

**THE INFLUENCE OF SOCIAL MEANING OF HIV/AIDS TREATMENT ON  
HIV/AIDS PREVENTION STRATEGIES AMONG THE YOUTH IN ELDORET  
TOWN- KENYA: A CASE STUDY OF MOI AND KISII UNIVERSITY  
STUDENTS.**

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## DECLARATION

### Declaration by the Student

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## **DEDICATION**

I dedicate this study to the youth of Eldoret Town

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First of all, I would like to thank the Almighty God, I would not be where I am today without Him. My appreciation goes to Moi University for providing me with the opportunity to learn, gain experience, acquire great knowledge and skills. I thank my supervisors Dr. Masese and Dr. Abuya for their guidance. Lastly, I would like to thank my family and friends for the financial and moral support.

## ABSTRACT

HIV/AIDS continues to be a major socioeconomic and medical problem affecting many youths in Kenya. Great medical advancements have seen its status decline from a fatal to a manageable, chronic disease. Despite this, it still has no cure. Prevention still remains core in mitigating the impact of HIV/AIDS. Guided by social construction theory, this study investigated the influence of social meanings of HIV/AIDS treatment on HIV/AIDS prevention using ABC strategies among the youth in Eldoret town, Kenya. Specifically, the study examined how the youth make meanings of HIV/AIDS treatment and how these meanings influence their practice of safe sex using ABC strategies. Data for this study was collected from 50 youths who were selected through snowball sampling and direct approach using in-depth interviews. Augmentative data was also collected from four key informants who were purposively selected and three focused groups involving the youths were held. Data from In-depth interviews, key informant interviews and focus group discussions were transcribed verbatim and then thematically analyzed. Findings of the study showed that the youth had diverse social meanings of HIV/AIDS treatment depending on age, gender, religious affiliation, level of formal education, sexual activity, future career path and perception of HIV/AIDS risk. These social meanings of HIV/AIDS treatment were; HIV/AIDS treatment as management of illness, HIV/AIDS treatment as cure of the illness, HIV/AIDS treatment as no cure for illness and HIV/AIDS treatment as unnecessary evil. These social meanings were further found to influence the practice of safe sex using ABC through the various forms of treatment associated with the youth meanings of HIV/AIDS treatment in relation to their socialized practice of sexuality. The study recommends that the youth should be provided with appropriate information on HIV/AIDS prevention strategies depending with their context and that the young people should be provided with accurate and adequate knowledge about HIV/AIDS prevention to enable them make informed choices on sexual matters.

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## ABBREVIATIONS

ABC	- Abstain, Be faithful, Condoms
AIDS	- Acquired Immune Deficiency Syndrome
AMPATH	- Academic Model for the Prevention and Treatment of HIV
ART	- Antiretroviral Therapy
ARV	- Antiretroviral
CATIE	- Canada's source for HIV and Hepatitis C Information
GDP	- Gross domestic product
HAART	- Highly Active Antiretroviral Therapy
HIV	- Human Immunodeficiency Syndrome
KARP	- Kenya Aids Response Progress Report
KPA	- Kenya ports Authority
NACC	- National AIDS Control Council
NGO	- Non-governmental organization
PEP	- Post exposure prophylaxis
PEPFAR	- The US President's Emergency Plan for AIDS Relief
PLWHA	- People living with HIV/AIDS
TASO	- The AIDS Service Organization

TB	- Tuberculosis
UNAIDS	- The Joint United Nations Programme on HIV and AIDS
UNICEF	- The United Nations Children's Emergency Fund
WHO	- World Health Organization

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Background of the Study**

HIV/AIDS remains a high priority global health and socio-economic problem. The HIV virus has caused worldwide devastation. At least 60 million people have been infected, with 90% of them living in developing countries. It is believed that over 20 million people have died of AIDS since its advent in the 1980s (WHO/UNAIDS, 2007). In Kenya, the HIV/AIDS pandemic has evolved, since the first case was diagnosed in 1984, to become one of the major causes of mortality and has placed tremendous demands on the health system and the economy (NACC, 2014).

Demographically speaking, HIV infection rates have continued to grow, with 67% of new HIV infections being recorded every year among young people between the ages of 15-24 with young women mostly affected (NACC,2001; UNAIDS, 2004). This is because most of these youth engage in risky behaviors such as having multiple sexual partners, a practice that puts most of them at risk of contracting sexually transmitted infections including HIV/AIDS (Conklin, 2012)

According to Schoepf (1991), the most common mode of transmission of HIV/AIDS is through heterosexual sex. As a result, most prevention strategies which are premised in the Health Belief Model have focused on sexual behavioral change through promotion of safe sex practices such as Abstinence, Being faithful and Condom use (Janz et al 1984). In these strategies, it is assumed that young people can prevent HIV/AIDS infection if they are empowered with information on the cause, the mode of transmission, the severity of the disease and the means of preventing

infection so that they can make rational decisions and avoid HIV infection by engaging in safe sex practices.

However, research findings have showed that despite people being informed about HIV/AIDS, the prevalence of HIV/AIDS is still high. Having knowledge about HIV/AIDS is not enough when attempting to influence sexual behavior change. Other studies have focused on contextual factors influencing sexual behaviour. Studies by Madise, Zulu, Ciera, 2007; Cradock, 2004; Hunter, 2002 and Baylies and Bujra, 2000) have shown that people engage in risky sexual activities because of socio-economic factors such as the need to meet their basic needs. Other studies also attribute this to retrogressive cultural practices where women are to prove their fertility by having unprotected sex before marriage (Mba, 2003). Other studies (see Gupta, 2002; Silberschmidt, 2001; Vagra, 2003; Wilton, 1997; Blanc, 2001; Campbell *et al*, 2001) have also attributed women vulnerability to HIV/AIDS to gender power imbalance which characterizes most African societies.

Moreover, recent studies investigating why individuals engage in sexual risk-taking have focused on meanings of sex, sexual practices and social norms in various cultural contexts. Studies by Chitando (2008) and Hunter (2004), for example, have shown that men engage in risky sexual behaviour because of cultural beliefs about sex. For instance, they believe that sex enhances their health and is a way of proving their manhood.

Apart from sexual behavioral change, other HIV/AIDS studies have focused more on prevention and treatment. According to Berhan et al (2012), the introduction of antiretroviral therapy has saved millions of lives since its introduction in 1996. Its use

in Sub-Saharan Africa begun in 2002. Antiretroviral therapy (ART) has contributed to a 19% decline in deaths from HIV infection from 2004 to 2009. It has not only reduced mortality rates from HIV/AIDS, but also improved the quality of life for those who are infected.

Increasingly, HIV/AIDS treatment has become a greater priority in the global fight against the disease. However, increased access to treatment has also affected sexual behavior. As noted by Kennedy et al (2007), improvement of health and life expectancy among HIV/AIDS infected people has created a perception that HIV/AIDS is no longer a fatal disease. This perception has led many in the population to engage in risky sexual behaviors. Therefore, there is need to investigate how adolescents make meaning of HIV/AIDS treatment in relation to HIV/AIDS prevention strategies, such as the ABC strategies.

## **1.2 Statement of the Problem**

According to Global HIV Prevention Working Group (2004), HIV treatment offers great opportunities for HIV/AIDS prevention by encouraging HIV testing and reducing stigma. However, as Mukherejee *et al.*, (2003) observes, HIV treatment may alter people's perception of HIV/AIDS and this may lead to increased risky behaviour. As accessibility to treatment continues to improve specifically in developing countries, there is need to examine how this development affects various group responses to prevention messages which specifically target behavioral change. This study therefore, investigated how social meanings of HIV/AIDS treatment influence prevention strategies among the youth. This is important because the way the youth perceive HIV/AIDS treatment will greatly influence their action towards HIV/AIDS prevention strategies.

As noted by social constructionist (Blurr, 2003, Huber *et al.* 1998), people synthesize information given to them into their common shared knowledge as it exists within their social institutions, everyday language, shared meanings and understandings. This common shared knowledge is constructed through socialization as a result of social interaction, negotiation and power informing action.

This means the youth will construct their own realities on what HIV/AIDS treatment means based on their cultural belief systems and the existing prevailing social and economic circumstances. These constructed realities which may or may not be an accurate interpretation of what HIV/AIDS treatment means, will nonetheless guide the youth towards certain HIV/AIDS prevention strategies. Therefore, understanding how the youth make sense of HIV/AIDS treatment is important. The success of interventions depends on both HIV/AIDS treatment and prevention.

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

The purpose of the study is to determine the influence of social meaning of HIV/AIDS treatment on HIV/AIDS prevention strategies among the youth in Eldoret town- Kenya: A case study of Moi and Kisii university students.

### **1.4 Objectives of the study**

This study was guided by the following specific objectives:

1. To establish how the youth make meaning of HIV/AIDS treatment.
2. To determine how the social meanings of HIV/AIDS treatment influence safe sex practices among the youth using the ABC model.

### **1.5 Research Questions**

1. How do the youth make meaning of HIV/AIDS treatment?
2. How does the social meaning of HIV/AIDS treatment influence safe sex practices among the youth using the ABC model?

### **1.6 Justification of the Study**

The importance of examining how youths understand HIV/AIDS treatment cannot be overemphasized given the fact that there is no cure for the disease. By using a social constructionist approach to frame this study, there is an understanding that there are multiple ways in which HIV/AIDS treatment is understood by various individuals in different contexts. This understanding may impede or facilitate HIV/AIDS prevention among a given population. By recognizing that there is no universal way of understanding HIV/AIDS treatment and the importance of individual context, findings of this study are important in making HIV/AIDS interventions more effective to different groups especially the youth. This is because meaning which form a basis for an individual's action stems from an individual context.

### **1.7 Significance of The Study**

HIV/AIDS is a major problem globally. The efforts to mitigate it seek for an effectual solution. Despite using various strategies to fight the pandemic, the prevalence level is still high. Findings from this study established the extent to which the youth in Eldoret were knowledgeable concerning HIV/AIDS treatment. This will be of great benefit to policy makers and HIV/AIDS campaigners to have an idea of where to direct their focus. The findings showed how knowledge on HIV/AIDS treatment

influenced youths' sexual behavior. This knowledge is important in determining the most effective approach of campaigns against HIV/AIDS infections.

This research also bears some theoretical significance. The study utilized the Social Construction theory, which examined how individuals and groups contribute to producing perceived social reality and knowledge (Berger et al 1967). In society, the meaning of illness is shaped by cultural and social systems, which is the same case for HIV/AIDS. The issue of sexual behavior is attributed to the culture and local meanings attributed to it. This implies that HIV/AIDS prevention strategies should not only focus in empowering people with knowledge but should also strive to understand how economic, social and cultural factors shape an individual's action towards HIV/AIDS (Parker, 2001). It is essential to engage in an in-depth exploration of these issues to facilitate participatory development of HIV/AIDS interventions which are culturally sensitive and linguistically appropriate and appealing to target populations. This study therefore demonstrated the versatility of this theory in explaining the problem under study.

### **1.8 Scope and Limitations of the Study.**

The study was limited to investigating how the youths makes meaning of HIV/AIDS treatment and how these meanings influences prevention of HIV/AIDS using Abstinence, being faithful and Condom use (ABC).



## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

Chapter two discusses related literature to the area of study. It details the findings of different studies that are related to the study area. The discussion will be presented in the following order; the problem of HIV/AIDS, the social meaning of HIV/AIDS, HIV/AIDS treatment and sexual behavior, youth and sexual behavior, youth and ABC and lastly the theoretical framework.

#### **2.2 The Problem of HIV/AIDS.**

The impact of HIV/AIDS in Kenya is socio-economic and medical. According to UNAIDS (2001), AIDS, while continuing to be an important health issue, has evolved into a complex social and economic emergency.

##### **2.2.1 HIV/AIDS as a Medical Problem**

HIV/AIDS as a medical problem has brought about great devastation in the world especially in Africa. According to UNAIDS (2001), since the beginning of the epidemic, 21.8 million people have succumbed to AIDS, placing ever-increasing demands on health services. The pandemic has adversely affected fragile economies, overwhelming public health systems. In 1997, public health spending on AIDS alone exceeded 2% of (GDP) in seven of 16 African countries sampled, a staggering amount for countries whose health expenditure for all diseases accounts for 3 to 5% of their GDP. Piling on the increased demands is the heavy burden of AIDS on health workers themselves.

A study in Zambia showed that in one hospital, deaths among health-care workers increased by a factor of 13 over a decade, largely because of HIV. Overburdened public health systems further marginalize minorities in the society such as the disabled and elderly women with HIV/AIDS. HIV-positive people also lack access to medicines and to health care, often facing discrimination from hospital staff or health-care systems (UNAIDS, 2001).

Furthermore, health costs are the most visible and direct costs of the epidemic. These costs are incurred at the national, sectoral, and household levels and may, when unmet at one level, be shifted to another. AIDS leads to increased demands on health centres (clinics and hospitals). AIDS is costly because many of the opportunistic infections associated with it (such as TB, pneumonia, cryptococcal meningitis) are expensive to treat. As a result, the productive age group that usually finances health care becomes a net consumer of services. The latest therapies for AIDS, being used in the industrialized countries, cost approximately US\$10 000 annually. This is multiple the GDP per capita in most African countries (Loewenson et al, 1997).

### **2.2.2 HIV/AIDS as a Social Problem**

Socially, it is an event that disrupts the life of a community and causes uncertainty, fear, blame, and flight (National Research Council, 1993). HIV/AIDS is a global pandemic that affects individuals, families, and entire communities around the world. It has profound social and economic implications. In 2004, the scourge killed an estimated 3 million people, and an additional 40 million were found living with the infection (InterAction, 2005).

According to UNAIDS (2005), the epidemic primarily affects the world's poorest people in countries with the greatest gender inequities, disparities in income, and access to productive resources.

HIV/AIDS immensely affects the family structure and the community. According to Loewenson *et al* (1997). The social impact of HIV infection stems from the illness and death of individuals and the consequent effect on the family, community and the broader society. The roles which people play in the family determine the extent of disruption and loss. The death of an adult male, who is an income earner, will affect the family's access to resources. The death of an adult female may result in children receiving less care and females being taken out of school.

In addition, children orphaned due to AIDS-related deaths of their parents or caregivers face an unpredictable future that is often compounded by the same stigma, discrimination, and social isolation faced by their parents/caregivers. According to UNICEF (2005), Children infected and affected by AIDS face similar problems like other children in other difficult circumstances. It was estimated that by the year 2010 in sub-Saharan Africa alone, more than 18 million children will have lost at least one parent to AIDS. The loss of parents can have far-reaching emotional, economic and developmental consequences for any child, especially in poor households. In Africa, AIDS has occasioned the phenomenon of child-headed households, where the older children have to care for their younger siblings in the absence of adults. This situation worsens in cases where some of the children may also have HIV/AIDS and are in need of consistent medical care. Child caregivers and other orphans in poor households are forced to earn a living off the streets where they are often poorly paid

increasing the risk of hunger, disease, or sexual exploitation and consequent risk of HIV infection.

According to UNAIDS (2005), social issues have allowed the virus to gain a major foothold in every nation around the world. The immense nature of this scourge has led to mass fear and paranoia and many misconceptions about the virus. This has led to stigma and discrimination of those infected as people seek to explain what they do not understand. Unfortunately, this only hinders the fight against the pandemic and ironically makes populations more vulnerable to infection

Caregivers, families and friends encounter the same stigma and prejudice as those they care for. The everyday psychosocial issues for persons living with or affected by HIV/AIDS are compounded by poverty, homelessness, addictions, unsanitary living conditions, war and trauma, discrimination, and societal indifference (Tamaszewski et al, 2006).

Lastly, WHO (2013) cites fear of stigma and discrimination as the main reason why people are reluctant to get tested, disclose their HIV status and take antiretroviral drugs. An unwillingness to take an HIV test means that more people are diagnosed late, when the virus may have already advanced to AIDS. This makes treatment less effective, increasing the likelihood of transmitting HIV to others and causing untimely death.

### **2.2.3 HIV/AIDS as an Economic Problem.**

HIV/AIDS affects economic growth by reducing the availability of human capital. The lack of adequate prevention, nutrition, health care and medicine that is available

in developing countries, a large number of people are falling victim to AIDS (Bel et al 2003). According to Dixon (2002), over 70% of the world's 40 million people living with HIV/AIDS are in Africa. It was found that besides the human cost, HIV/AIDS has significant effects on Africa's economic development and hence curtails its ability to cope with the pandemic.

The youth are the most infected group with HIV/AIDS. This scenario greatly affects the economy since they are at a productive age. The epidemic has grave implications for economies in affected regions as primary wage earners and caretakers fall sick, require care and eventually die (Lewis, 2001). According to Over (1992), by affecting mainly young adults, AIDS reduces the taxable population, in turn reducing the resources available for public expenditures such as education and health services not related to AIDS. This results in increased pressure for the state's finances and slower growth of the economy. This causes a slower growth of the tax base which is reinforced if there are growing expenditures on treating the sick, training (to replace sick workers), sick pay and caring for AIDS orphans.

According to Over (1992), at the household level, AIDS causes both loss of income and increased spending on healthcare. A study in Côte d'Ivoire showed that households having a member with HIV/AIDS spent twice as much money on medical expenses as other households. This additional expenditure also leaves behind less income to spend on education and other pressing needs.

HIV/AIDS has a great impact on the rural economy. According to Sehgal (1999), the effects of HIV/AIDS within a rural economy may include : Redistribution of scarce resources with an increasing demand for expenditure on health and social services; A

collapse of the educational system due to high morbidity and mortality rates amongst educators and learners; Younger and less experienced workers replacing older AIDS related casualties, causing reduction in productivity; employers becoming more likely to face increased labour costs because of low productivity, absenteeism, sick leave and other benefits (attending funerals), early retirement and additional training costs.

According to Dixon (2002), HIV/AIDS pandemic also diminishes labour supply, through increased mortality and morbidity. This is compounded by loss of skills in key sectors of the labour market. The long period of illness associated with AIDS reduces effectiveness in performance. One review reported that the annual costs associated with sickness and reduced productivity as a result of HIV/AIDS ranged from \$17 (£12; €19) per employee in a Kenyan car manufacturing firm. These costs reduce competitiveness and profits. Government incomes also decline as tax revenues fall and governments are likely to increase their spending, to deal with the rising prevalence of AIDS, thereby creating the potential for fiscal crises.

Further, HIV/AIDS has an effect on savings and investment. According to Loewenson et al (1997), individuals who fall ill will divert their savings into consumption (in order to maintain themselves and their dependents). They will also liquidate their existing savings and possibly their fixed assets. In some countries, the mechanisms for mobilising savings include pension schemes and life insurance. All these savings are at risk of depletion by the epidemic. The life insurance industry is aware of the implications of the HIV epidemic on their operations, but no one has looked at what this means for macro-economies and government revenues. This issue needs to be brought to the attention of finance ministers and central bankers.

### **2.3 Social Meaning of HIV/AIDS Treatment.**

HIV/AIDS treatment is viewed in terms of management since it has no cure. Management is seen as the use of ARVs to boost immunity to fight opportunistic infections in order to prolong life. HIV/AIDS now is viewed like any other normal disease. Society fears it less as it is manageable through ARV medication. This has made HIV/AIDS to transition from being a fatal disease to a chronic disease. According to Creighton (2015), Griffiths (2013) and Young (2013), advancements in modern medicine has made HIV/AIDS to be a “chronic, manageable illness” just like diabetes or heart disease, it is no longer seen as a terminal disease. HIV/AIDS is no longer seen as a death sentence it once was before. This has enabled individuals who have HIV to ultimately have the same life expectancy as those without the virus.

Even though HIV/AIDS can be managed through medication, there are some people in society who still view it as a killer disease. According to Paulson (2014), HIV still remains the world’s deadliest infectious disease killing nearly the same number of people every day than the Ebola outbreak in West Africa killed in nine months.

Ideally, this management has enabled people with HIV/AIDS to appear healthy and live a long life. This has made society to be more accepting of people living with HIV/AIDS leading to reduction of the stigma. Chan et al (2015) argued that in high-prevalence countries of Sub-Saharan Africa, the scale-up of HIV treatment has resulted in a lessening of stigmatizing attitudes in the general population. It suggested that because treatment improves the physical health of people living with HIV and allows them to contribute economically to society, treatment undermines one source of HIV stigma.

Despite HIV/AIDS treatment being a great contribution to HIV/AIDS management, some in the society are of the view that it promotes sexual immorality. People with HIV/AIDS are living longer and look healthy, thus society no longer views it as a threat. This poses the danger of careless sexual behavior in the society as it is known there is treatment to manage it in case of infection. In fact, most young girls are more afraid of getting pregnant than of contracting HIV/AIDS. According to Lakdwalla et al (2006), HIV treatment breakthroughs have lowered HIV mortality coinciding with increased HIV incidence. These are linked because new treatments have improved health and survival for the HIV positive persons, increasing their sexual activity and thus facilitating the spread of HIV/AIDS.

Gradually, the society is looking at HIV/AIDS treatment as contributing to the increase of the spread of HIV/AIDS. People taking ARVs appear just as healthy as those without HIV, hence it is difficult to know who has HIV and who does not. Therefore, if one has HIV and is on medication, they can ordinarily engage in sex and spread the virus to unsuspecting people. Atuyambe et al (2008) argued that people have expressed fears that the increased use of ARVs would result to increased HIV transmission which has made it difficult to differentiate between HIV-positive and HIV-negative persons, as they all appear healthy.

Cotton et al (2006) argued that spirituality and religion are often central issues for patients dealing with chronic illness. Most patients with HIV/AIDS belong to an organized religion and use their religion to cope with their illness. He argued that some Christian ministries had affected the treatment of AIDS. Moreover, some churches in London claim that prayer will cure AIDS and Cotton et al further reported



that several people have stopped taking their medication, on advice from their pastor, leading to a number of deaths.

## **2.4 Forms of HIV/AIDS Treatment**

### **2.4.1 ARVs**

According to WHO (2006), standard antiretroviral therapy (ART) is a combination of antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease. ART also prevents onward transmission of HIV. May et al (2012) argued that there were several classes of antiretroviral agents that act on different stages of the HIV life-cycle. The use of multiple drugs that act on different viral targets is known as highly active antiretroviral therapy (HAART). HAART decreases the patient's total burden of HIV, maintains function of the immune system and prevents opportunistic infections that often lead to death.

People living with HIV start taking ARVs as soon as possible after diagnosis without any restrictions of CD4 counts. ARV is not a cure for HIV/AIDS, but it keeps HIV under control. Antiretroviral treatment works by keeping the level of HIV in one's body low. This allows one's immune system recover and remain strong. Keeping one's viral load minimal also helps in preventing HIV transmission (Avert 2015). With proper adherence to the medication, those with HIV are likely to live for as long as those without (May et al 2012).

Despite ARVs being very helpful in HIV/AIDS management, they have certain adverse side effects. Some are mild and go away with time; others are recurring and hard to cope with. In rare cases, these side effects can be very dangerous. According

to Women's health.gov (2011), these side effects include nausea, diarrhea, fatigue, skin rashes, liver damage, kidney problems, bone loss and dystrophy.

#### **2.4.2 Cancer Drugs.**

In some cases, cancer medication has been used in an attempt to cure HIV/AIDS. Research shows that HIV can be flushed out of its hiding places in the body using cancer drugs. According to Gallagher (2015), scientists have developed a way to combat HIV's survival mechanism, flushing the virus out of its hiding places and killing it in the bloodstream. The treatment uses a "highly potent" cancer drug to target dormant reservoirs of HIV in the body. It was further stated that researchers at UC Davis School of Medicine in California were investigating a skin cancer drug known as PEP005 to study its effects on HIV. They believe that PEP005 may be able to "kick and kill" these reservoirs of hidden HIV, reactivating them so that they can be destroyed (Gallagher, 2015).

#### **2.4.3 Post Exposure Prophylaxis (PEP).**

Post-exposure prophylaxis, or PEP, is an emergency HIV treatment. Post-exposure prophylaxis is not a cure for HIV, it is a form of HIV prevention. It is a short course of antiretroviral drugs that stops exposure to HIV from becoming a life-long infection (WHO, 2014).

According to HIV.gov (2015), post-exposure prophylaxis is a month-long course of emergency medication administered to keep HIV from replicating and spreading through your body. Post-exposure prophylaxis is used by health care workers who

have been exposed to HIV-infected fluids on the job or anyone who may have been exposed through unprotected sex, needle-sharing injection, drug use, or sexual assault.

Post-exposure prophylaxis, if given to a person early enough, can stop the virus from replicating at the initial stage of exposure, preventing the virus from spreading throughout the body thus stopping the infection from becoming permanent. The cells that initially became infected would eventually die out and the virus would not be able to replicate (Davey et al 2010). It is recommended that should one think that they have been exposed to HIV, they should visit a clinic within 72 hours for post-exposure prophylaxis treatment (HIV.gov, 2015).

Davey et al. (2010) argued that post-exposure prophylaxis can fail to prevent HIV infection if one does not take the anti-HIV drugs as prescribed because consistency is central to the success of post-exposure prophylaxis. The author further stated that when one does not take post-exposure prophylaxis as prescribed, the amount of anti-HIV drugs in the blood could be too low to suppress the HIV, allowing the virus to evolve and develop resistance.

People on post-exposure prophylaxis may experience side effects which include fatigue, nausea or diarrhea. This may discourage one to stop taking their post-exposure prophylaxis drugs as prescribed, which then decreases the ability of the medication to prevent HIV infection (WHO, 2014).

According to Davey et al. (2010), some policy makers are concerned that promoting post-exposure prophylaxis may have a negative effect on people's behavior. They

worry that post-exposure prophylaxis may lead to a rise in risky sexual behaviour or injective practices and that we could end up with more HIV infections than before.

#### **2.4.4 Counselling.**

According to UNAIDS (1997), HIV counselling is a confidential dialogue between a client and a counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. The counseling process includes evaluating the personal risk of HIV transmission, and discussing how to prevent infection. Primarily, counseling concentrates on emotional and social issues related to possible or actual infection with HIV and to AIDS. After seeking the consent of the client, counselling can be extended to spouses, sex partners and relatives.

The main aim of HIV counseling is prevention and care. Counselling should be a process involving a series of sessions as well as follow-ups. It can be done in any location that offers peace of mind and confidentiality for the client (UNAIDS, 1997). HIV counselling has been proved effective in various ways. An evaluation of The AIDS Service Organisation (TASO) in Uganda has shown that it helps people accept and cope with the knowledge of being HIV-positive and fosters acceptance from families and communities (UNAIDS, 1997).

According to Okewo (2015), counseling encourages people living with HIV/AIDS to stick to their medication. This was due to the fact that they had accepted their status and no longer viewed HIV/AIDS as a death sentence.

### 2.4.5 Prayers

Religious beliefs significantly shape individuals' outlooks on living with HIV. Faith practices and beliefs can provide a sense of peace, hope and help people to prepare for and accept death (Genrich et al 2005). People often turn to religion to make sense of and come to terms with being HIV-infected. Prayer, meditation, participating in religious fellowships and other forms of religious activities have frequently been cited by PLWHA in Tanzania and other African countries as major strategies for coping with HIV/AIDS (Makoae et al 2008). Studies conducted in the United States have found that PLWHA use religion to cope with their illness (Cotton et al 2006; Pargament et al 2004), that being diagnosed with HIV often strengthens people's faith (Cotton et al 2006; Ironson 2006), that an increase in spirituality/religiousness after being diagnosed with HIV is correlated with slower disease progression (Ironson, 2006).

On the negative side, religious beliefs about HIV contribute to fatalistic attitudes, which hinders participation in treatment. According to Hess et al (2007), the belief that prayer can cure HIV challenges adherence to antiretroviral (ARV) treatment programs. A study on ARV adherence in Uganda found that 6 out of 558 (1.2%) patients discontinued their treatment because they believed that their pastors' prayers had cured them of HIV (Wanyama et al 2007).

In addition Lakhani (2011) argued that seriously ill patients suffering from conditions including cancer and HIV were being urged by some Evangelical Christian churches to depend on prayers rather than pills.

### 2.4.6 Myths

The virgin cleansing myth is the belief that having sex with a virgin girl cures a man of HIV/AIDS or other sexually transmitted diseases. This concept has been explored by Groce et al (2004) in their work titled, 'Rape of individuals with disability: AIDS and the folk belief of virgin cleansing'. They argued that young girls, who are presumed to be virgins because of their age, people who are "blind, deaf, physically impaired, intellectually disabled, or who have mental-health disabilities" are sometimes raped under the erroneous presumption that individuals living with disabilities are sexually inactive and therefore virgins.

According to the Umthuya (2009), in Zimbabwe, the myth is perpetuated by traditional healers advising HIV-positive men to cure their disease by having sex with virgin girls. Vickers (2006) also argued that in Zimbabwe, some people believe that the blood produced by raping a virgin will cleanse the infected person's blood of the disease.

Another myth is a HIV negative person taking a cold shower after having unprotected sex with a HIV infected person in order to reduce their chances of infection. This notion was made famous by the then ex deputy president of South Africa Jacob Zuma, who stated that he had showered with cold water after sex with a HIV positive woman believing that it would reduce the risk of being infected (see BBC News Africa, 2006).

#### **2.4.7 Witchcraft**

In many countries throughout the world, consulting witches is common, and black magic is considered part of everyday life. A 2010 poll of 18 countries in sub-Saharan Africa found that over half of the population believe in magic. Witch doctors are consulted not only for healing diseases, but also for placing, or removing, curses or bringing luck. According to Vidal (2005), the influence of witchdoctors in northern Zambia, where up to 25% of the population is HIV-infected, is enormous. People go to them first while fatally delaying treatment.

According to Mbabane (2010), blood and body parts of albinos were believed to cure AIDS. He claimed that witchdoctors use body parts in portions which they claim have a special potency in curing HIV/AIDS. Furthermore, Mbabane (2010) found that there was a disturbing development affecting women and girls with albinism. There was a myth spreading that sex with an albino female can cure aids. So they are raped by men with AIDS which spreads HIV in alarming proportions.

#### **2.4.8 Herbs**

In Africa, traditional herbal medicines are often used as primary treatment for HIV/AIDS and for HIV-related problems including dermatological disorders, nausea, depression, insomnia, and weakness (Essien et al 2004). Some herbal and traditional medicines are not well-researched, poorly regulated, may contain adulterated products and may produce adverse effects (Morris, 2002). Notwithstanding these concerns, the use of traditional medicines by Africans living with HIV is believed to be widespread (Sebit et al, 2000; Macphail et al, 2002).

Similarly, according to Hosein et al (2005), many people with HIV take herbs to support the immune system and to help it repair the damage caused by the virus. This is one of the most important uses of herbs but it's also an area which presents a challenge finding enough information to make informed choices.

Coincidentally, some people use herbs to cope with the side effects of the drugs they take to combat HIV infection such as nausea, diarrhea and headaches. Some herbs are used to treat these conditions, like ginger or marijuana for nausea, and peppermint or psyllium husks for diarrhea. Peppermint oil may also be used for headaches by applying a small amount to the temples (Hosein et al, 2005).

This is supported by Mosobo (see the article “Babu the new rich man from Loliondo”: Saturday Nation 2012). In the article, Babu, a Tanzanian herbalist attracted thousands of people into the Loliondo area by dispensing a herbal concoction purported to cure HIV/AIDS among other ailments.

## **2.5 HIV/AIDS Treatment and Sexual Behaviour**

The HIV virus has caused worldwide devastation. According to WHO (2005), at least 60 million people have been infected with 90% of them living in developing countries. It is believed that over 20 million people have died of AIDS.

During the early manifestation of HIV/AIDS, the disease was seen as fatal whereby most infected people died within a short time. HIV/AIDS was seen as the equivalent of death. However, with time new medicines have been discovered which have changed the perception of HIV/AIDS from fatal to chronic. According to Berhan et al (2012), the introduction of antiretroviral therapy has saved millions of lives since it



was widely introduced in 1996 and in Sub Saharan Africa in 2002. ART contributed to 19% decline in deaths from HIV infection from 2004 to 2009.

About 37% of HIV infected persons in sub Saharan countries who were eligible for ART were able to access antiretroviral drugs. The sub Saharan region bore 68% of the global HIV burden, by 2009. Just as in developing countries, ART has improved quality of life and survival in sub-Saharan Africa. As severely ill patients recover on ART, they feel general well-being and their sexual desire is likely to resume.

Since the introduction of antiretroviral therapy, its access has increased globally (Bunnell et. al 2006). This has led to improvements in life expectancy of HIV-infected people. Moreover, improvements in physical health may enable individuals to resume sexual activity, including unsafe sex. People also may experience “safer sex burnout” and exhibit difficulty sustaining safer sexual behavior over their lifetime. These have commonly been referred to as treatment optimism or behavioral disinhibition (Kennedy et.al 2007).

HIV/AIDS prevention has therefore focused on sexual behavior change as a way of mitigating the impact of HIV/AIDS. This focus has thus made research on sexuality central in the discourse of HIV/AIDS (Lear, 1997).

## **2.6 Youth and Sexual Behaviour.**

Research has shown that a large proportion of young people are not concerned about contracting HIV (UNICEF 2001). The foundations for sexuality, reproductive health and gender relations are laid very early in life and they largely shape the transition from adolescence to adulthood (Caldwell et al., 1989). In the era of AIDS, adolescents

are faced with new challenges and risks. It is important not only to enhance their general awareness of risks but also to persuade them to transfer this knowledge into their personal experience.

Demographically, HIV/AIDS is a major problem among the sexually and economically active people aged between 14-45 years (Kamaara, 2005). The risk of infection, however, is higher among females than males. This vulnerability is attributed to gender biased socialization which continue to enhance unequal power relations between females and males in issues of sexuality (Aggleton et al 1998).

Among the adolescents, the most common mode of HIV/AIDS transmission is heterosexual sex (Schoepf, 1991). According to World YOUTH Report, 2013, young people, like adults, contract HIV primarily in three ways: through sharing needles while indulging in drug abuse; through unprotected sexual activity between men and women; and through unprotected sexual activity between men. It is not having sex, but rather having unprotected sex, that places young people at serious risk of HIV infection. Because high levels of sexual activity among adolescents have not been accompanied by the consistent use of condoms, this population group faces a high risk of infection. In surveyed countries of sub-Saharan Africa, the proportions of unmarried, sexually active women aged 15-19 years who reported the use of condoms in their most recent sexual encounter ranged from 2 to 18 percent. Studies have found that even among adolescents who report recent condom use, less than half used condoms for each episode of sexual activity.

The main reason why youth continue to have unprotected sex, according to World YOUTH Report (2013) is because majority of young people remain uninformed about

HIV/AIDS. For more than 15 years, the need to communicate prevention messages related to HIV/AIDS has been internationally recognized; however, young people today still have only limited opportunities to learn about the disease. Some adults believe that sex education encourages sexual experimentation. Consequently, programmes and campaigns have been, and continue to be, limited in terms of what they can discuss. Reviews of programme evaluations indicate that HIV/AIDS education does not hasten the start of sexual activity, nor does it increase the frequency of sex or the number of sex partners. In fact, some programmes that have included discussion of contraception have delayed the debut of sexual activity and increased the likelihood of condom use.

## **2.7 Youth and ABC**

Since the late 1980s it had been known that individuals could take action to either reduce or avoid altogether the risk of becoming infected with HIV through sexual transmission. The risk could be avoided wholly by avoiding any sexual activities that could cause transmission of HIV; that is to abstain. The risk could also be reduced, through avoiding sexual intercourse other than with a mutually faithful uninfected partner that is; to be faithful or through the correct and consistent use of condoms that is; to use condoms (Avert 2003).

In a study on the adolescents' knowledge of "ABC" strategy in Kenya, half of the respondents demonstrated adequate knowledge of the meaning of abstinence and why it was important as an HIV prevention method. The knowledge regarding being faithful and condom use was found to be inadequate (Kaiser Report 2006). Another study on sexual abstinence behavior among youth by Koffi et al (2008) revealed that females were more knowledgeable about 'being faithful' than males.

According to McKeon (2006), abstinence is the safest option for youth who are not yet sexually active and should be included in all comprehensive HIV prevention programs for young people. However, programs must take into account the fact that a large share of unmarried adolescents in PEPFAR countries are already sexually active and require programs that will provide full information to enable them to make informed choices and to protect themselves if they choose to remain sexually active.

According to a study by Lillie et al (2009) on abstinence among the school going youth, the findings revealed that the majority (81%) of Kenyan youth indicated that they would wait until the right time to have sex. Another similar study by Kurtz et al (2005), the majority of Anguillan youths indicated that they would like to wait until they are older before having sex. In both studies, there were more females than males who indicated that they were ready to wait and avoid sex while in a relationship.

Research has shown that in sub-Saharan African countries (hardest hit by HIV/AIDS), sexual activity begins early and before marriage. According to surveys, on average, more than 40% of female young people in sub-Saharan Africa have had premarital sex before the age of 20 and among young men sex before marriage is even more common (Rahlenbeck et al 2004).

A study by Guiella et al (2008) provided understanding of patterns of adolescents' sexual behaviour and the factors that affect condom use. The findings showed that few (11%) males aged 15-25 years had had sexual intercourse in the last twelve months with more than two partners without a condom. The reason given for having multiple sex partners is that it is boring for some young people to have the same partner for a long time. Odu et al (2008) conducted a study on attitudes of young

people to HIV/AIDS in a tertiary institution in South-Western, Nigeria. In the study 51.8% reported having one partner and 48.2% had multiple sexual partners

According to UNAIDS (2004), condoms, when distributed with educational materials as part of a comprehensive prevention package, have been shown to significantly lower sexual risk and activity, both among those already sexually active and those who are not.

Card et al (2007) noted that the “ABC” strategy is sometimes hard to implement because when one partner insists on safe sex, the other partner may feel untrusted. Similarly, one person may not insist on safer sex out of fear of offending his or her partner. Partners may equate a request for safe sex as a sign of unfaithfulness and may react by withdrawing financial support or terminating the relationship. Women in particular may find it difficult to negotiate safer sex since women often have less power and control in their relationship.

## **2.8 Theoretical Framework**

The theory picked for this study is the social construction theory. The social construction theory examines how individuals and groups contribute to producing perceived social reality and knowledge about a phenomena (Berger et al, 1991). In the domain of social constructionist thought, a social construct is an idea or notion that appears to be natural and obvious to people who accept it but may or may not represent reality, so it remains largely an invention or artifice of a given society (Gale, 2008). It further involves looking at the ways social phenomena are created, institutionalized, known, and made into tradition by humans (Hurwitz, 2009).

This study employed social construction theory to explain how the social meaning of HIV/AIDS treatment influences the youths' HIV/AIDS prevention strategies using ABC. This theory was suitable for this study because in society, the meaning of illness is shaped by culture, social systems and experiences. Sexual behavior is closely associated with culture and local meanings attributed to it.

The youths' understanding of HIV/AIDS treatment is shaped by their context, so the meaning of HIV/AIDS treatment infers different things to different people (in this case the youth) and these perceptions influence their HIV/AIDS prevention strategies. This implies that HIV/AIDS prevention strategies should not only focus on empowering people with knowledge but should also strive to understand how various factors like economic, social and cultural underpinnings shape an individual's action towards HIV/AIDS (Parker,2001).

In using this theory to explain how youth make meaning of HIV/AIDS treatment, various perceptions were identified and analyzed in terms of their influence towards how the youth practice safe sex using ABC. This theory further explained whether or not the youths' safe sex practice using ABC was influenced by their social meaning of HIV/AIDS treatment.

## **2.9 Conclusion**

This chapter has reviewed literature related to the study. Past studies relevant to the study have been reviewed with a view of relating it to the study and to explore what other researchers have done to highlight knowledge gaps. Literature review started from the problem of HIV/AIDS, the social meaning of HIV/AIDS treatment, forms of HIV/AIDS treatment, HIV/AIDS treatment and sexual behavior, youth and sexual

behavior and youth and ABC. The theoretical framework that was used to examine the study (social construction) was also reviewed. The next chapter discusses the methodology adopted for this study.

## **CHAPTER THREE**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 Introduction**

This chapter covers the research design, study site, target population, sampling and sample size, methods of data collection, data analysis and ethical issues.

#### **3.2 Research Design**

Research design is the conceptual structure within which research is conducted; it constitutes the blueprint for the collection, measurement and analysis of data. It informs the arrangement of the conditions for the collection of data analysis in a manner that aims to combine relevance to the research purpose (Creswell 2011; Kothari, 2004).

This study adopted qualitative research design to collect data from the youths. Since the researcher was using social construction theory, it helped to explain deeper, the meaning of HIV/AIDS treatment among the youth because it is flexible and interactional, therefore it helped in sharing and collection of data relating to knowledge about HIV/AIDS treatment and how it affected their HIV/AIDS prevention strategy in their context in an in-depth manner . Qualitative methodology gives one an opportunity to explore the fullness and richness of the matter under study (Robson, 2002).

#### **3.3 Study Site**

The study was conducted in Eldoret town. Eldoret is a principal city in Western Kenya. It is the capital and largest city in Uasin Gishu County. Lying south of the Cherangani Hills, the local elevation varies from about 2100 metres above sea level at



the airport to more than 2700 metres in nearby areas 7000–9000 feet(Encyclopedia Britannica, 2016). Eldoret experiences high and reliable rainfall which is evenly distributed throughout the year. The average rainfall ranges between 624.9mm to 1,560.4mm with the wettest months occurring between the months of April and May and the driest months occurring between January and February (Weatherbase, 2011).

The main economic activity in Eldoret is large-scale grain farming, dairy and horticultural farming. It is also a local manufacturing hub which includes Raiply Woods, Rupa Textiles, Kenya Pipeline Company, Kenya Co-operative Creameries as well as corn, wheat and pyrethrum factories (Owuor, 2010).

Eldoret is home to various tertiary institutions both private and public which include Moi University, University of Eldoret, Kisii University, Mount Kenya University, Laikipia University, Catholic University among others (Manono, 2013). This made it very suitable for this study because of the high population of the youth in the universities.

There are various medical facilities that offer HIV/AIDS care, the major one being AMPATH which provides HIV care to over 120,000 patients in and around Eldoret and also serves as a referral site (Inui et al, 2007). This made Eldoret the suitable study site for this study.

Lastly, the infrastructure in Eldoret consists of the Eldoret International Airport. It is a large airport that serves the city of Eldoret and the surrounding towns. The roads network is excellent it includes the Trans-African highway which passes through the

city's central business district. The city is also served by the Kenya-Uganda railway (KAA, 2012).

### **3.4 Target Population**

A population is an entire group of individuals, events or objects having common observable characteristics. A target population is that population to which a researcher wants to generalize the results of a study (Mugenda et al 1999).

This study targeted the youth in various universities in Eldoret who were between the ages of 18-30 years. Prevalence rates of human immunodeficiency virus (HIV) infection among the youth is 75% which is disproportionately high compared to that of other age groups in Kenya (NACC, 2001; Othieno et al 2015). University students in particular and the university community in general represent high risk groups as far as infection by HIV is concerned. (Buchere, 2009)

Article 55 of the Kenyan constitution defines youth as those aged 18 to 35 years. In Kenya, an 18 year old is an adult and able to give consent thus the researcher did not go lower because of ethical issues.

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

In this study, the main participants were the youth, the researcher focused on the youth in the universities because they were most affected with the HIV/AIDS pandemic (Othieno *et al* 2015). The study took place in two universities in Eldoret namely Moi University (KPA campus) and Kisii University (Town Campus). The researcher used simple random sampling to select the universities to conduct the interviews in. The researcher made a list of all the universities in Eldoret and

randomly picked Moi University (KPA Campus) and Kisii University (Town Campus).

In the selection of participants, the researcher used the snowball sampling and direct method. Snowball sampling uses a small pool of initial informants to nominate through their social networks other participants who meet the eligibility criteria and could contribute to the study (Berg, 2006). The researcher made contact with one male student and one female from the universities who met the required characteristics for this study; that is, they were aged between 18-30 years and were students in either Moi University, KPA campus or Kisii University, Town Campus. Afterwards, the researcher gained their consent and interviewed them; they later referred the researcher to other youth who were willing to participate in the study. In selecting the participants, the researcher took into account diversities within the youth such as age, gender and year of study. Diversity was considered to ensure that the researcher got more in depth details on the study. This study used snowball sampling because HIV/AIDS and sexual behavior is a very sensitive topic. Some people are not comfortable talking openly to strangers about their sexual behavior so the researcher saw it fit to use the snowball method. The researcher managed to interview 29 participants using this method. The researcher faced various challenges when using this method. Some of the youth that were referred to the researcher refused to be interviewed. They were suspicious as to why they were referred to the researcher to discuss such a topic whilst those who agreed to be interviewed held back a lot of information. To counter these challenges, the researcher renegotiated consent in order to put the participants at ease and in some cases the researcher moved on to those participants who were willing to be interviewed.

Furthermore, the researcher used direct method in the selection of participants. This was because the researcher spent more time in the field and made some acquaintances. The researcher started approaching the youth directly by explaining to them about the study and requesting for consent for their interview. During the selection process, the researcher took into account the various diversities of the participants such as age, sex and year of study. Some of the youth approached accepted to be interviewed and some refused. Using this approach the researcher interviewed 21 participants.

According to Mason (2010), a number of issues can affect sample size in qualitative research; however, the guiding principle is the concept of saturation. There is a point of diminishing returns to a qualitative sample as the study goes on, more data does not necessarily lead to more information. The researcher was able to reach the saturation point at 50 youths when the researcher noticed that the data started getting repetitive and new information was not shedding any further light on the study. Hence the sample size was 50 youths.

### **3.6 Methods Of Data Collection**

This study adopted qualitative methods for data collection because it enabled the researcher to get in-depth information from the participants about their experiences and discourses (Mason, 2002). The researcher used three methods of data collection namely; in depth interviews, focus group discussion and key informant interview.

#### **3.6.1 In depth interviews**

This study used in-depth interviews to collect data from the youths who were selected using either snowball sampling or direct approach methods. According to Jwan et al

(2011), in depth interview is a two way process where the interviewer interacts with the interviewee in a conversation. In this interaction, the interviewer not only asks questions but shares his/her life experiences with the interviewee. Subsequently, in this study, the researcher used in-depth interviews in order to have a two way dialogue with the interviewees in the generation of information. This is because this study was carried from an ontological position which suggests that people's knowledge, views, understanding and interpretations are meaningful for the generation of knowledge (Burke, 2002; Campbell, 2003; Mason, 2002).

After the selection of participants, the researcher explained to them about the study and its objectives. Before the interview, the researcher negotiated consent which was verbal. The researcher went on to inform the respondents that the interview was going to be recorded and asked for their consent before proceeding with the interview. In carrying out the in depth interviews, all interviews were guided by broad topics or guiding themes (**See Appendix I**). These themes helped the researcher to create the atmosphere that was conducive for youths to talk about their understanding about HIV/AIDS treatment and how it influenced their HIV/AIDS prevention strategies using the ABC model and kept the interviews on track in order to prevent some interviewees from deviating from the main issue. As a complementary measure, the researcher wrote brief notes during the interviews.

### **3.6.2 Focus Group Discussion**

Focus group discussion is a form of group interview where a researcher facilitates a discussion with a small group of people on a specific topic (Jwan *et al* 2011). It

combines both elements of individual interviews and participant observation (Casey et al 2000) and involves six to eight people who have something in common.

The researcher conducted three focus group discussions, the first one consisted of ladies, the second one consisted of men and the third one was a mixed focus group discussion. The researcher organized the focus group discussion in such a manner in order to get diversity. The participants were chosen on the basis of age, sex and year of study in order to achieve diversity. The researcher asked several questions (**See appendix 2**). The researcher moderated the discussions and the participants responded. The discussions were recorded with consent from the youth and the researcher again took brief notes during the discussion. The study used focus group discussions because it provided an opportunity to generate data from many people within a short time and participants felt encouraged to open up when in a group (Jwan et al 2011)

### **3.6.3 Key Informant Interviews**

Key informant interviews involves interviewing those people in society with knowledge in the area of study. The researcher conducted key informant interviews because it provided rich data which was gathered in a relatively easy and inexpensive way and provided information directly from knowledgeable people (Mountain states group inc 1999).

The researcher conducted 4 key informant interviews which included two peer youth educators and two counselors. The key informants were purposively selected based on their knowledge on HIV/AIDS and the youth. The researcher chose the Peer Youth Educators from FHOK because they deal with the youth on a day to day basis,

educating them on matters affecting the youth such as HIV/AIDS, reproductive health, relationships among others. The researcher chose the counselors because they have counseled various young people and understand what they go through.

The researcher negotiated consent before interviewing the key informants. The researcher asked various questions (**See appendix 3**). The interviews with the key informant interviews were tape recorded with their consent and the researcher also made short notes during the interviews.

### **3.7 Data Analysis**

The researcher used qualitative data analysis technique because the researcher was collecting narratives to analyze the discourses.

First, the researcher did adhoc data transcription. The researcher took the audio recorded data from the interviews and transcribed it. The researcher transcribed all the data alone even though it was a tedious and time consuming process (Dornyei, 2007). This helped the researcher to internalize the data thoroughly. In addition, the researcher labeled the data from each participant and filed it separately to maintain order.

Secondly, the researcher re-familiarized with the data. The researcher read the transcripts in order to form a general idea of the data which helped with interpretation. Then the researcher consolidated the data by removing unnecessary words and phrases and also was able to identify issues emerging from the data.

Thirdly, the researcher embarked on coding the data and did so manually. This enabled the researcher to group the various categories of data into themes based on the research questions which were; how do youth make meaning of HIV/AIDS

treatment? And how does the social meaning of HIV/AIDS treatment influence safe sex practice using ABC model? The researcher then pulled out extracts from the file that were relevant to the themes identified.

Lastly, the researcher made use of the themes to write a research report.

### **3.8 Ethical Issues**

Research ethics are the moral principles that guide research from its inception through to its completion and publication of research (ESRC, 2005). This study involved a very sensitive topic hence it was important to treat the research participants humanely, with care, sensitivity and respect (Oliver, 2004). The researcher also maintained confidentiality with the respondents and also negotiated consent before interviewing the respondents. (Neuman, 2006)

To maintain confidentiality, the researcher ensured that the participants' information was kept confidential. To achieve this, the researcher changed all the names of the respondents and used pseudonyms. Also, the information for each participant was restricted to general background information only. Ethically, the researcher carried out the interviews alone.

Informed consent is the procedure in which individuals choose whether to participate in an investigation after being informed of the facts that would be likely to influence their decisions (Jwan *et al*, 2011). The researcher, negotiated consent with the respondents before interviewing them. The respondents were clearly made aware of the details of the study and its objectives so that they could make an informed choice at the end of the day. Since all the respondents were above 18 year of age, they could give consent. The consent was verbal.



### **3.9 Conclusion**

This chapter has covered the research design and methodology used in the study. It has presented the research design and the study area in detail, elaborating on the study population. The target population were the youth of Eldoret town and the sample size were 50 youths which was determined through saturation. The sampling procedure for the participants were snowball sampling and direct method. This chapter has highlighted methods used in data collection which were in depth interview, focus group discussions and key informant interview. Moreover, the researcher discusses the data analysis and finally the ethical issues in this study.

## **CHAPTER FOUR**

### **DATA PRESENTATION AND INTERPRETATION**

#### **4.1 Introduction**

This chapter presents a discussion of the research results. The study addresses the two research objectives which were; to establish how the youth make meaning of HIV/AIDS treatment and to determine how the social meanings of HIV/AIDS treatment influence safe sex using ABC. The researcher presents the social meanings of HIV/AIDS treatment which includes HIV/AIDS treatment as management, HIV/AIDS treatment as a cure, HIV/AIDS treatment as no cure and HIV/AIDS treatment as an unnecessary evil. Specifically, the researcher presents how HIV/AIDS treatment influences abstinence, being faithful and condom use among youths. The researcher presents the findings by developing descriptions and themes from the data and presents it in a descriptive qualitative narrative.

#### **4.2 Social Meanings of HIV/AIDS Treatment**

HIV/AIDS has no cure but there are treatments to enable most people with the virus to live longer and healthier lives. The most common form of HIV/AIDS treatment is antiretroviral drugs (ARVs), which work by stopping the virus from replicating in the body and thereby allowing the immune system to repair itself and prevent further damage (Creighton, 2015; Griffith, 2013 and Young, 2013).

Despite biomedical treatment as a means of management of HIV/AIDS, youths have different meanings of HIV/AIDS treatment. These meanings include HIV/AIDS treatment as management, cure, no cure and an unnecessary evil.

#### **4.2.1 HIV/AIDS Treatment as Management.**

HIV/AIDS treatment is viewed as a form of management by some of the youths interviewed. This is due to the fact that it has no cure. Management is seen as the use of HIV/AIDS treatment to boost immunity to fight opportunistic infections in order to prolong life. Advancements in modern medicine have made HIV/AIDS to be a “chronic, manageable illness” just like high blood pressure, diabetes or heart disease that are no longer seen as terminal diseases (Creighton, 2015 ; Young , 2013). HIV/AIDS is no longer seen as a death sentence. This has enabled individuals who have HIV/AIDS to ultimately have near to normal, life expectancy as those without the virus.

‘Claire’, a 19 year old 1<sup>st</sup> year female student remarked:

“HIV treatment to me is all about management not a cure, Management to fight opportunistic infections using ARVs and therefore prolong life”.

‘Hussein’, a 22 year old 3<sup>rd</sup> year male student added:

“Since HIV/AIDS cannot be cured, ARVs just mitigate the devastating impact of the disease therefore reducing the pain, prolonging life and improving quality of life. Thus with ARVs, HIV/AIDS is no longer a death sentence but a manageable lifestyle disease”.

‘Ken’, a peer youth educator agreed with Hussein and Claire, stating:

“HIV is a viral disease, which so far is incurable and treatment only manages the disease and reduces fatality. Hence HIV/AIDS is a lifelong condition whose main treatment is to attack and control opportunistic infections, strengthened immunity and reduce viral load so as to prevent the virus from replicating in the body”.

‘Ed’, a 22 year old 2<sup>nd</sup> year male student further added:

“The other day in the news they showed a person who has lived with AIDS virus for over thirty years and this was attributed to the continuous proper medication and healthy diet”.

‘Kathy’, a 26 year old 4<sup>th</sup> year female student said:

“Human immunodeficiency syndrome is a virus which infects, has no cure but can be controlled and managed”.

Some youths who view HIV/AIDS treatment as manageable, argued that HIV/AIDS treatment enables people with HIV/AIDS to appear healthier and live longer. As a result, HIV/AIDS infected persons become more accepted in society reducing stigma associated with the disease. ‘Joy’, a 25 year old 3<sup>rd</sup> year female student posited:

“People who view HIV/AIDS more positively and have come out openly to reveal their HIV/AIDS status, have received more support. For example in Sugunanga, health workers distribute medication to HIV/AIDS patients openly, they come out in public to be treated without fear of the public”.

‘Phil’, a 23 year old 2<sup>nd</sup> year male student reiterated:

“Society’s perception has changed because in the past, people used to fear HIV/AIDS. Infected persons were viewed as dead but now infected persons appear healthier, live longer with less discrimination and stigma”.

Another 27 year old 4<sup>th</sup> year female student, ‘Jessie’ revealed:

“In the past, society used to fear HIV/AIDS and there was much stigmatization but now people have accepted it and are taking ARVs which has enabled them to live normally. Society has accepted the situation and we can now say that even if someone gets infected,

people are less fearful but more open and therefore receiving the support they need”. (FGD).

Chan *et al* (2015) argued that in the high-prevalence countries of sub-Saharan Africa, the scale-up of HIV treatment has lessened stigmatizing attitudes in the general population. This treatment has improved the general physical health of people living with HIV/AIDS making them more economically reliable to the society. Thus treatment has undermined HIV/AIDS stigma.

Some of the respondents who perceive HIV/AIDS treatment as a manageable disease cited antiretroviral medicine (ARVs) as the most utilized form of HIV/AIDS treatment. They argued that treatment helps fight opportunistic infections and boosts immunity, which leads to healthier and longer lives. Jake, a peer youth educator shared:

“ARVs help boost immunity and fight the opportunistic infections but does not cure. It acts as a fence so that the virus does not spread, so the patients have to strictly adhere to the treatment. This reduces the viral load while increasing CD4 count”.

‘John’, a 25 year old 3<sup>rd</sup> year male student explained:

“It is effective because someone who is infected is able to take the drugs for his or her lifetime and be healthy. It helps to boost immunity and fight opportunistic infections. An example is Asunta<sup>1</sup> who has lived with HIV for over 20 years, she is so healthy and even has kids.”(FGD).

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<sup>1</sup> Asunta Wagura is the Executive Director, Kenya Network of Women with AIDS (KENWA). She has lived with HIV for over 25 years.

The above sentiments are echoed by Kennedy *et al* (2007) and Berhan *et al* (2012) who argue that ARVs improve life expectancy and reduce mortality rates of HIV infected people which makes HIV/AIDS patients live longer.

Finally, some of the respondents view HIV/AIDS management in terms of counselling. They argued that counseling relieves stress that patients go through and makes them accept their HIV/AIDS status, encourages them to start taking their medication and therefore begin living positively. According to ‘Selina’, a 23 year old 1<sup>st</sup> year female student:

“Counseling helps HIV/AIDS patients to accept their status and start taking their medication which reduce stress and ensures positive living”.

‘Colins’, a 22 year old 2<sup>nd</sup> year male student intimated that:

“Stress is a major factor that often affects HIV/AIDS patients but counseling and emotional support provides them with motivation and hope for the future”.

This was noted by Okewo (see the article “To take or not to take ARVs”: Daily Nation September 8<sup>th</sup> 2015). The article sheds light on the change in perception that HIV/AIDS is a death sentence. Therefore, counseling enables HIV patients to accept their status, take medication and live positively.

#### **4.2.2 HIV/AIDS Treatment as Cure**

HIV/AIDS treatment may sometimes be viewed by some as cure. This view makes people with HIV/AIDS to lead healthier lives and motivates them to act without focusing on the problem. Boasting healthier and normal lives, people living with

HIV/AIDS, may be convinced that the treatment is actually a cure and this perception may have a variety of consequences on their behavior and on society.

Respondents who perceive HIV/AIDS treatment as a cure, use cancer drugs as a form of treatment. Cancer drugs have been used in an attempt to cure HIV/AIDS. Research shows that HIV can be flushed out of hiding in the body, using a cancer drugs.

‘Janet’, a 25 year old 3<sup>rd</sup> year female student elaborated:

“I have heard of cancer drugs, that they kill the HIV virus and that they can cure a person with HIV by treating the blood in the bone marrow. In fact, there is a doctor from Aga Khan Hospital who had written an article that there was a lady who had HIV and was cured by the cancer drugs. They even sent her blood samples abroad to verify and it was found that she was now HIV negative”.

According to Gallagher (2015), scientists have developed a way to combat HIV’s survival mechanism by flushing the virus out of their hiding places and thus killing it in the bloodstream. The treatment uses “highly potent” cancer drugs that target dormant reservoirs of HIV in the body.

Some respondents who view HIV/AIDS treatment as a cure use Post-exposure Prophylaxis as a form of HIV/AIDS treatment and argue that it prevents the virus from entering the body within 72 hours of exposure. ‘Jen’, a 28 year old 4<sup>th</sup> year female student stated:

“PEP is effective when taken within 72 hours, it works like the E-pills and is a form of prevention strategy for unprotected sex or when one is raped. It prevents the HIV virus from entering the body”.

In addition ‘Jake’, a peer youth educator claimed:

“PEP is recommended for guys who are HIV negative, but for the HIV positive, it interferes with the medication one is taking. It must be taken within 72 hours of exposure and then continuously for the next 30 days. It is therefore recommended for emergency situations like rape or failure of protected sex scenarios”.

According to Nordqvist (2015), these are emergency HIV pills that are administered to individuals exposed to the virus but within 72 hours and may stop the infection. The treatment should be taken as soon as possible after contact with the virus. Post-exposure prophylaxis is a very demanding treatment lasting for up to four weeks but is also associated with unpleasant side effects such as diarrhea, malaise, nausea, weakness and fatigue.

Respondents who perceive HIV/AIDS treatment as a cure often use ARVs as a form of treatment, which those who were infected appear healthier but this increases risk of exposure.

‘Peter’, a 22 year old 2<sup>nd</sup> year male student explained:

“People living with HIV and on treatment are now looking healthier with less fear of AIDS or death. Thus AIDS today is just like a cold, because patients take ARVs and appear to be well. This disease is now a lighter subject, which has reduced abstinence that has convinced people that it does not kill and therefore people are now behaving more recklessly and getting more exposed to the virus”.

Atuyambe et al (2008) and Kennedy et al (2007) argued that increased access to ART in developing countries has improved HIV treatment and led to a decline in mortality rates from HIV/AIDS. However, more access to treatment has also led to rising sexual behavior. Improvements in health and life expectancy of HIV infected people has



convinced people that HIV is no longer a serious and deadly disease. Consequently, this has increased risks of exposure due to a decrease in abstinence, promiscuity, prostitution and rape since people no longer fear the disease.

Some religious respondents believe that HIV/AIDS can be cured through prayers and supported the belief that pastors and prophets are able to pray and heal people who have HIV/AIDS. 'Cindy', a 25 year old 3<sup>rd</sup> year female student said:

“I heard prophet Owuor of Repentance and Holiness ministry could cure AIDS. One faithful gave a testimony on how the prophet prayed for him and believes he got cured of HIV/AIDS”.

Further 'Chero', a 19 year old 1<sup>st</sup> year female supported the idea:

“Prayer is effective and I personally believe that faith cures HIV/AIDS so long as you believe that God cures”.

Lakhani (2011) noted that seriously ill patients suffering from lifestyle conditions such as cancer and HIV were being encouraged by some evangelical Christian churches to depend on prayers rather than pills. As a result, some believers stopped taking life-saving drugs after being persuaded about the healing powers of God.

Others believe that HIV/AIDS can be cured by sex with a virgin which is usually practiced by people who lack awareness about the disease. Some cleansing ceremonies often practiced by older men also believe that sleeping with virgins cures HIV. 'Tom' a 22 year old 3<sup>rd</sup> year male student gave his thoughts:

“If one sleeps with a virgin who is HIV negative, she is the one who will get HIV from the infected person. It is believed that HIV/AIDS is transferred from the body of the one who has the disease to body of the virgin”.

‘Lily’, a 26 year old 4th year male student elaborated:

“Sleeping with a virgin is practiced widely in Africa because it is believed that a pure girl has the ability to cure HIV/AIDS, and the younger, the virgin girls, the high the chances of the cure”.

Radford (2013) confirmed that one particularly pernicious myth in Africa holds that having sex with a virgin can cure a person of AIDS.

In this study, some of the respondents believed that HIV/AIDS can be cured by taking a cold shower immediately after having unprotected sex with an infected person.

According to ‘Patrick’, a 24 year old 2<sup>nd</sup> year male student:

“I have heard that people take cold showers after having unprotected sex with a person who has HIV/AIDS in order to prevent themselves from being infected”.

This perceived form of treatment has been associated with, the now President of the Republic of South Africa, Jacob Zuma. He publicly revealed that he had showered with cold water after having sex with a HIV positive woman. Jacob Zuma believed he had been cured by the shower. (See BBC News Africa, 2006<sup>2</sup>).

Similarly, other respondents reported that HIV/AIDS can be cured through witchcraft. Such people argue that witchdoctors in some areas use the body parts of albinos believing they can cure HIV/AIDS. ‘Rachel’, a 20 year old 1<sup>st</sup> year female student remarked:

“Witchcraft actually works mostly in Tanzania, they say if you slaughter an albino, eat their flesh and bones, you get cured of AIDS. That’s why many albinos are dying over there in large numbers”.

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<sup>2</sup> <http://news.bbc.co.uk/2/hi/Africa/4879822.stm>

‘Jeff’, an 18 year old 1<sup>st</sup> year male student also stated:

“In some instances, witchcraft is used to cure HIV/AIDS. For example, there are people who often claim that they have gone to seek a cure from the witchdoctors and their health has improved”.

In his studies, Mbabane (2010) noted that the blood and body parts of albinos were believed to cure AIDS. Witchdoctors were found to use body parts as a special potency not only to restore political power and wealth but also to cure HIV/AIDS. Mbabane (2010) found that there was a disturbing development affecting women and girls with albinism. There is a widespread myth that having sex with albino females can cure AIDS. Subsequently, this myth has been associated with increased rape cases, which further spreads HIV infections.

Finally, some people believe that some herbs cure HIV. This is mostly used by people who are opposed to conventional medicines. ‘Larry’, a 21 year old 2<sup>nd</sup> year male student confirmed:

“I remember Babu, the Tanzanian herbalist who claimed his herbal concoction can cure HIV/AIDS. As a result, many people flocked to his homestead hoping to be healed by his herbs”.

This is supported by Mosobo (see the article “Babu, the new rich man from Loliondo”: Saturday Nation 2012). In the article, Babu, a Tanzanian herbalist lured thousands of people into the Loliondo area by dispensing herbal concoctions purported to cure HIV/AIDS among other ailments.

### 4.2.3 HIV/AIDS Treatment as no Cure

While HIV/AIDS can be managed with medication, there are some young people who still believe that it is a killer disease. ‘Ken’, a peer youth educator confirms this fear:

“HIV/AIDS is still a dangerous disease despite the fact that people can live with it for many years. As much as ARVs prolong life, the disease is still very dangerous”.

According to ‘Njambi’, a 25 year old 4<sup>th</sup> year female student:

“HIV/AIDS cannot be treated because once the virus is in the body, it affects the immune system. This increases vulnerability to opportunistic infections but once infected, HIV/AIDS has no cure so far”. (FGD).

‘Kamau’, 24 year old 3<sup>rd</sup> year male student:

“HIV/AIDS has no cure. There are cases of people who have used ARVs for a long time and who ultimately have tested negative”.

Some of the respondents view HIV/AIDS treatment as having no cure. Moreover, HIV/AIDS treatment is not effective to everyone who uses it as it has many adverse side effects.. ‘Jake’, a peer youth educator stated:

“HIV/AIDS treatment depends with a person’s immune system. Indeed, there are people who react to ARVs and their immunity and impact of the disease worsens with such medication”.

Despite ARVs being very helpful in HIV/AIDS management, they have certain adverse side effects (Women’s health.gov, 2011). Some effects are mild but eventually go away with time. Some effects persist and become difficult to overcome and therefore hard to cope with. In rare cases, some side effects are problematic which

include nausea, diarrhea, fatigue, skin rashes, liver damage, kidney problems, bone loss, dystrophy and so on.

#### **4.2.4 HIV/AIDS Treatment as Unnecessary Evil.**

While HIV/AIDS treatment contributes to HIV/AIDS management, some youths view it as promoting sexual immorality. As people with HIV/AIDS live longer and appear healthier, society no longer view it as a threat. This has led people to engage in careless sexual behavior thinking that, after all, treatment is manageable if infected.

Others view HIV/AIDS treatment as unnecessary evil since it's associated with more harm than good for society. 'Ben', a 23 year old 2<sup>nd</sup> year male student explained:

“Treatment has brought immorality; this is due to the fact that it prolongs life. People are having unprotected sex carelessly because even if they get infected with HIV/AIDS, there are ARVs to prolong life. Most girls right now actually claim that they now fear getting pregnant more than being infected with HIV/AIDS”. (FGD).

'Giddy', a 19 year old 1<sup>st</sup> year male student added:

“HIV treatment is a negative thing because it promotes immorality among the youths who now engage in reckless sexual behavior claiming that even if they get infected with HIV, they will take the ARVs”.

'Selina', a 23 year old 3<sup>rd</sup> year female student mused:

“In the past, people used to abstain because they used to fear AIDS. This was because AIDS patients used to die faster and their bodies were severely emaciated and people feared going near them. Today, with ARVs, people appear healthier and live longer and this has reduced the fear of the disease”.

‘Emmanuel’, a 19 year old 1<sup>st</sup> year male student categorically said:

“I think that ARVs should not have been introduced in the first place, since it has reduced the fear of the disease and the young people now engage in reckless sexual behavior and the government should therefore restrict its use especially among young people”.

According to Lakdwalla et al (2006), breakthroughs in HIV treatment have lowered HIV mortality rates but has also coincided with increased HIV incidences. New treatments have improved health and survival of HIV positive patients and has increased sexual activities, thus facilitating the spread of HIV/AIDS.

In addition, other respondents viewed HIV/AIDS treatment as contributing to the increase of the spread of HIV/AIDS. They argued that they appeared as healthy as those who were not infected making it hard to know who has HIV/AIDS and who does not. This made unsuspecting sexual partners at risk of infection. According to ‘Kemboi’ a 23 year old 2<sup>nd</sup> year male student:

“Society is very scared of HIV/AIDS treatment because now it’s hard to distinguish between a person who has HIV and a person who doesn’t have HIV. They all look healthy and they may use that opportunity to spread to other unsuspecting people”.

‘Julie’, a 25 year old 4<sup>th</sup> year female student said:

“Society has taken ARVs as normal. People just go and pick them without feeling ashamed. Society no longer judges because it is everywhere now. Almost everyone is taking ARVs so it does not scare people. My friend who works in AMPATH at Eldoret District hospital told me that many university students come to pick ARVs. There is a certain lady from Moi University who is on ARVs and appears very healthy. There are also other three ladies from University of Eldoret who come for ARVs. They also appear healthy but are HIV positive. Although, these ladies are actually finished, they are so beautiful and appear healthy that no man can resist their

temptation and yet they do not bother whether one uses condoms or not”. (FGD).

‘Ed’, another 22 year old 2<sup>nd</sup> year male student warned:

“Some of the people who have HIV just want to deliberately spread it to others. Today, people on ARVs look okay and spreading it to unsuspecting partners”.

Atuyambe et al (2008) argued that people have expressed fears that the increased use of ARVs has instead increased HIV transmission. This is because it would be difficult to differentiate between HIV-positive and HIV-negative persons, as they all appear healthy.

### **4.3 Influence of HIV/AIDS Treatment on Abstinence, Be Faithful and Condom Use (ABC).**

#### **4.3.1 Social Meaning and Abstinence**

Abstinence means refraining from sexual activity. According to PEPFAR (2005), this approach emphasizes delay of sexual debut and encourages unmarried individuals to abstain from sexual activities as the best way to avoid contracting HIV/AIDS and other STIs. However, findings from this study established that sexual activity begins early and prior to marriage.

Some of the youths who perceive HIV/AIDS treatment as a cure do not abstain from sex. They engage in sex more often and generally appear unafraid of contracting HIV/AIDS because they know about ARVs. ‘Ken’, a peer youth educator confirmed:

“There are some youth who believe that if they get infected with HIV/AIDS, they will go for ARVs and would live longer just like everyone else. They are convinced that death affects everyone, whether HIV negative or positive, and that death can come in many ways including accidents and through other diseases that are not associated with HIV/AIDS”.

Increasingly, some young people who perceive HIV/AIDS treatment as a cure, do not abstain. Since they no longer view HIV/AIDS as a death sentence but rather a manageable disease due to the availability of ARVs. In fact, such young people are instead found to be more scared of pregnancy than of contracting HIV/AIDS.

According to ‘Chris’, a 23 year old 4<sup>th</sup> year male youth:

“Most young persons are not abstaining but instead think of the disease just like any other disease. They no longer feel like AIDS is a threat and therefore participate in sex freely. But pregnancy is the only fear they try to avoid because that is what worries them most. For them, AIDS now is just like any other disease”.

‘Sally’, a 23 year old 3rd year female student explained:

“The youth no longer abstain from sex because they believe there is PEP that prevents HIV yet medical workers say that that drug is for emergencies only and that people should not be reckless with sex without protection thinking that PEP drugs are available. Once a medical worker told me that she had a case where a certain man had sex with a lady and found ARVs in the lady’s room afterwards. So that man rushed to AMPATH at Eldoret District hospital to request for the PEP drugs. The doctor cautioned him to always use protection so as to avoid rushing for PEP drugs, especially because those drugs sometimes fail to work”.

Atuyambe et al (2008) and Kennedy et al (2007) argued that increased access to Antiretroviral Therapy in developing countries had improved HIV treatment and led to a decline in mortality rates from HIV/AIDS. However, increased access to treatment has also led to an increase in unprotected sex. Improvements in health and



life expectancy of HIV infected people have shifted people's beliefs that HIV is no longer a serious and deadly disease. Consequently, this has increased risky sexual behaviors including lack of abstinence, promiscuity, prostitution and rape cases.

Youths who see HIV/AIDS treatment as a manageable disease have not abstained from sex before marriage, because they perceive HIV/AIDS as a chronic illness which can be managed. According to 'Rachel', a 20 year old 2<sup>nd</sup> year female student:

“It's a chronic disease and not a fatal killer disease. It's like any other disease that infects or attacks your body like a lifestyle disease and people are now able to live longer with it due to ARV medications. Therefore, most girls now are not afraid of HIV like they are afraid of getting pregnant”.

According to Creighton, (2015), Griffiths, (2013) and Young,(2013), advancements in modern medicine has made HIV/AIDS to be viewed as a “chronic or manageable illness” just like diabetes or heart disease and it is no longer seen as a disease that kills quickly. Hence, HIV/AIDS is no longer seen as a death sentence as previously viewed. Ultimately, HIV/AIDS infected persons now have almost similar life expectancy as those without the virus.

Njung'e (2009) argued that young women were more willing to gamble on hiding symptoms of HIV or STDs for years than providing evidence that they had engaged in pre-marital sex. After all, they argued people who contract HIV can live for decades with ARVs, proper nutrition and counselling. Currently, a majority of young people are keen on taking E-pills to prevent pregnancy instead.

On the other hand some of the youth who perceived HIV/AIDS treatment as an incurable disease did abstain from sex. According to 'Karimi', a 24 year old 3rd year male student:

“People are abstaining because they know that there is no cure for HIV/AIDS. Even though there is medication they claim that it just manages it so they fear contracting HIV/AIDS”.

But young people who perceive HIV/AIDS treatment as unnecessary evil are abstaining from sex. Such people are also afraid of contracting other sexually transmitted diseases and tend to abstain from sex till marriage if they have to avoid HIV/AIDS including STDs. 'Phil', a 23 year old 2<sup>nd</sup> year male student stated

“It's my personal choice to abstain, even if they find a cure because by not abstaining I can get an STI which is drug resistant, I can also get a girl pregnant”.

According to Advocates For Youth (2008), abstinence is the only 100 percent effective method for avoiding unintended pregnancy and sexually transmitted infections, including HIV. It further argued that teenagers should be encouraged to delay sexual initiation.

#### **4.3.2 Social Meaning and Be Faithful**

To be faithful refers to mutual fidelity and partner reduction for sexually active adults (PEPFAR, 2005) and calls on individuals to practice fidelity in marriage and other sexual relationships. This is practiced to reduce risk of exposure to HIV/AIDS. The fewer the sex partners, the fewer the risk of contracting HIV/AIDS. However, this study found that young people have multiple sexual partners, which increases risks of contracting HIV/AIDS and other STDs. In particular the youth.

Youths who view HIV/AIDS treatment as a cure do not abstain. Instead, they admitted that being faithful is very difficult in today's world and also because of ARVs which manage the disease. According to 'Sam', a 24 year old 4<sup>th</sup> year male student:

“Being faithful nowadays is difficult, in fact, most married guys are also not faithful. Actually HIV/AIDS has increased among married people and some young men have up to five girlfriends at a given time. This is because they believe that even if they get HIV/AIDS, the use of ARVs to manage the disease are available”. (FGD)

Similarly, young people who view HIV/AIDS treatment as management, never practiced fidelity because they believe more on ARVs. They argue that people living with HIV/AIDS appear healthy and live a normal lives. 'Caro', a 21 year old 1<sup>st</sup> year female student explained:

“Faithfulness has reduced because of ARVs, when you take ARVs no one can tell that you are positive. Those on ARVs appear normal and keep their status secret. Since they hide their medication, it is difficult to tell who is infected and who is not. This behavior has reduced the faithfulness and increase HIV/AIDS infections among the risky population”.

According to Atuyambe *et al* (2008), enhanced access to Antiretroviral therapy has increased risky sexual behavior including promiscuity, lack of faithfulness among couples and having multiple sexual partners.

The social meaning of HIV/AIDS treatment and being faithful has undergone major transformation especially among the youth. In the past, faithfulness among partners was important among both the married and the not yet married. According to 'Jep', a 20 year old 2<sup>nd</sup> year female student:

“Faithfulness is a person’s choice, you decide if you decide to be faithful or not. Right now faithfulness is very hard for many people, people just want to explore other options. I don’t think the issue of HIV/AIDS treatment has influenced people in terms of being faithful”.

‘Josh’, a 24 year old 3<sup>rd</sup> year male student echoed:

“People are no longer faithful; very few people are being faithful in their marriages and relationships. PEP has not influenced people to cheat. It’s just human behavior they always want to have different experiences and explore”.

These ideas are supported by studies of Myers (2015) and Quirk (2016), who argue that unfaithfulness is not new and that willpower or self restraint alone does little to change sexual behavior.

#### **4.3.3 Social Meaning and Condom Use**

According to PEPFAR (2005), Correct and consistent use of condoms reduces the risks of HIV/AIDS infections. This approach emphasizes increased access of condoms to those most at risk for transmitting or becoming infected with HIV/AIDS. In this case, youths are at risk mostly and therefore access to condoms should be geared towards the youth. If used well, condoms will significantly reduce the risk of HIV/AIDS infections.

Some youths who view HIV/AIDS treatment as incurable use condoms. Even though HIV/AIDS can be managed; one has to live with it for the rest of their lives. ‘Sally’, a 21 year old 1<sup>st</sup> year female student observed:

“The use of condoms has gone high because condoms protects those most at risk of infection since HIV/AIDS treatment only manages the disease but it does not cure”.

A 22 year old 2<sup>nd</sup> year male student, ‘Dan’ stated:

“Many youths are using condoms because they believe reduces the risk of contracting STIs and HIV/AIDS”.

‘Joe’, a 23 year old 3<sup>rd</sup> year male student noted:

“The youth are using condoms and are influencing others to use condoms. This is because they believe that if they get infected, PEP may have very severe side effects such as nausea, hallucinations, loss of appetite, weight loss, diarrhea and general body weakness”.

‘Giddy’, a 19 year old 1<sup>st</sup> year male student further noted:

“To me it does not influence because if I have sex without protection with a girl who has AIDS, I am not sure if that drug will work because there is no proof that it actually works. So, I would rather use protection while having sex instead of depending that drugs that no one knows whether they are effective”.

CDC (2011), argue that condoms greatly reduce risks of STIs that are transmitted to or from the penile urethra, including gonorrhea, Chlamydia, trichomoniasis, Hepatitis B virus and HIV. Similarly, condoms provide protection against STIs transmitted via skin-to-skin contact or contact with mucosal surfaces, including genital herpes simplex virus, HPV, syphilis, and chancroid in those affected areas covered by the condom.

Love Life (2016) observed that while ARVs help improve lives of people living with HIV/AIDS, they are not a cure for HIV/AIDS. ARVs can extend the lives of people with HIV but one can still die from AIDS-related complications.

Some of respondents who view HIV/AIDS as a manageable disease generally use condoms. 'Liz', a 24 year old 4<sup>th</sup> year female student revealed:

“Mostly, youths are using condoms, especially when their spouses, in particular, ladies want to prevent pregnancy. Because of HIV/AIDS treatment, most girls in the universities do not view AIDS as something to fear. They believe that if they get pregnant, it will interfere with their education and bring shame to their families, specifically their parents. But with the AIDS they believe that they can take the medication and people won't know”.

The study found that some of the youth who view HIV/AIDS treatment as unnecessary evil do not use condoms consistently. 'Anette', a 26 year old 4<sup>th</sup> year female student observed:

“People use condom the first time, then when they get used to their partners they stop using condoms. So as much as a lot of condoms are distributed free of charge, people take them by don't use them as much”.

'Rachel', a 20 year old 2<sup>nd</sup> year female student argued:

“Today the youth stop using condoms when they reach a point in their relationship that they feel they are so in love with each other. That is not true love that is toxic love”.

Mukei (2015) noted that most new couples only used protection on the first two days after 'hooking up' and then they stopped. This was despite the fact that the government distributes over 180,000 condoms annually.

‘June’, a 25 year old 4<sup>th</sup> year female student explained:

“One day I took condoms home to my husband. I told him that I had brought condoms for him to even pick six and walk with them because I don’t know what he does when am not with him and he got so angry at me. I also gave some of the condoms to my lady neighbors who were married and their husbands threw them out. Yet these husbands may become unfaithful and fail to use protection. I think it’s important if they carry condoms with them in case of anything. It is not bad for husbands to carry condoms with them but they do not want”. (FGD)

Lastly, the youth who view HIV/AIDS treatment as cure do not use condoms. Such youth opine that using condoms lowers their sexual pleasure and they would rather not use condoms and instead get PEP to prevent HIV/AIDS infections. ‘Giddy’, a 19 year old 1<sup>st</sup> year male student revealed:

“The use of PEP lowers condom use since users want to achieve maximum sexual pleasure and use PEP afterwards”.

‘Karimi’, another 24 year old 3<sup>rd</sup> year male student also revealed:

“Youths are no longer using condoms but report to hospital to obtain PEP. They know that if they are exposed to HIV, they are safe with the PEP”.

Atuyambe et al (2008) observed that HIV medication has increased AIDS transmission rates because in the past people protected themselves by using condoms. However, today they no longer protect themselves since the treatment is available for those who may require.

#### **4.4 Conclusion.**

This chapter covered the data analysis and interpretation. The researcher discussed the research results based on the objectives of the study which was; to determine how youth make meaning of HIV/AIDS treatment and to determine how the social meaning of HIV/AIDS treatment influenced safe sex practice among the youth using the ABC model.



## CHAPTER FIVE

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS OF THE STUDY

#### 5.1 Introduction

This chapter covers the summary of the findings based on the study objectives and makes conclusions and recommendations of the study. The objectives of this study were; to determine how youths make meaning of HIV/AIDS treatment and to determine how the social meaning of HIV/AIDS treatment influences safe sex practices using ABC model.

#### 5.2 Summary of Major Findings.

The study found that the youths perceived HIV/AIDS treatment in different ways depending on their context. The youths had different meanings of HIV/AIDS treatment, which included HIV/AIDS treatment as manageable, curable, incurable and as an unnecessary evil.

In regards to HIV/AIDS as a manageable disease, the study found that some youths view HIV/AIDS treatment in terms of boosting immunity and prolonging life. Hence, HIV/AIDS is seen as a chronic disease that is no longer a death sentence. This has altered people's perception of HIV/AIDS as a deadly disease and reduced stigma associated with it. Today, the treatment has made patients appear healthier and stronger. Consequently, they are now able to live longer and this has increased risks of more infections.

In addition, the study found that other youths view HIV/AIDS treatment as cure. Advancements in medicine has enabled infected HIV/AIDS patients to lead healthier lives and resume normal day to day activities. Appearing healthier, without visible

manifestation of HIV, has convinced many that HIV/AIDS treatment is actually a cure for the disease.

On the other hand, youths who view HIV/AIDS treatment as an incurable disease, argued that HIV/AIDS is a killer disease and despite the availability of HIV/AIDS treatment, it still has no cure and one has to live with it for the rest of his/her life. The study also observed that HIV/AIDS treatment has some adverse side effects on patients and in some cases is associated with a variety of complications, which has convinced some that HIV/AIDS treatment is an incurable disease.

Results of the study also showed that some youths view HIV/AIDS treatment as an unnecessary evil and that HIV/AIDS treatment was promoting sexual immorality among youths because they no longer view HIV/AIDS as a threat. Hence, such youth engage in risky sexual activities with knowledge that there is a reliable treatment of the disease. Coincidentally, some youths view HIV/AIDS treatments as increasing the spread of HIV/AIDS because it has made infected people appear healthier, which has made it more difficult for their sexual partners to suspect their status.

The study further established that youth's knowledge of HIV/AIDS treatment has influenced HIV/AIDS prevention strategies using ABC. The HIV/AIDS treatment has created the perception that HIV/AIDS is no longer a fatal disease and hence it has led young people to engage in unprotected sex, increasing risks of exposure to HIV/AIDS.

With regard to abstinence, the study found that some of the youth who perceive HIV/AIDS treatment as a curable and manageable disease do not abstain, since HIV/AIDS is no longer a fatal disease. Following advancements in modern medicine

which has kept the disease under control, HIV/AIDS patients have resumed their day to day activities because of treatment. On the other hand, those who view HIV/AIDS treatment as an incurable disease and an unnecessary evil have abstained because they know that if they get infected, they would live with the disease for the rest of their lives.

On faithfulness, some youths who view HIV/AIDS treatment as a curable disease do not practice fidelity and this has made it difficult for them to be faithful because they are convinced that even if infected, at least there is treatment that prolongs life. Other respondents who perceive HIV/AIDS as manageable disease do not practice fidelity because they argue that HIV/AIDS treatment has made infected persons appear healthy and stronger. Moreover, some respondents who view HIV/AIDS treatment as an unnecessary evil were also not faithful. They claim that unfaithfulness has been there since time immemorial and part of human nature. Results from the study further showed fidelity is a personal choice whether there is HIV/AIDS treatment or not.

Condom use among the youth in this study was found to be high. Some youths who perceive HIV/AIDS treatment as no cure use condoms and argued that as much as HIV/AIDS is manageable, one had to live with it forever. Similarly, respondents who view HIV/AIDS treatment as manageable also used condoms and argue that even though HIV/AIDS is manageable, they feared unwanted pregnancies and other forms of STIs. Other youths who view HIV/AIDS treatment as an unnecessary evil also do not use condoms consistently because as soon as they developed trust with their sexual partners, they stopped using the condoms.

Lastly, youths who view HIV/AIDS as curable disease, do not use the condoms and claimed that since there is treatment, they saw no need of using any protection. 6.4

#### Conclusions

The study was able to establish that the youth viewed HIV/AIDS treatment in different ways depending with their context. In this study, they perceived HIV/AIDS treatment as management, cure, no cure and an unnecessary evil. Furthermore, the study was able to establish that as much as HIV/AIDS treatment does not cure HIV/AIDS, using them consistently greatly improves the quality of life of most HIV-positive patients and helps them to live longer which influences how the youth practice their safe sex using ABCs. This study found that increased availability and access to HIV/AIDS treatment increased risky sexual behavior among the youth especially in terms of abstinence and being faithful. Most of the youth were not abstaining or being faithful because of the social meaning of HIV/AIDS treatment. On the other hand, condoms use among the youth in this study was found to be high.

#### **5.3 Recommendations.**

The researcher came up with various recommendations based on the study findings.

The study recommends:

1. That HIV/AIDS prevention strategies should not only focus in empowering people with knowledge but should strive to understand how economic, social and cultural factors shape an individual's action towards HIV/AIDS. This is because the study found out that the social meaning of HIV/AIDS treatment did have an influence on how the youth practiced ABC.

2. That young people need accurate and adequate knowledge about HIV prevention to make informed choices on sexual behaviour. Comprehensive knowledge about HIV prevention among young people is below par. This shows a great need to raise awareness of HIV prevention among the youth using ABC.

#### **5.4 Suggestion for Further Research.**

From this study, the researcher found that there is need for further research still targeting the youth. The research should focus on the youth who are already infected with HIV/AIDS and how they make sense of HIV/AIDS treatment.

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## APPENDICES

### Appendix 1: Indepth Interview Guide

#### Dear Respondent

My name is Barbara Masinde, a student at Moi University pursuing a Masters of Arts degree in Sociology. My research topic is **The Influence of Social Meaning of HIV/AIDS Treatment on HIV/AIDS Prevention Strategies among the Youth in Eldoret Kenya: A Case Study of Moi and Kisii University students** I humbly request your participation and cooperation. The information given will be confidentially and will not be used outside this research. Thank you for your cooperation.

1. Age
2. Gender
3. Year of study
4. What is HIV/AIDS?
5. How does one get HIV/AIDS?
6. Is HIV/AIDS a major problem among the youth? If yes (why), if no (why)
7. Who are the most vulnerable to HIV/AIDS ?
8. Do you know your HIV/AIDS status? If yes (why), if no (why)
9. Do you think HIV/AIDS is fatal disease? If yes (why), if no (why)
10. Have you ever gotten information on HIV/AIDS treatment? Yes or No
11. Do you think HIV/AIDS can be treated? If yes (why) if no (why)
12. Which forms of HIV/AIDS treatment do you know? (probe)



13. What do you understand by HIV/AIDS treatment?
14. How does the social meaning of HIV/AIDS treatment influence HIV/AIDS “ABC” prevention strategies? (Explain)

## **Appendix 2: Focus Group Discussion Guide**

### **Dear Respondent**

My name is Barbara Masinde, a student at Moi University pursuing a Masters of Arts degree in Sociology. My research topic is **The Influence of Social Meaning of HIV/AIDS Treatment on HIV/AIDS Prevention Strategies among the Youth in Eldoret Kenya: A Case Study of Moi and Kisii University students**. I humbly request your participation and cooperation. The information given will be confidentially and will not be used outside this research. Thank you for your cooperation.

1. What is HIV/AIDS?
2. How does one get HIV/AIDS?
3. Do you know your HIV/AIDS status?
4. Which forms of HIV/AIDS treatment do you know?
5. What do you understand by HIV/AIDS treatment?
6. How does the social meaning of HIV/AIDS treatment influence HIV/AIDS “ABC” prevention strategies?

### **Appendix 3: Key Informant Interview Guide**

#### **Dear Respondent**

My name is Barbara Masinde, a student at Moi University Pursuing a Masters of Arts degree in Sociology. My research topic is **The Influence of Social Meaning of HIV/AIDS Treatment on HIV/AIDS Prevention Strategies among the Youth in Eldoret Kenya: A Case Study of Moi and Kisii University students**. I humbly request your participation and cooperation. The information given will be confidentially and will not be used outside this research. Thank you for your cooperation.

1. What is the youth understanding of HIV/AIDS treatment?
2. How do you think the HIV/AIDS treatment affects the youth's ABC?
3. How do youths practice their sexuality in relation to HIV/AIDS prevention?

**Appendix 4: Workplan**

<b>ACTIVITY</b>	<b>TIME</b>
Proposal writing	January-March 2015
Correction and Improvement of Proposal	April-May 2015
Preparation of Research Instruments	June 2015
Data Collection	July-September 2015
Data Analysis	February -April 2016
Report Writing	June-September 2016
Submission	December 2016

**Appendix 5: Budget**

<b>ITEM</b>	<b>AMOUNT IN KSH</b>
Travelling cost	5,000
Stationery	3,000
Printing	3,500
Typing	2,000
Binding	1,500
Field research	5,000
Photocopying	3,000
Books	2,000
Computer services	4,000
Internet services	1,500
Production of interview schedules	1,000
Contingency	3,150
<b>TOTAL</b>	<b>KSH.34,650</b>

# Appendix 6: Research Permit

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

**THIS IS TO CERTIFY THAT:**

**MISS. BARBARA NAMAEMBA MASINDE**

**of MOI UNIVERSITY, 5972-30100**

**ELDORET, has been permitted to conduct**

**research in Uasin-Gishu County**

**on the topic: THE SOCIAL MEANING OF**

**HIV/AIDS TREATMENT ON HIV/AIDS**

**PREVENTION STRATEGIES AMONG THE**

**YOUTH IN ELDORET MUNICIPALITY**

**for the period ending:**

**31st July, 2015**

**Permit No. : NACOSTI/P/15/8285/5721**


**Date Of Issue : 19th May, 2015**

**Fee Received : Ksh 1,000**

**Applicant's Signature**

**Director General**

**National Commission for Science, Technology & Innovation**



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION


**CONDITIONS**

- 1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.**
- 2. Government Officers will not be interviewed without prior appointment.**
- 3. No questionnaire will be used unless it has been approved.**
- 4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.**
- 5. You are required to submit at least two (2) hard copies and one (1) soft copy of your final report.**
- 6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.**


**RESEARCH CLEARANCE PERMIT**

**Serial No. A 5125**

**CONDITIONS: see back page**



## Appendix 7: Research Letter From NACOSTI



**NATIONAL COMMISSION FOR SCIENCE,  
TECHNOLOGY AND INNOVATION**

Telephone: +254-20-2213471,  
2241349, 310571, 2219420  
Fax: +254-20-318245, 318249  
Email: secretary@nacosti.go.ke  
Website: www.nacosti.go.ke  
When replying please quote

9<sup>th</sup> Floor, Utalii House  
Uhuru Highway  
P.O. Box 30623-00100  
NAIROBI-KENYA

Ref. No. Date:

**19<sup>th</sup> May, 2015**

**NACOSTI/P/15/8285/5721**

Barbara Namaemba Masinde  
Moi University  
P.O. Box 3900-30100  
**ELDORET.**

**RE: RESEARCH AUTHORIZATION**

Following your application for authority to carry out research on *“The social meaning of HIV/AIDS treatment on HIV/AIDS prevention strategies among the youth in Eldoret Municipality,”* I am pleased to inform you that you have been authorized to undertake research in **Uasin Gishu County** for a period ending **31<sup>st</sup> July, 2015.**

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


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

**SAID HUSSEIN**  
**FOR: DIRECTOR GENERAL/CEO**

Copy to:

The County Commissioner  
Uasin Gishu County.


The County Director of Education  
Uasin Gishu County.

  
**COUNTY COMMISSIONER**  
**UASIN GISHU COUNTY**

National Commission for Science, Technology and Innovation is ISO 9001: 2008 Certified

## Appendix 8: Research Letter Fromm The Ministry Of Education

**REPUBLIC OF KENYA**



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

Telegrams: "EDUCATION", Eldoret  
Telephone: 053-2063342 or 2031421/2  
Mobile : 0719 12 72 12/0732 260 280  
Email: cdeuasisingishucounty@yahoo.com  
: cdeuasisingishucounty@gmail.com

Office of The County Director of Education,  
Uasin Gishu County,  
P.O. Box 9843-30100,  
**ELDORET.**

When replying please quote:

Ref. No. **MOEST/UGC/TRN/9/VOL II/26**                      **25<sup>th</sup> MAY, 2015**


Barbara Namaemba Masinde  
Moi University  
P.O. 3900-30100  
**ELDORET**

**RE: RESEARCH AUTHORIZATION**


This office has received your letter requesting for authority to allow you carry out research on "**The Social Meaning of HIV/AIDS Treatment on HIV/AIDS Prevention Strategies among the Youth in Eldoret Municipality**", Within Uasin Gishu County."

We wish to inform you that the request has been granted for a period ending **31<sup>st</sup> July, 2015**. The authorities concerned are therefore requested to give you maximum support.

We take this opportunity to wish you well during this research.

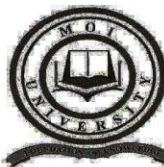
  
**OTIENO C. O**  
**For: COUNTY DIRECTOR OF EDUCATION**  
**UASIN GISHU COUNTY**

**FOR COUNTY DIRECTOR OF EDUCATION**  
**UASIN GISHU COUNTY**  
**P.O. Box 9843, ELDORET**  
**Tel: 0719-127 212/053-2063342**





## Appendix 9: Letter From Moi University



**MOI UNIVERSITY**  
**SCHOOL OF ARTS AND SOCIAL SCIENCES**  
**DEPARTMENT OF SOCIOLOGY AND PSYCHOLOGY**

Tel: 254-053-43620

P.O. Box 3900 - 30100  
 ELDORET - KENYA

Fax: 254-053-43047

Telex: 35047 MOIUNIVERSITY

E-Mail: [vcmu@irmmoi.com](mailto:vcmu@irmmoi.com)

30<sup>th</sup> MARCH 2015

The Director General/CEO  
 National Commission for Science Technology and Innovation  
 P.O BOX 30623 - 00100  
 Nairobi

Dear Sir,

**RE: LETTER OF AFFILIATION FOR BARBARA N MASINDE. (ADM. NO: SASS/PGS/001/12)**

This is to certify that the above named is a registered Master of Arts degree in Sociology student in the department of Sociology and Psychology in this University. Ms. Masinde has now successfully completed her first year course work and is due to proceed for field work/data collection. Her research proposal titled: "THE SOCIAL MEANING OF HIV/AIDS TREATMENT ON HIV/AIDS PREVENTION STRATEGIES AMONG THE YOUTH IN ELDORET MUNICIPALITY" has been presented and approved at the school seminar as per the requirements. She is expected to be in field between the months of April and November 2015.

Any assistance accorded to her for procurement of the research permit will be appreciated.

Yours Sincerely

  
 DR. JAMIN R. M. MASINDE (PHD)

E-Mail: [drjaminmasinde@yahoored.co.uk](mailto:drjaminmasinde@yahoored.co.uk)

HEAD OF DEPARTMENT, DEPARTMENT OF SOCIOLOGY AND  
 PSYCHOLOGY, MOI UNIVERSITY