. Some solution suggested by the world bank to overcome these problems include advising the ministries of education could also utilize existing teachers more efficiently by increasing teaching loads (the minimum number of hours spent teaching); having teachers teach multiple subjects; and sharing teachers across schools (World Bank, 2005).

Kenya, estimated that the following changes would enable a 50% increase in secondary education enrollments without adding new teachers. Increase teaching load from 18 to 25 hours, Use part time teachers for subjects taught a few periods a week, Increase student to teacher ratios to 45:1, Expand existing schools to at least three parallel streams, and Share teachers across schools. The study therefore analyzed the integration of HIV/AIDS education in the main secondary school curriculum. An important prerequisite for school-based programs themselves and subsequent teaching of HIV/AIDS education are clear policies and guidelines supporting teachers' access to both information and services. These policies should be widely known by teachers and service providers and should be implemented (Tijuana *et al.*, 2004).

In a survey by Education International of its member teacher union, 84% of those responding, most of them in Africa, said they received little or no support on reinforcing policies on the prevention of HIV/AIDS and related discrimination (Education International, 2000). Without clear guidance from mandated policies, teachers may avoid controversial areas (UNFPA, 1998), and this might lead to selective teaching (Gallant and Maticka, 2004). Avoiding controversial areas would in turn limit the youth from accessing potentially life-saving information (Boler *et al.*, 2003).

## **2.6 Summary**

From the afore-mentioned, it is evident that various studies have been carried out in the field of adolescents and HIV/AIDS. However, most of these studies have focused on knowledge, attitudes, and the use of VCT by the youth. A study carried out by Obiero *et al.*, (2000), indicated that despite adolescents having information and awareness on HIV/AIDS, many were still engaging in risky sexual behavior. Karuru,



(2004) looked at factors predisposing adolescents to HIV/AIDS in selected secondary schools of Kiambu District, Central Province, Kenya, but did not look at the factors influencing behavior change among the students, hence the need for this study.

Another study carried out in Uganda by the Makerere Institute of Social Research in 2003 focused on behavior change of the out- of- school youth. However, this study focused on school going youths where most of the behavior programs have been implemented. The concern for youths in secondary schools is overwhelming because in Kenya (Githunguri Division inclusive), age at first sexual intercourse is low (14 years) and age at first marriage seems to have been declining (16 years) contributing to observed increase in school dropouts (NASCO, 2005).

According to the global HIV prevention-working group (2003), dozens of studies have demonstrated that a variety of strategies can help individuals initiate behavior change and sustain healthy behavior to reduce risk. The need for this study is supported by the Global HIV prevention-working group (2003), which indicates that behavior change and maintenance programs provide essential health information, motivate people to reduce risks and increase an individual's skills in negotiating safer sex. It is also evident that in the recent years in Kenya, treatment has been over-emphasized overshadowing prevention. HIV responses in Kenya have been driven from the national level with general and overarching programmes that have not focused on the unique needs of specific most at risk populations like the youth in rural areas. Empirical evidence is still lacking on behavior change by the youth and others to effectively adhere to abstinence and condom use promotion among the youth in school is difficult, hence the need for this study.

The high level of awareness of HIV and AIDS in Kenya has not been matched by comparable behavior change especially among the youth. Further, according to the

KAIS 2008 report, 70% of HIV positive adults are currently living in rural areas while most of HIV campaigns are concentrated in the urban areas hence this study so that the study findings could be used in providing policies and guidelines on the HIV and AIDS response in Kenya. Youth represent the future of Kenya and need special attention in HIV prevention programs. They report high sexual activity and low condom use, which puts them at increased risk of infection with STIs including HIV. Around the world, successful prevention programmes among the youth are the ones that equip them with the knowledge, skills and attitudes to delay sex and to prevent infection once they become sexually active. Therefore this study has identified the gap in knowledge in; personal characteristics influencing HIV/AIDS prevention among students in resources related factors influencing HIV/AIDS prevention among students in public secondary schools. Policy related factors influencing HIV/AIDS prevention among students in public secondary schools and institutional factors influencing HIV/AIDS prevention among students in public secondary schools.

## **CHAPTER THREE**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 Introduction**

The chapter outlined the methodology, procedures and modalities in data collection. It also covered study area, research design, description of the sample size, sampling procedure, data collection instruments, data collection procedures, data analysis procedures, and Ethical Considerations

#### **3. 2 Research Design**

This study adopted descriptive survey design. The design enabled the researcher to describe the state of affairs as they are and report the findings (Kombo & Tromp, 2009). According to Kothari (2009), such design is efficient method of collecting descriptive data regarding the characteristics of populations to justify current conditions and practices. The design involved gathering of facts or obtaining pertinent and precise information concerning the current status of phenomenon and whenever possible draw possible conclusions from the facts discovered (Orodho 2008). Descriptive methods are widely used to obtain data useful in evaluating present practices and providing for decision. This method was appropriate as it gives a detailed description of the factors influencing prevention of HIV/AIDS among secondary schools' students in Eldoret East which may be generalized to other parts of Kenya.

This method was appropriate as it gives a detailed description of factors influencing the prevention of HIV/Aids among students in secondary schools which can be generalized to other parts of Kenya. This method lends itself to the administration of

questionnaire to the sampled individuals. This study used descriptive survey design, which employed a descriptive and qualitative survey which involved survey of intangibles (behavior). Personal characteristics, behavior and attitudes were inferred from responses made on the questionnaire and interview schedule.

Descriptive research was unique in the number of variables employed. Like other types of research, descriptive research may include multiple variables for analysis, yet unlike other methods, it required only one variable (Borg & Gall, 1989). On the other hand, descriptive research might simply report the percentage summary on a single variable. A descriptive study played an important role in educational research as it increased knowledge about what happens in schools. The design was intended to provide statistical information about factors influencing prevention of HIV/AIDS among secondary schools' students that interest policy makers and educators. By involving a broad category of head teachers, teachers and students the study fitted within the descriptive survey research design.

### **3.3 Study Area**

This study was undertaken in secondary schools in Eldoret East Sub County which is situated in Uasin Gishu County of the Republic of Kenya. The Eldoret East sub county borders the Eldoret North to the north, Wareng to the south, Koibatek, Keiyo and Marakwet counties to the East. It is worth noting that the newly created Eldoret East sub county is yet to be demarcated officially on the map of Kenya. Eldoret East Sub County was chosen for the current study because as a representative sample of other sub counties in Uasin Gishu county. It is therefore believed that the study area gave a wide and varied view of the problem under study just like any other areas in Kenya. The schools in the region were chosen because there have been reported cases

of HIV/AIDS infection among secondary school students. The region has school categories ranging from national to Sub-County schools. Hence, selection of schools of the various categories was not being a problem. Moreover, it is a multi-ethnic region thus the respondents are likely to represent the diverse ethnic groups in Kenya.

### **3.4 Target Population**

This refers to the members of a real or hypothetical set of people to which a researcher wishes to generalize the results of the study (Gall, Borg, & Gall 2003). The study population comprised of students enrolled in secondary schools, heads of the institutions and heads of Guidance and Counseling in Eldoret East Sub County. The sub county has 40 public and private secondary schools. The number of schools the study focused on was nine secondary schools. From the 40 schools, there was 1 national schools,3 county,4 sub county and 1 private school. The target population comprise of 3500 students, 40 HODs and 40 principals.

### **3.5 Sampling Procedures and Sample Size**

During the study stratified, purposive and simple random sampling was used. The researcher used stratified sampling to categorize the school types into various subgroups or strata's such as National, County, Sub county and Private schools. From each of the stratum the sample respondents were selected proportionally. The researcher used purposive sampling to select 9 head teachers and heads of departments. Purposive sampling was used since, head teachers and heads of departments were informed and have similar characteristic and therefore more homogeneous.

Simple random sampling was used to select 359 students to participate in the study. Simple random sampling was used because each respondent had an equal chance to be included in the sample. It was appropriate because the entire population is relatively large, diverse and sparsely distributed, hence random sampling technique will help to achieve the desired objective, it is cost effective and efficient in administration.

Using Yamane's (1972), sample size for proportions at 95% confidence level,  $P = 0.05$ , the sample size will be computed as below:

$$n = \frac{N}{1 + N(\epsilon)^2}$$

$$= 3500/1+3500 (.05)^2$$

$$= 3500/9.75$$

$$= 359 \text{ respondents}$$

**Where;**

$n$  = the sample size,

$N$  = the population size,

$\epsilon$  = the acceptance sampling error

From the target population of 3500 students, the researcher proportionally selected 359 students to participate in the study. The sample size comprise of 339 students, 9 HODs and 9 principals as illustrated in the table 3.1 below.

**Table 3.1: Sampling Procedures and Sample Size**

Type of school	Number of schools	Number of selected schools	Number of students
National	1	1	80
County	10	3	145
Sub county	23	4	114
Private	.6	1	20
<b>Total</b>	<b>40</b>	<b>9</b>	<b>359</b>

### 3.6 Data Collection Instrument

The instruments of data collection used were questionnaires, interview schedule, and document analysis.

#### 3..6.1 Questionnaire

A questionnaire contains a set of questions which can be answered by the research participants in a set of ways. According to Kombo and Tromp (2006), a questionnaire is a research instrument that is used to gather data over a large sample. Most questionnaires are designed to gather already structured data and so include a set of answers which the respondent can choose from, although some may include more open-ended questions which allow the respondent to answer the question in their own way, others give a provision where all the participants are asked the same questions, in the same order and using the same wording and have the same set of answers to choose from (Matthews and Ross 2010). Basing on this argument, the researcher was able to collect information from various schools over a short period of time.

According to Kothari (2008), questionnaires are usually free from the interview bias as the answers are in respondent's own words. Respondents have adequate time to give well thought out answers. Orodho (2003) also argues that a questionnaire is an

efficient research tool which when used the researcher will obtain personal ideas from a respondent. A questionnaire was preferred in the study for collecting data because the questions, wordings and sequence are fixed and identical to all respondents. Secondly, it was deemed to have the advantage of obtaining standard responses to items, making it possible to compare between sets of data. Thirdly, it allowed the participants to give their own opinion on the issue at stake for instance the Likert scale questions (Matthews and Ross 2010). The questionnaires were administered to Heads of Departments and students as this was meant to comply with requirements of the research design in use.

The questionnaire for the students (Appendix II) and HOD's (Appendix III) questionnaires were structured in such a way that the first section was aimed at getting personal information such as gender and age and type of school in order to identify their response on awareness of HIV/AIDS, followed by factors influencing the prevention measures and establish their opinion on challenges they experienced. The questionnaire was in two parts: The first part covered background information of the respondents; the second part sought to answer the research questions. The questionnaires adopted a five point Likert scale ranging from strongest concurrence through neutral concurrence to no concurrence in response to a particular concept. The closed ended questions from the questionnaire generated quantitative data.

### **3.6.2 Interview Schedule**

An interview is a particular type of conversation between two or more people. Usually the interview is controlled by one person who asks questions. Orodho (2008) postulates that many people are willing to communicate orally than in writing and they would provide data more readily and fully than on a questionnaire. Basing on Kumar (2006), the advantages of using a structured interview is that; the



researcher was able to clarify any queries concerning the questions. This ensured that answers were reliably aggregated and allowed comparisons to be made. In this, participants can discover, uncover or generate the rules by which they are playing this particular game. The interviewer can become more adept at interviewing, in general, in terms of the strategies which are appropriate for eliciting responses (Tight, Hughes and Blaxter, 2006). A structured interview guide was used to gather information from head-teachers as this was deemed to go in line with the research design adopted. The items in the interview schedules assisted in giving further in depth information on the required data that may not be captured in the questionnaire. This method was advantageous in the sense that the key informants provided and even expound precisely on most of the issues in detail and elicited qualitative data.

### **3.6.3 Document Analysis**

This is a qualitative research method in which documents are interpreted by the researcher to give voice and meaning around an assessment topic (Bowen 2009). It is also a detailed examination of documents across a wide range of social practice. The study analyzed documents like timetable to establish if HIV/AIDS education was implemented and taught as it should be in the time table. Textbooks pamphlets videos films and magazines were also analyzed to ascertain whether learners can access information from the resources available without depending on teachers, while files on training of peer counselors, resource persons talk and existence of HIV/AIDS clubs to ascertain the mounting of HIV/AIDS programs beyond the classroom. Last but not least was analyzing the awareness and existence of HIV/AIDS policy documents to ascertain the implementation of HIV/AIDS in secondary schools.

### **3.7 Validity and Reliability of the research instrument**

The validity of the research tools rests on whether they measure what they purport to. To obtain this, piloting of the research instruments was carried out in Wareng Sub-County. The exercise is done before the actual data collection in the study area. This sub-county was selected for piloting because it has the same characteristics as the area selected for the study. During this exercise, a sample which comprised of 3 schools 3 head-teachers, 3 head of departments, and 10 students. The purpose of the pilot study enabled the present research to ascertain the reliability and validity of the instruments, and also enable the researcher be familiar with the administration of the research tools, together with this, the exercise created a chance for improvement and review of the instruments and procedures that were deemed necessary.

#### **3.7.1 Validity of the Instruments**

According to (Paton, 2002) validity is quality attributed to proposition or measures of the degree to which they conform to establish knowledge or truth. The validity of the instrument was determined using expert judgment. This was done by discussing the items in the instrument with the supervisors and lecturers from the department of Education Management and policy studies. In order to evaluate the content validity of the instruments, the research came up with dimensions and elements that constituted adequate coverage as per the studies' objectives. Face validity simply means that the validity is taken at face value. As a check on face validity, research instruments were given to experts to obtain suggestions for modification. Face Validity was established by ascertaining whether at face value, the questions appear to be measuring the construct as per the research objectives. The study observed this to ensure that the instruments provided adequate coverage of the study concepts. Advice given by these

experts helped the researcher to determine the validity of the research instruments. These suggestions were used in making necessary changes to promote the quality of the instruments.

### **3.7.2 Reliability of the Instruments**

Reliability refers to the extent to which a measurement is accurate in relation to the instrument of data collection used to produce consistent results over repeated observations or administration of the instrument under the same conditions. According to Mugenda and Mugenda, (2008) reliability measures how research instrument yields consistency after conducting repeated trials. It is the precision or consistency of the test or it is the extent to which the test measures whatever it does consistently. Split-half technique was used to test reliability where it required only one testing session. In this approach, an instrument was designed in such a way that there were two parts. Respondents' scores from odd numbers were correlated with scores from even numbers.

Since it is a comparison of two halves of the test scores, the coefficient so computed does not reflect the reliability of the whole instrument. A correction is therefore applied on the computed coefficient. The adjusted coefficient represents the reliability of the whole test. The correction was done using the Spearman-Brown prophecy formula (Mugenda & Mugenda 2003). Split half in this procedure, classifying the odd number as one test and even number items as the other test artificially splits the test.

The two sets of scores (odd & even) are correlated. Splitting the test into two implies that the calculated reliability is based on half-length tests. To correct or step up the

half- length reliability correlation to full length reliability correlation, the following formula is applied:

$$r_2 = 2(r) / (r+1)$$

$r$  = is the reliability of the half test

$r_2$  = is the reliability of the stepped up test.

The correlation between two 10-item half-tests was 0.74. The reliability of a total test of 20 items is 0.85 which was accepted as reliable.

The questionnaires deemed reliable after several typographical errors and omissions detected are corrected in the instrument confirming that it was sufficient to be used in the main study.

### **3.8 Data Collection Procedure**

Before actual data collection exercise took place, a preliminary survey was undertaken in the selected schools in Wareng Sub- County. This was important because it enabled the familiarization with the study area, appointments with the identified persons were made and their contacts were also sought. The initial permission was obtained from School of education at Moi University and this was used for applying the research permit from the National commission for Science and Technology and Innovation (NACOSTI). The permit was then presented to the County Director of Education of Uasin Gishu County and sub county Education Office in Eldoret East sub county who in turn wrote an introductory letter to the head-teachers of selected schools. The sought introductory letter allowed the study to be carried out in the schools selected. To make this exercise efficient, the researcher left copies of the questionnaire with respondents and agreed on an appropriate day for

collecting the completed research tool, then proceeded with interviews to the identified schools.

### **3.9 Data Analysis Procedures**

Data analysis is the process of systematically searching and arranging data obtained from the field with the aimed of understanding them and enabling you to present them to others (Orodho, 2005). After all data was collected, the researcher conducted data cleaning, which involved in identification of incomplete or inaccurate responses, which were corrected to improve the quality of the responses. After data cleaning, the data was coded and entered in the computer for analysis using the Statistical Package for Social Sciences (SPSS) version 20. This research yielded both qualitative and quantitative data. Qualitative data was analyzed qualitatively using content analysis based on analysis of meanings and implications emanating from respondents information and documented data. On the other hand, quantitative data was analysed using descriptive statistics which include frequency counts and percentages. The results of data analysis were presented using frequency distribution tables.

### **3.10 Ethical Considerations**

The research proposal was approved by the department of education and policy studies of Moi University. The study ensured that an approval to carry out the research was obtained from NACOSTI and the Eldoret sub County education office Education office. The purpose of the study was explained to the respondents before the commencement of the study. The participation of respondents was voluntary with no benefits attached. The respondents were assured of feedback upon request after the study as this aimed at securing cooperation from them. Together with the mentioned

issues, a rapport with the respondent was established and this facilitated the collection of data. Questionnaire sets and interviews were carried out in an environment that allowed privacy of the information and the respondent's confidentiality.

## **CHAPTER FOUR**

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

#### **4.1 Introduction**

This chapter presents the findings of the study on factors influencing the prevention of HIV/AIDS among students in public secondary schools in Eldoret East sub county, Uasin-Gishu County, Kenya. The data for this study was collected using questionnaire and interview schedule and analyzed using descriptive statistics. The data gathered were analysed presented and interpreted according to the objectives of the study:-

- i. To find out personal characteristics influencing HIV/AIDS prevention among students in secondary schools
- ii. To establish availability of resources used in teaching of prevention of HIV/AIDS among students in secondary schools
- iii. To identify policy measures used for the prevention of HIV/AIDS among students
- iv. To assess institutional factors influencing implementation of prevention of HIV/AIDS policies among students in secondary schools.

#### **4.2 Response Rate**

From the study the response rate of students was 89.13%, since out of 359 questionnaires issued only 320 were used in the analysis. However for the heads of department had a response rate of 88.8%, in which 8 questionnaires were used out of 9, while interview scheduled for principal was a 100% since all the nine principals were interviewed.

### 4.3 Background Information of Respondents

This section summarizes the respondents background information sought during the study. The information includes their gender, age and teaching experience in the current school.

#### 4.3.1 Gender and Age of Students

The study used cross tabulation chi square to establish the association between gender and age of the students as summarized in Table 4.1. From the study the gender of the students comprised of 118(36.9%) male, while 202(63.1%) were female. The male students below 15 years of age were 18(15.1%), with 40 (33.9%) aged between 16-17yrs, while 60(51%) aged above 18yrs. For the female 30(14.9%) fell below the age of 15yrs, 80(39.6%) ranged between age 16-17yrs while 92(45.5%) above 18yrs.

**Table 4.1 Gender and Age of Students**

Gender	Age category of students			Total
	Below 15yrs	16-17yrs	Above 18yrs	
Male	18(15.1%)	40(33.9%)	60(51%)	118(36.9%)
Female	30(14.9%)	80(39.6%)	92(45.5%)	202(63.1%)
<b>Total</b>	<b>48(15%)</b>	<b>120 (37.5%)</b>	<b>152(47.5%)</b>	<b>320 (100%)</b>

According to the study findings 36.9% of students were male while 63.1% were female, thus more female students participated in the study than males. Most of the students aged between the ages of 15-18years and therefore they are in the age bracket of the population of contracting HIV.



This showed that majority of students were female, thus there was gender disparity in the distribution of students in study area. Majority of students 152 (47.5%) aged over 18 years. This agrees with UNAIDS, (2006) that the young people at the age of 15-24years form part of the group most at risk of contracting HIV than adults. This is also the group that is likely to engage in risky sexual behavior as they are adolescents moving from the phase of childhood. Thus factors influencing prevention of HIV/AIDS among students in secondary school is important because it is the age when sexual habits and decisions are made about risky behaviors and safe practices.

#### 4.3.2 Head of Departments' Gender and Age

The study used cross tabulation chi square to establish the association between gender and age of the Head of Departments as summarized in Table 4.2. On the gender of the HOD's, male comprised of 5 (55%) while female were 4(45%). The age category of those below 30yrs were 1(11.1 %), those that ranged between 30-39yrs were 3 (33.3%), 40-49 yrs 4 (44.5%) while above 50yrs 1 (11.1 %) below 3yrs were (11.1 %) 4-5yrs were 3 (33.3 %) 5-10yrs 2 (22.2%) while above 10yrs 3 (33.4%).

**Table 4.2 Gender and age category of HOD's**

Gender	Age category of HOD's				Total
	Below 30yrs	30-39yrs	40-49yrs	Above 50yrs	
Male	-	2(22.2%)	2(22.2%)	-	4(44.4%)
Female	1(11.1%)	1(11.1%)	2(22.2%)	1(11.1%)	5(55.6%)
<b>Total</b>	<b>1(11.1%)</b>	<b>3(33.3%)</b>	<b>4(44.4%)</b>	<b>1(11.1%)</b>	<b>9(100.0)</b>

According to the study findings 44.4% were male, while 55.6% were female, thus more female HODs respondents participated in the study than males HODs. Most of the HODs were aged between 40-49years of age, and therefore they had relevant experience in establishing prevention of HIV/AIDS measures in their schools.

### 4.3.3 Principals Gender and Age

The study used cross tabulation chi square to establish the association between gender and age of the principals as summarized in Table 4.3. On the gender of the principals male comprised of 4(44.4%), while 5(55.5%) were female. The age of the principals the researcher found that 1(11.1%) was below 35yrs of age, 3(33.3%) ranged between 35-40yrs, 3(33.3%) ranged between age 40-49yrs while 2(22.2%) were above 50yrs of age

**Table 4.3 Gender and Age of the Principals**

Gender	Age category of Principals				Total
	Below 35yrs	35-40yrs	40-49yrs	Above 50yrs	
Male	-	2(22.2%)	1(11.1%)	1(11.1%)	4(44.4%)
Female	1(11.1%)	1(11.1%)	2(22.2%)	1(11.1%)	5(55.6%)
<b>Total</b>	<b>1(11.1%)</b>	<b>3(33.3%)</b>	<b>3(33.3%)</b>	<b>2(22.2%)</b>	<b>9(100.0)</b>

### 4.3.4 Length of stay in the current school

From the study 33.3% of the principals had been in the current school for the last 4 and 5 years as well as for over 10 years as summarized in Table 4.4. However, 22.2% have been in their current school for between 5 and 10 years, with 11.1% for below 3 years. This indicated that the respondents had relevant experience in establishing prevention of HIV/AIDS measures in their schools.

**Table 4.4 Length of stay in the current school**

<b>Length of stay</b>	<b>Frequency</b>	<b>Percentage</b>
Below 1-3 yrs	1	1 (11.1%)
4-5yrs	3	3(33.3%)
5-10yrs	2	2(22.2%)
Above 10 yrs	3	3(33.4%)
<b>Total</b>	<b>9</b>	<b>(100%)</b>

From the table above most of the HODS are above 30years which means they have the experience and the skills to help the students to develop interactive strategies to keep them stay uninfected, they have the characteristics that allow them to be effective changing agents in the schools. Once provided with guidance they can develop and implement effective school-based programs for education on HIV/AIDS prevention. The number of years the HODs has been in their current school the more they give information on the prevention of HIV/AIDS in secondary schools.

#### **4.4 Personal Characteristics of Students influencing HIV/AIDS Prevention**

The first objective of the study was to establish the personal characteristics that influence prevention of HIV/AIDS among the students in secondary schools. The questionnaires as well as interview schedule was used to obtain information on the personal characteristics that influence prevention of HIV/AIDS

##### **4.4.1 Personal characteristics of the students**

The questionnaires as well as interview schedule was used to obtain information on the influence of personal characteristics on prevention of HIV/AIDS. The students

were requested to rate the statements on the influence of personal characteristics on prevention of HIV/AIDS using a 5 point likert scale and their response is summarized in Table 4.5. On whether the students age influenced the prevention of HIV/AIDS 50(16%) strongly agreed, 50 (15.6%) agree, 40(12.5%) were undecided, 80 (25%) disagreed while 100 (31.3%) strongly disagreed. On student attitude sex affect prevention 50 (15.6%) strongly agreed, 80 (25%) agreed, 80 (25%) were undecided (may be influenced by cultural view about sex), 70 (21.9%) disagreed while 40(12.5%) strongly disagreed.

**Table 4.5: Personal characteristics of the students**

	Strongly agree		Agree		Undecided		Disagree		Strongly disagree	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
My age factor	50	(15.6%)	50	(15.6%)	40	(12.5%)	80	(25%)	100	(31.3%)
My attitude towards sex	50	(15.6%)	80	(25%)	80	(25%)	70	(21.9%)	40	(12.5%)
My parents view on sex matters	80	(25%)	60	(18.6%)	20	(6.3%)	50	(15.6%)	110	(34.5%)
My personal goals an career advancement	90	(28.1%)	100	(31.3%)	70	(21.8%)	40	(12.5%)	20	(6.3%)
Peer pressure	90	(28.1%)	60	(18.8%)	70	(21.9%)	50	(15.6%)	50	(15.6%)
My belief that HIV/AIDS is not real	100	(31.3%)	50	(15.6%)	20	(6.3%)	100	(31.3%)	50	(15.5%)
Modern lifestyle and preference on sex	60	(18.8%)	80	(25%)	130	(40.5%)	20	(6.3%)	30	(9.4%)
Exposure to reading materials on HIV/AIDS	80	(25%)	20	(6.3%)	40	(12.5%)	50	(15.6%)	130	(40.6%)
VCT services are provided	95	(29.7%)	55	(17.2%)	60	(18.8%)	50	(15.5%)	60	(18.8%)
Media and abstinence influence the prevention	50	(15.6%)	80	(25%)	130	(40.6%)	20	(6.3%)	40	(12.5%)

On parents view on sex matters 80 (25%) strongly agreed, 60 (18.6%) agreed, 20 (6.3%) were undecided 50(15.6%) disagreed while 110 (34.5%) strongly disagreed. On my career goal and career advancement 90 (28.1%) strongly agreed, 100 (31.3%) agreed, 70 (21.8%) undecided, 40 (12.5%) disagreed while 20 (6.3%) strongly disagreed. On peer pressure 90 (28.1%) strongly agreed, 60 (15.6%) agreed 70 (21.9%) were undecided, 50 (15.6%) disagreed while 50 (15.6%) strongly disagreed. On belief that HIV/AIDS is not real 100(31.3%) strongly agreed, 50 (15.6%) agreed, 20 (6.3%) undecided, 100 (31.3%) disagreed while 50 (15.6%) strongly disagreed.

Modern lifestyle and attitude towards sex 60 (18.8%) strongly agreed, 80 (25%) agreed, 130 (40.5%) undecided, 20 (6.3%) disagreed while 30 (9.4%) strongly disagreed. On provision or reading materials on HIV/AIDS 80(25%) strongly agreed, 20(6.3%) agreed, 40(12.5%) undecided, 50(15.6%) disagreed while 130(40.6%) strongly disagreed. On the need to provide VCT services 95 (29.7%) strongly agreed, 55 (17.2%) agreed, 60 (18.8%) undecided, 50 (15.6%) disagreed while 60 (18.8%) strongly disagreed. Influence of media on abstinence 50 (15.6%) strongly agreed, 80 (25%) agreed, 130 (40.6%) undecided (based on environment) 20 (6.3%) disagreed while 40 (12.5%) strongly disagreed.

Most of the students are aware that HIV/AIDS is acquired through having sex with an infected person, but some respondents in rural schools belief that blood transfusion is the cause of infection, this may explain why there is high pregnancy rates among students in rural areas than urban areas. The students revealed that they discussed HIV/AIDS with their teachers in class during lesson hours, and this gave the researcher the confidence to conclude that HIV/AIDS education has been integrated into the curriculum hence being implemented. Students revealed that the curriculum

is too congested such that they only concentrate on examinable materials to improve their grades. The students also admitted that they never get time to identify resources in order to improve their knowledge and skills about HIV/AIDS. They also reported that in school the HIV/AIDS education material resources just gather dust in the libraries since they are not updated and so boring to read.

But HODS and principals interviewed reported that students didn't have time to read extra-materials on HIV/AIDS apart from what they are taught either in classroom, or by invited guests. The principals interviewed reported that girls especially in mixed schools were teased by the boys after an HIV/AIDS lesson, hindering open discussion hence leaving them less informed than their counterparts in single sex schools. Hence, there is need to reach even young children who are still in primary and are not at risk to develop health attitude towards HIV/AIDS early enough before it is late. NASCOP (2005) reported very early debut (experience of first sexual intercourse) among youth in Kenya. This report confirms that adolescents are sexually active before the age of 15 years, more so they are less likely to be protected from the consequences of sexual intercourse and more likely to be ignorant of the ways in which accident pregnancies or sexually transmitted diseases can be prevented. These attitudes hinder HIV/AIDS prevention as it is crucial that young people know about HIV and how it is transmitted before they are exposed to situations that carry a risk of HIV/AIDS. Piot (2002) argued that there is no set age at which HIV/AIDS education should start, yet young people are denied life saving AIDS education because adults consider the information too 'adult' for young people.

Kelly (2002) noted that schools need to incorporate sexual health and HIV/AIDS education into the curriculum for all ages. He added that through such programs young people will be equipped with relevant life skills – practical skills that make

them develop responsible gender roles, positive social attitude and safe sexual behavior, while enabling them to withstand peer pressure to engage in risky behaviors.

Many young people believe that HIV/AIDS doesn't happen to them. From the data analysis most of the students admit that their parents are too busy and they don't have time for them. Though majority of parents discuss sexual matters with their children there are still others who need to open up and discuss these issues freely with the young people. Parents are opinion leaders to their children and they should communicate to them, their principals and ideas about HIV/AIDS.

Data analysis and interpretation revealed that most of the students do agree that personal goal and career advancement has an effect. This agrees with (Kelly 2008) who advocated for expanded curriculum in schools which promotes values and attitude that say yes to life and no to premature unacceptable sex and sexual experimentation. He also added that providing information and inculcating skills that help self protection will promote behavior that will strengthen the young person's ability to avoid HIV/AIDS infection and enhance capacity to draw others back from the brink.

The students need to be kept in school by improving retention rate through well manned guidance and counseling services which will help students to be focused in their career, a factor to influence prevention of HIV/AIDS. The researcher also noted that without high retention rates in our schools HIV/AIDS prevention may not be effective because those who drop out of school will have little access to HIV/AIDS prevention activities. From data analysis and interpretation peer pressure influences HIV/AIDS prevention among students, with most of them in agreement that it has an effect. This is likely motivated by the culture in which the youth live in.

Telcher (2002) and Walberg (2002) were in agreement that providing students with skills on HIV/AIDS prevention needs to be done through interactive methods to eliminate the fear surrounding HIV/AIDS. The opinion of the researcher noted that peer pressure can be utilized positively to influence the prevention of HIV/AIDS, when the right information is given to them early enough before it is too late. Peer education is essential in educating young people as this will facilitate sharing of knowledge among peer members.

However there is need of training peer educators among students on HIV/AIDS, and when they get the message it translates into behavior change, hence prevention of HIV/AIDS among them. Data analysis and interpretation shows that most of the students 150 (50%) believe that HIV/AIDS is not real due to beliefs of the communities they come from. Kelly (2008) avers that HIV/AIDS education should explode the young people's illusion that HIV/AIDS is not real and so will never happen to them. He added that education should provide information and inculcate skills that motivate self-protection. The principals agreed that VCT services had an on HIV/AIDS prevention. Therefore the principals interviewed by the researcher revealed that the interpretation of data shows that provision of VCT will help students know their status. But the challenge is that there is the belief that students do not need VCT because they are not to involve in sex before marriage. Many parents and church leaders feel that it is encouraging immorality in the society.

All the principals interviewed denied the existence of VCT services in their schools and they recommended the need to know the status of their students so that the school can be in a position to give the necessary attention. They also agreed that students who are guided well are goal oriented, focus on their education and career hence a positive tool towards the prevention of HIV/AIDS. They recommended that despite



putting measures to change behavior, all the stakeholders needed to cooperate parents, teachers, governments and NGOS to realize a meaningful behavior change which will influence the prevention of HIV/AIDS.

Discussions with principals revealed that VCT services were rare since they were not brought to school. A few respondents who have ever gone for such services would do it during the holidays or through church or non-governmental organization which are community based. This was an indication that very few learners in Eldoret east Sub County know their zero status. However the principals and HODs suggested that the VCT services should be introduced to schools in order to enable more learners to go for HIV test as well as counseling.

#### **4.5 Resources used in the Prevention of HIV/AIDS**

The respondents were requested to rate the statements on the influence of policy measures provided on prevention of HIV/AIDS and their response is summarized below. Relevant materials should be availed for effective teaching of HIV/AIDS, education. The study sought to find the availability of HIV/AIDS education teaching materials. Several materials are required for the teaching of HIV/AIDS education. The interviewed principal reported that they had not come across the syllabus despite the importance of the syllabus. The respondents also reported that other important materials were not available. For instance, most of them reported that textbooks, charts, electronic equipment and the HIV/AIDS education policy were not available. However few of the principals expressed the need to avail HIV/AIDS education materials. The syllabus is one of the most important materials in teaching any subject because it gives the guidelines on teaching a subject. The study therefore sought to find the relationship between the availability of the syllabus and teaching of

HIV/AIDS education. The findings indicate that there was a significant relationship between coming across the HIV/AIDS education secondary syllabus and the teaching of HIV/AIDS education.

Principals are supposed to promote the teaching of HIV/AIDS education. One of the ways in which principals can support the program is by providing the relevant education materials through purchasing. The study sought to find out the proportion of schools that buy HIV/AIDS education materials. According to the interviews an overwhelming number of principals reported that their schools did not buy HIV/AIDS teaching materials, compared few of them who reported that their schools did so.

The study also sought to understand the reasons why schools did not buy HIV/AIDS teaching materials. The schools did not buy HIV/AIDS education materials due to lack of funds. This is the highest percentage compared to those who reported that it was given free by non-governmental organizations, and who reported that purchasing HIV/AIDS education was not a priority in school requisition. The school administration is supposed to ensure that schools are equipped with various education materials. The study sought out the opinion of the principals on equipping schools with HIV/AIDS education materials. The principals interviewed reported that equipping of schools with HIV/AIDS education materials should be a priority. Apart from purchasing HIV/AIDS education materials schools can also get them from other sources. The schools got their materials from mass media, non-governmental organizations and community based organizations and Ministry of Education despite the fact that it has with the responsibility of providing HIV/AIDS education.

Magazines having information on HIV/AIDS were available in national, some county and one private school, while most of the students in those schools without magazines lack important knowledge about how to protect themselves against HIV infection. The

schools without magazines are sub county schools, far away from town, which means their students are disadvantage and not equipped with life skills that make them stay uninfected.

Pamphlets on the other hand are scanty in sub-county schools while the national and county schools receive them resource persons who include parents who work in organizations. This calls for uniform provision of resources by the government to equip all learners for effective prevention of HIV and AIDS. Most schools the researcher visited had integrated HIV/AIDS in the curriculum; hence they have HIV/AIDS in the time table. Heads of department reported that the lessons face competition from examinable subjects.

Teachers would prefer to teach other subjects which are examined at the end of the year. They are under pressure to produce results and not only results but good results because the education is performance centered. Books to teach HIV/AIDS were still few especially in sub-county schools, which mean students depend on teachers for information. This cannot encourage interactive strategies required to influence prevention of HIV/AIDS among students in secondary schools. This is in agreement with (Kafu 2005) who advocated for distribution of scientifically accurate, good quality teaching and learning materials on HIV/AIDS education for prevention of the pandemic. Condoms are not availed in secondary schools, and the reason given to the researcher is that giving condoms to students means encouraging immorality in the society which is against Christian practices.

Teachers resisted including any reference to condoms because of norms and strong beliefs that teaching about use of condoms implicitly condoned or encouraging sexual activities among secondary school students in Eldoret east Sub County. In some schools especially those sponsored by churches, teachers who discuss condom use to

students can possibly be transferred. Parents and the society at large do not encourage sex outside marriage (Fornication) and so availing condoms is like giving their children freedom to have sex outside marriage, and such behaviors are meant for prostitutes who have no morals.

Though HIV/AIDS has been integrated into the curriculum the teaching materials are few which makes teaching and learning teacher centered. Video/films were available in the national and some county schools, this shows that sub-County schools have no resources to purchase ICT equipments, and at the same time films Which are hired out at exorbitant prices, leaving most of the students unequipped with life skills. Interview of principals pointed out that they had no guidelines as to where to get funds to source the resource materials to enhance and influence prevention of HIV/AIDS.

The principals interviewed agreed that though they have resources CDS, DVDS magazines, text books-the materials are still scanty especially for schools with a large numbers of students. They also commended that policies are in place, but there is need for serious commitment from both teachers and students So that the policies are implemented fully, hence become effective in all the schools. The principal and HODs agree that media influence is either positive way young people are educated either consciously or unconsciously by the media e.g. TV, radio newspapers and billboards. This agrees with Nasibi (2003) that information on HIV/AIDS is transmitted through the media, events which go on in society, and through non formal programs in school, churches and theatre. Therefore the media need to give information on HIV/AIDS to the young people TV, magazines and billboards in schools can influence prevention of HIV/AIDS among students in secondary schools. Despite the importance of availing HIV/AIDS education materials to schools. The ministry of education has not been active in the production and distribution of

HIV/AIDS education materials. Most of the teachers got their materials from non-governmental organizations, community based organization and mass media as compared to the ministry of education. This is despite the fact that the ministry is responsible for providing HIV/AIDS education learning materials (MOEST, 2004). This has tremendously lowered the adoption of HIV/AIDS education. There is consensus that secondary education is now the fastest growing segment of the education sector (SEIA, 2001; UNESCO 2001; Mulkeen *et al*, 2005; World Bank, 2005; Di Gropello, 2006; World Bank, 2007).

In many countries, movement away from seeing primary education as the terminal level of education towards policies that envision widespread completion of junior secondary and upper secondary as the goals of education system development is well underway, but has only recently begun in Sub-Saharan Africa (De Ferranti *et al.*, 2003 and World Bank, 2005). Many challenges to expanding secondary are particular to, and particularly pronounced in Sub-Saharan Africa.

Many countries will need to continue to devote resources to expanding and improving primary education to achieve the goals of Education for All. A realistic conversation about greater access to secondary education in Sub-Saharan Africa will need to confront the present status of education systems. In terms of their capacity to sustain the growth and improvement of primary education, as well as their existing limitations in terms of capacity and financing to simultaneously expand and improve secondary education, through providing learning resources and the necessary infrastructure.

HIV/AIDS education teaching materials are so important to the extent that various teachers felt that lack of training and timetabling could not prevent them from teaching HIV/AIDS as long as there were guidelines and reference materials to teach

it. These materials include HIV/AIDS education policy, textbooks and electronic equipment. HIV/AIDS education teaching materials are not available in most schools, despite the fact that most of the teachers want the materials to be availed. Availing the materials is important because it could help to eliminate myths and dogmas about HIV/AIDS, by creating awareness among both the students and teachers. As a result, the teachers and students would be in a position to understand the dangers and effects of HIV/AIDS. As important members of the society, the teacher work beyond the school to the community.

Teachers need to share their experiences and knowledge with other members of the community. Availing the HIV/AIDS education materials would play a crucial role in enabling the teacher to educate members of the community on HIV/AIDS and other related issues apart from effectively teaching it in the classroom. In case HIV/AIDS education learning materials are availed in school, students and interested teachers could easily access these materials. This would enable them to have a deeper understanding on the HIV/AIDS pandemic, its causes, consequences, remedial measures and management.

Knowledgeable students and teachers could in turn spread the information to other people in the community. The community members would also be encouraged and would in turn educate the students and teachers on the cultural ways of preventing HIV to supplement the formal knowledge. The ministry should therefore increase the production and distribution of HIV/AIDS education materials and encourage teachers to work with the community members to develop appropriate HIV/AIDS education materials specific to the needs of the society.

#### **4.6 Policy Measures Provided for the Prevention of HIV/AIDS**

The questionnaires as well as interview schedule was used to obtain information on the influence of policy measures provided on prevention of HIV/AIDS. The students were requested to rate the statements on the influence of policy measures provided on prevention of HIV/AIDS using a 5 point likert scale and their response is summarized in Table 4.6. From table 4.6 the researcher found that school management urge to the HOD's to domesticate NACCP into their situation with 1 (10%) strongly agreed, 2 (20%) agreed, 1(10%) undecided, 2 (20%) disagreed while 3(30%) strongly disagreed. On whether the institution provided uniform policy direction towards HIV/AIDS prevention, 1(10%) strongly agreed 2(20%) agreed, 1(10%) undecided, 2(20%) disagreed while 3(30%) strongly disagreed.

The researcher also found that school management provided guidance for interpretation and implementation of NACCP policy influenced prevention 1 (10%) strongly agreed, 2(20%) agreed, 0 (0%) undecided, 2(20%) disagreed while 4(40%) strongly disagreed. To determine whether leadership was provided on policy direction in HIV/AIDS prevention hence bore fruits, the researcher found that 2(20%) strongly agreed, 3(30%) agreed, 1(10%) undecided, 2(20%) disagreed while 1 (10%) strongly disagreed. To be able to run the activities of the department the researcher found that budgetary allocation influenced the implementation of HIV/AIDS prevention where 3(30%) strongly agreed, 3(30%) agreed, 1(10%) undecided, 1 (10%) disagreed while 1(10%) strongly disagreed. The researcher found that weak stakeholders least influenced the prevention measures on HIV/AIDS with 1 (10%) strongly agreed,

3(30%) agreed, none was undecided, 2(20%) disagreed while 3(30%) strongly disagree

**Table 4.6: Policy measures on the prevention of HIV/AIDS**

Policy measures	Strongly Agree		Undecided		Disagree		Strongly disagree			
	Freq	%	Freq	%	Freq	%	Freq	%		
School management have domesticated NACCP in to their situation	1	(10%)	2	(20%)	1	(10%)	2	(20%)	3	(30%)
Institution have HIV/AIDS policy on prevention of HIV.AIDS	1	(10%)	2	(20%)	1	(10%)	2	(20%)	4	(40%)
Clear guidance for interpretation and implementation of NACCP policy influence prevention	1	(10%)	2	(20%)	0	(0%)	2	(20%)	5	(50%)
Leadership provide policy direction in HIV/AIDS prevention	2	(20%)	3	(30%)	1	(10%)	2	(20%)	2	(20%)
Budgetary allocation affects implementation of HIV/AIDS prevention	3	(30%)	3	(30%)	1	(10%)	2	(20%)	1	(10%)
Weak stakeholders coordination influence of HIV/AIDS prevention	1	(10%)	3	(30%)	0		2	(20%)	3	(30%)

Data analysis and interpretation of responses shows that most respondents agree that HODS need to be aware, involved or participate in HIV/AIDS related prevention activities where 60% do agree, it has an effect. This is in agreement with the call by Walberg (2002) for the need to provide teachers and other educators with instructions and guidance on how to develop and implement on effective school based programs for education on HIV/AIDS prevention. This would have helped teachers and



educators to own these programs and implement them without any challenges. It was noted from the research that many do agree that budgetary allocation influence implementation HIV/AIDS prevention where 60% do agree to that effect. This is in line with the heads of schools call for adequate budgetary allocation for school for quality implementation of policy programs in the schools.

The feedback from heads of departments showed that policy dissemination was limited and not done in an organized formal way. Since the launch of the policy in 2005 ministry of education has not done specific sensitization and training to educate stakeholders on the content of the document, their role and the role of other key stakeholders in the dissemination and implementation. However key stakeholders in institutions were not empowered through training to draw from the general sector policy to form their own institutional policies which would encourage widespread support for effective interpretation.

The policy in the opinion of the researcher is appropriate, balanced and valid for the education sector and its partners. It is also adequately comprehensive, broad and inclusive. However it does not address the needs, the concerns, issues and problems of people living with disabilities and the same time not clear from the policy document where and how the resources for the implementation will be drawn from. Ministry of health and education need to work jointly to provide resource materials in secondary schools for effective prevention of HIV/AIDS among students.

The findings of the study according to (Kelly 2002) implicate that despite implementation of HIV/AIDS policy in schools less teaching and learning materials on HIV/AIDS are getting into the classroom because our secondary school education is performance centered and teachers are under pressure to provide results while

students undertake subjects in their assignments seriously in order to succeed in their studies.

The principal identify the HIV/AIDS policy in education lacked involvement of the teachers from the onset and this has denied the policy the serious support it needs in order to be effective in education system. That is why the national aids control units established in all the sub county education offices exist just by name and not in action. This agree with World bank (2010) that it is clear that future of HIV in Kenya will in large measures be determined by success in preventing new infection among the millions of young people who are becoming sexually active every year.

Therefore students' assignment is a powerful; learning tool which can be used with great advantage in the teaching and learning of HIV/AIDS for the prevention of the disease. The findings also confirm that need of VCT services to help students and teachers know their status and this is to be effective heads of schools must enforce existing codes and rules of conduct, professional ethics and disciplinary measures with respect to protect the learners from HIV/AIDS infection. They should also ensure that the right of the infected and affected persons is protected. They can do so by ensuring that sexual abuse, violence harassment, discrimination and stigmatization are not tolerated. This calls for serious ownership of policies, by stakeholders of education and good budgetary allocations to both primary and secondary schools for better implementation of such policy programs.

#### **4.7 Institutional Factors Influencing Implementation of Policy**

The questionnaires as well as interview schedule was used to obtain information on the influence of policy measures provided on prevention of HIV/AIDS. The students were requested to rate the statements on the influence of policy measures provided on

prevention of HIV/AIDS using a 5 point likert scale and their response is summarized in Table 4.7. On institutional factors that influence on the prevention of HIV/AIDS, the researcher found that lack of management support influenced implementation of policy where 2(20%) strongly agreed 1(10%) agreed 2(20%) undecided, 3(30%) disagreed and 1(10%) strongly disagreed. On whether the HOD's were aware, involved or participated in HIV/AIDS related prevention activities 2(20%) strongly agreed, 4(40%) agreed 1(10%) undecided, 1(10%) disagreed and 1(10%) strongly disagreed. On whether clear and workable communication channels existed between management and staff, the researcher found 4(40%) the HOD's, strongly agreed, 2(20%) agreed 1(10%) undecided, 1(10%) disagreed and 1(10%) strongly disagreed.

On whether the institution valued HIV/AIDS education 4(40%) strongly agreed 1(10%) agreed, 1(10%) undecided, 1(10%) disagreed and 2(20%) strongly disagreed. On whether the HOD's facilitated access to voluntary test to students 2(20%) strongly agreed 1(10%) agreed, 1(10%) undecided, 2(20%) disagreed and 3(30%) strongly disagreed. On the need to provide prevention measures against spread of HIV/AIDS 1(10%) strongly agreed, 2(20%) agreed, 1(10%) were undecided 2(20%) disagreed while 3 (30%) strongly disagreed. The researcher found that schools provided periodic health talk program where 1(10%) strongly agreed, 2(20%) agreed, 1(10%) undecided, 2(20%) disagreed while 3(30%) strongly disagreed.

**Table 4.7: Analysis on institution factors on prevention of HIV/AIDS**

	Strongly Agree		Undecided Disagree		Strongly disagree
	Freq %	Freq %	Freq %	Freq %	Freq %
Lack of management support hinder prevention and transmission	2(20%)	3(30%)	1(10%)	2(20%)	1(10%)
Low student involvement and participation in HIV/AIDS related prevention activities	2(20%)	4(40%)	-	2(20%)	1(10%)
Unclear communication channels between management and staff	4(40%)	2(20%)	-	2(20%)	1(10%)
Institution value for HIV/AIDS education	5(50%)	1(10%)	1(10%)	1(10%)	1(10%)
Access to voluntary test	2(20%)	4(40%)	1(10%)	1(10%)	1(10%)
Information and material measures on prevention of HIV/AIDS are provided	3(30%)	2(20%)	1(10%)	2(20%)	1(10%)
Health talk program are not provided by the school	3(30%)	2(20%)	1(10%)	2(20%)	1(10%)

Data analysis and interpretation of responses revealed the following major findings.

The findings revealed that lack of management support have an effect 5(50%) do agree that this factors do influence, management has an effect. From the percentages do agree that student's participation, clear communication channels between management and staff, institution value for HIV/AIDS education, access to voluntary test, provision of information and material measures as well as facilitation of health talk programs has an effect.

The findings revealed that all institutional factors have a greater effect on prevention of HIV/AIDS among students in public secondary schools in Eldoret east sub County. This is in agreement with (Kelly 2008) who noted that education system should ensure the integration into the curriculum good-quality sexual health and HIV/AIDS education, for those not infected and uninfected, and such expanded curriculum can work to reduce the likelihood of infection by promoting values and attitude that say yes to life and no to premature, casual or socially unacceptable sex and sexual experimentation.

Institutions can do this by providing information through health talk inculcating skills that help self protection, promoting behavior that will strengthen the young person's ability to avoid HIV infection, enhance the capability to draw others back from the brink of and reduce the stigma, silence, shame and discrimination so often associated with the disease. Schools can be seen as the key setting for educating children about HIV/AIDS and for halting further spread of the disease. Success in carrying out this function depends upon reaching children and young adults in time to reinforce positive health behaviors and alter behaviors that can place them at risk.

It was also noted that students reached adolescence from ages 13-18 years and school have excellent resources for delivering effective education; skilled teachers, and interactive education process that occurs over time, a variety of learning opportunities, materials and methods and the ability to involve parents in their children learning. Focusing resources on effective school health (FRESH) launched at the world education forum in Dakar (2000) held the belief that in combating HIV/AIDS infection the responsibility of the school (Institution) is to teach the young

people to avoid either infection or transmitting it to others, and as a catalyst for development of HIV/AIDS policies that are based on the most current scientific knowledge about HIV/AIDS. In doing so schools and especially secondary schools have the ability to make important improvements in the quality of health education provided to the young people in Kenya.

Therefore the principals interviewed by the researcher revealed that for institutions to play the vital role of influencing prevention of HIV/AIDS there is need for strategies towards identification and allocation of adequate resources, VCT to facilitate access to voluntary testing and serious commitment from all the stakeholders. All these will enable the institution to carry out the functions effectively. In the opinion of the researcher, HIV/AIDS has been integrated and infused into the already existing curriculum which is tight, rigid and more focused on performance.

This demand for performance and competition among institutions may force them not to implement fully the HIV/AIDS programs. Therefore there is need for serious examination into the curriculum again for better implementation of HIV/AIDS programs in the school to combat HIV/AIDS. The responsibility of secondary schools is to teach young people to avoid contracting HIV/AIDS or transmitting to others. The school management need to support programs established towards prevention of HIV/AIDS, involve students fully in the process of establishing and implementing these programs.

Walberg (2002) avers that for HIV/AIDS education to achieve its goals, teaching methods must evolve from lecture method to more participatory teaching where students play an active role in the learning process. He also added that HIV prevention and anti-discrimination are complex issues which demands experienced educators who have the characteristics that allow them to be effective behavior

challenging agents in the school. Secondary schools are key setting for educating students about HIV/AIDS and for halting further spread of the diseases, so there should be clear communication and value for HIV/AIDS education among all the stakeholders of the institution.

Heads of secondary schools must enforce existing codes and rules of conduct, professional ethics and disciplinary measures with respect to protecting learners from HIV infection. They should also ensure that the rights of the infected and the affected are protected. They can do this by ensuring that sexual abuse, violence, harassment, discrimination and stigmatization are not tolerated. The principals reported that they are not given any guidance on where to source funds to implement programs on HIV/AIDS preventing their schools or institutions and without clear directive on source of funds. Schools may not implement fully HIV/AIDS prevention programs. They also commended that effective prevention of HIV needs comprehensive information about how HIV is transmitted and what they can do to stop themselves from becoming infected. This information should be delivered without moral judgment

## **CHAPTER FIVE**

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

#### **5.1 Overview**

This chapter contains a summary on the findings, conclusions drawn and recommendations. These are based on the findings in chapter four and also on the literature review.

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

The summary of findings was based on the study objectives.

##### **5.2.1 Personal characteristics influencing HIV/AIDS prevention among students in secondary school**

The first research objective was to investigate personal characteristics influencing HIV/AIDS prevention among students in secondary schools in Eldoret east Sub County. The personal goal and career advancement has influence on prevention of HIV/AIDS among students in secondary schools, this calls for the need for well manned career, guidance and counseling services to guide students to be focused in their goals and career. Students who are focused in their career will be retained in school and benefit from HIV/AIDS education which contribute to prevention of HIV/AIDS among the youth. The student's attitude towards sex influence prevention of HIV/AIDS doesn't happen to them, which is a belief that leads them to diseases. Therefore the parents need to discuss sexual matters with their children, and schools are key settings to provide information that inculcates skills of the young people to self-protection and ability to avoid HIV/AIDS infection.



The peer pressure influence HIV/AIDS prevention among them. This is likely to be motivated by the culture of the communities they come from. However peer pressure can be used positively to influence the prevention of HIV/AIDS among students. This is done using peer education where peer educators are trained among students on HIV/AIDS so as they can share these ideas among the rest of the students. When students obtain HIV/AIDS messages from their peers, it is easier for them to accept these messages and translate them to behavior change, hence prevention of HIV/AIDS. The VCT services had an effect on HIV/AIDS prevention, and from the interview of principals, VCT services are not provided in schools. This calls upon all school stake holders to look into the issue and introduce VCT services which are youth- friendly. Students knew their status and kept it to themselves uninfected or avoid infecting others if they are already infected.

### **5.2.2 Available Resources Influencing Prevention of HIV/AIDS among students in secondary schools**

The second objective was to assess available resources used in the prevention of HIV/AIDS among students in secondary school in Eldoret east Sub County. The HIV/AIDS education materials include the syllabus, HIV/AIDS education policy, textbooks, charts, and electronic equipment. These materials are very instrumental in teaching HIV/AIDS education, but they are not available in most schools. However, a majority of the teachers feel that these materials should be availed in schools. The fact that HIV/AIDS education teaching materials are unavailable to teachers means that they might not be able to teach the subject. A large proportion of teachers who could access HIV/AIDS education materials taught HIV/AIDS education as compared to

their counterparts who could not access the materials. This implies the potential of schools as centers for teaching HIV/AIDS education is greatly underutilized.

The media influence on abstinence from sex as it makes students would like to practice what they see in the TV and hear from the radio. Students would like to ape their role models in the media especially musician and other artist who are highly adored by the youth whole over world. There are a lot of phonographic video places screened without considering the viewer's age or parental consent. Media should be used positively to pass information of HIV/AIDS education especially through the social sites where most young people communicate through whatsapp, twitter, and facebook. Through phone most high school students were connected to online and they share a lot of information especially over the holidays when they are free from books. Electronic and print mass media like schools-reading material, newsletter targeting at students like straight talk magazines and informal media like theatre, music are all behavior programs which enhance prevention of HIV/AIDS. The Ministry of education together with other stakeholders needs to support such programs by giving finances especially informal media programs where most students in high school take active role. This was an avenue to avert or reduce HIV/AIDS infection among the young people.

The available resources such as books, pamphlets, films, and DVDs have an effect. Report from principals is that condoms are not provided in the secondary schools and at the same time text books were scanty which showed that students were not able to access information on their own, they depend on teachers for information. Films and videos were hired from film industries which mean a lot of expenses to the schools which according to principals they are not given guidelines where to source funds to avail the resources. Well endowed schools have resources while young upcoming

schools mostly in the sub County have scanty resources e.g. magazines, pamphlets, textbooks and video and films.

The schools had integrated HIV/AIDS education in the curriculum hence had HIV/AIDS lessons in their time table, though heads of department reported that the lessons face competition from examinable subjects. Teachers were under pressure to perform and produce good results because the education system is performance centered. The Eldoret East Sub County secondary schools did not have time to read extra materials on HIV/AIDS apart from what they are taught either in classroom or by invited guests. The secondary education curriculum was too congested and learners only concentrate on examinable subjects to improve their grades.

### **5.2.3 Policy Measures Established to Influence Prevention of HIV/AIDS among students in secondary school**

The third research objective was to establish policy related factors influencing prevention of HIV/AIDS among students in public schools in Eldoret East Sub County. The government of Kenya had the commitment to reverse the spread of HIV/AIDS. The office of the president had established NACC to provide leadership and strong coordination mechanism for multi-sect oral national response to HIV/AIDS prevention 2005-2009. NACC also coordinated all HIV/AIDS programs policies and interventions in the country. Working and liaising with stakeholders from government and society private sector and schools. There was anti-discrimination laws and regulations that specify protection of sub population e.g. children, women and young people. There were policies and laws against child marriage sexual abuse and gender based violence.

The key stakeholders in education need empowerment that can draw their own institutional policy from general sector policy which would encourage wider support hence effective implementation and prevention of HIV/AIDS among students in secondary schools. The budgetary allocation influenced on prevention of HIV/AIDS.

#### **5.2.4 Institutional factors influencing prevention of HIV/AIDS among students in secondary school**

The fourth objective was to investigate the institutional factors that influence HIV/AIDS prevention among students in public secondary schools in Eldoret east Sub County. Education helps to reinforce positive health behaviors and alters behavior that places people at risk. Secondary schools are the key settings for educating students about HIV/AIDS prevention. Apart from training teachers and students there is need to be providing with adequate instructional resources material to enable teachers to implement the curriculum and students to interpret the content correctly.

The teaching of HIV/AIDS in schools requires that there is preparation and distribution of scientifically accurate good quality teaching and learning materials on HIV/AIDS. To curb the challenges on prevention of HIV/AIDS among students in secondary school there is need to for all players in the war against HIV/AIDS spread to agree that transmission of the right information through education to the group most at risk is the key to stamping out the scourge. This calls for attention from all players in education to provide resources, train educators, remove competition for performance in secondary schools and undertake campaign on prevention of HIV/AIDS among the youth beyond the classroom.

### **5.3 Conclusion**

Students need to be provided with information on prevention of HIV/AIDS so as to develop meaningful skills to stay unaffected. Interactive measures put in place to support safer sex and prevention of HIV/AIDS. Open discussion on health promotion information will instill health prevention beliefs within groups of students. There is need to encourage students to speak out on issues related to HIV/AIDS establish peer counseling clubs as well as mounting performance of peer counseling clubs.

The available resources such as books, pamphlets, films, and DVDs have an effect. Films and videos were hired from film industries. Well endowed schools have resources while young upcoming schools mostly in the sub County have scanty resources e.g. magazines, pamphlets, textbooks and video and films. The HIV/AIDS lessons in their time table, though heads of department reported that the lessons face competition from examinable subjects. The learners in Eldoret east sub county secondary schools did not have time to read extra materials on HIV/AIDS apart from what they are taught either in classroom or by invited guests. Most teachers lacked HIV/AIDS education materials textbooks, the syllabus, charts and the education policy. This prevented them from gathering enough knowledge and information to pass to students. This undermined its integration in the curriculum.

The government of Kenya has the commitment to reverse the spread of HIV/AIDS. Through the office of the president established NACC to provide leadership and strong coordination mechanism for multi-sect oral national response to HIV/AIDS prevention 2005-2009. There are anti-discrimination laws and regulations that specify protection of sub population e.g. children, women and young people. There

are also policies and laws against child marriage sexual abuse and gender based violence. The budgetary allocation has influence on prevention of HIV/AIDS. The ministry of health and ministry of education to jointly work towards availing more resources for sexual behavior change which leads to prevention of HIV/AIDS among students in secondary school.

All institution factors considered influenced the prevention of HIV/AIDS. The secondary school management needs to support programs established towards prevention of HIV/AIDS, involve teachers and students fully in the process of establishing hence programs and also the implementations. There is need to be provided with adequate instructional resources material to enable teachers to implement the curriculum and students to interpret the content correctly. The teaching of HIV/AIDS in schools requires that there is preparation and distribution of scientifically accurate good quality teaching and learning materials on HIV/AIDS.

#### **5.4 Recommendations of the Study**

The ministry of education should provide student with information on infection and prevention of HIV/AIDS so as to develop meaningful skills to help them stay uninfected. There is need to train peer educators among students to be positive role models that can positively influence students behavior facilitating access to creating trust among themselves. There is also the need to establish well manned peer counseling clubs to help students out on issues related to HIV/AIDS infection and prevention, and when students get the message from their peer it is easier to accept and translate into behavior change leading to HIV/AIDS prevention

Parents and stakeholders in education need to be involved in the process of HIV/AIDS education. They are opinion leaders to their children and so they need to talk openly with them on sexual matters for behavior change and prevention of HIV/AIDS.

From the study schools have no uniformity in the acquisition of resources which calls for clear guidelines as to where schools should source funds for implementation of policies in relation to HIV/AIDS prevention. Media need to be used positively in influencing HIV/AIDS prevention among students. Specific communication sites such as twitter, facebook, whatsapp common to the youth can be utilized to pass information on infection and prevention of HIV/AIDS.

Ministry of education and health should look into budgetary allocation to institutions because heads of institutions commended that they have no guidelines where to source finance for full implementation of policies. The secondary school management needs to support programs established towards prevention of HIV/AIDS, involve teachers and students fully in the process of establishing these programs and in their implementation

Education is powerful protective factor against HIV AIDS prevention and should therefore be promoted. Most school administrators have not supported the teaching of HIV/AIDS education. The ministry should sensitize the school principals, and provide the necessary funding and guidelines for implementing the teaching of HIV/AIDS education. It should also carry out frequent inspections to oversee the implementation HIV/AIDS education.

Most teachers could not access HIV/AIDS education materials because they were not available in their schools. The ministry should plan for HIV/AIDS education material production for students and teachers. The ministry should encourage the teachers to develop the teaching materials locally together with the community members, to cater for religious and cultural ideas that might be useful in preventing the spread of HIV, and to reduce conflict between cultural, religious and modern methods of teaching sex education.

The government and other stakeholders in the war against HIV/AIDS prevention should provide resources to all schools and clear guidelines as to where to source funds to purchase the resources to help in the prevention of HIV/AIDS among students.

Most the teachers have not adequately trained to teach HIV/AIDS education. The ministry of education should introduce courses on HIV/AIDS teaching methods at teacher training institutions and in-service training programs for the teachers in the field. This is important because teachers need to understand HIV/AIDS so that they can give reliable information to students and communities.

### **5.5 Suggestions for further study.**

There are important issues that this study was unable to address due to its scope. From the research findings and conclusions drawn, there are certain variables that the researcher felt needed some further investigations. It is suggested that the following be considered for further research:

1. There is need for similar designed studies in other districts in Kenya to get a broader picture of how factors influence the prevention of HIV/AIDS among



secondary school students. This will make it possible to determine whether the finding documented in this study holds for all students in Kenyan secondary schools.

2. There is need to replicate the study at primary and tertiary levels in order to provide a complete picture of how factors influence the prevention of HIV/AIDS among secondary school students.
  3. Although this study focused on secondary schools, there are several other social institutions other than secondary schools, which have a potential of teaching HIV/AIDS. These institutions include colleges, polytechnic and universities. It is important to study these institutions to exploit their potential in increasing the awareness of HIV/AIDS among the youth and provide continuity to the information given in secondary school.
- 4 Research should be done on high prevalence of HIV/AIDS epidemic among secondary school students.

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If you choose teachers, does the school provide official time for learning about HIV/AIDS?

Explain.....

**Part 111: Factors influencing Prevention of HIV/AIDS**

.5. Below are factors that may influence the prevention of HIV/AIDS among students in public secondary school. Kindly provide your response by putting a tick on your view by using either strongly agree (SA) Agree (A) Undecided (U) Disagree (D) and strongly disagree (SD)

prevention of HIV/AIDS influenced by; hindrance/stoppage/inhibit	SA	A	U	D	SD
My age factor					
My attitude towards sexual experience					
My parents view influence on sex matters					
My personal goals and career advancement					
Peer pressure					
My belief that HIV/AIDS is not real					
Modern lifestyle and preference on sex					
Exposure to reading materials on HIV/AIDS					
Consistent VCT services are provided					
Media adverts influence the prevention					
Religious beliefs and HIV/AIDS					
School administration expectations on HIV/AIDS prevention					
Cultural influence and HIV/AIDS					

6. What is your view about prevention of HIV/AIDS among students in secondary school? Kindly tick your suitable response

Am not aware of any student affected by HIV/AIDS [ ]

Not sure [ ]

7. What measures can be put in place to prevent spread of HIV/AIDS among students in public secondary schools?.....

THANK YOU



## APPENDIX II: HODS QUESTIONNAIRES

### Part 1: Bio data

Gender:        F [ ]                M [ ]

Age:

Below 30yrs        [ ]

30-39yrs            [ ]

40-49 yrs            [ ]

above 50 yrs        [ ]

Period of being in current school

1-3yrs                [ ]

4-5yrs                [ ]

5-10 yrs             [ ]

Above 10yrs         [ ]

Are you an appointed guidance/counseling?

Yes                    [ ]

No                     [ ]

### Part 11: Policy and prevention of HIV/AIDS

Have you attended seminars on prevention of HIV/AIDS?

Yes                    [ ]

No                     [ ]

Is there education policy measures provided on the prevention of HIV/AIDS among students in secondary schools in Kenya?

Yes                    [ ]

No                     [ ]

If yes, kindly explain.....

**The following are some of the resources that can be used to prevent the spread of**

**HIV/AIDS.** Kindly tick against those that is available in your school

Pamphlets and magazines [ ]

Curriculum guidance [ ]

Linkage to resources person [ ]

Books [ ]

Films and videos [ ]

What kind of support is provided by the school in order to utilize the above resources?

Kindly tick against your suitable answer:

Time provided within the school curriculum program YES [ ] NO [ ]

Adequate resources are provided YES [ ] NO [ ]

Training is offered YES [ ] NO [ ]

**The following institutional support measures can be provided on the prevention**

**of HIV/AIDS.** Kindly put a tick against your suitable response on the following

statement either by using strongly agrees (SA) agree (A) Undecided (U) disagree (D)

strongly disagree (SD)

Institutional support and prevention of HIV/AIDS	SA	A	U	D	SD
Provide room during school tuition time					
Provide appropriate books resources are provided					
Organize session with experts from Aids control unit					
Organize seminars and workshops on prevention measures of HIV/AIDS					
Exposes students to situations that discourages spread of HIV/AIDS					
Provide mentorship program					
Encourages free discussion between teachers and students about sexual matters					

Are there policy measures provided by the MOE on the prevention of HIV/AIDS?

YES [ ]                      NO [ ]

Explain your response.....

**13. Institutional factors that impede behavioral change among students.** Kindly provide your response by putting a tick against appropriate response either strongly agree (SA) agree (A) Undecided (U) disagree (D) strongly disagree (SD)

On institutional factors;	SA	A	U	D	SD
Inadequate management support hinder prevention					
Low student involvement and participation in HIV/AIDS related prevention activities					
Unclear communication channels between management and staff					
Institution value for HIV/AIDS education					
No voluntary test provide before conclusion					
Students found engaging in casual sex are served with capital punishment					
No prevention measures such as condoms are provided					
Health talk program are not provided by the school					
Counseling services provided aren't hardly appreciated					
School community do not prioritize on HIV/AIDS prevention measure					
School provide no VCT services					

14. On policy factors influence prevention of HIV/AIDS among students. Kindly provide your response by putting a tick on your appropriate response strongly agree (SA) agree (A) Undecided (U) disagree (D) strongly disagree (SD)

	SA	A	U	D	SD
School management have domesticated NACCP in to their situation					
Institution have HIV/AIDS policy on prevention of HIV.AIDS					
Clear guidance for interpretation and implementation of NACCP policy influence prevention					
Leadership provide policy direction in HIV/AIDS prevention					
Budgetary allocation affects implementation of HIV/AIDS prevention					
Weak stakeholders coordination influence of HIV/AIDS prevention					

14. Kindly provide your response on state of HIV/AIDS prevention in your school.....

THANK YOU FOR YOUR COOPERATION!

### **APPENDIX III: INTERVIEW GUIDE FOR PRINCIPALS**

The researcher is a Post graduate student at Moi University pursuing a Master of Philosophy (M. Phil) Course and would wish to enlist your support by answering the questionnaire below. Kindly provide honest answers and the findings will be handled with utmost confidentiality.

Thanks

CHELAGAT RUTH

Part 1: Personal Data

Gender male  female

Age: Below 30 , 30 – 39  40-49  above 50yrs

Academic Qualification: post graduate  graduate  certificate

Years of Experience: Above 35  26 – 35  16 – 25  6 – 15  Below 6 years

Part 11: Factors influencing Prevention of HIV/AIDS

Does the school provide VCT services at least once a term to test students on HIV and

AIDS status: Yes  No

What are the personal characteristics that influence HIV and AIDS prevention among students in your School?

---

What institutional factors influence behavior change towards HIV/AIDS prevention among students in your school?

---



---

What resource related factors influence HIV/AIDS prevention among students in your school?

---

a) Are there policies on HIV and AIDS prevention in your school?

Yes [ ]

No [ ]

What are the policies that influence HIV and AIDS prevention among students in your schools \_\_\_\_\_

---

Are these policies functional / effective in your school?

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What else would you want to say about HIV and AIDS policy in education? Comment

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THANK YOU

## APPENDIX IV: RESEARCH AUTHORIZATION (NCST)

REPUBLIC OF KENYA



### NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telegrams: "SCIENCETECH", Nairobi  
 Telephone: 254-020-241349, 2213102  
 254-020-310571, 2213123  
 Fax: 254-020-2213215, 318245, 318249  
 When replying please quote

P.O. Box 30623-00100  
 NAIROBI-KENYA  
 Website: www.ncst.go.ke

Our Ref:

Date:

NCST/RR/12/1/MED-011/144/4

19<sup>th</sup> September, 2011

Ruth Jeptui Chelagat  
 Moi University  
 P. O. Box 3900  
 ELDORET

#### RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "*Factors influencing the prevention of HIV/AIDS among secondary school students in Kenya: A case study of Eldoret East District*" I am pleased to inform you that you have been authorized to undertake research in Eldoret East district for a period ending 30<sup>th</sup> October 2011.

You are advised to report to **the District Commissioner the District Medical Officer of Health & the District Education Officer, Eldoret East District** before embarking on the research project.

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

**P. N. NYAKUNDI**  
**FOR: SECRETARY/CEO**

Copy to:  
 The District Commissioner  
 Eldoret East District

The District Medical Officer of Health  
 Eldoret East District

**APPENDIX V: RESEARCH PERMIT**

**PAGE 2** **PAGE 3**

**Research Permit No. NCST/RRI/12/1/MED011/44**

**THIS IS TO CERTIFY THAT:**


<b>Prof./Dr./Mr./Mrs./Miss/Institution</b>	<b>Date of issue</b>
<b>Ruth Jeptanui Chelagat</b>	<b>19<sup>th</sup> September, 2011</b>
<b>of (Address) Moi University</b>	<b>Fee received</b>
<b>P.O BOX 3900, Eldoret</b>	<b>ksh.1000</b>

**has been permitted to conduct research in**

<b>Eldoret East</b>	<b>Location</b>
<b>Rift Valley</b>	<b>District</b>
	<b>Province</b>

**on the topic; *Factors influencing the prevention of HIV/AIDS among secondary school students in Kenya: A case study of Eldoret East District***

**for a period ending 30<sup>th</sup> October 2011**



*Ruth Jeptanui Chelagat*

**Applicant's Signature**

*[Signature]*

**Secretary**

**National Council for Science and Technology**



**APPENDIX VI: MAP OF UASIN GISHU COUNTY**

