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Assessing the Need for HIV-AIDS
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ASSESSING THE NEED FOR HIV-AIDS INFORMATION AMONG TEENAGERS IN RURAL THIKA DISTRICT OF KENYA

By

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ABSTRACT

ASSESSING THE NEED FOR HIV-AIDS INFORMATION AMONG TEENAGERS IN RURAL THIKA DISTRICT OF KENYA

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The thesis presents the results of an assessment of the information available to teenagers in rural Thika District of Kenya. The principal research object was to assess the information that teenagers in this rural district of Kenya are aware of as it relates to HIV-AIDS.

The study adopted a qualitative approach, which utilized two focus group discussions. One group was male while the second one included female participants aged 14 to 19 years old. Each group was interviewed separately and included 10 participants.

The study's results indicated that both male and female teenagers in this rural area of Kenya are aware of the causes of HIV-AIDS and were also knowledgeable about the risks and preventive measures needed to counter HIV-AIDS. Many of them were also aware of the various information campaigns being disseminated against the disease.

Most of them however, lacked the knowledge regarding the ability to use condoms effectively. They also mentioned that present preventive measures were not enough in combating HIV-AIDS. Many felt that since there are multiple ways of getting infected with the virus, then there should be as many ways to avoid this, supported by multiple media campaigns that contain a higher threat portion in their message delivery when compared to the present ones.

DEDICATION

To my sweet daughter Njeri: May you blossom to be knowledgeable and happy. You are the sunshine of my life.

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CHAPTER I

INTRODUCTION

The thesis presents the results of an assessment of the information available to teenagers in rural Thika District of Kenya in Eastern Africa. The principal research object was to assess the information that teenagers in this rural district of Kenya are aware of as it relates to HIV-AIDS. In this manner, the research was interested in assessing ways on how to optimize existing information inputs in schools on HIV-AIDS among teenagers. The main rationale is that the marginal cost of preventing and treating HIV-AIDS goes up with the rate of incidence while the actual implementation problems are due to the lack of coordination between agencies involved in HIV-AIDS prevention.

The study was conducted in January 2000 and adopted a qualitative approach utilizing two teenage focus groups aged 14 to 19 years old. These groups which had 10 participants each were divided into female and male and were interviewed in two separate meetings.

BACKGROUND: ADOLESCENTS AND HIV-AIDS

HIV-AIDS is a major health and development problem in Kenya. At the the end of 1998, about 1.9 million adults aged, 15 to 49 years old, and 100,000 children were living with HIV, the virus that causes AIDS. Many Kenyans are infected with HIV, where for every eight adults aged 15 to 49 years old, one is infected. In urban areas, one out of every six adults is infected. Most of these people do not know they are infected. In Kenya more than 700,000 people have already developed AIDS since the first case was

discovered in the country in 1981.[1] Since there is no cure for AIDS, this disease threatens the social and economic well being of the country.

Since most new infections are transmitted by heterosexual contact, people are at risk of catching the infections as soon as they become sexually active. According to a study in Kisumu District of Kenya (Kahindo et al, 1997), the pattern of infection is similar everywhere in Kenya. Infection levels are extremely high for girls and young women. The highest infection levels for women are in the 20 to 24 years old age group, while for men the highest infection levels are found in the 30 to 39 years old age group. The same study found that 18 percent of women in Kisumu were infected within two years of becoming sexually active.

A person does not develop AIDS as soon as he or she becomes infected with HIV. The interval between getting infected with HIV to the onset of the disease, AIDS is between 3 and 10 years. During this incubation period the person may not have any symptoms and therefore, may not be ware that he or she is infected. This contributes to the spread of HIV, since the person can transmit the infection to others without realizing it. For children the incubation period is much shorter because their immune systems are not fully developed. Most children who are infected at birth develop AIDS and die within five years.

AGE AND SEX DISTRIBUTION OF REPORTED AIDS CASES

According to the Kenya National Aids and Control Programme (NASCOP1999), more than 75 percent of AIDS, and therefore of the resulting AIDS deaths occur to adults between the ages of 20 and 45 years old. Since this is the most economically productive population, these deaths constitute a serious economic burden[2]. This is also the age when investments in education are just beginning to pay off. These

deaths also have severe consequences for children since most people in this age group are raising young children. While male and female cases are about equal because HIV is predominantly transmitted through heterosexual contact, the peak ages for AIDS cases are 25 to 29 years old for females and 30 to 34 years old for males. Young women in the age groups 15 to 19 years old and 20 to 24 years old are more than twice as likely to have AIDS as males in the same age group. Also, about 10 percent of reported AIDS cases occur in children under five years of age. Most of these cases are due to mother-to-child transmission. The obvious absence of many AIDS cases in the 5 to 14 years old age group indicates that mosquitoes or casual contact such as shaking hands does not spread infection.[3]

According to NASCOP, factors as diverse as information on the threat of HIV-AIDS, education, cultural beliefs, willingness to change, age and gender may contribute to a corresponding decline or increase in the number of HIV-AIDS cases in the country. NASCOP however added that, poor use of condoms due to the inability to read, understand and follow the instructions on the label, unavailability of condoms in some areas, weak condoms or general failure to use condoms as claimed when condoms are handed out freely at clinics may partially help to explain this increase in incidence

Many people, according to NASCOP appear to have changed their behavior to stick with one faithful partner. However this does not necessarily translate into reduced numbers of cases as many other cases go unreported, especially in the rural areas. Many others have adopted condom use, others seeking treatment for sexually transmitted diseases.

NASCOP, (1999) estimated that increased condom use alone may have saved hundred of thousands of people from HIV infection in Kenya. These programs therefore have had an effect. Unfortunately, they have not been so widespread or effective to prevent all new infections. In fact, the number of infected people is still increasing. Only a much expanded prevention program, with participation from all sectors (government, NGOs, private sector, religious groups, churches, professional organizations, community groups) will be successful in reducing the number of infected people in the future. More AIDS education especially amongst teenagers in the rural areas, where communication systems are not as prevalent, is required.

NASCOP, Stover and Baltazar (1999) report that an increasingly number of new HIV infections occur among youth aged 15 to 19 years old. At the end of 1997, 3% of all AIDS cases occurred among teens aged 15 to 19 years old. Of this total, 2% were male and 6% were female. In 1996, 11.7 % adults in the 15 to 49 years old age group were infected with the HIV virus (UNAIDS, 1996). The Kenya National AIDS and Control Program (NASCOP, 1999) also reported that at the end of 1999, one out of eight Kenyans aged 15 to 49 years old is infected. The current estimates do not claim to be an exact count of infections. According to UNAIDS fact sheet on Kenya (1999), the HIV-AIDS surveillance methodology on prevalence being used has proved accurate at producing estimates which give a good indication of the magnitude of the epidemic in individual countries.

To protect young people against HIV and other Sexually Transmitted Disease infections, the Kenya Government has promised to provide direction in designing culturally, morally and scientifically acceptable AIDS education programs of youth

against anti-social behaviors that put them at risk (NASCOP, 1999). While several factors contribute to the increase of HIV amongst teenagers in Kenya, traditional constraints such as the break down of the extended family structure has occurred, where every child lived under the constant and watchful care and eyes of all adults in the compound.

In addition, children and adolescents were educated informally during their upbringing as well as formally during the rite of passage ceremonies starting at around age 14 years old (Kenyatta, 1965). It was common among the Gîkúyú of Central Province including Thika, for the adults to tell traditional folk stories to children gathered around the fire in the evening or during the time spent working on the farm or herding cattle, goats and sheep with uncles, aunts and grandparents.

Since this traditional family structure and education, especially during initiation ceremonies, has ceased with modernization among the Gîkúyú community for example, adolescent sexual education today occurs either in schools or amongst peers, but no longer in an organized manner as in the old days. The result is an increase in teenage sexual activity and corresponding HIV infection and pregnancy (NASCOP, 1999).

This study set out to answer several research questions that are contained in the methodology section of this thesis. In this section they have been broadly categorized into the following four areas:

1. Teenagers knowledge about the causes of HIV-AIDS and who is at risk;
2. Teenagers knowledge of prevention measures and related barriers;

3. Teenagers ability to use preventive measures such as condoms, abstinence and monogamy;
4. Teenagers awareness and responses to media information and campaigns against HIV-AIDS;

CONTENTS OF THE THESIS

This thesis is organized into the following chapters:

1. Chapter I is the introduction
2. Chapter II reviews literature related to HIV-AIDS in Africa and among teenagers
3. Chapter III details the research methods used in this study
4. Chapter IV contains data analysis and findings
5. Chapter V includes discussion and conclusions

The thesis also contains two Appendices and a Bibliography. Appendix I is the focus groups discussion guide and Appendix II details the notes and transcript from the focus group discussions.

CHAPTER II

LITERATURE REVIEW

HIV-AIDS in Africa

Six young people are infected with the AIDS virus, every minute globally, which roughly translates to 8,500 young people each day. More than two thirds of those affected in Kenya are under 25 years old. 20 % are students, aged 15 and 19 years old: 22 percent of them are girls and four percent of them are boys (National AIDS Control Program in Kenya, 1999).[4]

Statistics on Africa show that more than half of all new HIV-AIDS (Human Immune Virus/ Acquired Immune Deficiency Syndrome) cases affect youth under 25 years of age disproportionately, with twenty one million people in the continent suffering from AIDS. The epidemic is currently most prevalent in sub-Saharan Africa (UNAIDS, 1999).

HIV-AIDS in Kenya

In Kenya, an Eastern African nation of approximately 28 million people, AIDS is a leading cause of death for people aged 15 to 49 years with the spread of the disease among adults having shot up from 3 percent in 1990 to 13.9 percent in 1998. According to US Ambassador to Kenya, Johnnie Carson, with the average per capita income of US Dollars $300, Kenyans could hardly afford to pay US Dollars $15,000 to save one life. The Ambassador added that the mass media in the country were yet to

respond meaningfully to the fight against the scourge. He added that AIDS was a global problem and should be addressed forcefully.[5]

Just prior to AIDS awareness Day on December 1st, 1999, the entire Kenyan cabinet held a special National AIDS Conference. (November1999) in Mombasa, Kenya declaring that AIDS is a national disaster.[6] Complications and delay in the fight against HIV-AIDS has in the past been compounded by official Kenyan government's delay in declaring HIV-AIDS a national concern. In addition, the Catholic Church in Kenya has continued to oppose the use of contraceptives, especially condoms by its followers. A leading Catholic cleric, Bishop Nicodemus Kirima of Nyeri Arch-Diocese, in Central Province proclaimed on November 29th, 1999 ("The Daily Nation" Newspaper) that the Catholic Church wouldn't change its position on the matter of condom use "even if it one was to be killed for opposing condom use." The church urges abstinence. At the same time the Kenyan President, Daniel Arap Moi appeared to have changed his position on allowing condom use, citing that it was okay to use them to help prevent HIV-AIDS.

This power struggle, typical of policy making in Kenya and elsewhere, has resulted in wasted time and loss of lives, before a real and coordinated national AIDS policy and effort has been implemented.

RESEARCH AND KNOWLEDGE ABOUT HIV-AIDS

HIV-AIDS and Teenagers in Kenya

A growing body of research suggests that high proportions of Kenyan teenagers are sexually active, and their sexual behaviors put them at risk of HIV infection. The Kenya Demographic and Health Survey (KDHS, 1998) reports that the median age at first intercourse is 17 years for women and men. Median age at first

marriage is 19 years old for women and 25 years old for men. Thus there is a significant period of sexual activity before marriage that exposes young people to the risk of HIV infection.

It is not all young people who have sex because they want to. In a nation-wide study of 12 to 24 year-old women, one young woman in four said she lost her virginity because she had been forced to have intercourse. In Nyanza province in the western part of the country, NASCOP, Kahindo, et al (1999) found that a quarter of secondary school boys and girls described their first sexual experience as unpleasant or worse. Unwilling sex with an infected partner carries a high risk of infection, especially for girls, since if force is used, abrasions and cuts are more likely to occur and the virus can more easily find its way into the bloodstream. What's more, condom use is unlikely in such situations (NASCOP, Kahindo, et al, 1999).

Research on HIV-AIDS knowledge, attitudes and practice among Kenyan teenagers

A study conducted among teenagers (Poulussen, Hermans, Nyanjom and Ondiege, 1998) aimed at collecting knowledge and attitude protection data (KAP), in order to develop messages and materials for an information prevention campaign, concluded that among youth in school in a high prevalence area like Nyanza Province of Kenya, knowledge on sexually transmitted disease infection is high and that more than half of the youth is sexually active at age 15 years old. Almost half of the sexually active group in the survey used condoms.

The study recognized the need for behavior change but instruments for change were poorly known. It adopted both quantitative and qualitative techniques and indicated that the mean age for sexual debut by both genders was 11.2 years, that boys

initiated sex most of the time, but also that 6.75% of the sexually active girls comprising 33.75% of the sample had more than 5 sexual partners. Meaning of safer sex was poorly understood. The study also found that, attitude towards people with AIDS was non-discriminative and caring among the respondents; that self-reported sexual activity was high; that sex is defined as insertive vaginal sex; condom use was low as many misconceptions persist and that girls mainly consider sex as a service to the boy, while boys do it for pleasure and relieve. The study concluded that basic knowledge on sexuality and safer sex is low and that sexual debut at age 12 years old is considered normal.

Out of 1483 participants, 58% had heard of HIV, self-perceived risk was 40.5% for boys and 32.8% for girls while 22.6% of the girls and 52% of the boys stated they ever had sex. Of these, 26% said that they ever used condoms.

A study by Verstraeten, Kiok & Tawuo, 1998 among rural Maasai youth in Kajiado District, Kenya concluded that the level of knowledge on HIV-AIDS and the modes of prevention is relatively high. The self-assessment for the risk of infection was low. A majority of the boys and a large percentage of the girls were already sexually active in both primary and secondary schools. Although a very high percentage of both girls and boys had heard of condoms, only a minority had ever used them at the last sexual contact. Boys were more sexually active and reported high condom use, according to the study. In this study, 877 primary school pupils and 857 secondary school students from randomly chosen schools in the District filled out a questionnaire. The study's objective was to establish baseline data on the level of knowledge about, attitude towards and practices towards sexually transmitted infections.

Auka, Auma & Masuka (1998), asked 200 adolescents attending a health facility if they had read how to use instructions on condom packets, those answering yes (196) were given a packaged condom and asked to put it on a rubber penis. None of the subjects were able to perform the task correctly. The most frequent error was opening the package with their teeth. According to the authors of this study doubt is cast upon the effectiveness of printed material on the correct use of condoms for safe-sex purposes in adolescents. The authors also concluded that it seems that individual instruction or video-type instruction is necessary prior to offering printed materials.

Cross cultural HIV-AIDS research on teenagers in Kenya

Isacsson, Sonneson, & Erickson (1997) compared knowledge of HIV-AIDS, exposure to HIV-AIDS information and appreciation of given information levels between Kenyan and Swedish teenagers. They concluded that the overall knowledge about HIV-AIDS was high among the two groups, but in specific items, the knowledge and awareness of different risk behaviors for contracting HIV-AIDS differed for the Kenyan and Swedish teenagers. The dissemination of hard factual information about HIV-AIDS has thus been successful in reaching out although not in stopping the spread of HIV-AIDS. According to the researchers, this calls for new strategies in disease prevention and health promotion. Those strategies, according to the researchers, should focus much more on lifestyle changes. The health care system, the school and the existing strong civil and voluntary structures have an important role to play.

Peer education and HIV-AIDS

According to Action Nord Sud, recent data relating to 4 Districts of Kenya shows that 75% of the girls had become sexually active before 16 years and that teenagers between 15 and 19 years constitute 35% of all the reported cases of HIV-AIDS in Kenya.

Munialo, Fillebeen and Obbuyi (1998) from Action Nord Sud, argue that without information on sexuality and inherent dangers, the school going youths appear to be placed at a risk of contracting sexually transmitted infections/diseases including HIV. Therefore schools must be considered as a target population in HIV-AIDS global programs. In this study, 30 schools were targeted (20 primary, 10 secondary schools). The strategy used was the peer education system (training, follow-up and technical support to peer educators) and the teaching material support has been given through a quarterly newsletter ("AIDS Horizons" for primary and "Teens Talk" for secondary schools). This interactive method encourages the active participation of the pupils to the program through producing articles, drawings or cartoons and also through a mailbox addressed to the newsletter. It is strongly advocating sharing information and equality among boys and girls and it will obviously, according to the authors of this study, enhance networking among the pupils, their teachers and their schools.

According to the authors, the newsletter, as a participatory method, appears to be very attractive for the children. After 1 year, a survey shows that 91% of the children and 86% of the teachers find it relevant and appropriate. It shows that the peers are more involved and really recognized by the other pupils. The number of peers

within the schools has increased at 20%. In addition, 62% of the schools have presented more than 3 articles to the newsletter within the year. This is an indicator of interest by the pupils and teachers. Improvement of the knowledge among pupils has also been estimated at an average of 20%, an additional indicator of efficiency.

An example of a youth movement in Uganda that uniquely responds to the HIV-AIDS pandemic (Kirya, 1998) suggests that peer education enhances positive life attitudes and behavior change in young people and communities. The creation of a strong "Youth Alive" club in an area and community can positively change life styles of youth and many other non-club members through multiplier effects. The group promotes the formation of children and youth clubs, which seeks to enhance positive life attitudes, faith and human values as well as behavioral responsibility in the lives of young people. The youth is facilitated by "Youth Alive" in identifying problems and their root causes. Individuals and groups/clubs are supported through on-going seminars, activities that include drama, music and sports. Through these activities, individuals are empowered to live a positive lifestyle, avoid risky behavior and situations. Then they are assisted to make responsible new choices and commitments so that they live meaningful lives. The advantage of the "Youth Alive" approach is that it enhances the individual response to risky situations, which could result into the contraction of HIV-AIDS. The name "Youth Alive" invites youth people to become actively involved, as opposed to such names as anti-AIDS clubs.

As a result, "Youth Alive" in Uganda is now respected as one of the most vibrant youth non-government organization with a network of 72 clubs in Uganda and has even been started in neighboring countries with clubs formed in Kenya, Tanzania,

Zambia and Zimbabwe. The youth and children in Uganda constitute the biggest percentage of Uganda's population most vulnerable to the HIV-AIDS pandemic. The objectives of the youth group is to reduce the incidence of the spread of HIV-AIDS, foster positive attitudes and behavioral development that enhances young people between 10 and 25 years old, to make responsible decisions geared towards their integral development as well as their communities.

The role of Religion, culture and HIV-AIDS

Mekeb Negerie (1994) found that the risk for HIV infection was greater for traditional African believers (TABs) than both Seventh Day Adventists (SDA) and non-SDA Christians. This was, in part due to their significantly inferior knowledge about AIDS, greater number of current and lifetime sexual partners, more negative attitude towards condom and condom use, less reported inclination of changing risky sexual practices and lower perceived susceptibility to contracting HIV-AIDS. The SDA respondents reported significantly more positive religious beliefs related to sexual conduct that restricted their sexual contacts to one partner, followed by non-SDA Christians and lastly, TABs. Although both Christian groups were at lower risk for AIDS, this does not indicate the absence of risk for HIV infection between SDA and non-SDA Christians given the fact that HIV infection can occur through multiple ways.

The study also found that there is an association of religious beliefs with AIDS risk behavior among Kenyan males. The research observed, that while there has been an assessment of AIDS related knowledge, attitudes and behaviors amongst high risk groups, such as prostitutes in Kenya, examining risks amongst groups thought to be at low risk for AIDS, such as Christians, has largely been ignored.

According to Negerie, these findings suggest the need to introduce broad-based and comprehensive AIDS education programs with churches, schools and community groups and more specific group targeting in terms of age, gender, beliefs and location of participants and training programmes in the future.

Research on the economic impact of HIV-AIDS in Kenya

Hancock, Nalo, Aoko, Mutemi, Clark and Forsythe (1996) set out to estimate how HIV-AIDS is likely to affect the micro-economy of Kenya and to determine measures that could be taken in order to mitigate this impact, concluded that by the year 2005, Kenya's Gross Domestic Product (GDP) will be nearly one-sixth smaller than it is otherwise would have been had AIDS never occurred.

In addition, the study concluded that, per capita income projections are to be reduced by 10% as a result of AIDS. This loss was attributed to a loss in labor productivity, a reduction in investment and savings as well as changes in the labor market's supply and demand. Further projections from the same study indicate that Kenya's savings rate will decline by 15% by the year 2005 as a result of AIDS. The study indicated that the 1996 value of the indirect costs of AIDS are estimated to be 76 trillion Kenya shillings through the year 2005. By using a MACRO-AIDS model analysis that has been used in similar studies in Uganda and Tanzania, the analysis considered morbidity effects (i.e. increases in spending on health services and increases in absenteeism as well as mortality effects, i.e. a smaller or less experienced labor force) to determine how AIDS may affect Kenya's GDP. The model also predicted that annual

foreign aid would need to double from 4% of GDP to 8% beginning in 1996 in order to maintain output at levels predicted in the "No AIDS scenario."

The most important conclusions from the simulations in the above study, seem to indicate that the AIDS epidemic has already had a significant effect on the macro-economy of Kenya and will have an even greater impact in the near future. Measures to improve the development prospects of Kenya become significantly more important in light of AIDS including the need to improve domestic savings incentives and attract foreign capital. Additionally, the study reported that it would be important for the government of Kenya to review labor laws in such a way as to sustain growth while balancing concerns about basic human rights.

Finally, the study concluded that the potential extent of the impact of AIDS in Kenya's macro-economy again reinforces the urgency of HIV-prevention.

THE CHALLENGE OF DESIGNING MEDIA CAMPAIGNS FOR TEENAGERS

It is this study's contention, that, it appears nothing seems to jeopardize or undermine attempts to prevent adolescent AIDS more than the absence of a sense of responsibility for ones' own health. It is difficult for youngsters to suddenly become concerned about their health in their early teens for example. Concern for health must start at a much earlier age, according to many health practitioners. In particular, this concern must be based on a set of health values derived from parents, teachers and the community in general. Research questions used in this study have taken into account that teenagers in Kenya may have been socialized in varied ways since their childhood. While several research questions may appear inappropriate for teenagers, this study contends that given the current crisis posed by HIV-AIDS and the presence of numerous anti HIV-AIDS campaigns, being as candid as possible with the teens was important in order to generate as much useful information as possible under the circumstances.

Adolescents who receive sex education at home and or at school are less than likely to engage in sexual intercourse (Furstenberg, Moore, & Peterson, 1985). In an international review of sex education, Dryfoos (1985) found that teacher education was a key factor in the success of such programs. Yet in most countries, teacher-training education in sex education is acquired through short-term workshops rather than through university education or courses.

Thus the challenge remains however, not only to educate and inform adolescents about AIDS, but also to convert these gains into changed behavior and beliefs. In studies conducted in the US, Strunin & Hingston (1987) found that, although

the percentage of adolescents who respond accurately to questions about AIDS had risen in the eighties, for

example, still only 3% of adolescents interviewed changed their behavior in response to the AIDS threat in ways that might decrease their likelihood of infection. Rotheram-Borus, Koopman, and Bradley (1988) found that while their sample of youths had a reasonably high level of AIDS knowledge, they had little personal fear of AIDS, had moderate belief in the preventability of AIDS, and were fairly confident about their ability to behave safely.

These results alone indicate considerable gaps in knowledge and behaviors necessary to prevent AIDS. Their follow-up focus groups, however, showed that these same youths were in fact unable to simulate implementing safe behaviors, such as asking about a partner's sexual history, or using a condom. They also found that "perceived threat of AIDS, personal efficacy to implement safe behaviors, and knowledge of AIDS were highly correlated"

This research by Rotheram-Borus & Bradley (1987) supports the perspective that when confronted by discrepancies between their behavior and their values, people can be persuaded to change their behaviors. The authors argue that value self-confrontation encourages people to consider the relative importance of specific values in their value hierarchies. In this regard when people value having good health, they will place this as a top priority in their lives.

While little research has been done on the development of values, Rockeach (1987) argues that among young children, health is low on the value hierarchy. This may be due to the previously discussed tendency to exclude children from

participating in the protection of their own health. It may also be due, in part to the fact that we have reached a point time when most diseases are curable. AIDS on the other hand is a disease, like cancer, which also frequently defies cure, and is communicable. Prevention can be assured only if people place a high value on their health at an early age and throughout life. Ball-Rokeach, Rokeach and Grude in 1984 explained that:

"As values and value hierarchies develop during childhood out of individual needs and coordinated societal demands, they become the standards that are applied to oneself and others. When applied to oneself, they are crucial to the formation of a self-identity, or attitude toward self, a set of beliefs around the self that becomes increasingly the most central of all components within one's belief system. When applied externally, value hierarchies guide the formulation of countless favorable and unfavorable attitudes toward others encountered directly or vicariously."[7]

Thus unlike adult groups, for which the only choice involves the difficult route of persuading them to change their value hierarchy, with children one can develop a high priority for health before they've learnt to treat it with indifference.

To the extent that a strong value for health can be developed in young children, they are more likely to take an interest in avoiding disease and to adopt behaviors that protect them from AIDS later. With older children, the value for health is likely to have been low for some time. Value self-confrontation may be an effective means of encouraging them to raise the position of health in their value hierarchy. Teaching them to recognize health risks as contradictory to their values may prove an effective means of eliciting health-protective behaviors from adolescents. There is a lack of similar research on adolescents in Kenya.

CHAPTER III

RESEARCH METHODOLOGY

The research used a qualitative approach involving two focus groups each composed of 10 participants. The methodology followed Krueger 's (1994) recommendations. One group included female teenagers and the other male. All teenagers were aged 14-19 years and were attending secondary school. All research activities were conducted in January, 2,000 in Kenya, East Africa. Separating the two genders is a critical aspect of focus group interviews. Members of the same gender are more likely to express similar views on the same issues and are also more comfortable discussing amongst each other.

Research findings in chapter IV are based on the two focus group discussions moderated by two male facilitators. All discussions were conducted using a prepared discussion guide attached to this thesis as appendix I. It is possible that in this study, the male teens were much more comfortable with a male moderator than the females were. The male teens were also more open and candid than their female counterparts who probably would have been more comfortable with a female moderator.

Rationale for using Focus Groups in qualitative research

It is useful to note that focus groups in qualitative research have been used mainly in private sector marketing research. More recently however, many public sector organizations are beginning to discover the potential of this procedure. Educational and nonprofit organizations have traditionally used face-to-face interviews and questionnaires to get information. Unfortunately, these popular techniques are sometimes inadequate in meeting information needs of decision-makers.

In addition, the focus group is unique from other research procedures in that, it allows for group interaction and greater insight into why certain opinions are held.

Focus groups can improve the planning and design of new programs, provide means of evaluation for existing programs, and produce insights for developing marketing strategies. When properly conducted, a focus group is a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. It is conducted with approximately 7 to 10 people by a skilled interviewer who moderates or facilitates the discussion. The discussion is comfortable and often enjoyable for participants as they share ideas and perceptions. Group members influence each other by responding to ideas and comments in the discussion.

The focus group interview works because it taps into human tendencies. Attitudes and perceptions relating to concepts, products, services or programs are developed in part by interaction with other people. It is often argued that we are a product of our environment and are influenced by people around us.

An important point to remember in this study is that the intent of the focus group is to promote self-disclosure among participants. For some individuals, self-disclosure comes easily as it is natural and comfortable. But for others, it is difficult or uncomfortable and requires trust, effort and courage. Children for example have a natural tendency to disclose things about themselves but through socialization, they learn the values of dissemblance. Over time, the natural and spontaneous disclosures of children and teenagers are modified by social pressure.

The sample included Secondary school male and female teenagers aged 14 to 19 years old in rural Thika District of Central Kenya, East Africa.

Research in the present study set out to answer the following research questions:

Knowledge about the causes of HIV-AIDS and who is at risk

- What is the most significant health problem facing teenagers in Kenya presently?
- What is the teenagers' knowledge regarding the causes of HIV-AIDS?
- What is the teenagers' knowledge about what happens when one gets infected with HIV and then gets the disease AIDS?
- Who do teenagers think is at risk for getting infected with HIV?

Knowledge and ability to use prevention measures and related barriers

- What do the teenagers know about keeping from getting HIV-AIDS?
- How effective do teenagers think condoms are in preventing HIV-AIDS transmission?
- Do the teenagers think abstinence or monogamy is effective in preventing HIV-AIDS transmission?
- Do they think they are able to use condoms to prevent HIV-AIDS?
- What keeps the teenagers from using condoms to protect themselves from contracting HIV-AIDS?

Knowledge and awareness of information and media campaigns against HIV-AIDS

- Have the teenagers seen or heard messages against HIV-AIDS in the Kenyan media?
- What were the contents of these messages?

- Do the teenagers think the messages communicate any harmful consequences from HIV-AIDS?
- Do the teenagers think that getting infected with HIV-AIDS is implied in these messages?
- Do the teenagers think the messages recommend any effective responses to prevent HIV-AIDS infection?
- Do the teenagers think these media messages address one's ability to use the recommended responses?
- What specific issues related to HIV-AIDS and teenagers do they think these media messages should address? Are these media messages doing that now?
- What kinds of media messages do the teenagers think would make them believe they are at risk of getting infected with HIV-AIDS?
- What do the teenagers think are the best ways to prevent HIV-AIDS infection?

Responses to information and media campaigns against HIV-AIDS

- How do the teenagers think these media messages promote positive response to the dangers posed by HIV-AIDS?
- How in the teenagers' view can media messages convince people they are able to perform these recommended responses against HIV-AIDS?
- Do the teenagers think that there are any special local or cultural beliefs related to HIV-AIDS that should be addressed in these media messages? Are these issues being addressed presently?

CHAPTER IV

RESEARCH FINDINGS

Findings are based on four broad categories culled from the research questions in chapter III. These categories were:

1. Knowledge about the causes of HIV-AIDS and who is at risk;
2. Knowledge and ability to use prevention measures and related barriers;
3. Awareness of information and media campaigns against HIV-AIDS; and
4. Responses to information and media campaigns against HIV-AIDS.

Appropriate notes of the major views expressed by the teen participants and audio tape recording was done to aid in the eventual transcribing of the discussions. The notes are attached to this thesis as appendix II.

Category one: Knowledge about the causes of HIV-AIDS and who is at Risk

- ***Main health problem in Kenya***

"What is the most significant health problem in Kenya today?" and "What causes AIDS?" were the opening questions for discussion.

Females: More than half of the female teenage participants mentioned AIDS as the number one health problem followed by other sexually transmitted diseases (STDs) such as Syphilis and Gonorrhea.

Males: More than half of the male teenagers on the other hand, also mentioned AIDS as the main health problem in Kenya followed by STDS in general and Gonorrhea in particular.

Summary of responses: Both genders cited the fact that because AIDS is incurable and is killing many people in the country made it the number one health concern.

- ***Causes***

When it came to their knowledge regarding what causes HIV-AIDS, more than half of the participants on either gender side mentioned that they did not exactly know. However, they mentioned that the HIV virus is transmittable and is the one responsible for causing AIDS related diseases.

Females: More than half in the female group mentioned the mode of HIV-AIDS transmission as mostly through sexual intercourse between a man and a woman, followed by through blood transfusion, mother to child, as well as through un-sterilized needles used in clinics and hospitals. Unique to the female group is the mention of mother to child mode of HIV-AIDS transmission.

Males: Again more than half of the male respondents also mentioned the fact that HIV-AIDS is transmitted mostly through sex, then through un-sterilized needles and thirdly through blood transfusion.

A small number or less than half of the males also echoed the common worry amongst ordinary patients to Kenyan hospitals who may undergo blood transfusion, by saying, "If you get new blood, you may get HIV-AIDS." A similar number of the males mentioned that circumcision as one way of contracting HIV-AIDS. In Kenya, especially in the Gîkúyú community, it is common for teenage boys to undergo circumcision at age 14 or 15 years old. While circumcision is commonly done in hospitals today, there are several situations and other communities where the practice is

carried out in the rural areas without proper medical supervision and care. A common practice is the use of one knife or scalpel for several circumcisions. The mention of circumcision as one way of HIV-AIDS transmission was unique to the male participants.

Less than half of the male participants mentioned that the HIV virus could be transmitted through dirty towels as well as by using other peoples' toothbrushes.

Summary of responses: More than half the respondents in both teen groups, mentioned that sex "between a boy and a girl" is the main mode of HIV virus transmission. However given the reality of their country, the participants mentioned other modes of transmission such as through blood transfusion, mother to baby transmission, through un-sterilized needles in hospitals and through un-sterilized knives and scalpels during circumcision, particularly in the rural areas, as significant modes of transmission for HIV-AIDS.

Thus the most common responses by both genders were, "AIDS is caused by sexual intercourse between a boy and a girl." This reflects the almost "non existence" of open homosexuality in this rural part of Kenya.

- ***HIV Versus AIDS***

In differentiating between HIV and AIDS in the discussion on causes, more than half of participants in the two groups said, "HIV and AIDS are the same," and "HIV and AIDS (is) so small and can pass through a condom." There is thus some confusion as to the distinction between the two or that a few of the (less than half) participants in both teen groups had gotten used to seeing the two acronyms used as one

with only a hyphen between them. No significant gender differences in opinions were recorded. This naturally led to a discussion on HIV versus AIDS.

It was apparent that the majority of both gender participants used the acronyms HIV and AIDS interchangeably. However when called upon to clarify the distinction between the two, more than half of the teens in the two groups were able to say that HIV is a virus that leads up to AIDS "sometimes taking up to ten years before you die." Several participants in both groups expressed the opinion that "doctors should sterilize needles."

- ***HIV-AIDS Symptoms***

The majority of the responses from both genders ranged from, "you become thin," "you look 50 years as teenager," "it takes you ten years after infection and then you die," "when you get HIV-AIDS, it is painful, not being able to eat and seat," to "a HIV-AIDS person has swelling of feet, wounds in the mouth, is seen getting thin."

Females: A majority of the female responses ranged from "not wanting to look 50 years old", to "yes, I am concerned about getting HIV-AIDS, I don't want to look very old," "yes I am scared about dying from HIV-AIDS. There is a lot of pain," "I heard of getting wounds in the mouth."

Males: For one male respondent it was "you start getting sores on the body" that added to the notion that youth and blemish free image is synonymous with youthful adolescence; HIV-AIDS is a threat to the very essence of being young.

- ***High Risk Groups***

Females: One female said, "I am not at risk because I don't have careless sex." More than half of the females agreed, that "prostitutes and people who drink in bars are

most at risk for getting HIV-AIDS," while more than half from both genders said, "doctors are also at risk for getting HIV-AIDS from patients in hospitals."

When it came to gender specific responses, the majority of the female participants made comments such as "boys want sex all the time and are therefore at most risk for getting HIV-AIDS," "if a boy has the virus and has sex with a girl, the virus will pass even through the condom."

A lone female said, "my boyfriend is not at risk because he has only me," while another girl said, "it is hard for a girl to give AIDS to boys." A more general comment by more than half of the girls was, "boys don't want to use condoms. They say it is going to prevent them from the sweetness."

Males: Likewise, a majority of the male participants directed their blame at the opposite gender as well as other older people with responses such as, "girls are at most risk for getting HIV-AIDS," "older women and men aged 20 to 40 years are also at risk for getting infected with HIV-AIDS because they are the ones having sex."

One male participant said, "my friends and family are also at risk for getting HIV-AIDS if they don't take care."

Another male participant expressed his view on how the threat of HIV-AIDS confronted him by saying; "I am also at risk if I have many girlfriends."

Summary of responses: The majority of the participants expressed a common view, across both genders, that people at risk for getting HIV were, "people who engage in careless sex or sex with more than one partner," "people who engage in sex before marriage," "anyone who gets blood transfusion," and that by "sitting down on a dirty toilet in the city," one can get the HIV virus.

More than half of the comments from both male and female teens ranged from, "people in the city are more at risk because Nairobi and Thika are dirty," while the girls said, "Boys who are careless and want to have sex with different girls will get HIV-AIDS," "to a comment by less than half of all the participants that, our brothers, sisters, and uncles who live in the city are more at risk of getting HIV-AIDS."

The majority female participants' responses may reflect their role in their culture where girls and women in general are expected to give standard answers without being seen to be too adventurous. The presence of a male facilitator may also have added to a certain amount of anxiety. A majority of the male participants on the other hand were more willing to give more non-conventional responses and spoke their minds more openly.

Category Two: Knowledge and ability to use prevention measures and related barriers

Discussion on the causes of HIV-AIDS naturally led to how Kenyan teenagers and Kenyans in general kept themselves from getting HIV. Both genders mentioned abstinence, being faithful and using condoms.

Females: More than half of the female teens mentioned "Avoiding sex before marriage," followed by "remaining virgins," using condoms," "avoiding careless sex," and "being faithful to your boyfriend or partner."

More than half of the female participants accused the boys in the following manner: "Boys want sex all the time." "Boys say sex is too sweet," lack of control," "lack of satisfaction with one girl." "Some are into drugs and cannot reason,"" and that "carelessness and having sex carelessly are the main reasons for the spread of HIV-AIDS."

A majority of the female participants seemed to favor abstinence as an effective way to prevent HIV-AIDS. More than half of these female participants mentioned abstinence and remaining virgins until after marriage than did less than half of the male participants.

Other responses from many of the female participants were "yes, abstinence is a good prevention," "yes I am able to abstain from having sex," "avoiding sex is a good way of prevention," "being responsible, having one husband, wife, boyfriend," "being faithful to your boyfriend or girlfriend." In voicing their support for monogamy, the majority of the female participants said that it is effective, and added, "being faithful to one another," "Keeping him only," and "avoiding careless sex with anybody." They seemed to agree that monogamy could be an effective measure against HIV-AIDS when there is trust between a boy and a girl.

Many or more than half of the female participants were mostly vague or silent on whether they are able to use condoms while more than half of the boys came out and said that they either used condoms or did not, and the reasons for the latter.

Males: Less than half of the male participants, while echoing similar behavior to counter HIV-AIDS mentioned, "not sharing personal items such as towels and toothbrushes." One male participant also added "abstinence is not effective in preventing HIV-AIDS because you can get HIV-AIDS through other ways." Another male participant added that, "one girl, one boy is not effective because if one partner is not faithful then both of you can HIV-AIDS."

More than half of the male participants on the other hand responded with statements such as, "stopping to have sex or using condoms is not effective. Some friends think it doesn't help. They don't want to listen. They take it easy."

The male participants' majority views ranged from "I prefer total abstinence," "nobody practices one man one woman," "one guy, one girl is not effective. If one partner is not faithful, then you can get HIV-AIDS."

For less than half of the male participants monogamy is not a complete protection. They added, that the disease poses a high a threat, and therefore cannot guarantee full personal protection or prevention through monogamy alone. One male participant said, "Nobody practices one man one woman," another said "one guy, one girl is not effective. If one partner is not faithful, then you can get HIV-AIDS."

When asked whether they ever used Condoms, less than half of the male participants answered yes with one of them saying, "Condoms can prevent pregnancy." However, when asked whether they used Condoms to prevent HIV-AIDS infections, one male said, "I don't use Condoms because I don't like them.

They can still allow the virus through the tiny holes." A third participant said, "Condoms prevent complete sexual satisfaction." A fourth participant said,

"condoms are not 100% effective," while yet another one added "they are 70% effective.

Critical to this study is the fact that a majority of the males did not view Condoms as being completely effective against HIV-AIDS infection. Equally important is the difficulty, cited by one male teen, that obtaining condoms is "embarrassing since the shops and kiosks in the area are owned and operated by grown-ups known to me."

While these views were by less than half of the males, they seemed to match the girls' who accused some boys of not using condoms as this interfered with sexual satisfaction. These responses could be a piece of information and knowledge that could be used to justify these male teens not using a condom.

Summary of responses: Responding to the discussion about reasons which keeps teenagers like themselves and Kenyans in general from protecting themselves against HIV-AIDS, more than half of the teens in both groups said, that "carelessness and having sex carelessly are the main reasons." The girls seemed to blame boys and the girls seemed to do the same, for the spread of HIV-AIDS. Both teen groups also blamed older people and those who live in nearby urban centers of Thika and Nairobi.

A majority in both teen groups mentioned several preventive behaviors to counter the causes and spread of HIV-AIDS, such as, "making sure blood you get in the hospital is screened for HIV-AIDS," "doctors should use sterilized needles," "avoiding careless sex, by having one boyfriend, girlfriend, husband, wife." A lone male participant mentioned "cleaning yourself thoroughly with the antiseptic Dettol." It was not clear whether he meant cleaning oneself in general or soon after having sex.

A more general comment from a majority in both groups as to why people in general do not protect themselves against HIV-AIDS was "Yes. But the game is sweet, the boys say," "People do not want to listen or respond to anti HIV-AIDS messages because they are illiterate, ignorant."

A majority in both groups expressed support and the need for being faithful to one partner. While faithfulness is obviously based on trust, the respondents did not say how they would guarantee this with their partners and therefore protect themselves from getting infected with HIV-AIDS.

Category three: Awareness of information and media campaigns against HIV-AIDS

Females: More than half of the female participants mentioned campaigns that referred to prevention against HIV-AIDS such as, "Use Condoms," 'AIDS Threatens Love." "Using condoms and abstinence" seemed to dominate in the female group discussions.

Over half of the female participants confined themselves to within what they described, as the "ABC" of sex message recall as echoed in at least one ongoing media campaign. The campaign talks about "Abstaining, Being faithful to your partner and using Condoms."

Males: Less than half of the male participants mentioned and continued to discuss a campaign entitled "Beware of AIDS." Most of the discussion centered on the positive information contained in this presentation, which has been useful to them in increasing their knowledge about HIV-AIDS.

A male participant said, "if we identified people in this area with or who have died of HIV-AIDS, this can very be effective with people." More than half of male teens appeared distrustful of condoms and cynical of "being faithful to one partner" or monogamy. This they claimed was not a full- proof guarantee against HIV-AIDS infection.

Summary of responses: More than half of all the participants in both male and female groups were aware of a number of anti HIV-AIDS media campaigns. They also seemed to equate lack of education, drugs and lack of discipline in the understanding or in the taking of the messages seriously. They cited a general lack of threat or "shock therapy" message effect in the present media campaigns.

Most notable messages and campaigns mentioned by more than half in both teen groups, were, "the ABC of Sex," "AIDS has no Cure!" "AIDS does not choose," "Avoid Making Love Carelessly," "Ukimwi Una Ua: AIDS Kills!"

It was apparent that the lack of knowledge or failure to admit knowing a close relative, friend or neighbor who is suffering or has died from HIV-AIDS seemed to lessen the threat of the disease in the participants' view. Lack of first hand experience and feeling of susceptibility to the disease would appear to interfere with behavior that can be described as efficacious by personally using condoms for example, abstaining from having sex, being faithful or even being monogamous and being faithful to a partner.

Over half of both the male and female teen participants were equally aware of what happens when one contracts HIV-AIDS. However there was discussion about the reasons why it seems that risky sexual behavior seems to continue, despite existing media messages and despite alarming statistics related to the HIV-AIDS menace.

Most of the responses and opinions from both genders ranged from the need for "more shock therapy testimonials" and other tangible evidence from people who are victims or are dying from HIV-AIDS. These they argued may motivate people into more positive action against HIV-AIDS infection.

Some notable opinions and comments on media campaigns by the majority of all the participants were, "Ukimwi Una Ua: AIDS Kills," "they should show someone who has died from HIV-IDS." This was echoed by more than half of the female participants," who also added, "they should show people, who are suffering," "they should advise people more." A majority from both gender participants, did however seem to agree that media information campaigns needed to be more honest and dramatic in presenting the realities of the HIV-AIDS issue.

Category four: Responses to information and media campaigns against HIV-AIDS

Females: One female teen said that many HIV-AIDS media campaigns are not as impactful because they are "so serious!" "If they are entertaining and educational, they would be more popular, educative, effective and impactful." Interestingly, typical of the majority of the female participants throughout the discussions, was the theme of "Abstinence is a prevention," and "Abstinence is good prevention, better than having one partner," and "Avoiding sex completely until after marriage." This appeared to be very important to them. Chastity as possibly expected of the girls and women in general seemed to dominate the discussion with these particular female participants.

One female participant actually sang the song that accompanies the campaign and said, "It is a nice song!" Another campaign mentioned by less than half the female teens was, "Be Careful!" More than half of females said that, "Showing films about people dying from AIDS would be effective" in making people, particularly

teenagers believe that they are susceptible to contracting HIV-AIDS. This need to see visual imagery is probably due to the absence of television and cinema media as well as theatrical presentations and drama in this rural area.

A female respondent said that these two campaigns in particular show exactly what is happening in Kenya. A majority in both groups agreed that several of these local campaigns conveyed the HIV-AIDS situation realistically and were enjoyed by the Kenyan audiences. A female participant was however eager to share information of an unusual cure suggested for HIV-AIDS: "I heard from an older man that eating the brain of a dog could cure HIV-AIDS."

This probably suggests that, in the absence of alternative and credible information regarding the HIV-AIDS issue and how to respond to it effectively, people may believe several things and cures in responding to the threat of the disease.

More than half of the female participants suggested "Using radio and drama much more," to portray the threat of HIV-AIDS by showing actual HIV-AIDS infected individuals. Additionally, a female participant added that, "they should advise people more." One can imagine that in stating the latter, the participant may have meant that the present advice on HIV-AIDS is inadequate, in her opinion.

Males: One male participant was strongly supported by his colleagues when he said, "if we identified people we know in this area who are dying or have died from HIV-AIDS, it can be very effective with people." A male majority seemed to have adopted a more "fatalistic" approach to the HIV infection and prevention, through their claims that in spite of following the three basic recommendations of the "ABC of Sex" slogan, one is

not guaranteed against HIV infection. In this regard, they seemed to view the threat as too high to respond to effectively.

Most of the males dwelled on the campaigns entitled "there`s no cure," and "Anybody can get AIDS." This seemed congruent with their stated cynicism of monogamy and distrust for condoms.

More than half of the male participants felt mostly, that some of their peers and friends as well as some relatives were ignorant of the facts about HIV-AIDS, were illiterate, and lacked personal discipline when it came to a personal issue such as responsible sex.

A male participant argued, "Monogamy or using a condom is not an effective prevention against HIV-AIDS. If one partner is not faithful, you will get HIV-AIDS." And "Abstinence is not effective. You can still get HIV-AIDS through other ways."

Summary of responses: More than half of the teen participants from both genders said that they thought that media campaigns against HIV-AIDS would work well if they were repeated more often not only in the media but also as prevalent themes in class instructions. They claimed that repetition is important for the message to sink in.

Overall, a majority in both groups spoke highly of the existing media campaigns that talk about the "The ABC (Abstinence, Being Faithful, Using Condoms), and "AIDS does not discriminate." They felt that these campaigns conveyed the Kenyan situation in a very realistic way.

At the end of the discussions, a female student as well as a male teacher remarked that the productions especially the sing-along "ABC of sex' are appropriate and

appeal to wide ranging sectors of the Kenyan audience, and to a society in transition due to HIV-AIDS. The teacher contended that the "ABC of sex" slogan has become a "classic of the HIV-AIDS media campaign" amongst students in particular.

The teacher emphasized that direct effects from the campaign shouldn't be expected, but that the campaign and other "catchy" ones could contribute to long-term effects in the fight against the threat of the HIV virus and diseases associated with AIDS.

More than half of both male and female participants mentioned that, campaign materials frequently mention that people die from HIV-AIDS related ailments, that there is no cure for the disease, that HIV-AIDS is a threat to love, and that they convey the fear of dying. While it is not possible to accurately measure the level of risk of getting infected with HIV-AIDS as communicated by the media campaigns, it was evident that the messages do highlight the risk involved.

A large number in both teen groups mentioned information messages such as, "AIDS Kills," "You have wounds," and that "You will get infected with other diseases because your immune system is weak." More than half in both teen groups also mentioned and discussed the media campaigns entitled, "AIDS has no cure," "You will be very weak," and "They tell you negative consequences of AIDS. The same participants mentioned the campaign entitled "Ukimwi Una Ua: AIDS Kills!"

According to the majority in both genders, the media campaigns against HIV-AIDS currently playing on the Kenyan media mention such responses such as "Stop having careless sex!" "The ABC of sex: Abstain, be Faithful and use Condoms." However, according to more than half of the teens in the two groups, the media messages

do not seem to either address the ability to use or fit condoms properly for example, or being able to abstain totally from having sex or remaining faithful to one sex partner.

Respondents' recommendations for future media campaigns against HIV-AIDS

Females: Many more female respondents dwelled on the three advocated ways of keeping from getting the HIV virus mentioned in the "ABC of sex" media campaign, namely abstinence, being faithful to one partner and using a condom. Many of them recommended more shocking campaigns that contain a higher threat portion be presented than the ones currently being shown in their area.

Males: The male teens were also knowledgeable and aware of the various campaigns against HIV-AIDS in their area but also recommended that future campaigns should contain a higher threat portion than the presents ones.

Summary of responses: Discussion on this issue seemed to center on recommendations by both teen groups to media designers about what campaigns to design. This is no doubt was in response to the absence in the teens' views, of messages that address for example, the teenagers' ability to successfully protect themselves against HIV-AIDS and to use such responses as recommended in these presentations.

More than half of all participants' in both teen groups opinions, centered on the need to design more appropriate media messages against the threat of HIV-AIDS. The participants mentioned that for example, "messages should be more relevant to teenagers." Their opinions pointed to the need to include issues such as obtaining and being able to use condoms successfully and correctly, for example.

Other issues included, the need for more honest discussions with teachers, parents, counselors, pastors, priests, peers and members of the opposite gender should be addressed. There may be a gap in the knowledge that teenagers need to be equipped with in successfully comprehending and acknowledging the threat posed by HIV-AIDS and their willingness and ability to respond in protecting themselves.

A majority in both teen groups seemed to think that campaigns lack the necessary ingredients to threaten and shock some teenagers in Kenya.

According to more than half of them in both genders, the "ABC of Sex" slogan seem to have a formed the basis for much of the discussion on preventing HIV-AIDS infection.

The general opinion by both many male and female participants, however was that since their were multiple ways of getting infected by the HIV virus, it was equally hard to prevent it completely.

To many of the teens, it would take multiple ways to prevent HIV-AIDS infection such as, "Avoiding circumcision outside the hospital," "Avoiding sex with an infected person," "Using condoms," "Not sharing personal items such as towels, toothbrushes," "Avoiding surgery."

Again more than half in both groups mentioned that an increase in the threats (i.e. threat portion) posed by HIV-AIDS in the messages might be more effective in promoting more anti HIV-AIDS infection prevention behavior and attitude change.

This same number in both groups suggested the use of traditional songs, drama and dances to enact situations where one is likely to get HIV-AIDS infection and the various ways of protecting oneself.

Whether special local beliefs should be addressed in campaigns

More than half of the participants from both teen groups did not approve using "traditional healing" which they equated with "witchcraft." A female participant said, "No witchcraft techniques," while another added, "Use the church, prayers, advice from the church." Suggestions ranged from, "One would like to see materials in Gîkúyú or in all Kenyan languages," to "They can use Gîkúyú songs for example by using musicians like Kamarú and Músaimo."

Another half in both teen groups suggested that campaigns could communicate the threat of HIV-AIDS infections more effectively, through a "series of testimonials by HIV-AIDS victims." Such messages enhanced by visual aids, such as posters, films or face- to- face meeting with victims can be more effective than the present campaigns.

Over half of all the teens across the gender line, emphasized that "No witchcraft techniques" should be employed in disseminating anti-HIV/AIDS media messages.

This research contends that there seems to be a gap in knowledge about the HIV-AIDS menace as demonstrated by the limited and sometimes conflicting information regarding the causes and preventive measures against the disease. This gap can be bridged through an additional quantitative data collection study and subsequent designing of more effective media campaigns that will have been pre-tested on the teens based on what the audience knows on HIV-AIDS and what they need to know in order to effectively design a relevant media campaign. This is addressed in Chapter V.

CHAPTER V

DISCUSSION AND CONCLUSIONS

The chapter discusses research findings and implications of this study. Based on the findings, both male and female teenagers in this rural part of Kenya are aware of the various causes of HIV-AIDS and were also knowledgeable about the risks and preventive measures needed to confront the disease. They were also aware of the various information campaigns being disseminated against the disease.

In general however, the focus group participants seemed to lack knowledge and trust on the effectiveness and ability to use condoms as a preventive measure against HIV-AIDS. Many more female participants said using condoms, together with other preventive measures is effective against infection from HIV-AIDS. Many more male teens saw condoms as effective in preventing pregnancy but not against HIV-AIDS than did the females. Both gender participants acknowledged that present preventive measures were however, inadequate in effectively combating the spread of HIV-AIDS, which so far is incurable.

Literature review on HIV-AIDS provided background information on the Kenyan situation, regarding research on HIV-AIDS and teenagers. A personal visit and discussion with community members in Thika District of Central Kenya, and two focus group interview discussions with teenage girls and boys provided immediate reactions to the threat and concerns over HIV-AIDS. Additionally, it gave an insight into the information dissemination efforts geared towards creating awareness among teenagers and Kenyans in general on the disease.

THE PROBLEM: ASSESSING AVAILABILITY OF INFORMATION ON HIV-AIDS AMONG RURAL TEENAGERS

If any research study could be able to assess teenagers' level of information need towards an issue such as HIV/AIDS, then this study was right on cue. Given the saliency of the issue at the moment and the Kenya government's determination to introduce HIV-AIDS education curriculum in spring (January 2000), this study could not have been conducted at a better time. Equally, being able to conduct a study within a school setting has many advantages, mainly the fact that these students spend an entire day interacting with each other. Peer influence is critical to teenagers in the way they process and share information.

Teenagers in rural setting such as Thika District of Central Kenya are not exposed to television or cinema. Most of their media information comes from radio, posters and a few newspapers and magazines, as well as from churches and schools.

Designing media messages or generating media related information from and for them is challenging in this manner.

It is evident from this study that despite all the information and knowledge on HIV-AIDS, the disease remains a threat to teenagers and to Kenyans in general. While many possible explanations exist for why the disease continues to ravage Africans mostly, there seems to be a need to approach the causes and interventions for this disease differently from the past.

Poverty and other societal failures continue to adversely affect people in the developing countries due to macro-structural factors and related "violence."

While many explanations abound and there is no evidence from this study to support this student's allegations, it is my humble submission that appropriate blame

can be laid on the political and economic mismanagement by politicians in Kenya and their accomplices inside and outside the country. This has no doubt led to many social, political and economic structural failures that have resulted in many hardships for ordinary citizens in Kenya.

These factors, coupled with harsh and mostly unfair global economic policies, designed to harmonize the world along the dictates of global capitalism, using structural adjustment policies, for example, as advocated by the World Bank (WB) and the International Monetary Fund (IMF) have made Africans poorer. Consequently they have become more vulnerable to additional multiple and adverse economic, social, political, environmental problems and diseases such as HIV-AIDS.

These problems and conditions have their historical origins in colonialism as well as in present neo-colonial arrangements between the poor nations of the south and those rich nations in the north (Walter Rodney, 1972). This argument may lead to more arguments and inherently to more research.

The causes and remedies for HIV-AIDS should and will possibly continue to be examined within this not so new global context and sad reality. In the meantime, for teenagers and other present and potential HIV-AIDS casualties in Kenya, Africa and elsewhere in the so-called developing world, the threat of HIV-AIDS remains real today and so far unmanageable.

LINKS TO THEORETICAL BASE

Based on these conclusions, what can one say about the schools of thought related to persuasion and fear appeal as persuasion in the health belief model or in the social learning theory, or as related to the communication campaign approach?

Additionally, what other important research questions and hypotheses should have been used on whether for example, there are any significant relationship between teenagers' perceptions of the severity of HIV-AIDS and their compliance with safer-sex recommendations. If there are, what does this mean for present and future HIV-AIDS media campaigns?

The health belief model using fear appeal and persuasion in health communication contends that the link between cues to action contained in media exposure messages leads to perceptions of the threat of HIV-AIDS, it's severity and susceptibility to the disease. Consequently this leads to behavior that is geared towards adoption of preventive measures against this threat in response efficacy as mediated by feelings of personal efficacy, and sources of referent knowledge from parents, teachers, peers, priests and other religious personnel.

Fear researchers such as Kirsch, Tennen, Wickless, Saccone, and Cody (1985) have offered the perspective of fear-related self-efficacy. They concluded that phobic people for example generally attempt to avoid feared situations; thereby avoiding the sense of fear they expect to occur. In brief, avoiding fear is one of the purposes of avoidance behavior. It is therefore possible, they argue, for people to be so afraid, or of appearing afraid, that even perception of self-efficacy in terms of performing the behavior does not encourage them to do so.

According to the aforementioned study, adolescents, who are quite capable of resisting peer pressure to place their health in jeopardy may avoid doing so because compliance-resisting situations elicit in them considerable discomfort and fear of appearing afraid to take risks. They therefore perceive the punishment of fear as outweighing the potential of protecting their health.

To be effective, fear as persuasion to protecting one's health may be designed in information campaign messages and therefore provide these campaigns with the visual impact of emphasizing to adolescents of the more immediate consequences of HIV-AIDS.

Some other fear research (Longshore, 1988) suggests that adolescents who perceive the threat of death as remote from their own experiences may respond to visual images of the mental problem, skin rashes and sores, and to the disastrous influence on a teenager's social life that accompany HIV-AIDS for example. Another promising approach prescribed by fear research is to emphasize the existence of the symptoms that are mentioned in the above research, amongst people living in close proximity to the viewer.

Designing future media campaigns using severity and threat as core ingredients

Many studies and literature support the Health belief model as an organizing framework for predicting the adoption of preventive health actions (Bond, Aiken & Somerville, 1992). Although the model has been widely tested with respect to a variety of diseases, this model has yet to be sufficiently tested to explain risky sexual behavior related to HIV-AIDS, especially among teenagers in rural areas such as in Kenya. The HBM has been delineated in a number of ways but this study's purposes, the

original framework adapted by Janz and Becker (1984) and Becker (1990) is instructive for future media design campaigns. The HBM considers: perceived risk; perceived benefits and barriers; perceived self-efficacy; and cues to action.

The health belief model can be used to formulate several useful hypotheses that can be integrated in media design. These could be used to help increase the threat and severity of HIV-AIDS among these teenage population targeted in this study. These hypotheses would be:

1. That the teenagers' perceived severity of contracting HIV-AIDS would be associated with compliance to safer-sex recommendations;
2. That the teenagers' perceived susceptibility of contracting HIV-AIDS would be positively associated with safer-sex recommendations.

The assumptions would then be, that feeling susceptible to the threat of a disease such as HIV-AIDS will heighten the severity of the disease in the teens view thereby moving them to respond efficably to the threat thereby leading to personal efficacy behavior such as using condoms, being faithful and abstaining from having sex. This research therefore calls for an increase in the threat portion of the media messages as suggested by the teens who indicated that the severity of the disease can be highlighted by for example showing or presenting real victims from their area, who have been infected with the HIV virus and suffering from AIDS related diseases.

The qualitative data in the present study supports the contention that teenagers in this part of Kenya attend to information campaigns on HIV-AIDS and seem to understand them. They have found the present information campaigns against HIV-AIDS targeted at them, to be both educational and realistic.

However, there was not enough evidence to conclude that the messages were effective in communication the threat of HIV-AIDS and motivating the teenagers to respond effectively by being able to use condoms, abstaining from sex or practicing monogamy. This requires an impact assessment study as opposed to the explorative nature of this present study.

RECOMMENDATIONS FOR FUTURE MEDIA CAMPAIGN DESIGNS

The purpose of focus groups is to establish what people know in order to be able to design to relevant media campaigns to bridge the knowledge gap between what the target audience should know and what they presently know regarding an issue. The knowledge gap in this research and how to address it is as follows:

What to communicate: "CHOOSE BEING ALIVE!" (Avoid the tired phrase ANTI -AIDS)

What the teens know:

1. HIV is a virus that causes the human being's body immune system that fights diseases regularly to weaken and thereby allowing various opportunistic diseases to attack it
2. That the HIV virus therefore leads to AIDS;
3. That HIV can be transmitted through sex between couples
4. That the HIV virus can be prevented by using condoms as well as remaining faithful to one partner or totally abstaining from having sex
5. That all these methods can be used to protect oneself from getting infected with the virus

6. That there is no cure for AIDS

What the teens do not know:

1. That HIV-AIDS affects both young and older men and women equally
2. That age or location (urban and rural) is unimportant when it comes to getting infected with the HIV virus
3. That teenagers also die from HIV-AIDS
4. That they can effectively protect themselves by using condoms "properly," staying faithful or abstaining from having sex
5. That it is possible to avoid getting the HIV virus in the hospitals by requesting blood to be screened before undergoing a blood transfusion

How to address the gap:

1. Design media campaigns that are gender specific; segment the target audience into male and female for appropriate message delivery
2. Design media campaigns that are culturally relevant
3. Design media campaigns that are interesting, educational and entertaining
4. Introduce messages with both a visual appeal and impact in the campaigns
5. Use a multi-pronged approach to media campaign design such as combining the various media, images, words, music, teen peers, teen idols (techniques and characters and ingredients the teens can relate to)
6. Utilize peer groups to share and disseminate information on the threat posed by HIV-AIDS

7. Introduce and promote dialogue on HIV-AIDS amongst teens, with peers, with teachers, parents, community, religious and church leaders
8. Introduce the use of telecommunications such as telephone hotlines to the administrators and community leaders for use by teens to facilitate information services and counseling for teens in the area in the future. This is happening in the urban areas and the few public telephones in the area can be engaged for this purpose at certain times of the day
9. Combine educational, community and peer strategies to design appropriate media messages and campaigns
10. Repeat the messages often is as many media forms and update the campaigns through regular research
11. Encourage and facilitate dialogue through awareness workshops, training among parties in the community with administrators, private organizations and corporations for financial, moral, logistical policy formulation support.
12. Conduct need assessment and pre-testing of messages among the teens before producing final media campaigns

RESEARCH LIMITATIONS

The present qualitative data generated in this study seems to support the idea that teenagers in this rural part of Kenya attend to information messages on HIV-AIDS and also seem to understand them. They appear to have learnt considerable amounts of information and related knowledge about the threat of the disease. This information, according to the data has been both educational and extensive.

However, this present baseline study was not able to establish or evaluate any impact these information messages may have had on these teenagers. Its role was purely exploratory. It is did not generate evidence (it was not designed to do so) to conclude that the present information and media messages against HIV-AIDS are effective in communicating the threat of the disease, and in motivating teenagers to respond effectively by being able to use condoms, let alone to abstain or to practice monogamy and faithfulness. This will require an impact assessment study in the future.

Future research studies in this area will be useful in pursuing the various ways to understand teenage sexual behavior and the ways in which more culturally and gender relevant media campaigns can be designed and executed. Additional and continuous research could unravel the entire spectrum of reasons why HIV-AIDS remains such a challenge for Kenyans and teenagers in particular. All the above considerations will no doubt be made in light of the recent (December 1999) national declaration and cue to a policy of official co-operation government in so far as HIV-AIDS research is concerned, by Kenyan President Daniel Arap Moi that AIDS is a national disaster.[8]

DIRECTIONS FOR FUTURE RESEARCH

This thesis report reveals some gaps and inconsistencies in research. More than one area of related research are suggested given the constraints of the present study: a thorough approach to assess impact of the media campaigns on behavior, and a further analysis of the different mechanisms suggested by both the health belief model and social learning theory.

A study of the influence of the media campaigns within the context of a longitudinal or in-depth observational study of adolescent behavior would for example,

have provided more valuable information. As has been seen in the present study, several intervening processes linking learning and behavior need to be addressed: attitudes and attitude change, memory and learning, and the part played by peer groups and authority figures for example, such as parents, and teachers.

Given the expense of a more representative study, a more limited, in-depth approach using multiple methods and multiple sites may provide more detailed evidence for the effectiveness of media campaigns to influence teenage behavior on responsible sexuality and protection against the threat of HIV-AIDS. One approach may be to follow groups of teenagers at particular schools or locations over a period of years.

It seems more likely that this kind of study and expense involved would be undertaken to investigate a larger area of inquiry, such as determinants of teenage sexual activity and perception toward HIV-AIDS.

Given the sensitive nature of the subject matter, the research method used must assure confidentiality for the respondents. For this reason, a panel study may not be possible. A suggested variation on the panel study could be done by following particular students in particular classes in secondary schools or villages, and in keeping overall lists of class participants to ensure some minimum continuity of survey participants.

Based on the possible success of the combination of qualitative and quantitative methods used in several other studies, a parallel approach is recommended for further research. Engaging the respondents in discussion and interviews can reveal rich experience and related information. At the same time, the survey data will need to addresses specific and crucial issues that can be measurable. In combination, such data can provide a compelling case and evidence.

APPENDIX A

FOCUS GROUP DISCUSSION GUIDE

January 2000
KURIA GITHIORA

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ASSESSING THE NEED FOR HIV-AIDS INFORMATION AMONG TEENAGERS IN RURAL THIKA DISTRICT OF KENYA

INTRODUCTION. [Statement of purpose, goals, informed consent, rapport building time.]

A. Introduce self, observers and each other (distribute soft drinks, snacks; informal Conversation). We're doing this as part of a project on how best to serve the health needs of Kenyans. A researcher from Michigan State University, United States is conducting the project.

B. Introduce format of focus group:

We want to find out what you think and know about AIDS, so we can design the kind of health education programs that fit your needs. We want to know what you really think and know about the disease of AIDS, as well as things that people are promoting, like condoms, to prevent the spread of AIDS. We want everyone to feel free to say exactly what he or she thinks (no matter how silly or odd it might seem). EVERYTHING you say here will be kept confidential and anonymous -- no one will ever know what you personally said (Only what everybody's combined responses are). Please speak up

If you disagree with what's being said -- we want lots of different ideas and opinions. What I'll do is begin by asking some general questions to get the discussion going, _____ will be writing down what you say (with no names of course! this is totally anonymous), and just in case we can't get everything down on paper we're tape recording this session.

C. Any questions before we start?

D. Go to questioning.

PART A: KNOWLEDGE AND RISK PERCEPTIONS

INTRODUCTION. [Statement of purpose, goals, informed consent, rapport building time.]

SECTION I. PERCEIVED HEALTH PROBLEMS

Question 1. What do you feel is the most significant health problem here in Kenya?

Probe 1. What are other major health problems?

Probe 2. Do you feel that AIDS is a significant health problem here in Kenya? Why or why not?

SECTION II. KNOWLEDGE ABOUT CAUSES OF HIV-AIDS; KNOWLEDGE OF WHO IS AT RISK

Let's focus on the disease AIDS.

Question 1. What causes AIDS?

Probe 1. How do you get it?

Probe 2. What are some of the other ways you've heard about how to get it?

Probe 3. How do some of your friends think you might get it?

Probe 4. Any other ways you've heard of people getting AIDS?

Question 2. What is the HIV?

Probe 1. How is it different from AIDS?

Probe 2. How do your friends think you get it?

Probe 3. How do you think you can get it?

Probe 4. Any other ways you've heard of people getting the virus?

Now let's talk about ways to keep yourself from getting HIV or AIDS.

Question 3. How do you keep yourself from getting HIV? AIDS?

Probe 1. What are some things your friends have done or told you to do to keep from getting the HIV? From getting AIDS?

Probe 2. Any other things you've heard of people doing to keep themselves from getting HIV? From getting AIDS?

Probe 3. Which of these do you think is the best way to protect yourself against HIV? Against AIDS?

SECTION III. KNOWLEDGE OF HEALTH RISKS FROM HIV-AIDS

Question 1. What happens when you get infected with HIV?

Probe 1. Are you concerned about getting HIV? Why or why not?

Probe 2. Is there anything about your getting HIV that would scare you? (dying, children as orphans, pain, etc.)

Question 2. Do you think HIV eventually leads to AIDS? Why or why not?
(People in this country seem to think that no one dies from AIDS and/or it's not a serious threat.)

Probe 1. What do your friends or family think?

Question 3. What happens when you get the disease AIDS?

Probe 1. Are you concerned about getting AIDS? Why or why not?

Probe 2. Is there anything about your getting AIDS that would scare you? (dying, children as orphans, pain, etc.)

Question 4. Who do you think is at risk for getting infected with HIV?

Probe 1. Are your friends or family members at risk? Why or why not?

Probe 2. Are your partners at risk? Why or why not?

Probe 3. Are you at risk for getting HIV?

Question 5. Who do you think is at risk for getting the disease AIDS?

Probe 1. Are your friends or family members at risk? Why or why not?

Probe 2. Are your partners at risk? Why or why not?

Probe 3. Are you at risk for getting AIDS?

[KNOWLEDGE ABOUT PREVENTION MEASURES]

Let's talk about some responses people recommend to protect yourself against AIDS.

Question 5. Are condoms effective in preventing HIV-AIDS transmission? Why or why not?

Probe 1. What do you think might be immediate benefits to using condoms?

Question 6. Is abstinence effective in preventing HIV-AIDS transmission? Why or why not?

Question 7. Is monogamy effective in preventing HIV-AIDS?
transmission? Why or why not?

[ABILITY TO USE CONDOMS FOR PREVENTION]

Question 8. Are you able to use condoms to prevent transmission? Why or why not?

Probe 1. Do you use condoms to protect yourself? Why or why not?

Question 9. Are you able to be abstinent to prevent transmission? Why or why not?

Probe 1. Do you practice abstinence to protect yourself? Why or why not?

Question 10. Are you able to be monogamous to prevent transmission? Why or why not?

Probe 1. Do you practice monogamy to protect yourself? Why or why not?

Probe 2. Does your partner practice monogamy to protect both you and s/he? Why or why not?

PART B. AWARENESS OF MEDIA CAMPAIGNS AND INFORMATION AGAINST HIV-AIDS

TRANSITION. Now we'd like to find out what you think about some AIDS prevention materials used here in Kenya, so we can design the kind of health education programs that fit your needs. We want to know what you really think about the posters and brochures we'll be showing you -- whether you think they work or not. Also, we'd like your ideas on what kinds of messages you think would motivate people to protect themselves against getting infected with HIV or getting AIDS. Any questions?

SECTION IV. REACTIONS TO EXISTING CAMPAIGN MATERIALS

Question 1. Have you seen (or heard) any materials (posters, pamphlets, audiotapes) before?

Probe 1. When did you first see (or hear) these materials? How long ago did you first see these materials?

Question 2. What do you feel that these specific campaigns materials posters, pamphlets, audiotapes) say to you?

Probe 1. What do you think that these materials are trying to convey?

[RESPONSES TO MEDIA INFORMATION AND CAMPAIGNS AGAINST HIV-AIDS]
Question 1. Do any harmful or negative consequences come from being infected with HIV according to these messages? Please explain.

Question 2. Do any harmful or negative consequence come from actually getting the disease AIDS according to these messages? Please explain.

Question 3. What level of risk for you getting infected with HIV is implied in these materials?

Probe 1. Does it make you feel like you might get infected? Why or why not?

Probe 2. Do you think it might make your friends or family members feel like they could get infected? Why or why not?

[RECOMMENDED RESPONSES FROM HIV-AIDS INFORMATION AND CAMPAIGN MATERIALS]

Question 4. What kinds of responses do these materials recommend to prevent HIV-AIDS?

Probe 1. Do you think these responses are effective in preventing HIV infection? Why or why not?

Probe 2. Do you think your friends or family would think these responses are effective in preventing HIV infection? Why or why not?

Question 5. Do these materials address one's ability to use the recommended responses? Why or why not?

Probe 1. Do these materials make you feel like you can? Successfully use the recommended responses? Why or why not?

Probe 2. Do you think these materials would make your friends or family believe they were able to use them? Why or why not?

SECTION V. KNOWLEDGE OF BARRIERS, OTHER ISSUES IMPEDING CAMPAIGN SUCCESS

TRANSITION. In the last part of the session, we'd like to find out what you think would work best in getting people to protect themselves against HIV/AIDS infection in Kenya. We're also interested in what keeps some people from protecting themselves.

[KNOWLEDGE ABOUT PERCEIVED BARRIERS TO PREVENTION AGAINST HIV-AIDS]

Question 1. What keeps people in Kenya from protecting themselves against HIV-AIDS?

Probe 1. What keeps you from protecting yourself against?
HIV-AIDS?

Question 2. What keeps you from using condoms to prevent contraction of HIV-AIDS?

Probe 1. What do you feel is the largest barrier to the use of condoms here in Kenya?

[KNOWLEDGE AND PERCEPTIONS ABOUT ANTI HIV-AIDS INFORMATION CAMPAIGNS]

Question 3. Why do you think HIV-AIDS prevention campaigns don't work?

Question 4. What issues do HIV-AIDS prevention experts fail to address when they talk with you?

Question 5. What should campaigns talk about but they don't?

Question 6. What kind of campaign materials would make you believe that HIV or AIDS is harmful?

Question 7. What kind of campaign materials would make you believe that you were susceptible to contracting HIV?

Question 8. What are the best ways to prevent HIV infection, in your opinion?

Probe 1. How should campaigns promote these responses?

Question 9. How can campaigns convince people they are able to perform the recommended responses?

[KENYAN LOCAL AFRICAN BELIEFS]

Question 10. Finally, are there any special local beliefs that should be addressed in campaigns that aren't?

APPENDIX B

Field Notes Reporting Form

ASSESSING THE NEED FOR HIV-AIDS INFORMATION AMONG TEENAGERS IN RURAL THIKA DISTRICT OF KENYA

Information about the Focus Groups

Date of Focus Groups	**January, 12th, 2000**
Location of Focus Groups	**St, Joseph the Worker Secondary School, Mangu, Thika District, Kenya**
Number and Description of participants	10 male and 10 female participants aged 14-19 years. Currently attending Junior High School (Secondary School)
Moderator/Phone Number	**Christopher Kuria Gîthiora**: 517-355-9941
Assistant Moderator Name/phone Number	**Doctor John Cege Gîthiora**: 617-492-2154

Responses to Questions

Responses to Questions

Q.1. What is the most significant health problem facing teenagers in Kenya presently?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Mentioned AIDS, Sexually Transmitted Diseases such as Gonorrhea, Syphilis, Cancer 2. AIDS was mentioned as the most serious since there is no cure for it and "Kenyans have sex carelessly."	"Kenyans and young people our age have sex carelessly." Mentioned by one **female** participant. "What scares most about AIDS is that it has no cure." Mentioned by a **male** Participant. "Aids can be spread easily." **Male** participant.	Rated AIDS as the most significant health problem amongst Teens and Kenyans	Rated AIDS as the most significa nt health problem amongst Teens and Kenyans

Q.2. What is the teenagers' knowledge regarding what causes AIDS?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Through (heterosexual) sex 2. Through Blood transfusion from contaminated blood 3. Mother to baby transmission un-sterilized needles 4. Through circumcision outside the hospital 5. Through dirty towels, toothbrushes 6. Through surgery	"AIDS is caused by sexual intercourse between a boy and a girl." "AIDS is caused by circumcision outside the hospital." "Doctors should sterilize needles.' "If you get new blood, you may get HIV/AIDS."	"AIDS is caused through mother to baby transmission	"AIDS is caused by circumcision outside the hospital." "You can get AIDS through dirty towels and other peoples' toothbrushes "If you get new blood, you may get HIV/AIDS."

Q.3. What is the teenagers' knowledge about what HIV is?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Some participants were aware that HIV leads to AIDS 2. Others Equated HIV and AIDS as one	"HIV/AIDS are the same." "HIV/AIDS virus is so small and can pass through a condom."		HIV can pass through a condom

Q.4. How do the teenagers know about keeping from getting HIV-AIDS?

Brief Summary/Key Points	Notable Quotes	Females	Males
"Not sharing personal items such as towels and toothbrushes." "By not having many partners.' "Abstinence is not effective in preventing HIV/AIDS because you can get HIV/AIDS through other ways.' "One girl one boy is not effective because if one partner is not faithful, then both of you can get HIV/AIDS."	"Not sharing personal items such as towels, toothbrushes." "Avoiding surgery is one way of avoiding getting AIDS."	"Avoid sex before marriage." "Using Condoms." "Abstinence ." "Making sure blood you get is screened." "Avoid careless sex." "Being faithful to one partner." "Remaining a virgin." "I am not at risk for getting HIV/AIDS because I am a virgin."	

Q.5. What is the teenagers' knowledge, about what happens when one gets infected with HIV-AIDS?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. You become thin 2. You look old 3. Body becomes weak 4. Your hair starts falling off 5. You get mouth wounds 6. Your skin changes to an unwanted color; if brown, you become black 7. You suffer from other diseases 8. You swallow on the left (?) 9. You loose appetite 10. You lose weight 11. You die finally Most of the participants seemed to equate getting infected with HIV with getting the actual disease AIDS.	"You look 50 years as a teenager." "It takes you ten years after infection and then you die." This indicated an awareness of the distinction between HIV/AIDS. When you get HIV/AIDS. It is painful, not being to eat and seat." "A HIV/AIDS person has swelling of feet, wounds in the mouth, is seen getting thin."	"You look 50 years as a teenager "Yes I am concerned about getting HIV/AIDS. I don't want to look very old." "Yes I am scared about dying from HIV/AIDS. There is a lot of pain." "I have heard of getting wounds in the mouth	"You start getting sores on the body."

Q.6a. What is the teenagers' knowledge about who is at risk for getting infected with HIV-AIDS?
[Please see question 6b following Q. 22]

Brief Summary/Key Points	Notable Quotes	Females	Males
1. People who engage in careless sex, i.e. sex with more than one partner 2. People who engage in sex before marriage 3. Anyone who is sexually active 4. Anyone who visits the hospital for surgery or to get an injection 5. Anyone who gets blood transfusion 6. Sitting down on a dirty toilet in the city.	"People in the city are more at risk because Nairobi and Thika are dirty." "Boys who are careless and want sex with different girls will get HIV/AIDS." "Our brothers, sisters and uncles who live in the city are more at risk of getting HIV/AIDS." "I am not at risk because I don't have careless sex." "Prostitutes and people who drink in bars are at most risk for getting HIV/AIDS." "Doctors are also at risk for getting HIV/AIDS from patients in hospitals."	"Boys want sex all the time and are therefore at most risk for getting HIV/AIDS "If a boy has the virus and has sex with a girl, the virus will pass even through the condom." "My boyfriend is not at risk because he has only me." "It is hard for a girl to give AIDS to boys."	"Girls are at most risk for getting HIV/AIDS ." "Older women and men aged 20 to 40 are most risk for getting HIV/AIDS ." "Teenagers aged 15-30 years are also at risk for getting infected with HIV/AIDS because they are the ones having sex." "My friends and family are also at risk for getting HIV/AIDS if they don't take care." "I am also at risk if I have many girlfriends. "

Q.7. Do the teenagers think condoms are effective in preventing HIV-AIDS transmission?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. The HIV virus can pass through the condom. 2. Condoms are not effective for HIV/AIDS prevention 3. Condoms are available in kiosks and dispensaries 4. Cost of condoms is Ten Shillings (7 US cents)	"Condoms are not effective in preventing HIV/AIDS transmission." "Stopping having sex or using condoms is not effective. Some friends think it doesn't help. They don't want to listen. They take it easy.'""	"If a boy has AIDS and has sex with a girl, the virus will pass even through the Condom." "Boys don't want to use condoms. It is going to prevent them from the sweetness."	"Condoms are not effective in preventing HIV/AIDS. " "Condoms Break." "I don't trust condoms. One can still get the virus through the tiny holes." "I have never used a condom." "I don't use condoms because I don't like them."

Q.8. Do the teenagers think abstinence is effective in preventing HIV-AIDS?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Abstinence is a prevention 2. More girls mentioned abstinence and remaining virgins until marriage than did the boys.	"Yes. Abstinence is a good prevention." "Remaining a virgin and waiting to have sex until after marriage."(Female) "Stopping having sex and using condoms is not effective. Some friends thin it doesn't help. They don't want to listen. They take it easy."	"Yes. It is a good prevention." "Yes. I am able to abstain from having sex. "Avoiding sex is a good way of prevention."	"I prefer total abstinence. "

Q.9. Do the teenagers think monogamy is effective in preventing HIV/AIDS?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Both gender expressed support and need for being faithful to one partner 2. While faithfulness is based on trust, it was hard to express how they can guarantee prevention and spread of HIV/AIDS.	"Being responsible. Having one husband, wife, boyfriend, girlfriend." "Being faithful your boyfriend or girlfriend."	"Being faithful to one another. Keeping him only." "Avoiding careless sex with anybody."	"Nobody practices one man one woman!" "On guy one girl is not effective. If one partner is not faithful, then you can get HIV/AIDS."

Q.10. Are the teenagers able to use condoms to prevent HIV-AIDS transmission? What are their reasons for using or not using them?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Girls were mostly vague or silent on whether they are able to use condoms 2. Boys came out and said that they used, have ever used, or did not like to use condoms and reasons why. 3. There is feeling/outlook of fatalism: "I can get HIV/AIDS even if I used a condom, became monogamous, abstained or even used a condom." 4. No mention of using condoms as a response efficacy mechanism.	"Condoms are available in dispensaries, kiosks. They cost ten shillings (7 US cents)." Male "Condoms are effective in preventing HIV/AIDS."	When asked whether used condoms, several females answered no.	When asked whether used condoms, several males answered yes. "Condoms can prevent pregnancy." "I don't use condoms because I don't like them. They can still allow the virus through the tiny holes." "Condoms prevent complete sexual satisfaction." "Condoms are not 100% effective." "Condoms are 70% effective."

Q.11. What, in the teenagers' opinion, are the reasons, which Prevent people in Kenya from protecting themselves against HIV-AIDS?

Brief summary/Key Points	Notable Quotes	Females	Males
1. Participants said that carelessness and having sex carelessly are the main reasons 2. Girls seemed to blame the boys and voce versa for the spread of HIV/AIDS.	"Yes. But the game is too sweet!" "People do not to listen or respond to anti HIV/AIDS messages because they are illiterate, ignorance, desire. Lack of control. Lack of satisfaction with one girl. Some are into drugs and cannot reason." "Emotions drive you.' "Because I am educated, I listen."	"Boys want sex all the time." "Boys say sex is too sweet." "Boys say sex is a good game."	"Stopping to have sex or using condoms is not effective. Some friends think it doesn't help. They don't want to listen. They take it easy."

Q.12. What are the teenagers' thoughts on why HIV-AIDS information and prevention campaigns don't work?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. People are not getting shocked enough, according to the participants 2. There is a "fatalist" attitude by people, i.e. even if I abstained, used a condom or became monogamous, I can still get HIV/AIDS 3. Participants felt lack of education, caring, lack of personal discipline, lack of control of one's emotions are to blame for people not believing the campaigns' advise against HIV/AIDS.	1."Taking people to see dying people in hospitals. Shock treatment can work."	"They should show people who are suffering. " "They should show a body of a person who has died from AIDS." "They should advise people more." "Some are into drugs and cannot reason." "I don't behave irresponsibly because I am educated. "	"People do not respond to media campaigns out of ignorance, illiteracy, desire, lack of control. Lack of satisfaction with one girl." "Emotions drive you."

Q.13. What is the teenagers' knowledge and information of media messages against HIV-AIDS?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Participants were aware of a number of anti HIV/AIDS media campaigns 2. Participants seemed to equate education, drugs and lack of discipline in understanding or taking the message seriously. 3. Lack of "shock therapy" message approach	"The ABC of Sex." "AIDS has no cure.' "AIDS does not choose." "Avoid making love carelessly." "Ukimwi una ua: AIDS kills!"	"Use Condoms." "AIDS threatens love."	"Beware of AIDS."

Q.14. Are the teenagers' aware of any harmful consequences from HIV-AIDS as communicated by the media?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Participants were aware of what happens when one contracts HIV/AIDS 2. It seems that risky behavior continues despite the media messages. 3. More "shock therapy", testimonials /evidence from dying people in the form of testimonials was called for by participants 4. Lack of/or knowledge of a close relative or friend who is suffering or has died from HIV/AIDS seemed to be important in convincing tens of harmful consequences of HIV/AIDS	"AIDS Kills: Ukimwi una ua." "Beware of AIDS." "AIDS has no cure." "AIDS doe not choose." "Avoid making love carelessly." "ABC of sex: Abstain, Be faithful and use Condoms." "Films and movies about people dying of AIDS can be very effective."	"They should show the body of someone who has died from HIV/AIDS." "They should show people who are suffering." "They should advise people more."	"If we identified people in this area with or have died of HIV/AIDS. This can be effective with people."

Q.15. What, in the teenagers' view is the level of risk of getting infected with HIV-AIDS is implied in these information and campaign messages?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Materials mention dying, no cure for AIDS, threat to love/loving, conveys fear of dying	"AIDS Kills." "You have wounds." "You will die." "You will be infected with other diseases because your immune system is weak." "Ukimwi una ua. AIDS kills are a song. A nice song."	"AIDS has no cure." "AIDS threatens love.'" "You will be very weak." "They tell you negative consequences of AIDS." "Be careful."	"There's no cure." "Anybody can get AIDS."

Q.16. Do the teenagers think media messages address one's ability to use recommended responses against HIV-AIDS?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. The media messages mention recommendations such as "stop having careless sex", the ABC of sex message 2. The recommendations do not seem to advise the teens on how to successfully fit a condom	"Stop having (careless) sex." "Use condoms."		

Q.17. Do the teenagers' think that there are issues that should be addressed in messages when directed at them (Kenyan teenagers)?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Messages should be more relevant to teenagers 2. Issues such as obtaining and being able to use condoms 3. Issues of honest discussion with teachers, parents, counselors, pastors, priests, peers and members of the opposite sex should be addressed 4. Condoms are trustworthy 5. Prevention with a condom is better than being "fatalistic."	"They should tell about other teens."		

Q.18. What, in the teenagers' opinion are campaign materials that would make them believe they are likely to contract HIV/AIDS?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Participants seem to think the campaigns lack the power to threaten and shock for some Kenyans and teens in particular. 2. The males mostly felt that some of their peers and relatives were ignorant of the real facts/issues besides being illiterate and lacking in personal discipline 3. Identifying people with AIDS in their area/community	"Films about people dying of AIDS."		"If we identified people we know in this area who are or have died of AIDS, this can be effective with people."

Q.19. What, according to the teenagers, are the best ways to prevent HIV-AIDS infection?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. The ABC of sex slogan formed the basis for much of the opinions 2. Girls talked more about these ways of keeping from getting HIV/AIDS 3. The boys adopted a more "fatalistic" approach, claiming that following the tenets of the ABC of sex is not a guarantee against HIV/AIDS.		"Abstinence is a prevention. A good prevention. Better than having even one partner" "Avoiding sex completely until marriage."	"Avoiding circumcision outside the hospital." "Avoiding sex with an infected person." "Using condoms." "Not sharing personal items such as towels, toothbrushes." "Avoiding surgery." "Monogamy or using a condom is not effective prevention against HIV/AIDS. If one partner is not faithful, you will get HIV/AIDS." "Abstinence is not effective. You can still get HIV/AIDS through other ways."

Q.20. What in the teenagers' opinion are the best ways that campaigns should promote these recommended responses?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. The respondents mentioned an increase in the threat portion of the messages. 2. Use of drama. Song, traditional dances, musicians was recommended 3. However the teens disapproved of using "traditional healing" which they equated with "witchcraft."	"One would like to see materials in Gîkúyú or in all Kenyan languages." "They can use Gîkúyú songs for example by using musicians like Kamarú and Músaimo."	"No witchcraft techniques." "Use the church, prayers, advise from the church."	"If we identified people with AIDS in the area. This can be effective with people."

Q.21. How in the teenagers' opinion, can people be convinced, that they are able to perform these recommended responses?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Campaigns can communicated the reality of HIV/AIDS through a series of testimonials by victims 2. Messages would be more impactful and effective if they related more to the teens through testimonials by real victims and other by teens or people known to the audience.	"If we identified people we know in this area who have died of AIDS, this can be effective with people." "Films about people dying of AIDS." "Can use Gîkúyú songs by musicians such as Kamarú, Músaimo and others."	"Stick with local languages to enact dramas series on HIV/AIDS." "Use radio." "Use drama." "They should people who are suffering." "They should show a person who is suffering from HIV/AIDS." "They should advise people more."	"Cultural beliefs to be addressed through these campaigns."

Q.22. What special local beliefs, according to the teenagers, should be addressed in these information campaigns against HIV-AIDS?

Brief Summary/Key Points	Notable Quotes	Females	Males
1. The teens that are mostly of various Christian religious and are attending a Catholic Secondary School. They did not mention many cultural beliefs to be addressed. 2. One female respondent told of an unusual story she has heard: that one can cure HIV/AIDS by "eating the brain of dog." 3. Many teens might not be willing to discuss certain cultural beliefs with a stranger. On the other hand, they may not know of any. 4. The teens quite like other modern Kenyan Christians frown upon traditional methods of healing	"Use Gîkúyú songs for example by Kamarú and Músaimo." These two are popular musicians who sing in Gîkúyú.	"I heard from an older man that eating the brain of a dog could cure HIV/AIDS." "No witchcraft techniques."	

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Q. 6b. In the teenagers' opinion, what kinds of responses are effective in preventing HIV-AIDS infection?
[Belongs with question 6]

Brief Summary/Key Points	Notable Quotes	Females	Males
1. Participants mentioned Abstinence, Avoiding sex before marriage, Being Faith faithful to one partner, Using condoms, making sure the blood you get is screened for the virus. 2. Monogamy, abstinence, using condoms, being faithful to one partner is important to most female participants as responses to preventing HIV infection, but not to most males.	"Avoiding careless sex." "Being faithful to one partner." "Using condoms." "Being responsible by having one husband, wife, boyfriend, girlfriend."	"Doctors should sterilize needles." "Avoiding sex before marriage." "The best way is avoiding careless sex." "Cleaning yourself thoroughly with antiseptics." "Being trustworthy to your boyfriend." "Being a virgin." "Waiting until marriage."	"My friends and family are at risk if they don't take care." "By not having many girlfriends."

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