EGERTON UNIVERSITY LIBRARY

ASSESSMENT OF STUDENTS' AWARENESS LEVEL OF HIV/AIDS AND ITS IMPACT ON THEIR SEXUAL BEHAVIOUR: A CASE OF SELECTED SECONDARY SCHOOLS IN OTHAYA DIVISION, NYERI DISTRICT, KENYA

BY

JOSEPH KING'ORI WANYINGI

A Research Project Report Submitted to the Graduate School in Partial fulfillment of the Requirements for the Award of the Degree of Master of Education in Guidance and Counseling of Egerton University

EGERTON UNIVERSITY

AUGUST, 2006

EULIB
027 101

DECLARATION

I declare that this research project report is my original work and has not been previously presented for the award of a degree or diploma in this or any other university.

Signed ..... Date 18-8-2006.

Joseph Kingori Wanyingi

EM16/0948/03

RECOMMENDATION

This research project report has been submitted to Graduate School with my approval as University Supervisor.

Signed ..... Date: 18/8/2006

Dr. M. C. Chepchieng

DEDICATION

To my God. Also to my beloved wife Mary Nyawira Kingori who gave me unwavering and overwhelming support in my endeavour to understand the plight of secondary school going youths in light of the HIV/AIDS scourge.

COPYRIGHT

© 2006 Joseph King'ori Wanyingi

All rights reserved. No part of this project report may be reproduced or transmitted in any form by any means, including photocopying, recording, or any information storage or retrieval without written permission from the author or Egerton University on behalf.

ACKNOWLEDGEMENT

Thanks to Egerton University for having granted me the opportunity to pursue a masters degree in Education (Guidance and counselling). Special thanks go to the Department of Psychology Counselling and Education Foundations and it's entire staff who helped, guided and enriched me academically.

Special appreciation is extended to Dr. Chepchieng who supervised my work entirely and Dr. Kariuki who gave testimonials whenever they were required. Many thanks to Mr. C.C. Cheruiyot for exposing me to KANCO for further reading and research.

Thanks to the D.E.O Nyeri for allowing me to carry out research in Othaya division, Nyeri district. I appreciate the principal Chinga girls, Gatugi girls, Othaya boys, Kenyatta Mahinga boys, Kagonye mixed, Kairuthi day and Mucarage mixed, secondary school for allowing me to conduct research in their schools.

I hereby wish to recognize Mr. Wamukuru Kuria of Egerton University who spared his time to read and guided me in writing this Project Report. Thanks to Mrs. Laura Kiige and Peter of P.K. Computers for their typing and computer analysis assistance in regard to this document. Many thanks to teacher counselors, all respondents and not the least my beloved wife for taking care of our home while I was away and busy with the studies. May I appreciate all the other people who contributed in any way towards making this document as it is. God bless them all.

Most importantly, I thank God for enabling me to achieve as much.

ABSTRACT

Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) is currently the most threatening menace to the current and future generations. The youth are seemingly the worst hit. The government is employing intensive HIV/AIDS campaigns and has even provided a secondary school curriculum on HIV/AIDS. However, high levels of new infections are still being reported among the youths and students in particular. This could be attributed to the HIV/AIDS awareness level among them. Therefore the main purpose of this study was to investigate the students' awareness level of HIV/AIDS and how this influences their sexual behaviour. The study was carried out in Othaya Division, Nyeri district. *Ex-post facto* design was used. The target population of about 5000 students was used and was drawn from seven schools for: boys only, girls only and mixed schools. A sample of 360 students, was selected through proportional stratified and simple random sampling methods. Data was collected by use of questionnaires. The data was analysed using descriptive statistics and to be precise frequency tables and percentages. The Statistical Package for Social Sciences (SPSS) version 9.0 was used to aid in data analysis. An analysis of the results indicated that there are many students who have low awareness level of HIV/AIDS related facts. This study found that there is a large number of students who do not have correct facts about HIV/AIDS. It was further noted that teenage premarital sex is common among high school students with 38% of all respondents being sexually active. Owing to incorrect facts that students have, it is evident that the students engage in unprotected or casual sex considering that 83% revealed that they have never used a condom and are therefore prone to HIV infections. The study recommended that precise and simplified HIV/AIDS information sources should be made available to high school students. These may include wall charts, brochures and HIV/AIDS information updates from the Ministry of Health. The study further recommended that peer group directed programmes on sexual behaviour and the spread of HIV/AIDS should be introduced and strengthened in schools. The findings and recommendations of this study are therefore, helpful in improving and re-inventing the HIV/AIDS awareness campaign strategies.

TABLE OF CONTENTS

DECLARATION ii

RECOMMENDATION ii

DEDICATION iii

COPYRIGHT iv

ACKNOWLEDGEMENT v

ABSTRACT vi

TABLE OF CONTENTS vii

LIST OF TABLES x

LIST OF FIGURES xi

LIST OF ACRONYMS / ABBREVIATIONS xii

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study 1

1.2 Statement of the Problem 3

1.3 Purpose of the Study 4

1.4 Objectives of the Study 4

1.5 Research Questions 4

1.6 Significance of the Study 5

1.7 The Scope of the Study 5

1.8 Assumptions of the Study 5

1.9 Limitations of the Study 5

1.10 Definitions of Terms 6

CHAPTER TWO: LITERATURE REVIEW 7

2.1 Introduction 7

2.2 The Concept and Epidemology of HIV/ AIDS 7

2.3 AIDS Prevalence among Adolescents and Young Adults 11

2.4 Factors that put Adolescents at Risk of Contracting HIV 11

2.5 Sexual Behaviour among the Adolescents 13

2.6 Gender Differences in Susceptibility to Contracting HIV/AIDs 13
2.7 Adolescents Awareness of HIV/AIDS and its Impact on their Sexual Behaviour 14
2.8 The Conceptual Framework 17

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction 20
3.2 Research Design 20
3.3 Location of the Study 20
3.4 Population of the Study 20
3.5 Sampling Procedure and Sample 21
3.6 Instrumentation 22
3.7 Data Collection Procedures 22
3.8 Data Analysis Procedure 22

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1 Introduction 23
4.2 Demographic Characteristics of Respondents 23
4.3 Students HIV/AIDS Awareness Level 24
4.4 Students Sexual Behaviour and how HIV/AIDS Awareness Impacts on the Behaviour 27
4.5 Factors that Influence HIV/Aids Awareness 33
4.6 Gender Difference in HIV/AIDS Awareness Level and Sexual Behaviour . 36

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction 43
5.2 Summary of Findings 43
5.3 Conclusion 43
5.4 Recommendations 44
5.5 Suggestions for Further Research 45

REFERENCES **46**

APPENDICES **49**

APPENDIX I: SECONDARY SCHOOL STUDENT QUESTIONNAIRE. 49

APPENDIX II: REQUIRED SIZE FOR RANDOMLY CHOSEN SAMPLE

APPENDIX IV: MAP FOR OTHAYA

APPENDIX III: MAP OF KENYA

LIST OF TABLES

Table 1. Regional infection and death rate caused by HIV/AIDS in the year 2000 . 1

Table 2: Estimated HIV –prevalence rates in selected regions of the world in the year 2003 10

Table 3: Proportional distribution of sampled students per school 21

Table 4: Distribution of respondents according to gender 23

Table 5: Distribution of sampled students according to their classes 25

Table 6: Students' response on whether they know of a recent AIDS related death 25

Table 7: Frequency on students awareness of the meaning of VCT 25

Table 8: Student' view of distance of the VCT centre from home 26

Table 9: Students' opinion on the knowledge of a relative who had died of AIDS.. 26

Table 10: Students' opinion on the view that it is hard to be a virgin today..... 28

Table 11: Students' Opinion on whether one can stop the sex habit 28

Table 12: Students' response on whether they had partners who loved sex 29

Table 13: Students' response on whether their partners have asked for a sexual experience from them..... 29

Table 14: Sexual Intercourse debut..... 30

Table 15: Students' attitude on whether knowledge of HIV/AIDS made them keep off sex 30

Table 16: Students' responses on whether they had visited a VCT centre 31

Table 17: What moved the students into taking a HIV test..... 31

Table 18: Frequency distribution of those who influenced students to abstain from sex. 32

Table 19: Source of information that influenced students to visit VCT centre..... 32

Table 20: Distribution of sexually active students according to the guardian they stay with. 34

Table 21: Frequency distribution of knowledge of various HIV/AIDS related facts among students scored by their peers 35

Table 22: Opinion whether jeered students know what ART stands for..... 35

Table 23: Knowledge of the meaning of HIV 36

Table 24: Gender Distribution of Respondents on the meaning of the slogan 'to chill' 37

Table 25: Students response according to their sex on whether one can contract HIV virus through sharing needles 37
Table 26: Knowledge of one or more roles of VCT centre..... 38
Table 27: Responses on whether students discuss HIV/AIDS with Parents /Guardians 38
Table 28: Students responses on whether their churches discuss HIV/AIDS according to their gender 39
Table 29: Students' opinion on the availability of school programmes which address HIV/AIDS. 39
Table 30: Students' feeling that teenage sex with one partner is okay 40
Table 31: Student' view on whether Condom should be used for protection during sexual intercourse..... 40
Table 32: Students' response on whether they had ever used a condom 41
Table 33: Students attitude on whether teenagers are too young to get AIDS 41

LIST OF FIGURES

Figure. 1: A model showing the impact of HIV/AIDS awareness on sexual behaviour among secondary school students.....18

LIST OF ABBREVIATION AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research & Foundation
ART	Anti Retroviral Therapy
D.E.O	District Education Officer
G.O.K	Government of Kenya
HIV	Human Immunodeficiency Virus.
KANCO	Kenya AIDS, NGO's Consortium.
KDHS	Kenya Demographic and Health Survey.
KIE	Kenya Institute of Education
MOEST	Ministry of Education Science &Technology
MOH	Ministry of Health
NACC	National AIDS Control Council
PLWHA	People living with HIV/AIDS.
STIs	Sexually Transmitted Infections
UNGLS	United Nations Non-governmental Liaison Service
UNICEF	United Nations Children Education Fund.
VCT	Voluntary Counseling & Testing
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) is the world's fourth leading cause of death. The number of people suffering from HIV/AIDS has reached pandemic proportions. In fact over 25 million people have died from AIDS related illness and over 36 million people worldwide are HIV positive (UNESCO 2004).

Gitonga (2001) likens HIV/AIDS to the great plague, which killed a quarter of European's population in the middle age. HIV/AIDS problem now transcends religious, political and ethnic boundaries and affects all and sundry, rich and poor, the infected and those who are not. In Sub-Saharan Africa, one in every five people is living with HIV/AIDS, which is the leading cause of death (E. A. Standard Correspondent, 28th August, 2003). New infections in Sub-Saharan Africa are extraordinary high in comparison to other regions of the world as illustrated in Table 1.

Table 1:

Regional infection and death rate caused by HIV/AIDS in the year 2000

Region	New infection	Adult & children deaths
North America	45,000	15,000
Caribbean	60,000	42,000
Western Europe	30,000	8,000
Eastern Europe & Central Asia	250,000	25,000
Latin America	150,000	60,000
North Africa & Middle East	83,000	37,000
South & South East Asia	800,000	440,000
Sub-Saharan Africa	3,500,000	2,460,000
East Asia & Pacific	270,000	45,000

Source: UNAIDS (2003)

In addition, National AIDS Control Council (NACC, 2004) reports that 57% of the people living with HIV/AIDS in Sub-Saharan Africa between 1985–2004 are women whereas men and children constitute 43%. This shows gender disparities with women being the vulnerable group. The report further indicates that by the year 2004, Sub-Saharan Africa's 25.4 million people were living with HIV against 15 million for the rest of the whole world. This justifies the fact that Sub-Saharan Africa bears the blunt of the epidemic.

Kenya is among the countries that are hard hit by the HIV/AIDS. As at the year 2000, 78,000 children, 900,000 men and 1,100,000 women were HIV positive, a total of 2,07,800 Kenyans. This is 7% of the then population of 29 million. By the same year, there were 730,000 orphans; 30% of these had died (Willis, 2002). NACC (2004) reports that the prevalence rate among women stands at 9% compared to that of men at less than 5%. The rate for the urban areas is 38% as the rural people take the lions share of 62% (NASCOP, 2003).

The youth is a vulnerable group in issues relating to HIV/AIDS. According to UNAIDS (1999) there are more than one billion youths worldwide aged 10 to 19 years. The same report further asserts that the youth could also be defined as people aged between 15-24 according to UN definition. This study considered the young people in the age bracket of 10-24 where secondary school students fall. WHO (2003) estimates that half of the HIV/AIDS infected people were infected between ages 15-24 years. UNAIDS (1999) says that 85% of the youth infections live in developing countries and that more than half of all new infections-worldwide (over 7000 each day) are among the adolescents. These reports are indicators that the youths are vulnerable to contracting HIV/AIDS through sexual intercourse.

According to Johnstone (2000), one third of HIV positive cases worldwide are aged between 14 and 24 years. The HIV cases of youths (10-24 years) in Kenya are alarmingly high bearing in mind that a third of Kenya's population fall in the teenage category. Johnstone (2000) further says that half of Kenya's population is below 16 years and 20% of teenagers are said to be HIV positive. It was projected that by the year 2006, 40 % of all a new infections would occur among those under 20 years. The same report further says that most sexual activity among teenagers is unprotected hence the high level of HIV prevalence. Research done in Kisumu revealed that 18% of teenagers became HIV positive within the first year of sexual

debut and that by the age of 19 years, 33% of those who were sexually active had been infected with the virus. These high rates of infections could be due to lack of awareness or even failure to internalize the consequences of irresponsible sexual behaviour. NACC (2004) asserts that 98% of HIV infections among adolescents are through sexual intercourse.

The government of Kenya (GOK) has tried very hard to create HIV/AIDS awareness in Kenya. This is done through making information on HIV/AIDS available for the Kenyan secondary schools. GOK has further provided HIV/AIDS syllabus and textbooks which include: Bloom or Doom; Your choice, AIDS facilitators handbook and Let us talk about AIDS. Besides, the awareness in schools, there are posters, billboards at road junctions, wall hangings with HIV/AIDS related information, calendars, newspaper adverts and mass media programmes, all creating awareness on HIV/AIDS to as many as would hear, read and watch, yet despite all these efforts, the prevalence is still high among the youth. New infections are reported every day. The teenagers, among whom some are in secondary schools, are recording high rate of infection cases. This study aimed at establishing the impact of the HIV/AIDS awareness level on the sexual behaviour of both boys and girls in secondary school. The research has also established factors that influence HIV/AIDS awareness.

1.2 Statement of the Problem

HIV/AIDS has continued to bite hard despite relentless efforts to contain and stop its spread. In the past, it was common among adults only but now it is common among adolescents most of whom are enrolled in secondary schools. Every time blood screening is done, the number of donors from secondary school students with HIV positive sero status continues to rise. Although the Ministry of Education, the Ministry of Health (MOH) and other stakeholders in the Education sector are seen to put efforts to fight the spread of HIV/AIDS, there is a likelihood, that there is a problem of HIV/AIDS awareness among secondary school students. This study was aimed at determining the HIV/AIDS awareness level among secondary school students. There are many factors that influence creation of HIV/AIDS awareness and this study sought to establish the factors that influence HIV/AIDS awareness level among the secondary school students. Even after establishing a Guidance and Counseling department in secondary schools, a good number of students still drop from school due to unwanted pregnancies. Others are still visiting health institutions for treatment for sexually transmitted

infections. This provides evidence that irresponsible sexual behaviour is common among the secondary school students. This therefore, portends that they stand high chances of contracting HIV.

1.3 Purpose of the Study

The purpose of this study was to establish the HIV/AIDS awareness level and how it affects the sexual behaviour of secondary school students.

1.4 Objectives of the Study

The following objectives guided the study:

(i) To assess the level of awareness of HIV/AIDS among secondary school students.

(ii) To investigate the impact of HIV/AIDS awareness on sexual behaviour among secondary school students.

(iii) To determine the factors that influence the level of awareness of HIV/AIDS among secondary school students.

(iv) To establish whether there are differences in the HIV/AIDS awareness level between boys and girls in secondary school.

1.5 Research Questions

(i) What is the level of awareness of HIV/AIDS among secondary school students?

(ii) Does HIV/AIDS awareness level have any impact on the sexual behaviour of secondary school students?

(iii) What factors determine the level of awareness of HIV/AIDS among secondary school students?

(iv) Are there differences in the level of HIV/AIDS between boys and girls in secondary school?

1.6 Significance of the Study

The findings of this study are useful to guidance and counselling teachers for improving and revising the approaches in counselling secondary school students on HIV/AIDS and sexual behaviour. The results of the study could also be useful to KIE in developing a more effective HIV/AIDS curriculum for secondary schools. The findings would also benefit curriculum developers and MOE in coming up with HIV/AIDS and other counseling programmes that are more effective in meeting the needs of the students. The findings of this study may be very helpful to family life educationists by providing information, which would form the basis of revising their campaign strategies. This would go along way in addressing the ever-rising rate, of HIV/AIDS infections among secondary school students.

1.7 The Scope of the Study

This study was carried out in secondary schools in Othaya division of Nyeri district. The study targeted form two to four students who responded to items that measured their awareness level of HIV/AIDS and its impact on their sexual behaviour. Further, the study assessed the factors that influenced the awareness level of the said students.

1.8 Assumptions of the Study

The study was based on the following assumptions:-

(i) Secondary school students had some knowledge on HIV/AIDS.

(ii) The respondents would give true views that provided the required information about the awareness of HIV/AIDS and how it influences their sexual behaviour.

1.9 Limitations of the Study

The study was confined to Othaya division schools only and this could limit generalization to Othaya division only.

1.10 Definitions of Terms

The study adopted the following definitions:

AIDS: Acquired Immune Deficiency Syndrome

Assessment: Determining to what extent; evaluating or estimating to what extent were the students aware of the HIV/AIDS and its effects.

Awareness: Knowledge that students have regarding the meaning, infection and modes of transmission and any other fact on HIV/AIDS.

Awareness level: This is the extent to which students have correct facts relating to HIV/AIDS.

Clients: Students who are in need of guidance and counselling services in secondary school.

Counselling: This is a process where professional services are provided to students by a trained professional counsellor (helper) in order that the client may solve his own problems.

Guidance: This is a process where a teacher counselor, counselor, religious leaders and other educators provide the necessary information to students and youths on how to lead responsible lives.

Impact: Strength and ability to influence or change students behaviour.

Promiscuity: The behaviour where a person has many sexual partners.

Sexual Behaviour: Any conduct where a student engages in an intimate relationship with another person with an aim of getting sexual satisfaction.

Sexual Permissiveness: Allowing sexual conduct or freedom that many cultures disapprove.

Teacher Counselor: A teacher in a secondary school who also doubles as a counselor within the school set up.

Safer Sex: Where those involved in sexual intercourse use their male or female condom for boys and girls respectively

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The purpose of the study was to asses the HIV/AIDS awareness levels among secondary school students. The study drew relevant, valuable and useful information from both local and foreign studies. Issues concerning HIV/AIDS concept, epidemology and vulnerability are addressed. Also addressed is the topic of sexual behaviour and gender differences as far as HIV/AIDS awareness is concerned.

2.2 The Concept and Epidemology of HIV/ AIDS

HIV stands for Human Immuno-deficiency Virus, whereas AIDS stands for Acquired Immune Deficiency Syndrome. The common biology microscopes cannot be used to see the HIV virus since it is quite tiny (one drop of blood can easily hold 100,000 viruses). However, only one virus is sufficient to infect a person with Aids (Babendreier, 2003). Many scholars have attempted to explain the nature of the HIV virus. Kogi (nd) explains that the virus is made up of 8 strings labelled A, B, C, D, E, F, G, H. A, C and E are the worst and are found in Sub-Saharan Africa. The three are associated with heterosexual transmission while B and D are found among the homosexuals and lesbians. F, G and H are found among drug addicts/pendlers i.e. from the infected needles. The 8 strings are found in category of HIV referred to as HIV1 & HIV 2. Type 2 has no known strings and is predominantly found in West Africa (Hide & Delameter, 2000). HIV is a member of a class of infectious agents known as Retroviruses that is rare in human beings (K.I.E, 1997). It has not been easy to come up with a vaccine for HIV since HIV mutates rapidly. The virus also resists immune responses that usually control vital infections.

The data on the AIDS epidemics is worrisome and the history is largely distorted. Willis (2002) asserts that it may never be found out when the virus first found its way into the human race. The first cases were discovered in human beings in 1981 in America. Consequently, more cases were also established in Uganda in 1982. A few more cases were reported among wealthy Africans who were seeking treatment in Europe by Belgian and French doctors. In America, the first cases were reported among homosexual relations.

(Willis, 2002). Since the strange disease was rapidly manifesting among the homosexuals, many scientists were thrown into the activity of research.

According to Johnstone (2000), HIV virus is transmitted through three major ways.

(i) Sexual affairs: this includes both heterosexual and homosexual (lesbianism and gay) relations.

(ii) Transmission of mother to child during child birth.

(iii) Mixing of fresh blood of the infected to that of the uninfected person. This could be through blood transfusion, sharing needles, razors and other cutting objects.

Among the three major ways, sexual relationship has been the major factor contributing to the spread of the virus (Hide & Delamater, 2000). World Bank (2002) reports that HIV/AIDS has become the word's fourth leading cause of death.

UNAIDS (2002) asserts that, 33 million people including children had been infected with the virus by 1998. Out of the 33 million, 12 million had died. However, by the year 2002, the number of the people infected had soared to over 60 million. The deaths had accumulated to 25 million and this reveals that the effects of the pandemic had started to bite hard (UNAIDS, 2002). In 2002, 36 million people were living with the virus. Two years later, a rise of 7.65% (3.4 million) had been reported. The number stood at 39.4 million by the end of the year 2004 (NACC, 2004). According to WHO (2003) lack of access to Antiretroviral treatment (ART) by the millions who need it has led to many deaths. For this reason, UN has devised a strategy in which WHO target to treat 3 million people by the year 2005. However, WHO (2003) asserts this would not be easy since there were only 400,000 people including children worldwide who were on ART. Out of the approximate 40 million people infected with the virus, 65% come from Sub-Saharan Africa. This translates to about 26 million people (Willis 2002). However out of 4.4 million people world wide who needed ART, only 2% or 100,000 people were receiving (WHO, 2003). Johnstone (2000) reports that by 1998, the Sub-Saharan Africa contained 74% of the AIDS cases globally but only accounted for 3% of the global spending on Aids related consequences. This explains why the scourge is spreading so fast in the Africa continent, south of the Sahara.

According to NASCOP (2000), fifteen countries with the highest HIV virus prevalence worldwide were all in Sub-Saharan Africa, Kenya being one of them. World Bank (2000) reports that Aids has reduced life expectancy of Sub-Saharan Africa from 62 to 47 years. Johnstone (2000) writes that in East Africa, the AIDS pandemic has passed through a series of stages. The first stage is the rapid spread of infection among high-risk groups, which include commercial sex workers, STIs patients and sexually active population in transport towns. The second stage is where the virus spreads slowly amongst the general population, antenatal women and vulnerable groups, while the third stage is the spread among youths who include adolescents and youths below 24 years. The first Aids case in the country was officially reported by the MOH 1984. By 1994, the prevalence rate had risen to about 7 % of all adults. The figures are alarming in that 12 % of the adults prevalence rate were in the urban areas while 5% was in the rural. USAID (2003) reports that the rate had risen to about 13% among the adults by the year 2000. In the urban areas, the rate stood at 6% compared to the rural with 13% rate of infection. According to USAIDS (2000) there were 1.4 million infected people in Kenya by the year 1990. The number rose to 1.7 million in 2000 and it is estimated that 2.7 million people will be living with the virus by the year 2010. This reveals the sorry state that HIV/AIDS puts Kenya in.

Table 2:

Estimated HIV –prevalence rates in selected regions of the world in the year 2003

Country	Young Women %	Young Men %
West Africa		
Cote'd' Ivoire	6-7 12.3	2.1- 5.47
Nigeria	4.35-5.89	1.68-3.35
Senegal	1.12-2.07	0.39-1.02
EAST AFRICA		
Kenya	11.07-14.98	4.26-852
Tanzania	6.85-9.27	2.64-5.28
Uganda	6.65-8.99	2.56-5.12
SOUTH AFRICA		
Botswana	32.55-36.07	13.68-18.00
Mozambique	13.36-16.11	4.49-8.97
South Africa	22.51-27.13	7.56-15.11
ASIA		
India	0.4-0.82	0.14-0.58
Thailand	1.53-3.11	0.47-1.89
Eastern Europe		
Russian Federation	0.09-0.15	0.19-0.32
Ukraine	0.6-0.98	0.95-1.63
United States	0.16-0.3	0.15-0.44

UNESCO (2004)

Table 2 shows that while young people are vulnerable to the HIV virus, more females than males are even more vulnerable. It is also clear that regions in Sub-Saharan Africa are hard hit in comparison to other regions of the world.

Willis (2002) gives more details that almost confirm what Johnstone (2000) had predicted. 13.95% of Kenya adults were HIV positive, there were 2 million Kenyans living with the virus. Out of this figure, 1.1 million were women, 900,000 men and 78,00 children. This

translates to a ratio of 53:43:4 for women, men and children respectively. The same report adds that by the same year, there were 547,000 orphans, 180,000 of whom had died. The difference in infection rate between the males and females is another thing that raises alarm. NACC (2004) reports that while the prevalence rate among men stands at 5%, the one for women is 9%. The same report further explains that by the year 2004, 1.5 million Kenyans could have died of the scourge, 2 million living with the virus and there were over 700,000 orphans.

2.3 Aids Prevalence among Adolescents and Young Adults

For a long time, it has been thought that HIV/AIDS is for adults only especially the very sexually active. Johnstone (2000) records that it was thought that the commercial sex workers, the careless and the morally loose adults are the victims of HIV/AIDS scourge. But this is no longer the case. Currently, many adolescents are living with the virus. Hence, they are among the vulnerable group. These adolescents join secondary schools on turning 13 or 14. A good number complete the secondary school course at seventeen or even up to nineteen years hence, secondary school students are among youths that are at risk of contracting the deadly virus. E. A Standard correspondent (2003) reports that 76% of HIV cases among adolescents and young adults (15-24 years) in sub-Saharan Africa are females. AIDSCAP (1996) reveals that females aged between 15-19 years are infected with the virus five times more than their male counterparts. Table 2 further illustrates the disparities that exist between males and females as far as HIV prevalence rates among youths (15-24 years) are concerned.

Willis (2002) says that 50% of Africans get infected with the HIV virus before attaining the age of 25 years. Johnston (2000) give the predictable figures on teenagers (under 20 years). Out of all new infection in the year 2000, 30% were from girls under 20 years and 20% among boys of the same age. However, the figures were expected to change by the year 2005. The prediction here is that of all infections, 40% will be from their female counterparts. This prediction gives a feeling that young people are vulnerable.

2.4 Factors Contributing to Adolescents Risk of Contracting HIV

Gayle and Lamptey (2001) list some factors that expose the teenagers (adolescents) to the risk of contracting the virus. Some factors may be implicit while others are explicit. These include:

(i) The first sexual encounter occurs during this time (10-19 years). Johnston (2000) confirms this by saying that the sexual debut in Kenya tends to be at a younger age than elsewhere in Sub-Saharan Africa, thus the number of sexually active youths is on the increase.

(ii) Many young people are denied access to information about sexuality hence get uncensored misleading information on sex and sexual activity. This could be as a result of cultural inhibitions, religious rules, or social economic factors where parents, guardians are too busy with work to get time to pass and discuss such information with their children.

(iii) Gender distinctions and discrimination on exposure to HIV/AIDS reveal that young girls are at a higher risk than their counterpart boys. There is also increased trafficking of girls for prostitution, on return, the girls bring their prostitution art to their colleagues.

(iv) Poverty and limited economic resources. The adolescents, some of whom are in secondary schools engage in commercial sex for survival.

(v) Little parental awareness of young people's sexuality. This leads to vulnerability since the young people do not understand their sexuality and how to go about growth and development in relation to their sexuality.

(vi) Stigma and discrimination may hinder services for young people with special needs. HIV/AIDs is still stigmatized and hence those with special needs are neither informed nor taught on mature treatment of sex and sexual behaviour.

(vii) The identity crisis and role confusion among adolescents. There are psychological needs regarding their rapid body changes, social and gender roles and emotional problems. This may drive them into sexual activity (Johnston, 2000).

(viii) Cultural practices such as Female Genital Mutilation (F.G.M). Many are still ignorant that F.G.M can contribute to the spread of HIV/AIDS.

(ix) Inhuman orgies such as rape and back street abortion attempts on multiple clients. These are possible means through which HIV/AIDS is spread.

The listed factors indicate clearly that youths are at high risk of contracting the HIV virus through exposure to teenage sex.

2.5 Sexual Behaviour among the Adolescents

Research has shown that in some African cultural traditions, young people were not allowed to engage in sex before marriage. For instance, the Gikuyu community treated one as an outcast if she was found not to be a virgin at the time of marriage and the Maragoli community also had the same cultural system. Today it is different. Liberal sexual attitudes promote high risk of contracting the HIV (Willis, 2002). In Kenya, HIV/AIDS among the adolescents is almost an entirely sexually transmitted infection and the Kenyan survey data show that 98% have been infected by sexual contact (Johnstone 2000). This is why the study dealt with sexual relationships almost exclusively as the (major) cause of HIV/AIDS infections. In a survey carried out in the U.S, 25% of 15 year old girls engaged in sex in 1990. As for secondary school students, 17% of high school girls admitted having had sex with four different partners during their school life (Willis, 2002). These multiple sex partners increase the risk of the fast spread of HIV. Johnstone (2000) reports that in Kenya, over 50% of Kenyan teenagers are sexually active by age 15-16 years and over 90% of adolescents are sexually active before they clock 20 years. The same report adds that young teenagers are less likely to have protected sex. Kenyan teenagers commonly report relationships with multiple sexual partners with boys being seven times more promiscuous than females. Babendreier (2000) observes that promiscuity among teenagers and young adults has been a major boost for HIV/AIDS.

2.6 Gender Differences in Susceptibility to Contracting HIV/AIDS

In a study carried out in 1999 in Kisumu among teenage boys and girls, 33% of girls and 9% of boys tested HIV positive at 19. The same study reported that young people with a sexually transmitted disease are much more likely to become infected with HIV/ AIDS. Gender disparities still reflected that 30% of girls and 8% of boys who had Herpes simplex (HSV2) were also HIV positive (Johnston, 2000). This was a clear indication that there were more cases of HIV/AIDS prevalence among teenage girls as compared to boys. AIDSCAP (1996) observes that the peak ages of HIV/ AIDS infections is lower in young adults for women (20-29) than in men where the peak is in the age bracket of 30-39 years. Gender disparities on the prevalence of HIV/AIDS could be explained by the observation made below.

(i) The female reproductive tract remains immature until at least 18 years of age.

(ii) The walls of the vagina, cervix and uterus are thin (single layered) and are easily ruptured, penetrated and infected.

(iii) Cervix mucus output is frequently inadequate in very young women and lack of lubrication can increase the likelihood of infection.

(iv) Young girls are often preferred by older men who believe in the myth that intercourse with a virgin will cure a sexually transmitted disease. In this context, young girls who are unaware of the sexual history of older partners are at a high risk of infection.

(v) Young girls living in poverty may be attracted to wealth, power and position of older men.

This is a clear indication that girls are prone to contracting the HIV virus more than boys.

NACC (2004) observes that sexual intercourse among adolescents (15-19 years) is as a result of an obligation, a gift, a favour or monetary payment. The young give in to sexual advances through coercion and this is rape. Gallagher (1996) writes that more than 80% of rape cases are never reported. Rape is one of the ways through which HIV/ virus is rudely and horrendously passed to the victim. Among teenagers, date rape is also reported. NACC (2004) reported that 30% of 15-19 year old women experienced physical violence, 13% of whom were sexually abused. Tarantola (2000) reports that biological, cultural and social economic conditions contribute to women's greater vulnerability to HIV/AIDS. This is further echoed by Muarrah and Kiarie (2001) who assert that in Sub-Saharan Africa for instance, there were 13 infected women for every 10 men by the year 2001.

2.7 Adolescents Awareness of HIV/Aids and its Impact on their Sexual Behaviour

Johnstone (2000) writes that 28% of adolescent boys aged 15-19 years know more than two safer add sex practices. This implies that they know that risky sex could lead to contracting of HIV/AIDS. Further, survey by KDHS (2000) reflects that 84% of Kenyan adolescent boys and 80% of their counterpart (girls) perceive themselves to be at no risk or at a small risk of getting AIDS. The government started an AIDS Awareness Campaign Programme right from primary school through secondary school and also in colleges through Curriculum and Instruction. This could be due to lack of HIV/AIDS awareness or low level of the same. The purpose of the Secondary School AIDS curriculum is to equip the students with the necessary

(ii) The walls of the vagina, cervix and uterus are thin (single layered) and are easily ruptured, penetrated and infected.

(iii) Cervix mucus output is frequently inadequate in very young women and lack of lubrication can increase the likelihood of infection.

(iv) Young girls are often preferred by older men who believe in the myth that intercourse with a virgin will cure a sexually transmitted disease. In this context, young girls who are unaware of the sexual history of older partners are at a high risk of infection.

(v) Young girls living in poverty may be attracted to wealth, power and position of older men.

This is a clear indication that girls are prone to contracting the HIV virus more than boys.

NACC (2004) observes that sexual intercourse among adolescents (15-19 years) is as a result of an obligation, a gift, a favour or monetary payment. The young give in to sexual advances through coercion and this is rape. Gallagher (1996) writes that more than 80% of rape cases are never reported. Rape is one of the ways through which HIV/ virus is rudely and horrendously passed to the victim. Among teenagers, date rape is also reported. NACC (2004) reported that 30% of 15-19 year old women experienced physical violence, 13% of whom were sexually abused. Tarantola (2000) reports that biological, cultural and social economic conditions contribute to women's greater vulnerability to HIV/AIDS. This is further echoed by Muarrah and Kiarie (2001) who assert that in Sub-Saharan Africa for instance, there were 13 infected women for every 10 men by the year 2001.

2.7 Adolescents Awareness of HIV/Aids and its Impact on their Sexual Behaviour

Johnstone (2000) writes that 28% of adolescent boys aged 15-19 years know more than two safer add sex practices. This implies that they know that risky sex could lead to contracting of HIV/AIDS. Further, survey by KDHS (2000) reflects that 84% of Kenyan adolescent boys and 80% of their counterpart (girls) perceive themselves to be at no risk or at a small risk of getting AIDS. The government started an AIDS Awareness Campaign Programme right from primary school through secondary school and also in colleges through Curriculum and Instruction. This could be due to lack of HIV/AIDS awareness or low level of the same. The purpose of the Secondary School AIDS curriculum is to equip the students with the necessary

knowledge; skills and attitudes that will enable them adopt behaviour that will help them prevent being infected with, and spreading HIV/AIDS. AIDS messages could be carried through most of the subjects in the curriculum (K.I.E, 1999). Scheniker and Nyirenda (2002) argue that effective awareness will be made if we have professionally trained and actively involved educators. He further tips that we could establish partnerships within the school and community and utilize non-conventional methods of teaching. These could be participatory methods that encouraged active learning. We could also encourage discussion on controversial issues. We need to provide multiple sessions through multiple media use and apply gender specific approaches and also deal with culturally sensitive content.

We need to consider the value of peer-based support and skill based education where we teach life skills as a component of HIV prevention. Eventually, we need to monitor and evaluate our own progress and that of our students. In a school set up, some of the factors that fuel the prevalence of HIV/AIDS are:

(i) Peer pressure
(ii) Improper use of condoms
(iii) Poverty
(iv) Unemployment
(v) Prostitution
(vi) Drug abuse
(vii) Ignorance

Aggleton and Shaw (2002) report that more than twenty years into the epidemic, majority of young people remain unknowledgeable about sex and STI's. Continuing stigma and discrimination may prevent them from finding out more about the disease and its consequences while some may understand the mechanism of sex, few have been provided with the opportunity to consider the consequences of unprotected sex. This may result to their being ill prepared in protecting themselves and their partners against STI's including HIV. Open discussion of sex, 'safer' sex and drug use is never done in many communities. On gender balance, dominant ideologies of masculinity may prevent boys and young men from asking about sex for fear of being regarded as unmanly while dominant ideologies of feminity may silence the voices of young women; they fear stigmatization if they knew much about sex.

Johnstone (2000) reports that only 69% and 88% of women and men aged (15-19) respectively have had regular exposure to mass media. This tells us that a good number do not have access to information on HIV/AIDS. Also, more young men have had access to information of HIV/AIDS from the mass media than girls. USAID (2001) reports that 99% of boys and girls respectively aged 15-19 years have heard about HIV/AIDS. 72% of adolescent girls 15-19 years and 81% of their male counterparts know of one or more ways of preventing HIV/AIDS transmission. Yet despite this awareness, only 69% and 77% of girls and boys respectively aged 15-19 years believed that they had little or no risk of contracting HIV/AIDS. These were sexually active adolescents. The reason they give for this risk is that they have only one partner. Despite the awareness; in a survey conducted in Kenya, only 10% of girls and 37% of boys aged 15-19 years reported using a condom in their last sexual encounter before the study (USAID 2001). Nevertheless, even within this level of awareness, 48% of adolescents mothers aged 15-19 years reported birth as unintended.

In Kenya, 95% of girls aged 15-19 years reported knowledge of at least one modern contraceptive method according to UNAIDS (2001). Further, UNAIDS (2001) writes that young people are vulnerable to HIV because of risky sexual behaviour, substances use and lack of access to information regarding infection and prevention of HIV. Ignorance about the epidemic remains pervasive among young people. They do not know how to protect themselves from HIV infection. Half the teenage girls in Sub-Saharan Africa do not realize that a healthy looking person can be living with HIV/AIDS (UNAIDS 2001). Many young people do not believe that HIV/AIDS is a threat to them. Many adolescents get sexually active without the necessary information about HIV/AIDS. Many people are exposed to sexual abuse and exploitation without due awareness of their rights regarding sex. Stigma, social exclusion and lack of information put young men who have sex with men at high risk of contracting HIV/AIDS (Johnstone, 2000). The survey conducted in Kenya suggests that less than 10% of Kenya parents seek to educated their children on matters of sexual or preventive reproductive health.

Johnston (2003) reports that over 50% of Kenya parents had made no attempts to sexually educate their youths on sexuality and admitted that they had no intention of ever doing so. Too many Kenyan parents believe that threatening, warning and preaching are effective means of communication. They do not approve dialogue. The report further asserts that the

Johnstone (2000) reports that only 69% and 88% of women and men aged (15-19) respectively have had regular exposure to mass media. This tells us that a good number do not have access to information on HIV/AIDS. Also, more young men have had access to information of HIV/AIDS from the mass media than girls. USAID (2001) reports that 99% of boys and girls respectively aged 15-19 years have heard about HIV/AIDS. 72% of adolescent girls 15-19 years and 81% of their male counterparts know of one or more ways of preventing HIV/AIDS transmission. Yet despite this awareness, only 69% and 77% of girls and boys respectively aged 15-19 years believed that they had little or no risk of contracting HIV/AIDS. These were sexually active adolescents. The reason they give for this risk is that they have only one partner. Despite the awareness; in a survey conducted in Kenya, only 10% of girls and 37% of boys aged 15-19 years reported using a condom in their last sexual encounter before the study (USAID 2001). Nevertheless, even within this level of awareness, 48% of adolescents mothers aged 15-19 years reported birth as unintended.

In Kenya, 95% of girls aged 15-19 years reported knowledge of at least one modern contraceptive method according to UNAIDS (2001). Further, UNAIDS (2001) writes that young people are vulnerable to HIV because of risky sexual behaviour, substances use and lack of access to information regarding infection and prevention of HIV. Ignorance about the epidemic remains pervasive among young people. They do not know how to protect themselves from HIV infection. Half the teenage girls in Sub-Saharan Africa do not realize that a healthy looking person can be living with HIV/AIDS (UNAIDS 2001). Many young people do not believe that HIV/AIDS is a threat to them. Many adolescents get sexually active without the necessary information about HIV/AIDS. Many people are exposed to sexual abuse and exploitation without due awareness of their rights regarding sex. Stigma, social exclusion and lack of information put young men who have sex with men at high risk of contracting HIV/AIDS (Johnstone, 2000). The survey conducted in Kenya suggests that less than 10% of Kenya parents seek to educated their children on matters of sexual or preventive reproductive health.

Johnston (2003) reports that over 50% of Kenya parents had made no attempts to sexually educate their youths on sexuality and admitted that they had no intention of ever doing so. Too many Kenyan parents believe that threatening, warning and preaching are effective means of communication. They do not approve dialogue. The report further asserts that the

church (religious groups) have claimed that the introduction of family life/sex education in schools would lead to increased accidental pregnancy rate, adolescent promiscuity, increased pregnancy, school drop out and dramatic increase of STI's. Aggleton and Shaw (2002) say that many young people in adolescence do not know how to respond to their physiological changes. In this case many engage in a risk taking sexual behaviours oblivious of the consequence. Young people value hedonism and thrill seeking, without assessing long-term effects or consequences of their action.

In summary, it can be observed that young people have had access to sex education and a good number are still ignorant of the risks involved in teenage sex. However, teenage sex is still rampant despite the HIV/AIDS campaign efforts to stop further spread. Research has also been done and this reveals that the infections of HIV/AIDS are not due to lack of knowledge on the same.

2.8 The Conceptual Framework

This study was guided by the communication model theory. According to Brown and Falb (1981), the communication model is a process that has the following components: source, message, channel, receiver, and feedback. In this study, the teachers, counsellors, researchers and religious leaders are the sources of HIV/AIDS information whereas the posters, massmedia and training sessions are the channels used to pass the message to the receiver. The receiver is the secondary school student. The feedback is the behaviour change expected which will help the sources of information to review the approaches or better still, innovate effective ways of communication. There are other factors of HIV/AIDS information, which affect the source, message, channel, receiver and feedback. These extraneous variables include gender bias social stigma, social economic background, beliefs and customs. The dependent variables include change of sexual behaviour, abstinence and safer sex. This will be the result of non- manipulative relationships between the student and HIV/AIDS awareness, which are our independent variables. Figure 1 gives a summary of the interactions between source, information, channels of transmission the receiver and the feedback of HIV/AIDS awareness.

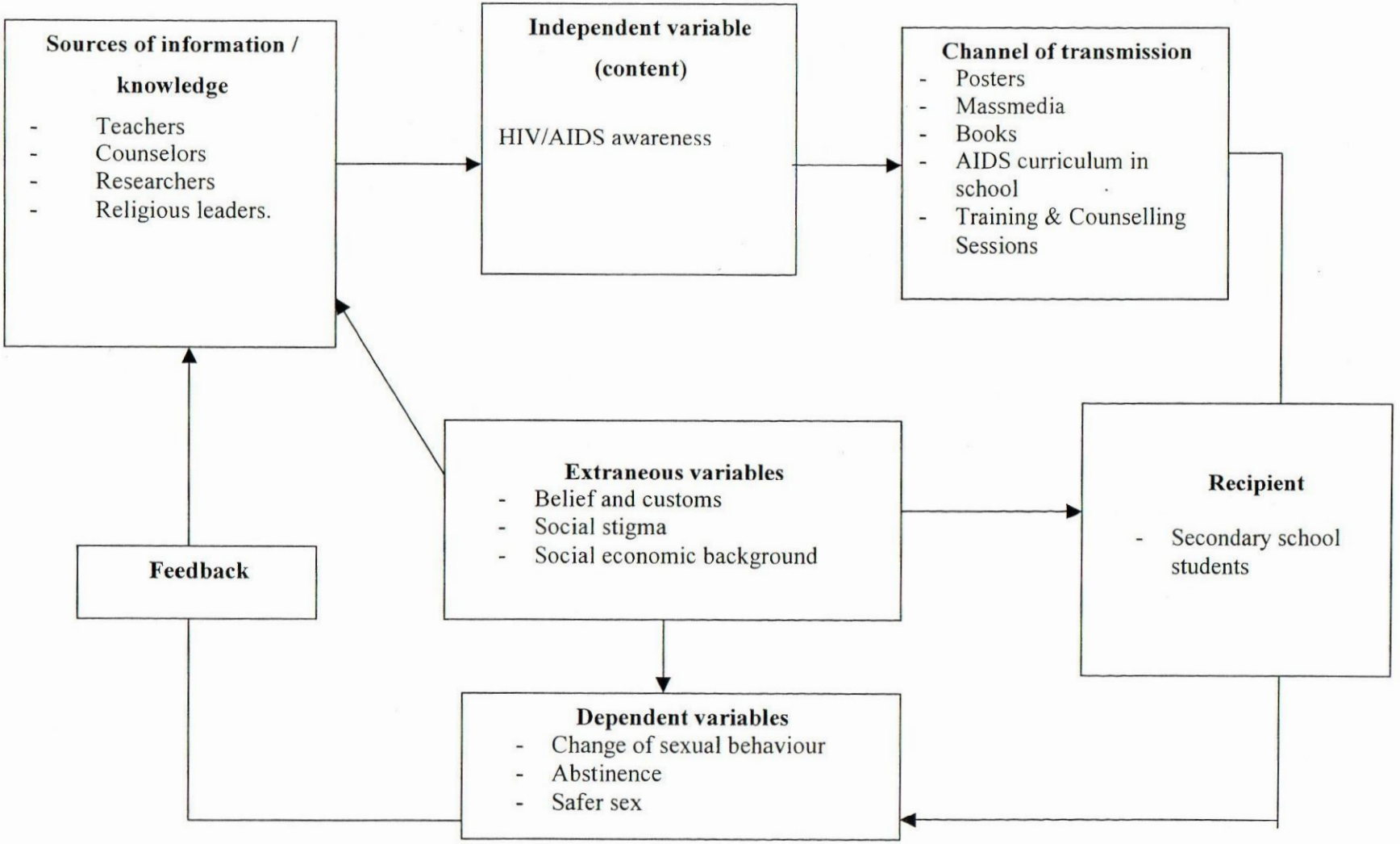


Figure. 1: A model showing the impact of HIV/AIDS awareness on sexual behaviour

From figure 1, creating awareness on HIV/AIDS infection and Prevalence is the main task. Teachers, counsellors and religious leaders are the source of this information and they use such channels as posters, books, and mass media among others. If the student gets this information, behaviour change is expected. Yet, factors like belief and customs and social economic background need to be addressed if HIV/AIDS awareness campaign is to be effective.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter deals with the research design, population, sample and sampling procedure, instrumentation, data collection and data analysis procedures.

3.2 Research Design

The study used *ex-post facto* design. Kerlinger (1973) describes *ex-post facto* design as a systematic empirical inquiry where the researcher does not have direct control of independent variables because their manifestations have already occurred or because they cannot be manipulated. Inferences about relations among variables are made without manipulating independent variables. This design was deemed appropriate because the study was conducted in public schools with classes already established hence the respondents could not be manipulated.

3.3 Location of the Study

The study was carried out in Othaya division of Nyeri district. The division has all the categories of secondary schools that the researcher required in order to get well distributed results. The fact that HIV/AIDS cases are recorded among the youths, some of which are in secondary school prompted the selection of this location.

3.4 Population of the Study

The population from which the sample was drawn consisted of Form two to Four students in Othaya division secondary schools. The reason for exclusion of Form one students was that they had not been in secondary school long enough to have benefited from guidance and counselling programs and curriculum where HIV/AIDS awareness is addressed. Othaya division has 27 secondary schools, with a total of 5000 students excluding Form ones. The schools were stratified into three categories boys only, girls only and mixed schools. MOEST (2005) divisional headquaters in Othaya reveal that there are 27 secondary schools. Out of

EGERTON UNIVERSITY LIBRARY

these, four are in the boarding category for boys six for girls boarding and seventeen are mixed day and boarding.

3.5 Sampling Procedure and Sample

A sample is a subset of the population to which the researcher intends to generalize the results (Wiersma, 1986). The study adopted proportional, stratified and random sampling procedures. Stratified sampling was used to take care of both genders (boys and girls). Random sampling was used to get specific respondents in a given school. The researcher obtained a sample of 360 students from a population of 5000 secondary school students as recommended by Kathuri and Pals (1993) in the table for determining sample size (Appendix II). Proportional sampling was used to arrive at the exact number of students per school using the formula:

$$\frac{X}{N} \times S$$

Where

(N) The access population which was 2000 students

S) Sample size was 360

(X) School target population

The researcher sampled the population as illustrated in Table 3

Table 3:

Proportional distribution of sampled students per school

School	Status	School target population	Sample size
Othaya Boys	Boarding	400	72
Chinga girls	Boarding	500	90
Gatugi girls	Boarding	300	54
Kenyatta Boys	Boarding	150	27
Kagonye mixed	Day & Boarding	300	54
Kairuthi mixed	Day	200	36
Mucarage mixed	Day & Boarding	150	27
		2000	**360**

3.6 Instrumentation

The researcher used a questionnaire to collect data. The questionnaire had two sections. Section A dealt with information on biodata while section B dealt with students awareness of HIV/AIDS, sexual behaviour and the factors perceived to influence the level of awareness.

A pilot study was conducted before the actual data collection in two schools outside the division. It was done in order to make the necessary adjustments on the questionnaire items so as to establish the reliability and validity of the research instruments.

Cronbach's coefficient alpha was used to determine the internal consistency of the questionnaire items. This is a method of testing reliability of test scores by administering the test once (Mugenda & Mugenda, 1999). Reliability coefficient of 0.7 and above was to be considered appropriate for this study. The questionnaire had a reliability coefficient of 0.74 upon piloting and was therefore considered reliable (Frankel & Wallen, 2000). The questionnaire was validated through adequate consultation with the supervisor and research experts in the university. The researcher also carefully considered the objectives of the study to validate the questionnaire items. A variety of questionnaire items were constructed on each objective.

3.7 Data Collection Procedures

The researcher obtained an introductory letter from the university. Further permission was sought from the D.E.O, Nyeri to access Secondary Schools in the district. The researcher then presented the letters to the headteachers to be allowed to collect data. The researcher administered the questionnaire to the respondents with the help of teacher counsellors. Few students who sought clarification were assisted accordingly.

3.8 Data Analysis Procedures

Data was analysed using descriptive statistics. These included frequency tables and percentages. The responses in the questionnaires were tabulated, coded and processed by use of a computer Programme – Statistical Packages for Social Science (SPSS) for windows version 9.0.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents research findings, which are related to the objectives that guided this study.

This study measured the following objectives.

(i) To assess the level of awareness of HIV/AIDS among secondary school students.

(ii) To investigate the impact of HIV/AIDS awareness on sexual behaviour among secondary school students.

(iii) To determine the factors that influence the level of awareness of HIV/AIDS among secondary school students.

(iv) To establish whether there are differences in the level of HIV/AIDS awareness between boys and girls in secondary school.

4.2 Demographic Characteristics of Respondents

A total of 360 student responded to the questionnaire. Out of these, 58% or 210 were girls while 42% or 150 were boys. This is as presented in Table 4.

Table 4:

Distribution of respondents according to their gender

Gender	Frequency	Percentage
Boys	150	42
Girls	210	58
TOTAL	**360**	**100**

Further, the sampled students were distributed according to classes so as to arrive at an even distribution for proportional representation. Table 5 gives the distribution of respondents according to their gender and class

Table 5:

Distribution of respondents according to their class and gender

Class	Boys	Girls	Total	Percentage
Form two	61	69	130	36
Form three	49	75	124	35
Form four	40	66	106	29
TOTAL	**150**	**210**	**360**	**100**

4.2 Students' HIV/AIDS Awareness Level

The first objective of the study was to assess the level of awareness of HIV/AIDS among secondary school student. The researcher sought to answer the question: What is the level of awareness of HIV/AIDS among secondary school students? From the study, it was evident that the level of awareness on HIV/AIDS varied from one student to another. On the meaning of AIDS, 73 % of the sampled students knew what AIDS means while 18% did not have the facts right but 9% did not give the responses on the meaning of AIDS and hence the researcher could not conclude that they were aware. This implies that about 27% of all the respondents could not tell the meaning of the acronym AIDS.

On across –tabulation, only 14% or (51) knew what HIV meant, while (278) or 77% of all the respondents who chose to respond to this item got it wrong. This is clear indicator that there are students who do not know what this particular term means. On further analysis, 93% (or 334) of all the respondents knew that HIV virus has no cure and 2% (or 8) were not sure whereas 4% (or 15) did not think that the virus had no cure.

The researcher wanted to find out if students had come across AIDS patients who had passed away recently. Table 6 reflects students' response on whether they knew of a recent AIDS related death.

Table 6:

Students' response on whether they know of a recent AIDS related death

Class	Yes	%	No	%	No response	Total
Form two	103	69	23	18	4	130
Form three	105	85	17	14	2	124
Form four	92	87	13	12	1	106
Total	**300**		**53**		**7**	**360**

Although 98% responded to this item, (53) or 15% of the entire sample acknowledged that they had not known of any one person (below thirty years) who had died of AIDS related illness. This reflects that there are students who believe that young people cannot die of AIDS - an idea that is grossly flowed. Further, the researcher wanted to establish whether students knew the meaning of VCT and the outcome is as reflected in Table 7.

Table 7:

Frequency on students awareness of the meaning of VCT

Class	Aware f	%	Unaware f	%	No Response f	%	Total
Form two	72	20	28	8	30	8	130
Form three	88	24	22	6	14	4	124
Form four	72	20	18	5	16	5	106
Total	**232**	**64**	**68**	**19**	**60**	**17**	**360**

From table 7, Out of all the sampled students, only 64% (232) of the total sample got the correct meaning of VCT. The rest (36%) either did not know or were unsure. This confirms the studies done earlier by Johnstone (2000) which revealed that some young people cannot tell what VCT stands for. The study revealed that 11% of the respondents did not know of a VCT centre anywhere near or far from their place of residence. Interestingly, of all the students who have heard of a VCT centre, 183 or 51% claimed that the facility was not within reach. They say that it was more than five kilometers away as illustrated in Table 8.

Table 8:

Students' view of Distance in Kilometers of the VCT centre from home

Class	Near (0-5 km)	%	Far (Over 5km)	%	Total	%
Form two	70	53	60	47	130	100
Form three	57	46	67	54	124	100
Form four	50	47	56	53	106	100
Total	**177**	**49**	**183**	**51**	**360**	**100**

As reflected in Table 8, those who reported that the facility was far from reach and hence out of mind were 51%. This implied that only 49% of all the respondents may often think of a VCT centre by virtue of frequently seeing it and therefore may consider paying a visit to the facility in future. Despite having seen or heard about a VCT centre or even having one near home, only 47 (13%) or had gone for VCT services and 83% stated categorically that they had never done so. Only 13 or 4 % did not give their response. This is consistent with the findings by the MOH (2005) that the VCT facility had not made impact regarding its availability and the services provided.

An issue that could contribute to students' ignorance of the effects of HIV/AIDS in the society could be lack of openness among the family members. 54% of all the respondents did not know of a relative who had died of HIV/AIDS related illness within the last two years. A further 8% were not sure and only 131 or 36 % had seen or known as indicated in Table 9.

Table 9:

Students' Opinions on the Knowledge of a relative who had died of AIDS

	Students response							
	Yes	**%**	**No**	**%**	**Unsure**	**%**	**No Response**	**Total**
Form two	45	12.5	74	20	10	3	1	130
Form three	45	12.5	66	19	12	3	1	124
Form four	41	11	53	15	7	2	5	106
Total	**131**	**36**	**193**	**24**	**29**		**7**	**360**

This confirms that there is low awareness level of even the most common slogan or statement in the concern for the HIV menace.

The abbreviations ABC (where A stands for Abstain; B for Be faithful and C stands for Condom) was also examined. On average, only a half or 51% could tell what ABC stands for. The rest either were not sure or did not know altogether. This confirms the fears that there are a number of students who are not aware of the trends and dynamics of the HIV/AIDS scourge and how best to take care of oneself from contracting the scourge. The school programmes that take care of HIV/AIDS awareness are limited to a few schools and also known to a limited number of students. According to the research findings, only 215 or 60% were aware of such programmes. The rest, 40% either did not know or were not sure while others did not respond indicating that they may not be sure or aware, given that the question was not personal and one was not expected to withhold information to this question.

In conclusion, it is clear that there are still so many students who are not aware of vital facts in relation to HIV and AIDS. It is also clear that there are some students who are unaware of programmes that would create awareness to them on the concept, prevalence and how to be safe from the HIV/AIDS scourge within the school setup. It is also clear that some facilities like the VCT are out of reach and therefore students do not access them.

4.4 Students Sexual Behaviour and how HIV/AIDS Awareness Impacts on the Behaviour

The objective of this section of study was to investigate the impact of HIV/AIDS awareness on sexual behaviour among secondary school students.

Sexual behaviour has been one issue often avoided during discussions among the youth. However, it is clear that sexual behaviour is a major factor in the prevalence or prevention of HIV/AIDS. The sampled students had varied views and opinions on how one should address sexual behaviour. For instance, 67 or 19% of all the respondents believed that the climax of love with a friend was sexual intercourse. This confirms the earlier findings by Babendreier (2003) that there are so many youths who are sexually active. Such behaviour may contribute

immensely towards HIV/AIDS infections. On cross tabulation, 39% of the sampled students believed that it was hard to be a virgin today. Although 60 % believed it is possible, a ratio of 39:60 is rather high and this reveals that there could be many teenagers in school who are sexually active. Table 10 gives a distribution of opinion on the issue of virginity among students in high schools.

Table 10:

Students' opinion on the view that it is hard to be a virgin today

Opinion	Frequency	Percentage
Agree	139	39
Disagree	216	60
Total	**355**	**99**

The issue of having sexual partners was also examined. Majority of the students (70%) did not believe that one should have sexual partners; 30% or 108 of the respondents believed that one should have one sexual partner. Nevertheless, the fact that one can change sexual partners should a relationship with one partner go sour does not rule out room for infection. Also, the point at which one starts a new sexual relationship leaves many gaps unfilled and therefore the risk still stands with either the new or a previous friend. Students admitted that they could not stop sexual intercourse once they get into the habit of practicing it. Table 11 gives an illustration to that effect.

Table 11:

Students' Opinion on whether one can stop the sex habit

Class	Agree %	Disagree %	Total
Form two	66	64	130
Form three	71	53	124
Form four	65	41	106
Total	**202**	**158**	**360**
Percent	**56%**	**44%**	**100%**

Table 11 reveals that 56 % of the respondents felt that it was hard to stop sex once you started this habit. Only 44% felt that one can stop. However the overall impression is that majority of the respondents felt that one cannot stop sex once one has engaged in it. An item was constructed to find out whether students had partners who loved sex. Out of all the respondents, 34% admitted that they had partners who loved sex as indicated in Table 12.

Table 12:

Students' response on whether they had partners who loved sex

Response	Frequency	Percentage
Yes	124	34
No	230	64
No response	6	2
Total		**100**

From table 12, 230 or 64% of the respondents said that sex was not a priority in their relationship with teenage friends or peers. However, of the 230 respondents whose partners did not love sex; 228 or 99% had never asked for sexual encounter from their partners. It was further observed that out of 124 respondents whose partners loved sex, 120 or 97% had asked for sexual experience from their so called lovers or partners as illustrated in Table 13.

Table 13:

Students' response on whether their partners have asked for a sexual experience from them

Opinion on Love for sex	Frequency	Have interest on sexual experience		No interest on sexual experience	
		f	%	f	%
Yes	124	120	97	4	3
No	230	2	1	228	99

The information from Table 13 verifies the fact that both males and females who love sex make sexual advances from their partners.

Johnstone (2000) did a research on sexual debut and reported that it is setting on earlier today than it was in the past. The findings of this study confirmed this since 6% of the respondents had had their first sexual encounter when below 12 years and 20 % of all the respondents or 71 respondents had had the first sexual encounter when 15 years and below while it was only 59% of all respondents who had not had a sexual experience at teenage while they were secondary school students. Table 14 gives the age at which students got exposed to sexual intercourse.

Table 14:

Sexual intercourse debut

Age in years	Frequency	percent
Below 12	20	6
12-15	51	14
16-20	60	16
Above 20	7	2
Total	**138**	**38**

Results in Table 14 show that 38% of all the respondents had experienced sexual intercourse while in school.

During the research, items were constructed to measure students view on stopping sex for fear of contracting the HIV virus. The responses are as reflected in Table 15.

Table 15:

Students' attitude on whether knowledge of HIV/AIDS made them keep off sex

Attitude	Frequency	Percentage
True	218	61
False	59	16
Not sure	20	6
No response	62	17
Total	**360**	**100**

Johnstone (2000) did a research on sexual debut and reported that it is setting on earlier today than it was in the past. The findings of this study confirmed this since 6% of the respondents had had their first sexual encounter when below 12 years and 20 % of all the respondents or 71 respondents had had the first sexual encounter when 15 years and below while it was only 59% of all respondents who had not had a sexual experience at teenage while they were secondary school students. Table 14 gives the age at which students got exposed to sexual intercourse.

Table 14:

Sexual intercourse debut

Age in years	Frequency	percent
Below 12	20	6
12-15	51	14
16-20	60	16
Above 20	7	2
Total	**138**	**38**

Results in Table 14 show that 38% of all the respondents had experienced sexual intercourse while in school.

During the research, items were constructed to measure students view on stopping sex for fear of contracting the HIV virus. The responses are as reflected in Table 15.

Table 15:

Students' attitude on whether knowledge of HIV/AIDS made them keep off sex

Attitude	Frequency	Percentage
True	218	61
False	59	16
Not sure	20	6
No response	62	17
Total	**360**	**100**

It is evident from the table that 61% had decided to abstain from sex while 16% had not been influenced by the awareness to stop sex, and 23 % were silent about the impact of the HIV/AIDS awareness on their sexual behaviour. The researcher also wanted to establish whether students made use of the VCT centres near their home. Many students had not utilized the availability of VCT centres and only a small group had. On cross tabulation; only 13% had sought services from the facility as illustrated in table 16.

Table 16:

Students' responses on whether they had visited a VCT centre

Opinion	Frequency	Percent
Yes	47	13
No	300	83
No response	13	4
Total	**360**	**100**

From Table 16, 313 (or 87%) had not made use of the facility and this revealed that many students had not embraced their idea of taking a HIV test in order to determine on how to remain HIV negative. The researcher further wanted to find out whether knowledge of a person who had died of AIDS helped students visit a VCT centre. While 43 had gone for VCT after knowing of a person who had died of AIDS before the age of 30 years, the rest (4) had gone for VCT for other reasons as illustrated on Table 17.

Table 17:

What made the students into taking HIV test

Knowledge of one who died of AIDS		Unspecified reasons		Total	%
(f)	%	(f)	%		
43	92	4	8	47	100

The study sought to find out those students who were influenced by parents, (guardians) the school or even the church to 'Chill' from sex. The results are as presented in Table 18.

Table 18:

Frequency distribution of those who influenced students to abstain from sex

Sources of influence (f)	Total- who abstained (f)	Those who were influenced (f)	Percentage
Parents	230	170	74
Church	254	189	74
Both Church and Parent or any other	224	167	75
School	208	165	79

Only 170 of the 230 students who said that they had avoided sexual intercourse for fear of AIDS had discussed these issues with their parents or guardians. The guardians or parents had influenced 74% to stop being sexually active at teenage. According to Table 19, 189 out of 254 or 74% had heard their religious leader talk about AIDS and had therefore avoided sex. Of the 224 students who had avoided sex, 167 or 75 % had at least heard the message concerning HIV/AIDS from someone; be it a parent, guardian, religions leader or a teacher. However, of the 208 students whose schools had programmes that at times discuss HIV/AIDS, 165 or 79% had resolved to chill from sexual activity completely. This reveals that parents, church and the school programmes influence students in their sexual behaviour. The researcher wanted to establish who influenced students to go for VCT. The study discovered that 45 out of 47 students who had gone for VCT had heard their religious leaders talk about AIDS. These findings are contained in Table 19.

Table 19:

Source of information that influenced students to visit VCT centre

Information Source	Influence f	%	Not influenced f	%	Total
Parents	45	96	2	4	47
Church	43	91	4	8	47
School (Programmes)	34	72	13	28	47

In contrast, only 34 out of the 47 had had a programme in their school that addresses HIV/AIDS. It was also discovered that 43 out of 47 had heard about HIV/AIDS from their guardians or parents. This implies that the guardians, school and even the religious leaders have influenced students to going for VCT though only a small number. USAID (2003) asserts that although VCT centers have been made available, few people and particularly the youth utilize the facility. This theory has been confirmed in the current study.

In conclusion, it is evident that the sexual debut sets in quite early. The study also revealed that most of the sexual partners on the first encounter are fellow teenagers. However, as they remain sexually active, they may involve older partners for gains more than just the sexual pleasure. It is also evident that high number of students are sexually active thereby raising the chances of contracting sexually transmitted infections. This implies that chances of contracting HIV/AIDS are also high.

Further, it can be concluded that religious leaders, parents and schools or institutions play a great role in enhancing the HIV/AIDS awareness campaign. The fact that HIV/AIDS is transmitted largely through sexual intercourse should be emphasized among students, in order that they may either 'chill' completely from sex or adopt safer sex.

4.4 Factors that Influence HIV/AIDS Awareness

The third objective of the study was to find out the factors that influence the awareness level of HIV/AIDS among secondary school students. This section examined the factors that affect the HIV/AIDS awareness level of the students. For instance, 78 or 22 % of all respondents said that they had never discussed HIV/AIDS with parents or guardians. However, 70 or 19% of all respondents believe that discussing sex with parents/guardians is a taboo. Among all the sampled, 246 or 68% did not know that people could be tested of HIV/AIDS free of charge. This implies that a good number of teenage high school students do not discuss HIV/AIDS and issues of sex with their parents or guardians. The researcher sought to establish the percentage of students who had a sexual experience according to whom they stayed with. It was observed that out of the 60 respondents who stay with their mother, 47% or 28 have had sexual experience. This is a high percentage considering that it was 39% of all the sexually active students. Concerning those who stayed with their fathers, 9 out of 16 or

56% were sexually active and among those who stayed with both parents (85 out of 255), 33% were sexually active. Among those who stayed with a guardian or relative, 6 out of 15 or 40% were sexually active as illustrated in Table 20.

Table 20:

Distribution of sexually active students according to the guardian they stay with

Guardian	Sexually active		Sexually inactive		Total
	(f)	%	(f)	%	
Mother	28	47	32	53	60
Father	9	56	6	44	16
Both parents	85	33	170	67	255
Relative	6	40	9	60	15

The impression created here is that; 56 % of those who stay with the father, 47% of those who stay with the mother, 40% of those who stay with the guardian and 33% of those who stay with both parents were sexually active. This comprised 35% of all the sampled students. The fact that 35% of all the respondents were not comfortable discussing HIV/AIDS and sex related issues with their parents; and that an average of 35% of all the respondents had had a sexual encounter is a pointer that many guardians/parents do not discuss the HIV/AIDS and sexual behaviour with their high school going children. The reason given was that parents/guardians were too busy to afford such time. 26% (94) of all respondents gave this opinion. The family seems to have neglected the responsibility of educating their high school going children on the dangers of casual sex in the light of HIV/AIDS scourge.

In the case of religion, 7 out of 25 or (28%) of those discouraged by their religious leader from discussing HIV/AIDS and sex related issues did not know what VCT stands for. This means that a great percentage of the students who were discouraged from evaluating and discussing sex related issues and HIV/AIDS did not have much of the relevant information that could help them make informed choices. Peer influence also prompts ignorance on the issue of HIV/AIDS as illustrated in Table 21.

Table 21:

Frequency distribution of knowledge of various HIV/AIDS related facts among students jeered by their peers

Knowledge of	Yes		No		Total
	(f)	%	(f)	%	
What HIV stands for	12	12	88	88	100
Meaning of VCT	77	70	32	30	109
Meaning of ART	76	84	14	16	90

From table 21, among 100 students who were discouraged from discussing issues related to HIV/AIDS and sex by their peers, only 12% know the meaning of HIV whereas 88% were ignorant.

However among 109 students discouraged by their peers through jeering or being laughed at, 32 or 30 % of them did not know what the abbreviations VCT stand for. Among those students who were jeered at by their peers whenever they wished to discuss HIV/AIDS and sex, 14 out 90 or 16% did not know what ART stands for even when it was given in the objective choices as illustrated in Table 22.

Table 22:

Opinion whether jeered students know what ART stands for

Students Response	Frequency	Percentage
Yes	76	84
No	14	16
Total	**90**	**100**

It can therefore be concluded that discouragement by peers is a major factor that contributes towards being ignorant on the prevalence or risk of HIV/AIDS. Further, the study also concluded that there are factors that hinder the awareness levels of HIV/AIDS among high schools students. These include:

a) Parenting (Parent - child relationship)

b) Religious teachings

c) Peer influence.

This implies that something has to be done to ensure that the given factors are not a barrier to information accessibility.

4.5 Gender Difference in HIV/AIDS Awareness Level and Sexual Behaviour

The fourth objective of the study was to establish whether there are differences in the level of HIV/AIDS awareness between boys and girls in secondary school.

In the society, the female seems to be the marginalized gender. As reported earlier in this study, the young girl is more vulnerable to contradicting the HIV Virus in comparison to her male counterpart. This section discusses the differences between girls and boys as far as HIV/AIDs awareness is concerned and their opinion and feelings on sexual behaviour.

On cross tabulation, more boys than girls can give the meaning of HIV as reflected in Table 23.

Table 23:

Knowledge of the meaning of HIV

Gender	Know		Don't know		Total
	(f)	%	(f)	%	
Male	26	17	124	83	150
Female	25	12	185	88	210
Total	**51**		**309**		**360**

From table 23, 17% of boys compared to 12% of girls can tell the meaning of HIV. This reveals that more boys than girls are aware of what the acronym HIV/AIDS stands for. Further analysis reflected that 114 out of 150 or 76% of all male respondents had heard of HIV/AIDS within a month before answering this questionnaire as compared to 148 or 70% for girls. This could mean that 30% of girls had not heard of HIV/AIDS within the last one month as compared to 24% of the boys. Johnstone (2001) says that boys are not restricted

from leaving home as is the case with girls. The freedom for exploration could have exposed boys to HIV/AIDS information more than girls, an observation confirmed in this study. The researcher further investigated whether there existed any gender difference on the knowledge of the phrase " To Chill". The results reflected that more males (71%) compared to 49% for female respondents knew the meaning of the phrase '*To chill'* as given in Table 24.

Table 24:

Gender Distribution of respondents on the meaning of the slogan "to chill"

Gender	Know	%	Don't know	%	Total
Male	106	71	44	29	150
Female	103	49	107	51	210
Total	**209**		**151**		**360**

This indicates that there is a difference on the meaning of vital facts regarding HIV/AIDS between boys and girls with the female being reflected as the less informed.

The researcher wanted to find out if there is a difference between boys and girls of those who believe that they can't contract HIV/virus through sharing needles as illustrated on Table 25.

Table 25:

Students response according to their gender on whether you cannot contract HIV virus through sharing needles

Gender	Yes (F)	%
Boys	7	5
Girls	6	3

It was further discovered that 7 out 150 or 5% of the sampled males believed that one cannot contract HIV through sharing needles while only 3 % of their female counterparts shared the same knowledge. This difference could explain why many male students share needles especially those who engage in drug abuse as reported by Johnstone (2001). This poses a risk in contracting HIV/AIDS. There was a difference between boys and girls where 90% of the

boys knew that one can be tested free of charge compared to 92% of the girls. On the same breath, those who knew what VCT stands for were 91 or 61 % for the boys compared to 67 % for the girls. In this context, more girls seemed to be informed than boys and this implied that more awareness campaigns could have been put in place amongst the girls than is the case for boys. There are more ignorant boys than girls in the case of roles of a V.C.T centre as indicated in Table 26.

Table 26:

Knowledge of one or more roles of VCT center

Gender	Know	%	Don't know	%	Total
Male	106	71	11	7	117
Female	165	79	11	5	116
Total	**271**		**22**		**293**

The figures reflect that more girls than boys know the roles of a VCT centre. The explanation here is that 106 or 71% of the boys have discussed HIV/AIDS with the parents/guardians as compared to 165 or 79 % for girls. The researcher wanted to establish whether students discussed HIV/AIDS with their parents. Table 27 reflects the findings on the responses of both boys and girls opinions on their discussion of HIV/AIDS with their parents.

Table 27:

Responses on whether students discuss HIV/AIDS with Parents /Guardians

Gender	Yes (frequency) f	%	No f	%	Total
Male	107	71	40	27	147
Female	172	82	38	18	210
Total	**279**		**78**		**357**

Table 27 revealed that many of the boys had not discussed HIV/AIDS with their caretakers and this could lead to the lower level of awareness as compared to the girls. On the issue of whether the church discusses HIV/AIDS or not, 125 or 83% of the boys had heard their

religious leader discuss HIV/AIDS as compared to 179 or 85% of girls as illustrated on table 28.

Table 28:

Students' responses whether their churches discuss HIV/AIDS according to their gender

Gender	Response Yes (f)	Percentage
Boys	125	83
Girls	179	85

This further reflects that more girls are being reached for awareness than boys. Johnstone (2003) asserts that the society has concentrated so much on giving the girl child more attention than the boy child.

On cross tabulation between gender and schools that had programmes which discuss HIV/AIDS, 50 % of the males compared to 67% of their female counterparts had such programmes in their schools as indicated in Table 29.

Table 29:

Students' opinion on the availability of school programmes which address HIV/AIDS

Gender	Yes	%	No	%	Total
Male	75	50	70	47	145
Female	140	67	68	32	208
Total	**215**		**138**		**353**

The reflection that 47% of all male respondents compared to females 32% who had not known of programmes in their school which addressed HIV/AIDS is an indicator that fewer boys than girls are effectively reached with HIV/AIDS information.

The issue of teenage sex was examined. It was found that male respondents seemed to be in favour of teenage sex more than their female counterpart. From the study 77 of the males respondents or 53% believe it is hard to be a virgin while only 30% of the females share the same feelings on the issue of being sexually active at teenage. However 39 % of male respondents believed that sex was okay if one had one sexual partner compared to 23 % as reflected in Table 30.

Table 30:

Students' feeling that teenage sex with one partner is okay

	Okay	%	Not okay	%	No response	%	Total
Male	59	39	87	58	4	3	150
Female	49	23	156	74	5	3	210
Total	**108**		**243**		**9**		**360**

The impression created in this context is that more boys than girls approved teenage sex. On the issue of protected or safer sex, a higher number of boys compared to girls feel that they should use a condom for protection every time they engage in sexual experience. This is indicated in Table 31.

Table 31:

Students' view on whether Condom should be used for protection during sexual intercourse

Gender	Yes		No		No response		Total
	f	%	f	%	f	%	
Boys	98	65	37	25	15	10	150
Girls	79	37	77	37	54	26	210
Total	**177**		**114**		**69**		**360**

It can therefore be concluded that females exposure and vulnerability to contracting HIV/AIDS is quite high. This can be explained by a study conducted by Johnstone (2003) which reports that female condoms are expensive. The fact that a female condom is more expensive than the readily available and affordable male condom explains why many girls do not support the use of a condom during sex. Only 3 boys which was 2 % of all the males

sampled said they failed to use a condom because it was expensive compared to 3% of the girls. Thus girls could be at a higher risk since they are not strict on unprotected sex. This is the outcome of cross tabulation of those respondents who had ever used a condom according to Table 32.

Table 32:

Students' response on whether they had ever used a condom

	Response				No			
Students	**Yes**	**%**	**No**	**%**	**response.**	**%**	**Total**	**%**
Boys	35	23	113	75	2	2	150	42
Girls	18	9	185	88	7	3	210	58
Total	**53**		**298**		**9**		**360**	**100**

From table 33, it is clear that almost a quarter of all boys have used a condom during sex as compared to less than 10% of all girls that were sampled.

The belief of some of the students that teenagers are too young to contract HIV/AIDS is another stereotype that misleads them and thus risk contracting the virus. The researcher wanted to establish the students attitude on whether teenagers are too young to contract HIV/AIDS. The results were as reflected on Table 34.

Table 34:

Students' attitude on whether teenagers are too young to get AIDS

Attitude	**Yes**	**%**	**No**	**%**
Male	18	12%	130	87 %
Female	25	12%	181	86%
Total	**43**	**12%**	**311**	**86%**

As seen in table 34, 86% of all students said that they were not too young to get AIDS.

This clearly indicates that majority of both boys and girls believe that they are not too young to contract HIV/AIDS. The figures above are a clear indication that the students are still aware that they too can contract HIV/AIDS.

In conclusion, one would notice that there are gender differences in the level of awareness as well as related sexual behaviour. While girls seem to be more informed than boys, the latter seem to be aggressive sexually, a factor that prompts fast HIV/AIDS prevalence. Nevertheless, the difference in awareness is not significant. However, girls are more vulnerable since they hold to some opinions that expose them to infection of HIV.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The present study was designed to evaluate the students' awareness levels of HIV/AIDS and its impact on sexual behaviour among secondary school students. The conclusions arrived at are stated and recommendations made with an overall goal of enabling the students to make informed decision in their sexual behaviour in light of HIV/AIDS scourge.

5.2 Summary of the Findings

The purpose of the study was to establish HIV/AIDS awareness level and whether it influences the students' sexual behaviour. From the frequency and percentage tables, results obtained indicated that 14% and 73% of the students were aware of the meaning of HIV and AIDS respectively. Results also indicated that 38% of the interviewed students were sexually active and that not every student was keen on safer sex for those who cannot abstain. It was further discovered that more girls were informed of the dangers of HIV/AIDS compared to boys. The study revealed that social factors also influence HIV/AIDS awareness level with some holding to the fact that they were too young to get the virus. This explains why HIV/AIDS prevalence remains a problem amongst high school students.

5.3 Conclusion

The findings of the study form the basis upon which the conclusions and recommendations of this study were made. This study came up with the following conclusions:

(i) A large number of high school students reflect high level of HIV/AIDS awareness with girls showing a higher level of awareness than boys.

(ii) There is still a large number of students who do not have correct facts relating to HIV/AIDS scourge.

(iii) There are students who know little about VCT centres and their roles

(iv) There are many schools which do not have a clear programme that address HIV/AIDS awareness on infection, spread and prevention.

(v) Teenage sex is common among high school students; it could be unprotected or casual thus leading to HIV infection.

(vi) Sexual debut sets in quite early and many high school students who do not have reliable HIV/AIDS awareness could be sexually active before turning 15 years.

(vii) HIV /AIDS awareness promotes abstinence or safer sex.

(viii) Agents of advocacy on HIV/AIDS awareness such as churches, homes and schools enhance awareness and positive change of sexual behaviour among the teenagers.

(ix) Parenting or active participation in taking care of young people (students) influences the students' sexual behaviour.

(x) Religious leaders, parents, teachers and counsellors are key contributors in creating HIV/AIDS awareness among students.

(xi) Peers influence one's HIV/AIDS awareness and the sexual behaviour of students.

(xii) Girls have a higher level of awareness on HIV/AIDS related facts than boys.

(xiii) More boys in secondary schools are sexually active compared to girls.

(xiv) Girls are more open in discussing HIV/AIDS and sex with their parents and guardians than boys thus learning a lot on the same.

5.4 Recommendations

(i) Precise and simplified HIV/AIDS information sources should be made available to teenagers and in particular those who are in high schools.

(ii) VCT centres be made available in high school. This will prompt students to pay a visit so as to know their HIV status and this will help them make proper decision on their sexual behaviour.

(iii) Detailed sex education be introduced to primary and secondary schools to enable adolescents as young as 10 years make informed choices on their awareness of their sexual behaviour to check on early sexual debut.

(iv) Parents/guardians should take the responsibility of discussing HIV/AIDS and sex with their children.

(v) Churches and other religious organizations should develop a detailed HIV/AIDS curriculum for the youth in their churches to enhance creation of HIV/AIDS awareness.

(vi) Peer group-directed programmes be introduced and strengthened especially in issues related to sex and HIV/AIDS in order that they may influence their peers positively.

(vii) More exposure to cases of young HIV/AIDS patients be availed to students frequently especially those which look pathetic and at their last (terminal) stage for emphatic expression of the effects of HIV/AIDS to the teenagers who believe that high school students are too young to contract the virus.

(viii) Boys should also be given attention in the creation of HIV/AIDS awareness and sexual behaviour as opposed to the current emphasis on the girl child only.

5.5 Suggestions for Further Research

This study suggests that:

(i) Studies of similar nature be carried out in other parts of the country, where HIV/AIDS is prevalent.

(ii) Study be carried out to establish inappropriate means of advocacy in promote the spread of HIV/AIDS among high school students.

(iii) A study be carried out to establish why VCT centres are quite unpopular with high school students.

(iv) To study the obstacles to HIV/IDS awareness in schools.

(v) Investigate HIV/AIDS counseling techniques in secondary schools.

(vi) To identify cases of students who are affected by HIV/AIDS.

REFERENCES

Aggleton, P. and Shaw, C. (2002) Preventing HIV AIDS and Promoting Sexual Health. Washington: DFID.

Babendreier, J. (2003). AIDS Education for the Youth. Nairobi: Focus Publications Limited.

Boswell, D. and Baggaley, R. (2002). VCT TOOLKIT. Boulevard: Family Health International.

Brown, C. W. & Falb, M.C. (1981) Fundamentals of speech communation (3rd Edition), IOWA: W.M.C. Brown Company Publishers.

Cohen, L. Lawrence, W. (1990) Station for Social Scientism. London: Marborough House.

Coolican, H. (1994). Research Methods and Stations Psychology (2nd Ed) London: The Bath.

East African Standard Correspondent (2003 August 28). *Claws of a killer*, special reports on HIV/AIDS. E.A Standard, Nairobi: East Africa standard Ltd.

Fraenkel, J. R. & Wallen, E. N. (2000) How to Design and Evaluate Research in Education (4th Ed.) Boston. USA. McGraw Hill Companies.

Gallagher, J. and Anna, T. (1996). Young Woman, England: House Publishing. Granteam England.

Gitonga, N. (2001) A study on Secondary school headteachers attitudes towards guidance and counselling. Unpublished Master of Education thesis, University of Nairobi.

Johnstone, T. (2000) The Adolescent AIDS Epidemic in Kenya, (4th Ed). Nairobi : Kenya, New World Printers.

Johnstone, T. (2001). A Kenyan Programme of Family Life Education; Impact Analysis. Nairobi: New World Printers.

Johnstone, T. (2003). The Sexual Abuse of Kenyan Women and Girls. Nairobi: New World Printers.

KANCO (1998) Information package on HIV/ Aids and Adolescents in Kenya. AIDS NGO'S Consortium Networking and United Fight AIDS (unpublished).

KANCO (2000). Information Package on gender and HIV/AIDS consultations Limited.

Kathuri, J. N. & Pals (1993). An Introduction to Educational Research. Njoro: Egerton University Press.

Kerlinger, (1983). Foundation of behavioural Research. (2nd Ed) New Delhi: Indiana Printers.

KIE, (1999). AIDS Education Syllabus for Schools and Colleges, Nairobi: KIE publishers Kenya.

KIE, (1999). Bloom or Doom: (Your Choice, An Aids resource book for youths in and out of Secondary Schools). Nairobi: KIE Publishers Kenya.

Kogi, A.M(nd) A to Z of HIV/AIDS for Schools and Colleges (no publisher/town).

Lamptey, P. and Gayle, H. (2001). HIV AIDS Prevention and Care in Resource Constrained Settings. Boulevard: Family Health International.

Ministry of Health (2005). Kenya National guidance for researcher and development of HIV/AIDS vaccines. Nairobi: MOH publishers.

Mugenda, O. M. and Mugenda, A.G (1999). Research methods in social sciences Nairobi: Acts Press.

Muraah, W. S. & Kiarie, W. (2001). HIV/AIDS: Facts that could change your life, (1st edition). Nairobi: English press Ltd.

NACC, (2000). The Kenya National HIV/ AIDS strategic plan 2000-2005 (popular version). Nairobi: Office of the President.

Onlango and Rogo (1989). Sexual Maturation and Fertility issues among high school males in rural. (A journal of obstetrics and Gynecology for East and Central Africa Vol 8 No. 7.) Embu:

Tarantatola, D. (2000) 'Reducing HIV/AIDS Risks impact and vulnerability bulleting' of the world health organisation 78, no 2 pp 236-237 Washington Dc: World Health Organization.

UNAIDS (1999). AIDS Epidemic Update. Nairobi: UNAIDS.

UNAIDS (2001). Children and Young People in a World of Aids. Nairobi: UNAIDS.

UNAIDS (2002). Report on the Global HIV/AIDS. Geneva: Gelky Images Co. ltd Switzerland.

UNESCO (May 2004). Education sector Policy on HIV and AIDS. Nairobi: KIE, Kenya.

USAID (2001). Youth in Sub-Saharan Africa. Nairobi: Population Reference Bureau.

USAID (2003). VCT Fool Kit. Alington: family health international.

WHO, (2003). Guidelines for the Management of Sexually Transmitted Infection. Geneva: 20 Avenue Appia.

WHO, (2003) Treating 3 million by 2005 (Geneva) World Health Organization.

Willis, R. (2002). The AIDS Pandemic. Lincolnshire: The Stanborough Press Ltd.

World Bank (2002). Education and HIV/AIDS, A window of Hope. Washington D.C: USAID Publications.

APENDICES

APENDIX 1

SECONDARY SCHOOL STUDENT QUESTIONNAIRE

Dear respondent,

Please answer the questions given below as honestly as possible. The information you give will be treated with confidence.

Do not write your name anywhere in this questionnaire.

Thank you.

Section A

(Please tick the correct choice).

1. How old are you? 1 [14-16 yrs] 2 [17-19 years] 3 [over 20]
2. Date of admission to this school [write]_____
3. Your class; 1 Form ☐ 2 Form ☐ 3 Form ☐
4. Your gender 1 Male ☐ 2 Female ☐
5. I stay with my: 1 Father, ☐ 2 Mother ☐ 3 Both Parents ☐
   4 Relative ☐ (Specify) _____ 5 Guardian ☐

Section B

6. What does HIV stand for _____
7. What does AIDS stand for_____
8. I have heard/seen/read the message of HIV/AIDS from/in
   1 The mass media ☐ 2 Advertisement on billboards ☐
   3 From the church ☐ 4 In books ☐
   5 A teacher/counselor ☐ 6 The newspaper ☐

9. HIV/AIDS is transmitted from an infected person to uninfected through

1 Blood transfusion ☐ 2 Breast-feeding ☐

3 Kissing ☐ 4 Sharing clothes ☐

5 Sexual intercourse ☐ 6 Can't tell ☐

10. You can't contract HIV virus through:

1 Sharing needles ☐ 2 Sexual intercourse ☐

3 Shaking hands ☐

11. Teenagers are too young to contract HIV/AIDS.

1 True ☐ 2 Don't know ☐

3 False ☐

12. HIV virus has no cure.

1 True ☐ 2 False ☐ 3 Don't know ☐

13. I know of a person who died of AIDS and was below 30 years of age.

1 Yes ☐ 2 No ☐

14. People can be tested for HIV/AIDS free of charge

1 True ☐ 2 False ☐ 3 Don't know ☐ .

15. What does VCT stand for? (Write)_____

16. Do you know of a VCT centre around your home/town/village?

1 Yes ☐ 2 No ☐

17. If yes, how far is the nearest VCT centre from your home?

1	0-3 km	☐	2	10 – 2km	☐
3	3-5 km	☐	4	Over 20 km	☐
5	5-10 km	☐			

18. Give two roles/functions of a VCT centre

_____

_____

19. Have you ever discussed HIV AIDS with your father/mother/guardian?.

1 Yes ☐ 2 No ☐

20. My religious leader occasionally talks of HIV AIDS.

1 True ☐ 2 False ☐ 3 Can't tell ☐

21. Someone has spoken to me about HIV/AIDS in the last one month.

1 True ☐ 2 False ☐ 3 Can't remember ☐

22. Our school has programs that at times discuss HIV/AIDS

1 Yes ☐ 2 No ☐

23. I know of a relative who died of HIV/AIDS within the last 24 months.

1 Yes ☐ 2 No ☐ 3 Not sure ☐

24. Anti-retroviral therapy is abbreviated as .....

25. The climax of love with my friend is sex.

1 Agree ☐ 2 Partly agree ☐ 3 Disagree ☐

26. To 'Chill' means .....

27. In relation to sex, ABC stands for

1 A..... 2 B..... 3 C.....

28. It is hard to be a virgin today.

1 Strongly agree ☐ 2 Agree ☐

3 Disagree Strongly ☐ 4 Disagree ☐

29. It is not wrong to be sexually active at teenage, what is wrong is to have many partners.

1 Strongly agree ☐ 2 Agree ☐ 3 Disagree ☐ 4 Strongly disagree ☐

30. Once you experience sexual intercourse, it is hard to stop the habit.

1 Strongly agree ☐ 2 Agree ☐ 3 Disagree ☐ 4 Strongly disagree ☐

31. Sex should be enjoyed by

1 Only that boy and a girl in true love ☐

2 By a boy with only one girlfriend ☐

3 Only those who are married ☐

32. Do you have a partner /friend /lover who loves sex ?.

1 Yes ☐ 2 No ☐

33. Has the partner ever asked for a sexual experience from you?

1 Yes ☐ 2 No ☐

34. State the age at which you experienced the pleasure of the first sexual intercourse.

1 Below 12 years ☐ 2 16 –20 years ☐

3 12- 15 years ☐ 4 21- 24 years ☐

5 Not applicable ☐

35. What is the age of the person you had the first sexual experience with?

1 Below 15 years ☐ 2 15 – 19 years ☐

3 20 - 24 years ☐ 4 Above 24 years ☐

5 Not applicable ☐

36. Have you ever used a condom?

1 Yes ☐ 2 No ☐

37. If yes, where did you get the condom from?

1 Hospital ☐ 2 Chemist ☐ 3 Clinic ☐ 4 Club ☐

5 Shop ☐ 6 A friend ☐ 7 The sexual partner ☐

38. Any time I have sex, I must use a condom for protection from HIV/AIDS

1 Strongly agree ☐ 2 Agree ☐ 3 Disagree ☐ 4 Strongly disagree ☐

39. I failed to use a condom because:

1 It is very expensive ☐ 2 It bothers me when enjoying the act ☐

3 I didn't know where to get one ☐

4 My partner said sex is sweeter without ☐

40. Since I came to know of HIV/AIDS I decided to retain only one sexual partner

1 Yes ☐ 2 No ☐

41. I have stopped sexual intercourse for fear of contracting HIV/AIDS.

1 True ☐ 2 False ☐

42. HIV/AIDS awareness helps me to

1 Select only the good sexual partners ☐
2 Change all my sexual partners to new ones ☐
3 Remain with only one faithful partner ☐
4 Stick to same sex partners only ☐
5 'Chill' from sex completely ☐

43. Have you ever gone for VCT, 1 Yes ☐ 2 No ☐

44. In our culture/community talking about sex related issues with my parents/ guardians is a taboo. 1 True ☐ 2 False ☐ 3 Don't know ☐

45. My parents/guardians are always busy so we have no time to discuss issues that affect life such as sex and HIV/AIDS

1 True ☐ 2 False ☐

46. I am always shy whenever issues of sex and HIV/AIDS are discussed at home, so I slip away to another place/room.

1 True ☐ 2 False ☐

47. My religion discourages me from listening to such issues like sex related topics and HIV/AIDS among others, since they are regarded as evil.

1 True ☐ 2 False ☐

48. Whenever you discuss sex and HIV/AIDS. Your peers laugh at you or avoid you thus discourage you.

1 True ☐ 2 False ☐

APPENDIX II

REQUIRED SIZE FOR RANDOMLY CHOSEN SAMPLE

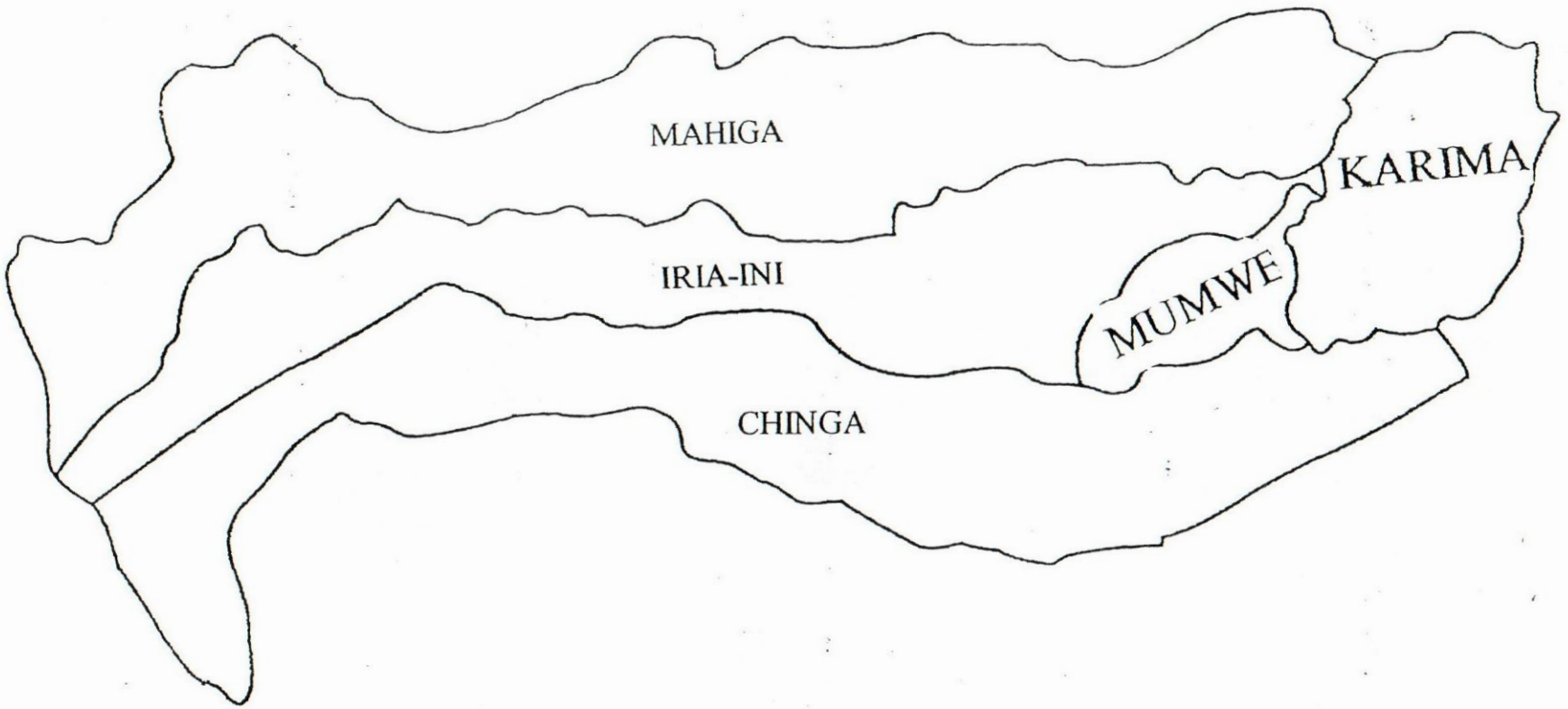
N	S	N	S	N	S	N	S
10	10	140	103	550	226	4500	354
15	14	150	108	600	234	5000	357
20	19	160	113	650	241	6000	361
25	24	220	140	700	248	7000	364
30	28	230	144	750	254	8000	367
35	32	240	148	800	260	9000	368
40	36	250	152	1200	291	10000	370
45	40	260	155	1300	297	15000	375
50	44	270	159	1400	302	20000	377
55	48	280	16	1500	306	30000	379
60	52	290	165	1600	310	40000	380
65	56	300	169	1700	313	50000	381
70	59	320	175	1800	317	75000	382
75	63	340	181	1900	320	100000	384
80	66	360	186	2000	322		
85	70	380	191	2200	327		
90	73	400	196	2400	331		
95	76	420	201	2600	335		
100	80	440	205	2800	338		
110	86	460	210	3000	341		
120	92	480	214	3500	346		
130	97	500	217	4000	351		

N= POPULATION SIZE

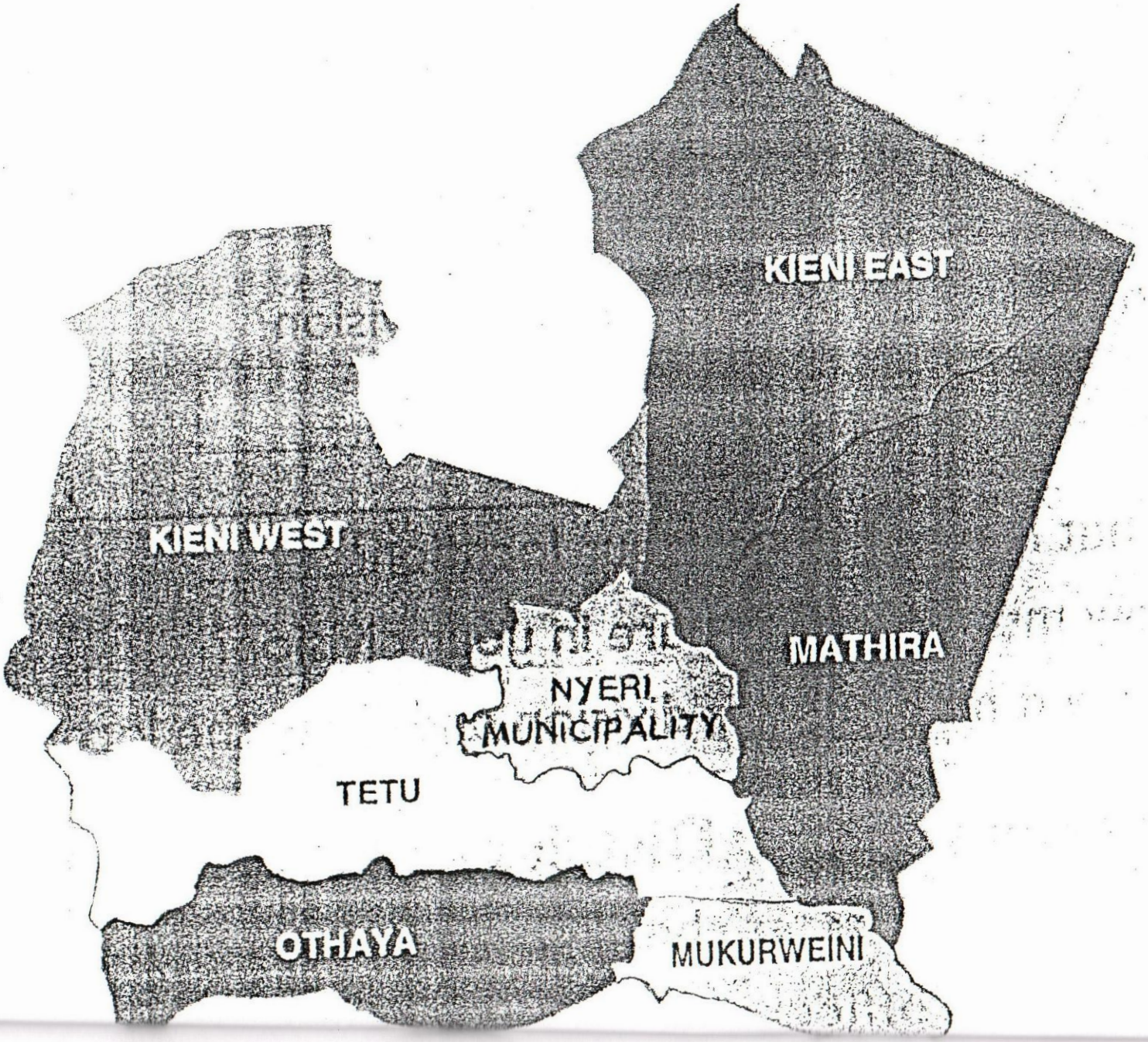
S= SAMPLE SIZE

SOURCE- Kathuri, J.N & Pals D.A (1993)

MAP OF OTHAYA DIVISION IN NYERI DISTRICT, KENYA



MAP OF NYERI DISTRICT : KENYA



MAP OF KENYA


Lokichogio
Mandera
Moyale
Lodwar
Marsabit
Wajir
Kitale
Maralal
Malaba
Bungoma
Eldoret
Busia
Kakamega
Meru
Garissa
Kisumu
Nakuru
Nyeri
Embu
Kericho
Muranga
Thika
Kisii
Narok
Nairobi
Isebania
Lamu
Namanga
Malindi
Taveta
Voi
Kilifi
Mombasa
Vanga

EGERTON
Tel: 051-
62276//9/62280/-4
Fax: 051- 62213
Ext: 3343



UNIVERSITY
P.O. Box 536
Njoro, Kenya

EMAIL: regadmin@egerton.ac.ke

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY AND COUNSELLING

TO WHOM IT MAY CONCERN

RE: GUIDANCE AND COUNSELLING STUDENTS' RESEARCH

The above programme is offered in our University at Master's level. In order to complete his study requirements he has to carry out a research. He is currently seeking place to do so and have found your institution a valuable place to enhance their learning.

I wish to introduce to you Mr. Joseph Kingori Wanyingi registration number EM16/0948/03 for your kind assistance in his study.

Topic: Assessment of HIV/AIDS Awareness Level and its Impact on Sexual Behaviour among secondary School Students. A Case of Olkaya Division of Nyeri District Kenya.

Please, accord him the help he may need in order to achieve this objective. While he is carrying out a research, he is familiar and bound by the ethical standards of collecting information, safeguard of the same, and using the findings pro-actively.

On behalf of the University, we wish you well and thank you for your partnership in the training of our students.

Sincerely,

CHAIRMAN
EGERTON UNI.
EDUC. PSY & COUN.
P.O. BOX 536 NJORO

Dr. M. Kariuki
Ag. CHAIRMAN, DEPARTMENT OF EDUCATIONAL, PSYCHOLOGY AND COUNSELLING.

For: Vice-Chancellor - Egerton University

Allowed to visit our Schools

Ext. M

21-7-05

EGERTON UNIVERSITY LIBRARY