

**THE LEVEL OF HIV/AIDS AWARENESS AMONG SECONDARY SCHOOL
STUDENTS AND THEIR PERCEPTION OF SELECTED KIPSIGIS CULTURAL
PRACTICES IN THE SPREAD OF HIV/AIDS IN BELGUT DIVISION, KERICHO
DISTRICT**

By

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EGERTON UNIVERSITY

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DECLARATION AND RECOMENDATION

DECLARATION

This Research Project Report is my original work and it has not been presented for a degree, diploma or other awards in this or any other university/institution.

Signature _____ Date _____

Harry K. Langat

RECOMMENDATION

This Research Project Report has been submitted for examination with my approval as a University Supervisor.

Supervisor

Signature _____ Date _____

Dr. Maurice O. Udoto

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DEDICATION

To my wife

Lena Langat

For her love for education, concern and patience over my study period the crown for this work is a true realisation for her long cherished dream.

ABSTRACT.

HIV/AIDS has continued to ravage the human population and Kenya has felt the brunt of the scourge. The situation has become more threatening as more youth are infected daily and others die. The upsurge of HIV/AIDS among school going youth is not only alarming but poses a serious threat to human resource development and economic growth of this country. The economy of a country depends on the productivity of its citizens. With a healthy population the country can realise economic growth since everyone will take part in production. The farms will be productive and those working in institutions like schools will maximise their man-hours accordingly and therefore finances directed to the right points of production. In Kenya with the advent of the HIV/AIDS a lot of man-hours have been lost, with the productive members being medically unfit to work. The finances meant for economic growth is now directed to medical care and support of the sick. This has also affected students in various ways, some lack school fees due to loss of parents to the pandemic; others remain at home to take care of the sick. Among the predisposing factors to HIV/AIDS infections are some cultural practices. The purpose of this study was to determine the level of awareness about HIV/AIDS among secondary school students and their perceptions towards selected cultural Kipsigis practices thought to predispose the community to HIV/AIDS. The population for this study will consist of 3,900 Form 3 secondary school students in Belgut Division from the Kipsigis community. They are purposely selected because of their knowledge of the Kipsigis cultural practices. The respondents were selected using stratified random sampling, stratified by gender in mixed schools. The respondents were then selected using simple random sampling to arrive at the required sample of 400 students (205 boys and 195 girls). The data was collected using self-administered questionnaires and interview schedules. The instruments were piloted in Ainamoi division to establish the reliability which should be above the required index of 0.70 in social sciences. The validity of the instruments was established with the help of five experts from the department of Educational Administration and planning. The independent variables to be studied will include cultural practices and belief systems; Circumcision, clitoridectomy, tattooing, dental extraction, wife inheritance, and polygamy. The findings of the study indicated that secondary school students are aware of the dangers of HIV/AIDS and prefer abstinence as a protection measure. These results are intended to sensitize the community on cultural practices which predisposes them to HIV/AIDS infections. It can also be useful to school administrators, policy makers and those in charge of guidance and counselling.

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LIST OF ABBREVIATIONS AND ACRONYMS

ADEA:	Association for the Development of Education in Africa.
AIDS:	Acquired Immune Deficiency Syndrome.
ARVS:	Anti-Retrovirals.
D.C:	District Commissioner
D.E.O:	District Education officer.
FGD:	Focus group Discussions.
FGM:	Female Genital Mutilation.
HIV:	Human Immune Deficiency Virus.
MOEST:	Ministry of Education Science and Technology.
NASCOP:	National AIDS and STD Control Programme.
STD:	Sexually Transmitted Disease
STI:	Sexually Transmitted Infection.
UNAIDS:	Joint United Nations Programme on AIDS.
UNICEF:	United Nations Children Education Fund.
VCT:	Voluntary Counselling and Testing.
WHO:	World Health Organization.
NACC:	National AIDS Control Council

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The world is facing a disaster of major proportions due to the relentless march of the fearsome Human Immune Deficiency Virus (HIV), which causes Acquired Immune Deficiency Syndrome (AIDS). Dortzback (1988) indicates that the mode of transmission in which the pandemic spread is through sexual contact among the youth and adults. Children may also get the disease at the time of birth from infected mothers. The other way to contract HIV virus is when fresh blood is transfused to uninfected person. Circumcision, dental extraction or surgeries are other modes of transmission particularly when one knife is used on a group without sterilizing it.

UNAIDS Report (2003) indicates that in sub-Saharan Africa 23.3 million people are HIV-positive and 13.7 million people have died of Aids. In Kenya, it is estimated that about 14% of all adults are HIV-infected. This means that 2.1 million Kenyans are infected and 1.1 million Kenyans have died of AIDS. Kenya has achieved some success in making information and services available to her people. ADEA (2003) reported that the level of HIV/AIDS awareness was over 90% in both rural and urban areas).

The social-economic impact of HIV/AIDS is devastating and it affects individual, families, communities, institutions and governments. One of the worst impacts of HIV/AIDS deaths to young adults is an increase in the number of orphans. It is estimated that there are about 860,000 orphans in Kenya today. ADEA (2003) projected the cost of HIV/AIDS in Kenya to 15% of GDP by the end of 2005. The main sectors of the economy that are worst hit by this pandemic include agriculture and education.

HIV/AIDS has taken an immense toll on Africa's teachers. HIV/AIDS increase attrition and absenteeism among teachers, managers, and students thus seriously threatening national and international education goals. HIV/AIDS erodes the educated workforce, and makes retention and recruitment of trained teachers a costly challenge. Teachers are often absent due to their own illness and the need to care for family members, or to attend to funerals. HIV/AIDS drains the

teacher's supply, impacts the quality of teaching, weakens access to higher learning and increases costs within an already struggling sector (Thube, 2003).

Thube (2003) further reports that teachers are of vital importance to the future of Kenyan Communities. It is imperative to assist teachers living with HIV/AIDS by giving them access to ARVS and strong social support so that they can continue with their work. Teachers are respected and they play a key role in HIV/AIDS prevention. They are able to capture the attention of students, parents, leaders and serve as role models to raise awareness and encourage behaviour change. Teachers living with HIV/AIDS who choose to reveal their status have the potential to profoundly influence behaviour change, and decrease stigma and discrimination associated with HIV/AIDS. Kenya lacks reliable data on the prevalence of HIV/AIDS among teachers and secondary school students, which could guide the design prevention care and support interventions. The impact of HIV/AIDS pandemic is devastating to Africa's economy, given that the majority of the infected population fall within the productive age of 15-49 years. Dortzback (1998) found out that most youths were having sex between the ages of 12 and 18 years and Thube (Ibid) said the average age of first sexual encounter was 14 years.

Aduda (2000) reported that "the impact of HIV/AIDS on education is alarming, with a total of 860,000 children in sub-Saharan Africa who went without teachers in 1999. Among these 195,000 were in Kenya followed by South Africa with 100,000. Other Countries that were also affected without teachers include: Zimbabwe with 86,000 pupils, Nigeria 85,000, Uganda 81,000.

Many classrooms have been closed in some parts of Kenya because pupils have dropped out of school as a result of death of their parents and teachers due to the HIV/AIDS scourge. MOEST (2000) cited HIV/AIDS as one of the causes which led to the drop in school enrolment from 96% to 87% and the annual death of teachers from 5,000 in the year 1999 to 8,000 at the end of the following year, 2000. It was noted that the huge resources normally used to purchase books or pay school fees was to be directed to paying for medicine for those infected leading to high rate of absenteeism and drop outs from school. Juma (2000) reported that primary school enrolment had dropped at least by five pupils in every class. In-fact there is now compelling evidence that the trend in HIV/AIDS infections will have a profound impact on future rates of child and maternal mortality, life expectancy and economic growth. Former U.S. President Bill Clinton in

an opening session of the African continent largest ever HIV/AIDS conference in Abuja Nigeria remarked that the disease had doubled mortality and reduced life expectancy by 20 years in some countries. Ouma (1999) said that life expectancy in Kenya had dropped from 59 years in 1989 to 49 years in 1999.

Brown (2000) estimated that by the year 2010, Africa is expected to have 40 million orphans as a result of death of parents caused by HIV/AIDS. Though the African extended family is resilient and capable of caring for orphans, it will be staggered by this challenge. Therefore, there is a high possibility of those orphans becoming street children because of the HIV/AIDS scourge. HIV/AIDS is claiming more females than males in Africa because of married men tend to have multiple partners before and after marriage. Brown (2000) and Nzioka (2001) both agree that females are exposed to sexual activities at a tender age by older males who are already infected.

Kenya, until 1990, was one of the African countries with a high population growth rate, but it is now threatened by HIV/AIDS. By 1999, the population was only 28.7 million against a projection of 30 million (Opalu, 2001). The decline was coupled with two factors; the decline in fertility and increase in HIV/AIDS related deaths (Bureau, 1971).

The Kenya government, on November 25th, 1999 declared HIV/AIDS a national disaster but there are still indications that we are not moving fast enough to mobilize and head off new infections. Kenya has continued to respond to challenges through several government and non-governmental programmes. Mungari (2001) said the programmes confirm varied approaches of addressing HIV/AIDS pandemic; that is through medical, political, religious and cultural spheres.

It is important to address the pandemic from a multi-disciplinary approach because it has been difficult to realize behaviour change among Kenyans. According to Terer (2000), matters of human sexuality are closely tied to traditional beliefs and cultural practices in the African context, which are themselves obstacles to behavioural change. Therefore, the cultural practices, belief system and customs in various ethnic communities promote the spread of HIV/AIDS.

The Kipsigis people of Kenya in Rift valley province inhabit three Districts: Kericho, Bureti and Bomet. They practise most of the African cultural beliefs and traditions. These cultural practices are circumcision, clitoridectomy, scarification, dental extraction, clean head hair shaving, polygamy, wife inheritance (levirate) and woman to woman ‘marriage’ (pseudo marriage). Dortzbach (1998) observed that some of these cultural practices and beliefs contribute to sickness and death through HIV/AIDS.

1.2 Statement of the Problem

Behaviour formation and modification among students is largely influenced by peer indulgence in sexual behaviour, which causes HIV/AIDS. During secondary schools heads’ conference in the year 2004, it was reported that despite the rigorous campaigns by schools, churches and other organizations against risky indulgence in unprotected sex, cases of STDs are still reported when students return back to school from their holidays. The presence of sexually transmitted diseases (STD), such as syphilis, herpes and chancroid increase the risk of HIV/AIDS infection. The big question is why is the pandemic spreading despite the awareness? Why is the rate of STD infection rising higher despite the campaigns? There is thus a need to study HIV/AIDS awareness among secondary school students and their perception towards selected Kipsigis cultural practices, and their contribution to the spread of HIV/AIDS. This study established secondary school students’ level of awareness of the HIV/AIDS and the risks posed by some of those cultural practices.

1.3. Purpose of Study

The purpose of this study was to establish the level of awareness of secondary school students about HIV/AIDS and their perception of selected Kipsigis cultural practices, which are likely to predispose them to pandemic.

1.4 Objectives of the Study

This study aimed to achieve the following objectives:

- (i) Investigate the level of HIV/AIDS awareness of secondary school students in Belgut Division, Kericho District.
- (ii) Identify the cultural practices that may promote the spread of HIV/AIDS among the Kipsigis community.
- (iii) Find out the perception of students towards selected Kipsigis cultural practices.
- (iv) Investigate the student's level of awareness of preventive measures used to curb the spread of the HIV/AIDS.
- (v) Find out sources of information on HIV/AIDS accessible to Secondary School students in Belgut Division.

1.5 Research Questions

- (i) What is the level of HIV/AIDS awareness among the Kipsigis students?
- (ii) Which cultural practices and beliefs are likely to promote the spread of HIV/AIDS among the Kipsigis people?
- (iii) What traditional Kipsigis taboos are still observed that may promote the spread of HIV/AIDS?
- (iv) Which preventive measures are preferred by students; and why?
- (v) Can sensitisation on the mode of HIV/AIDS transmission change the sexual habits among the Kipsigis people?

1.6 Significance of the Study

The findings of this study is expected to inform school managers of the calamities caused by of the HIV/AIDS scourge; and the Kipsigis society about some its cultural practices and belief system that promote the spread of HIV/AIDS and its impact on the education sector. The findings informs on the impact of HIV/AIDS campaign in school. The findings of the study are expected to assist educational administrators, parents and the entire Ministry of Education to combat Aids and its spread in Secondary schools. Appropriate campaign strategies may be implemented based on the findings of students' level of awareness of HIV/AIDS and knowledge of deeply rooted cultural practices that promote or inhibit the spread of HIV/AIDS among

secondary school students. This information is important in fighting the HIV/AIDS scourge. The application of knowledge offers the AIDS awareness campaign projects a better dimension in reducing the rate of HIV infections. The knowledge of the level of awareness of the learners is very important to school managers since it will give them a chance to guide and counsel with relative ease. It will also enable them to plan for the students with the knowledge that enrolment will remain stable or even know the likely variation in enrolment as a result of the pandemic.

By establishing the level of awareness among the students, school managers, guidance and counselling teachers and health educationists will find equilibrium of building upon the knowledge students have regarding HIV/AIDS. They will be able to choose and design life skills to inculcate in the students which will help the students respond to their sexual needs responsibly. It will enable policy makers to design the content and methods of integrating HIV/AIDS education into the curriculum; guide on the form of media to be used when disseminating HIV/AIDS information so as to reach as many youths as possible.

The findings will help students to make informed choices and decisions regarding initiation rites and sexual relationships. The boys will be expected to seek hygienic and safe methods of circumcision while the girls are expected to shun clitoridectomy.

The findings may also be useful to the Kenya government, non-governmental organization and parents in guiding and counselling the youth in schools, universities and churches on sexual behaviour so as to reduce the spread of AIDS. The Ministry of Health in conjunction with the Ministry of Education may find the study useful in imparting knowledge to students on the dangers posed through premature sexual behaviour so as to reduce the spread of AIDS.

1.7 Scope of the Study

The study concentrated primarily on HIV/AIDS awareness among secondary school students in Belgut Division of Kericho District. It specifically looked at form three students level of awareness regarding the transmission, effects and preventive measures of HIV/AIDS. The study also looked at Kipsigis cultural beliefs such as circumcision, clitoridectomy, dental extraction, pseudo marriage, polygamy, betrothal, elopement, tattooing, ear piercing and wife inheritance; and how they promoted the spread of the pandemic. The study also sought to establish the students' perception of Kipsigis belief system because belief systems impact directly on how we understand health and respond to illness.

1.8 Limitation of the Study

The research touches on a very sensitive matter; sexual habits of adolescent students. This is a subject where a number of respondents might have been tempted not to give honest responses for fear of losing their credibility and being stigmatized. However, a data-gathering instrument was validated to capture the needed information for the study. Anonymity was promised and sensitive questions were answered by use of self administered questionnaires. The other limitation was the secrecy which shrouds sexual matters among the Kipsigis. Sexual matters are never discussed in the open particularly between the youth and the elders. Therefore, factors such as age barrier might have come in between during the interview schedule.

1.9 Assumption of the Study

The researcher carried out the study with the following assumptions:

- (i) HIV/AIDS has affected the secondary school students in Belgut division, Kericho District.
- (ii) HIV/AIDS is a major hindrance to education and other aspects of development in the division.
- (iii) The respondents will be able to give honest and sincere responses to all items in the questionnaire.
- (iv) Cultural practices are still dominant in Kipsigis community.
- (v) Secondary school students are exposed to similar HIV/AIDS information/awareness activities.

1.10 Definition of Terms.

Clitoridectomy: In the Kipsigis community, this is a rite of passage which marks the transition from childhood to adulthood. A girl's clitoris is slit open; this is meant to inhibit her sexually drive. Girls were married off immediately after the rite.

Levirate: This is a cultural practice whereby a man is obliged to assume the conjugal responsibilities of his deceased brother's wife. An older brother or clan member of the deceased is usually a preferred choice to the widow. The chosen man is expected to take care of the widow and her children.

Prenatal Transmission: this is a situation where the mother passes or gives a condition to the infant. This occurs during pregnancy, labour or delivery.

Polygamy: It is a marital situation where a man marries more than one wife without losing the first one either through divorce or death. It is found in almost every African traditional society.

Pseudo Marriage: This is an unusual marriage where a married woman marries another woman. It happens when the former is unable to bear children or when all her children are girls. The later begets children who will be regarded as the formers.

Rites of Passage: These are rituals which are marked at birth, initiation, marriage and in death. The Kipsigis community observed all these rites, but the most significant was the initiation rite which marked the end of childhood and the onset of adulthood. The boys were circumcised while the girls underwent clitoridectomy. This rite is still observed in the contemporary Kipsigis community.

Level of Awareness: In this study, the level of awareness refers to the form three students of Belgut division in Kericho district understanding of HIV/AIDS; the nature of the disease, how it is spread, how it can be prevented, its effects and how it can be contained.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter gives a review of literature related to HIV/AIDS knowledge, cultural practices and sexual behaviours. The chapter will review literature on community and support mechanisms, students' risk of contracting HIV/AIDS, HIV/AIDS in Kenya, Kipsigis rites of Passage and cultural practices, HIV/AIDS effects on Education and the conceptual framework.

2.2 Community and Family Support Mechanisms

The majority of new HIV Infections are transmitted through unprotected sex. The presence of sexually transmitted diseases (STD), such as syphilis, herpes and chancroid increase the risk of infection. A significant number of Kenyan adults suffer from STD and may have a number of sexual partners. As a result of this most HIV infections are due to heterosexual contact. Programmes designed to slow the spread of HIV would need to focus on reducing transmission through sexual contact. There are however, other modes of transmission such as transfusion of infected blood, use of unsterilized surgical and skin piercing instruments like contaminated needles and syringes and exposure to other non sterile skin piercing instruments. It has also been proved that infected mothers can pass the virus to their unborn children during pregnancy (National AIDS and STD Control Programme, NASCOP, 1991).

2.3 Students Risk of Contracting HIV/AIDS

In the Countries now hard hit by HIV/AIDS, the extended family has traditionally been the source of support and care for orphans and other children needing special protection. In many Countries, it has become clear that the extended family is now overstretched and unable to provide its traditional level of protection and care for children deprived of family environment. In the body, HIV gets into the defensive system and knocks it out". It gets into the extended support system and decimates it according, Foster (1999). Bagnoud, (1999) noted that in Kenya, the extended family has been a social safety net for centuries that accommodated orphaned children but it is now collapsing under the strains of HIV/ AIDS.

The deterioration of family support begins with the immediate family of the person with HIV/AIDS. John Williamson in UNAIDS (2000) analyzed the situation of AIDS affected children and traced a pattern of weakening of the African family in the face of HIV/AIDS; he reported that when symptoms of HIV/AIDS appear, a bread winner or parent becomes increasingly ill and is unable to work. The combination of losing that person's income or daily household work and the financial burden of expensive medical treatments, including anti-retroviral drugs leads to problems of food insecurity and other resources for young children. Increased poverty in the household also means reduced access to health services for all members, not just the person or persons living with HIV/AIDS. He considers problems of inheritance of widows and children a common occurrence after deaths from HIV/AIDS. He also noted that psychosocial distress following the death in the family is exacerbated by stigmatisation on the part of the community and more distant relatives UNAID (2000). The situation of families affected by HIV/AIDS, as opposed to other conditions that result in orphans was described succinctly by WHO and the United Nations Children's Fund, that other epidemics and disasters also cause death on a large scale and leave orphaned children, but the pattern of HIV/AIDS is unique. UNICEF (1994) reported that HIV/ AIDS is a protracted problem, which does not allow the prospects of a return to normality.

Those who should be caring and providing for children and the elderly are the ones who are dying. In the communities hardest hit, there are fewer able-bodied adults to produce crops or income or to care for children, who are often pushed into poverty. The survival of those already poor becomes even more precarious. The problems are further exacerbated by the fear and stigma of AIDS which make other members of the Community unwilling to help (UNICEF, 1994).

Many of the Countries and communities hardest hit by HIV/AIDS in Sub-Saharan Africa have also suffered from war, natural disasters, extreme poverty and widespread corruption. By early 1990's, when the impact of HIV/AIDS began to be felt by the general population in most parts of Eastern and Southern Africa, community-level safety nets were already over stretched. It is not surprising that caring for children affected by AIDS poses a major challenge as noted by Fylkensnes (1994).

The number of orphans in countries with severe HIV/AIDS epidemic is already straining the ability of extended families and communities to absorb and provide for their needs. Gichuhi (1999) raises a number of questions such as: how much coping can be expected of families and communities? How much of the inevitable gap in support will be taken up by the state? what can the civil society, with the support of government and the international community do to help?

2.4 HIV/AIDS in Kenya

Young people are a high-risk group for contracting HIV/AIDS, particularly if they do not have regular access to appropriate and clear information on HIV transmission and safe sex, as is the case in most of Africa. Their risk is greater when they are out of school, impoverished on the streets or otherwise in circumstances that have been associated with the presence of HIV/AIDS in the family. The most contributory factor to the spread of HIV/AIDS among the youth are drugs and peer influence (Milimo, 1998).

Ayisi (1992) found out that every society observe variety of sexual practices. Some African societies regard sex as the most important factor in marriage and therefore a premium is placed on virginity. Girls to be married are expected to be virgins and are rewarded accordingly. The preservation of virginity among the Kipsigis was a great victory and honour. Boys would sleep with their sweet hearts without intercourse. In modern times virginity is rare and boy/girl friendships do not preserve their virginity; while promiscuous society has been stated to promote the spread of HIV/AIDS (K.I.E., 1999). Pristiany (1939) indicated that the mother of the girl who loses the virginity and conceives before initiation could not only have her marriage disgraced but also the baby would be killed by being choked to death before it draws in its first breath. Mbogoni (2001) reported that traditionally a virgin girl at her initiation was specially honoured. She would be allowed to dance before undergoing the rite of passage (clitoridectomy) and to hold in her hands the ceremonial tail, the flywhisk of the elders. Girls would preserve their virginity because they were trained on self-control and self-respect. The young men and girls were made to sleep together naked; the man lying on his left hand side and the girl on her right, the girl's legs between the legs of the man. No sexual intercourse was allowed to take place. Such closeness between a girl and a boy was meant to instil self control and prevented promiscuity and risk of contracting STDs.

Currently, most of these practices are dying out, while the youths have become more vulnerable to HIV/AIDS infections. The preservation of virginity has almost died out among the youth. Lovers are shy to take pre-marital HIV/AIDS tests, while young couples are avoiding church weddings for fear of having to face HIV tests. Mbogoni (2001) says a nervous flight has been triggered by regulations imposed by several churches requiring couples to be screened for HIV/AIDS before being allowed to tie the knot.

2.5 Kipsigis Rites of Passage

In Kenya, HIV/AIDS is a national disaster. An estimated 2.1 million adults and children live with HIV/AIDS, representing about 14 percent of the sexually active population. UNAIDS (2000) estimated that about 500 persons died daily of HIV/AIDS in the country in 1999. Many experts in Kenya now use the figure of 600 deaths or more per day. According to a U.S. census, Bureau projections indicate that by 2005, there would be about 820 deaths per day from HIV/AIDS in Kenya. About 75 percent of the deaths from HIV/AIDS in Kenya so far have occurred in adults aged 18 years to 45 years (NASCO, AIDS in Kenya). HIV/AIDS remains shrouded in denial and silence in much of Kenya, which complicates discussions on policy and legal measures to address the problem as well as the delivery of services to those affected.

HIV/AIDS has ravaged Kenya during a period of dramatic increases in the rate of poverty (defined as an income level less than U.S. one dollar per day). Today the number is about 15 million or about 52 percent of the population (GOK 2000). Nyanza province, which has the highest rate of HIV infection in the country of about 29 percent (NASCO, 2000) records the highest poverty rate of 63 percent, whereas in the early 1990s it was among the least poor regions.

HIV/AIDS has contributed to the economic downturn in several ways. The agricultural sector employs about half of the labour force in Kenya. In Nyanza province alone, HIV/AIDS has reduced the workforce on agricultural estates by an estimated 30 percent. The World Bank estimated that in 2000, an average co-operative society in Kenya paid the equivalent of 8 percent of its profit for HIV/AIDS related costs such as worker absenteeism and deaths (NASCO, 2000).

The average rural small-scale holder loses between 58 and 78 percent of its income following death from HIV/AIDS of an economically active adult (Future Groups International, 1999). The loss suffered by urban households is in the same range. The death of a second adult result in the loss of an estimated 116 to 167 percent of household income; that is, households incur debts, forcing them to liquidate assets, withdraw children from school or send children away to live with relatives (Ibid). Social services including those, on which children rely on, are greatly affected by HIV/AIDS in Kenya.

The Teachers Service Commission estimates a national shortage of about 14,000 teachers at the primary and secondary levels attributable in large parts of the Country to AIDS deaths. According to the Ministry of Education, a school in Kenya might easily have seven out of eighteen positions vacant because of attrition due to AIDS.

The care and treatment needs of a person with HIV/AIDS have overwhelmed health services in some parts of the country causing reduced access to services, including basic child health and survival services. A study conducted by K.I.E (1999) estimated that by the year 2000, expenditures made to care for HIV/AIDS patients in government health facilities would be about the equivalent of the entire 1993-94 Ministry of Health budget. It is only recently that due to pressure from non-governmental organizations, the government has begun to take measures to improve access to anti-retroviral drugs for the vast majority of persons with HIV/AIDS in the country for whom these drugs are unaffordable. In June 2001 there was stiff opposition by the pharmaceutical companies, when the Kenyan parliament passed Industrial Property Bill, which allowed the country to import and manufacture generic anti-retroviral drugs (Reuters, 2001). In addition, the Minister for finance announced that tariffs on imported condoms had been removed to accelerate the fight against HIV/AIDS.

Girls are especially affected by HIV/AIDS pandemic in Kenya. The rate of HIV/AIDS infection in girls and young women from 15 to 19 years old is about six times as high as that of their male counterparts in the most heavily affected region (NASCO, 2000). Although there are biological reasons why HIV transmission in this age group may be more efficient from male to female than in the opposite direction, biological reasons alone cannot account for a disparity this great. Several observers concluded that girls in this age group are getting infected with the virus from

older men, in many cases they engage in sex to survive economically. ADEA (2000) reported that one Kenyan girl out of five had her first sexual experience by coercion or force.

Girls are more readily pulled out of school when someone in the house is ill with HIV/AIDS, as has been noted in other African countries. The Ministry of Education figures show that after four years of primary school in heavily HIV/AIDS affected Nyanza Province, girls make up only six percent of those who are promoted to grade five. In Eastern province, which has the lowest HIV/AIDS prevalence in Kenya, 40 percent of those promoted to grade five are girls. The Permanent Secretary in the Ministry of Education attributed these disparities to HIV/AIDS (NASCOP AIDS, 2000).

2.6 Marriage Practices in the Kipsigis Community

The initiation rite of both boys and girls among the Kipsigis is mandatory. It is a stage in which one shifts from the status of a child to an adult. It marks the end of childhood and the onset of adulthood. During initiation, one is expected to discard all childish ways to learn and to control his/her feelings and to behave in a mature manner. The foreskin of the boy's penis is removed with a knife and while in seclusion, they are taught social values, which include how to raise children and how to handle sexual activities (Fish and Fish, 1995).

Mbiti (1975) states that 'initiation rite' is one of the main African social practices, which must be observed. The practices are highly treasured in traditional life. He agrees with Fish (1995) that circumcision involves cutting off the foreskin of the boy's male organ while clitoridectomy involves cutting some part of the girls' female organ. In both cases, blood is spilt and the operation is very painful, because no pain relieving herbs were used. Mugambi and Kirima (1976) state that the shedding of blood is often interpreted as a sacrifice to God, the spirits and the ancestors as a symbolic union with the living dead. Parrinder (1962) found out that the circumcision of boys and clitoridectomy on girls was done by qualified persons but NASCOP (1999) said the operation was crude and unhygienic.

Mulindi and Kimani (1997) stressed that various cultures should practice circumcision hygienically. They further emphasize that one who is circumcised in the hospital is not a lesser man and may have an advantage of avoiding HIV/AIDS infection. Female genital mutilation is a

practice that should be discarded. It not only has a life-long effect on the girl but it is also a high risk source of HIV/AIDS infection (NASCOP 1999).

The use of one knife in the rite when circumcising all the initiates signified togetherness and unity among the Kipsigis. The practice therefore, could be one of the modes of transmitting HIV/AIDS if one of the initiates is infected (NASCOP 1999). The practice in some areas is still prevalent. A girl who was a virgin at the time of her initiation was honoured. The inspection was done by a qualified woman before the operation. The practice encouraged youths to be morally accepted and respected in the Community. She was allowed to sit on a concave stool, which belonged to the father. After the operation, girls traditionally could spend as long as two or more years in seclusion. The main purpose of seclusion was to train women to be responsible. The reason of clitoridectomy was to reduce sexual desire, removing the clitoris. This enabled women to control their sexual urge and to remain faithful when their husbands were far away taking care of cattle; Kipsigis were pastoralists.

Ayisi (1992) observed that the practice of operation changes the status of the girls. The practice is common in East Africa, Northern Ghana and some parts of Nigeria. The initiation in its educational aspect helps the individual to learn about the traditions of the society and to understand his duties and privileges Ayisi observed that the female genital mutilation is still being practised amongst Nubian women. The practice still persists despite the campaigns to stop. He observed that the mutilation was meant to contain sexual desire. Ayisi further said that 100 to 132 million women in the world have undergone the rite while 6,000 girls in Africa are circumcised daily and 2,000 annually in Kenya alone. Statistics show that 75 percent of the population practised it.

2.6 Marriage Practices in the Kipsigis Community

The 'initiation rite' prepares one for marriage in the Kipsigis Community. Girls in particular would marry anytime after the completion of the puberty rite (Parrinder, 1962). HIV/AIDS experts have warned that married women are more vulnerable to AIDS infections compared to their single counterparts.

Mbiti (1975) stated several meanings and purposes of marriage: the obligation to bear children, a uniting link in the rhythm of life, the building of a family, new relationships between families, remembrance of parents after death, giving a status in society and that justifies multiple marriage. Marriage therefore, is a contract between lineage as between families, or husband and wife. The value of marriage is important if its virtues are kept, marriage can be a source of death if its tenets are not preserved. Donahne, J. & Hunter, S. (1999) stated that one of the modes of HIV/AIDS transmission is through sexual intercourse out of wedlock. If marriage principle of being faithful to a single partner were obeyed, then we would avoid the risk of infection.

However, the Kipsigis people do not believe in one partner. Roolreck, ((1982) reaffirms the fact that the Kalenjin society is a polygamous community. Pristiany (1939) observed that sexuality was not for pleasure among the Kipsigis for after birth; sexual intercourse would not take place before a year had elapsed that is, after the child had been weaned. The practice encouraged kipsigis men to be polygamists. Donahne, J. & Hunter, S. asserted that the practice encouraged extra marital sex, which promotes the spread of HIV, which causes AIDS (Donahne, J. & Hunter, S., 1999).

Marriage practices/customs, regulations on marriage in Africa culture, is at the centre of human life. It is associated with marriage customs which include methods of choosing the marriage partner, engagement, weddings, husband and wife relationships, the setting up of family relationships between the couple and other relatives, rules governing whom not to marry, and rules governing separation, divorce, inheritance and other aspects. Powell (2001) informs Kenyans to break away from taboos in order to fight HIV, which causes AIDS (Pristiany, 1964).

2.6.1 Betrothal in the Kipsigis Community

Fish and Fish (1995) found out that Kipsigis parents of both a boy and of a girl who were under age would agree on behalf of their children for marriage. A marriage ceremony was performed for their children, just the same as if they were adults. After each child had completed the initiation rites the two lived together (immediately) as if they had already been married. Roderic, (1982) established that men marry more than one wife among the Kipsigis community. Therefore, because of shortage of unmarried young women, some youths would look for younger girls as future wives. Girls under six years of age could be engaged. The practice is common among the kipsigis, but many have agreed that it can be of high risk since both women and men

were not screened for HIV before marriage and that polygamy should be discouraged in areas where it still persists. In certain cases, a girl could be married when she is very young, even before her breasts had developed and before circumcision. If it happened that a girl slept with a man before circumcision and become pregnant, she could be circumcised immediately, so that the child and her do not become outcasts (Snell, 1968).

2.6.2 Elopement Marriage in the Kipsigis Community

Fish and Fish (1995) acknowledged that elopement marriage among the Kipsigis was common. It would happen if the man had no dowry or was of a bad character. Elopement is practised in various communities including Gusii and the Luo. This occurred when a man lacked bride wealth. Elopement is a common way of initiating a marriage. Elopement, which is the act of establishing a union of cohabitation between a man, and unmarried woman that has not been legitimised by payment of bride wealth, was common among most Kipsigis men because a herd of cattle was not easy to come by. However, eloped women were at the mercy of their partners, and their position was insecure. Lack of legal sanctions; make cohabitation less tenable than legitimised marriages. The worst and the most deadly is that an infected man can elope with a partner who is free of HIV, and ends up infecting her (National AIDS Control Council [NACC], 2000).

2.6.3 Polygamy in the Kipsigis Community

Mbiti observed that polygamy is a custom found all over Africa. It is common among the Kipsigis people. It would be practised if the first wife had only daughters or no children, which follow without exception that the husband would add another wife, partly to remedy the immediate concern of childlessness and partly to remove the shame and anxiety of apparent unproductivity. Polygamy was used to prevent or reduce infidelity and male prostitutes on the part of the man. In such cases the husband was unlikely to keep concubines or go to female prostitutes. However, besides quarrels and fights among the wives and conflicts among the children, any form of polygamy can be a source of HIV/AIDS or sexually transmitted infections (Nyage 1997; Mbiti 1969).

2.6.4 Wife Inheritance in the Kipsigis Community

Fish and Fish (1995) noted that wife inheritance was a practice of a man taking over responsibilities for the care of the widow of his deceased brother and her children. He expressed

that no ceremony was connected with the practice. The appointed man did not own the widow, but would care for the children. Although a clan or family set up protects a lady from being owned by every person in the community, still she is not safe from HIV/AIDS scourge if the practice is not abandoned. The custom of inheriting the wife of a deceased brother is fairly common. Mungari (2001) on wife inheritance has been campaigning to stop widow rituals, the practice that is blamed for AIDS infection.

2.6.5 Pseudo Marriage in the Kipsigis Community

Mbiti, (1975) indicates that in the African societies, marrying several wives, inheriting the wife of a deceased brother (or husband of a deceased sister) or arranging for the wives of impotent or long-absent husbands to have children by close relatives or friends are practices commonly found among the Kipsigis. In the community, Kipsigis respect and accept a barren woman to 'marry' a woman or a young girl to produce children for her. The family would arrange for whoever was responsible as a biological father but the social father of the children is the woman who married the young lady. The main purpose of such unique, uncommon marriage was to ensure that nobody was left out of marriage or without children. These customs worked in their own way within the traditional Kipsigis set up, but such practices are high risk of HIV, which causes AIDS. The practice can be the best source of spreading HIV/AIDS since part or the married lady no longer sticks to the one man appointed by the family (Mbiti, 1975).

2.7 Marriage Taboos in the Kipsigis Community

There are many taboos and observations among the Kipsigis people. Fish and Fish, (1995) observed that a husband and wife were not to have sexual intercourse from the time she knew she was pregnant until about one year after birth of the baby, thus after its first hair cut. Such a taboo encourages infidelity among men, which promotes the spread of HIV/AIDS. Sharter and Onyanha (1998) confirm that a clean hair shaving with un-sterilized knives and razor blades on a group can lead to HIV infections.

It was also a taboo among the Kipsigis people for a widow to be married a second time by other persons apart from being inherited by the deceased person's brother. It is a taboo, which encouraged the spread of any sexually transmitted diseases. Adultery among the Kipsigis women was punishable. In some cases, the father of the woman who committed adultery was made to

pay a cow as atonement. Adultery on the other hand should be discouraged because it can cause the spread of HIV/AIDS (Pristiany, 1964).

Fish (1995) found out that it was taboo for a woman to touch the male sexual organ. It was punishable by divorce or a good material compensation. This taboo inhibits or hinders the woman from insisting that her sexual partner uses a condom during sexual intercourse. As a result the taboo enhances the spread of HIV/AIDS because it does not encourage protected sex. To date, Kipsigis men still believe that “touching male organ weakens the strength of erection or cause impotence”.

2.8 Removal of Teeth in the Kipsigis Community

Childhood is an important period of growth in every society and practices various rites of passage as part of growing up. Dental extraction is a childhood practice, which is a prerequisite to initiation. Fish and Fish (1995) stated that the removal of two lower centre teeth of a child was done in preparation of initiation among the Kipsigis to test courage and endurance. The other purpose is for passing liquid food in cases of fits. The practice was done by a traditional professional operator using a special knife. The practice would be for a good purpose but “the use of one knife” should be discarded lest it spreads the HIV/AIDS. If the practice must continue, then one knife per individual should be used to curb the spread of HIV/AIDS (Parrinder, 1975).

2.9 Ear-piercing in the Kipsigis Community

Among the Kipsigis community a child between ten and fifteen years of age could face East outside the house while his or her earlobes were pierced in preparation for initiation. Facing the “east” was meant to get the blessings from God whose power was equated with that of the Sun. Thus in every initiation god’s intervention was considered paramount. Ear piercing is still practiced in some areas of the Kipsigis community for beauty purposes. Amongst the Kipsigis community such rites were performed by specialist with the use of special knives for the functions for all the initiates. However scholars have criticised the use of un-sterilised instruments as the main mode for the spread of HIV/AIDS. (Fish & Fish, 1995)

2.10 Tattooing in the Kipsigis Community

Donahne, J. & Hunter, S. (1999) and Pristiany (1939) found out that girls made themselves more attractive to the young men by making marks around breasts, naval and loins. The marks are produced by piercing the skin with sharp objects on a number of girls by an expert. Since the girls were pierced in a group using the same sharp objects, the practice remains a risk because it enhances the spread of HIV/AIDS. The HIV/AIDS transmission mode is through blood contact or through the use of unsterilised piercing instruments on several batches of persons of a given age set (Toweet, 1979).

2.11 HIV/AIDS Effects on Education

The HIV/AIDS pandemic in essence affects the individual, the family, the immediate society and the country as a whole both socially and economically. The pandemic affects education in different ways, such as:

- The demand for education.
- The supply of education.
- The education process.
- The content of education.
- The role of education.
- The organisation of the school.
- The planning and management of the education system.

HIV/AIDS affect the demand for education because;

- Fewer children will attend school.
- Fewer children will afford education.
- Fewer children will be able to complete their education.

The negative impact of HIV/AIDS on enrolment and attendance is being felt in Kenya. In provinces especially Nyanza and some districts of coast province the number of children not attending school is already large. Despite the government providing free primary education the facilities are not put to full use. This decline in school participation is attributed mostly to poverty caused by HIV/AIDS infection. The disease has also caused an increase in the number of orphaned children leading to poor school enrolment. The primary reason for this is inability to

pay school levies. For some children this inability is HIV/AIDS related. It occurs because with HIV/AIDS in the family, either there was no more regular source of income or whatever income is forthcoming is diverted into treating the sick person. Due to death of parents, pupils stopped attending school because of lack of school fees and other necessities (K.I.E, 1999). Because of social and economic reasons more children will drop out of school before completion. It also seems likely that fewer children will want to be educated, partly because of the trauma's they have suffered through the experience of AIDS in their families, partly because they have to work to generate income for family support or are needed to care for the sick and younger siblings. Most of them have lost hope and see little value in education as a way of surmounting their problems.

HIV/AIDS has also had an impact on teachers, teaching and the supply of education. The pandemic affects the supply of education because of:

- The loss of trained teachers through mortality
- The reduced productivity of sick teachers
- The reduction in the systems ability to match supply and demand because of the loss through mortality or sickness of education officers, management personnel among others
- The closure of classes or schools because of population decline in the catchments areas hence a decline in enrolment.

There are at least four dimensions to the impact that HIV/AIDS is already having on teachers and education in Kenya; teacher's mortality, teacher's productivity, teaching cost and teacher stress. The pandemic affects the availability of both public and private resources for education. One international estimate is that because of HIV/AIDS, global economic growth is 1.4% lower than it would otherwise have been (UNAIDS, 2000). The adverse economic impact would be due to decreased revenues and increased costs. Absenteeism due to illness, time off for funerals, times spent on training and a less experienced labour force would result in reduced productivity and hence in lower revenues. Spending on health care costs, burial expenses, retrenchment and training of replacement employees would tend to increase costs (K.I.E, 1999).

The impact on economic growth is being felt because what should be directed to other sub-sectors of the economy is now going to the treatment of the pandemic. Recent evaluations show

that Kenya without unprecedented infusion of foreign aid, national income could be reduced by as much as ten percent. The impact of the disease on other economies is severe. One implication of this is that with public resources being smaller than they would have been in AIDS free circumstances less would be available for national spending in education as in other sectors (Shueffer, 1999).

There are also the effects on health budgets and the possibility that even though economic growth is being retarded, health budget may have to increase if it is to cope with the disease. This increasing expenditure on AIDS care will not only divert spending from other important health care needs, but also threaten efforts to protect expenditure in sectors like education. At the social level and family unit level, AIDS sickness and mortality strike disproportionately at the working population. Deprived of the breadwinners, households are left without the resources to pay school fees and to meet the many educational needs of their children. With the households resources greatly reduced many have resorted to traditional healing, local medicine, special diets and cleansing drugs to AIDS infected persons to the detriment of what might have been spent on meeting the education cost of children and especially the girl child. The girls in most cases drop out of school to take care of the sick parents and younger siblings. AIDS reports show that the infected are so weakened through poverty, hunger and sickness that they are unable to participate in self-help activities in the society. Reports also indicate that those who are strong and healthy cannot participate in such activities effectively because so much of their time is used in caring for those who are;

HIV/AIDS affects the potential clientele for education because of;

- The rapid growth in the number of orphans.
- The massive strain, which orphan hood problem, is placing on the extended family and the public welfare services.
- Increase in the number of street children.
- The need for children who are heading households, orphans, girls and street children to undertake income-generating activities.

The growth in the number of HIV/AIDS orphans is taxing the coping strategies of families and society at large. In many cases the extended family is finding it difficult to cope economically and psychologically with the numbers it is required to cater for. Few orphans are able to pay their

school or training fees. Many have to care for others in their homes where they live. Many have to work to support themselves and younger siblings dependent upon them. Many carry responsibilities well beyond their capabilities as children. Some are so traumatised by what they experience when a member of the family dies of Aids such that they cannot learn. A significant number are at risk of contracting HIV/AIDS through income generating activities such as prostitution and most are excluded from the joy of a normal childhood. Economically and psychologically they have needs, which the school must necessarily respond to (Mungari, 2004).

The number of street children is increasing rapidly due to poverty and family disintegration. This is mainly as a result of death and divorce, which is a major factor leading to children being in the street. The family structure that would have supported them has collapsed because of HIV/AIDS leaving them with no choice but to have resources from the street to support them. Their counterparts in the rural areas are children who do not attend school because AIDS care has absorbed the meagre family resources leaving nothing for school fees. It could also be because they are engaged in household chores, caring for the sick or the children herding cattle or other roles that can no longer be undertaken by infected adults (World Bank, 2000).

2.12 Conceptual Framework

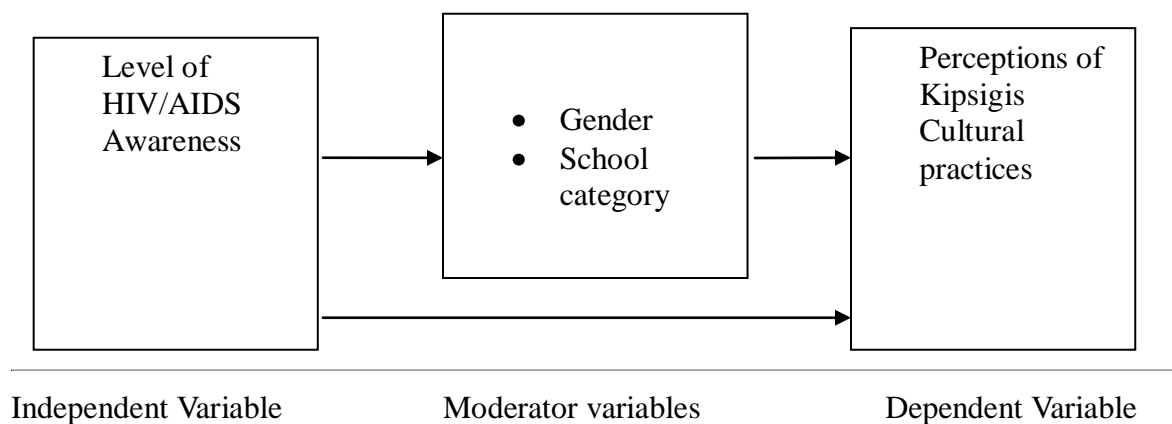


Figure 1.

Interaction between variables.

Figure 1 shows that gender and school category is the moderating variables of the study while HIV/AIDS awareness is the independent variable and the perception of Kipsigis cultural practices is the dependent variable. Increased level of HIV/AIDS awareness may influence the perception of the Kipsigis cultural practices by gender or school category.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The Chapter will discuss the research design, the target population, sample and sampling procedures, research instruments, data collection procedures and data analysis techniques.

3.2 Research Design

The study used descriptive survey research Design in order to gather the relevant information. According to Mugenda and Mugenda (1999) survey research is a self-report study, which requires the collection of quantifiable information from the sample. Survey research will be preferred to other methods for it seeks to obtain information that describes existing phenomena by asking individuals about their behaviour or values. This method will be used to explore the existing HIV/AIDS knowledge status of three variables: knowledge, sexual behaviour and cultural practices.

3.3 Location of the Study

This study was carried out in Belgut constituency of Kericho District. The constituency has three divisions; Belgut, Sigowet and Kabianga. It is located west of Kericho town but sandwiched between Roret division and Ainamoi divisions. Belgut is the most populated among the three constituencies of Kericho District. The main agricultural cash crops are tea and coffee, while maize is both a cash and subsistence crop. The constituency has four tea factories and dairy farming is another key economic activity.

3.4 Target Population

Belgut Division has 21 secondary schools with a population of 8400. The target population was 4223 form three Kipsigis students between the ages of 15 to 18 years. They were randomly selected from two purely boys' schools with a population of 1000, two purely girls' schools with a population of 1343 and 17 mixed schools with a population of 1880.

3.5 Sampling Procedures and Sample Size

According to the latest list obtained from Kericho District Education office, there were 78 secondary schools in the District of which ten of these schools were private. Random sampling

was used in the selection of the ten schools so that each school had an equal chance of being included in the study. Care was taken to include different categories of schools in terms of sex of the pupils, their sizes and whether they were day or boarding. The researcher adopted a cluster sampling approach when selecting girls and boys' schools. Purposive sampling was used to select students from the Kipsigis community because they understand the cultural practices carried out by the community. Stratified random sampling was used to select respondents (stratified by gender) so as to give equal chances to both groups (Mugenda & Mugenda, 1999). Finally the respondents were selected using simple random sampling for inclusion in the study. The researcher concentrated only in form three students. Form four students were not selected because they were preparing for National Examinations. Form 1 and 2 students were excluded in the study because most of them are still under age to comprehend some questions in the questionnaire. The ten schools were randomly selected from 22 schools in the division. Out of the ten selected schools two were boys schools boarding, two girls boarding schools with a population of 1343 and 1000 respectively. The remaining eight are mixed schools with a population of 1880 (1200 boys and 680 girls).

Table 1 gives the proportions of the respondents by gender. There were 205 male students which represented 51.3% while the female students were 195 represented 48.7%.

Table 1.

Gender Proportions of Respondents

		Frequency	Percent
Valid	Boys	205	51.3
	Girls	195	48.7
	Total	400	100.0

Table 2 indicates the proportions of students from each school category who responded to the questionnaires. 66.5% were from boarding schools, 6.8% were from day schools and 26.8% were from mixed day and boarding schools.

Table 2.

School category

		Frequency	Percent
Valid	Boarding	266	66.5
	Day	27	6.8
	D/B	107	26.8
	Total	400	100.0

3.6 Instrumentation

In order to test reliability of the instrument, six schools in Ainamoi Division of Kericho District were used to carry out the pilot study. The study used self-administered questionnaires as the main instruments of data collection and an interview schedule. The questionnaire consisted of both structured and unstructured questions. There were 49 items classified into individual characteristics, HIV/AIDS awareness, condom use, Sexual behaviour and cultural practices.

3.6.1 Validity

The validation of the instruments was done with the help of education experts in the department of educational Administration Planning and Economics. This was done to ascertain both content and face validity.

3.6.2 Reliability

In order to test reliability of the instruments, six schools in Ainamoi Division of Kericho District were used to carry out the pilot study. The results of the pilot study assisted the researcher to fine-tune the instruments in order to clarify unclear instructions. The study used self-administered questionnaire as the main instrument of data collection and an interview schedule. The questionnaire consisted of both structured and unstructured questions. There were 49 items classified into individual characteristics, HIV/AIDS awareness, condom use, sexual behaviour and cultural practices.

3.7 Data Collection Procedures

The researcher sought for permission from Ministry of Education science and Technology. Introduction letters to heads of schools was got from the District Education officer. Data was collected using self-administered questionnaire and an interview schedule. The instruments were administered by the researcher himself.

3.8 Data Analysis

Data collected was analysed descriptively using percentages and frequency tables. The researcher used descriptive statistics, which measures central tendency. These measures of central tendency enabled the researcher to establish the level of awareness and also the perception of the role of the cultural practices in the spread of the scourge amongst secondary school students. The collected data was coded and keyed into the computer and the analysis was done with the assistance of a computer program, Statistical Package for Social Science (SPSS) research. Table 3 show the research questions and how they were analysed.

Table 3.

Research Questions and how they were Analyzed.

Research questions	Analysis procedure
i. What is the level of HIV/AIDS awareness among the kipsigis students?	Frequencies and percentages
ii. What cultural practices and belief systems may promote the spread of HIV/AIDS among the kipsigis people?	Frequencies and percentages
iii. What traditional kipsigis taboos are still practiced that may promote the spread of HIV/AIDS?	Frequencies and percentages
iv. Which preventive measures are preferred by students and why?	Frequencies and percentages
v. Can sensitisation on the mode of HIV/AIDS transmission change the behaviour pattern among the kipsigis people?	Frequencies and percentages

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introductions

In the chapter the findings of the study is presented by use of descriptive statistics, tables and a brief discussion. The results are presented in the order in which the research questions are stated. Frequencies and percentages is used to describe the findings.

4.2 Results

Objective one wanted to investigate the level of HIV/AIDS awareness of secondary school students in Belgut Division, Kericho District. This was achieved with the help of the following questions.

What is the level of HIV/AIDS awareness among the Kipsigis students?

Table 4 indicate the age level at which students were first exposed to sexual activity. The results indicate that the students got to know of sex from as early as ten years and the majority of them got inform during the adolescent period (at the age of 11-15 years).

Table 4.
Age of First Sexual Encounter

		Frequency	Percent
Valid	10 years and below	52	13.0
	11-15 years	106	26.5
	16-20 years	41	10.3
	Over 21 years	7	1.8
	Never	101	25.3
	Total	307	76.8
	No response	93	23.3
Total		400	100.0

The results in table 4 indicate that 16.9% of the respondents had sex before their 10th birthday and 51.5% before the age of 15. This is an indication that children get exposed in sex in their tender age even before they are aware of the dangers involved in the activity.

Table 5 gives the sources of information about protective sex particularly the use of the condom. This information is critical to the students for purposes of avoiding infection and the way it is given and the person giving information has to be well informed. If the information were provided wrongly we would not win the war against the pandemic.

Table 5.
Sources of Information about the Condom

		Frequency	Percent
Valid	Parents/Guardians/ Relatives	13	3.3
	Teachers	17	4.3
	Media	294	73.5
	Doctors	12	3.0
	Friends	52	13.0
	Total	388	97.0
	No Response	12	3.0
Total		400	100.0

The results in table 5 indicate that students get their information from the media (73.5%) followed by the friends (13%) while teachers, parents and doctors each contributed less than 4%. These results indicate that students get information about sex from the media and their peers. Such a scenario could result in student having misconceptions that in turn make them experiment hence the danger of infections increases.

Table 6 gives the proportions of those students who understand about AIDS and whether they think it can be cured. This will indicate the position of the students on how well informed they are about AIDS. If they understand that AIDS is incurable then they would be in the best position to avoid infection however if they think the disease is curable then they are at a higher risk since they would think they could be treated.

Table 6.
Can HIV/AIDS be cured?

		Frequency	Percent
Valid	Yes	26	6.5
	No	344	86.0
	Don't Know	11	2.8
	Total	381	95.3
	No Response	19	4.8
Total		400	100.0

86% of the students indicated that AIDS has no cure, 6.5% say there is a cure and only 2.8% did not know whether there is a cure. This is an indication that the majority of the students are aware that AIDS is a terminal disease. This high degree of awareness put the students in a better position in protecting themselves against infections.

Table 7 is a confirmation of the results in table 6, the fact that there is no cure for AIDS means that there is nobody who can cure the disease. From the two tables it is clear that the majority of the students are aware that there is no cure for AIDS and therefore they are in a position to avoid the disease by all means.

Table 7.
Who can cure HIV/AIDS?

	Frequency	Percent
Doctor	3	.8
Herbalist	8	2.0
Prayers	47	11.8
All The Above	1	.3
No Cure	341	85.3
Total	400	100.0

The findings in table 5 indicate that the majority students (85%) know that there is no one who can cure AIDS. Only 11.8% believe that prayer and 2% by herbalist can cure it.

Table 8 gives the proportions of the likelihood of a student to get infected. These responses gives a chance for a learner to evaluate his position based on his/her behaviour before giving the answer. This can also make them think of reforming if their behaviour is risky and hence think of ways of protecting themselves.

Table 8.
Do you think you can get HIV/AIDS?

		Frequency	Percent
Valid	Yes	137	34.3
	No	223	55.8
	Don't Know	30	7.5
	Total	390	97.5
	No Response	10	2.5
Total		400	100.0

The findings in table 8 indicate that 137 (34.3%) say that they cannot get AIDS, 223 (55.8%) indicate that they cannot get infected and 30 (7.5%) are uncertain while 10 (2.5%) of the students did not give their opinion. The students gave various reasons for their answers, which are shown in table 9. The results give the various reasons why one can or cannot get infected.

Table 9.
Why do you think you can/cannot get HIV/AIDS?

		Frequency	Percent
Valid	Abstain	144	36.0
	Be Faithful To One Partner	33	8.3
	If I Get Involved With Many Partners	50	12.5
	Everyone is Vulnerable	92	23.0
	I Protect Myself	57	14.3
	Total	376	94.0
	No Response	24	6.0
Total	400	100.0	

The results indicate that those who say cannot get infected are because 36% abstain, 8.3% are faithful to their partners and 14.3% use protection. Those who say can be infected gave the following reasons; 12.5% if they get involved with many partners and 23% say that everyone is vulnerable with some citing accidents and un-sterilised needles as the likely causes.

Table 10 gives the proportion of students who are willing to establish their HIV status. This proportion can be an indicator as to how many students are in a position to take control of their lives. The knowledge of ones status can make one take precautions and live an HIV/AIDS free life and if infected live positively with virus.

Table10.
Will you go for VCT?

		Frequency	Percent
Valid	Yes	308	77.0
	No	48	12.0
	Not Sure	39	9.8
	Total	395	98.8
	No Response	5	1.3
Total		400	100.0

77% of the respondents indicated readiness to go for an HIV test and 12% indicated that they are not ready and only 9.8% were not sure whether they could go for an HIV test. The 77% who are willing is an indication that secondary school students are aware of the consequences of the disease and are willing to get a solution to this problem.

Table 11 will give the proportions of students who if they were to take an HIV test, they would be willing to know the results. The findings give the no of students who were willing to face the situation they could find themselves in.

Table 11.
Would You Like to Know the Results?

		Frequency	Percent
Valid	Yes	319	79.8
	No	46	11.5
	Not Sure	27	6.8
	Total	392	98.0
	No Response	8	2.0
Total		400	100.0

79.8% of the respondents indicated that they will be willing to know the results, 11% are not willing and 6.8% were undecided and only 2% did not indicate their opinion. The results indicate that that the majority of the students were willing to know their status and face the future with it.

Table 12 is trying to establish the kind of reaction they would expect should the results come out and are HIV positive. The various reactions are discussed after the table.

Table 12.
What would you do if the results were positive?

		Frequency	Percent
Valid	Commit suicide	26	6.5
	Tell my family	204	51.0
	Tell my friends	4	1.0
	Announce publicly	54	13.5
	Keep quite	66	16.5
	Be more promiscuous and Spread	28	7.0
	Seek advice	6	1.5
	Total	388	97.0
	No response	12	3.0
Total		400	100.0

6.5% indicated they would commit suicide if found to be HIV positive, 51% are willing to inform family members, 1% will inform their friends, 13.5% will announce publicly, 1.5% are willing to seek advice if found to be HIV positive and 7% indicated that they will be promiscuous and spread the disease. This last group is the most dangerous group because they will compromise the lives of others.

Table 13 provide information as to how many partners the students have had. The purpose is to give the picture as to how many students have exposed themselves to risky behaviour patterns.

Table 13.
How many partners have you had in the past?

		Frequency	Percent
Valid	One	93	23.3
	2 or more	98	24.5
	Non	170	42.5
	Total	361	90.3
	No response	39	9.8
Total		400	100.0

23.3% indicated that they had a single partner in the past, 24.5% had more than 2 partners and 42.5 had no partner. From the results it is indicated that only 24.5% are engaged in multiple partners hence at a higher risk of infections.

Table 14 is trying to establish whether the behaviour pattern in table 13 is still persisting. It is however indicated that the risky group of multiple partners has dropped from 24.5% to 15.8%.

Table 14.
How many partners do you have now?

		Frequency	Percent
Valid	One	119	29.8
	2 or more	63	15.8
	Non	176	44.0
	Total	358	89.5
	No response	42	10.5
Total		400	100.0

At the present time 29.8% have a single regular partner but the number with multiple partners dropped to 15.8% and those without partners increased to 44%. This is an indication that the students are trying to avoid risky behaviours, which may lead to HIV/AIDS infection. From the

above results there is an indication that a greater percentage of secondary school children are aware of the dangers of HIV/AIDS. The results indicate that the learners are well informed of the mode of transmission, the risk behaviours and the modes of protection against the pandemic.

From the research results it is clear that majority of the learners are aware about the problem of HIV/AIDS. They are well informed of the pandemic and the consequences that result when an individual is infected. Whether HIV/AIDS incidence rises or falls in the future does not fundamentally change the understanding that the disease poses grave health and developmental problems in Kenya. Although the HIV/AIDS impact is difficult to measure, the effect can be seen in society where orphans no longer go to school because there is no one to meet the school requirements. There is increasing poverty in society where most people live below the bread line, increasing influx of street families among other social problems. Having the above scenario the school odd to take up its role of education the children and the society about the pandemic and lead from the front by showing positive values that help an individual to respect and protect himself or herself from the scourge.

Objective two was meant to identify the cultural practices that may promote the spread of HIV/AIDS among the Kipsigis community. This was realised by the help of the following questions.

What cultural practices and belief system may promote the spread of HIV/AIDS among the Kipsigis people?

Table 15 gives the various cultural practices among the kipsigis people. It also gives the effects it has on HIV/AIDS infections. The responses expected here is whether the effect of the practice is major, minor or it has no effect.

Table 15.
Cultural practices

Practices	IS IT		EFFECT ON HIV/AIDS INFECTION			
	YES	NO	MAJOR EFFECT	MINOR EFFECT	NO EFFECT	MISSING
Circumcision	100%	0%	66.7%	33.3%		
Clitoridectomy	100%	0%	44.4%	22.2%		33.3%
Dental Extraction	44.4%	22.2%	11.1%	11.1%	33.3%	44.4%
Scarification	11.1%	22.2%		33.3%	33.3%	33.3%
Wife Inheritance	55.6%	11.1%	44.4%	22.2%		33.3%
Ear Piercing	44.4%	22.2%	22.2%	11.1%	22.2%	44.4%
Epiglottis				11.1%	33.3%	55.6%
Surrogate					33.3%	66.7%
Traditional Midwifery	22.2%	77.8%		55.6%	33.3%	11.3%
Clean hair Shaving				11.1%	44.4%	44.4%

Results from Table 14 indicate that majority of the learners know the practices that are factors in the spread of HIV/AIDS. 66.7% indicate that circumcision has a major effect in HIV infection. 44.4% indicated that clitoridectomy and wife inheritance are the other two major avenues of infection.

From the findings of this study, the respondents indicated that both male and female circumcision had an influence in the transmission of HIV/AIDS. While not traditionally

considered a background characteristic, male circumcision may be an important factor affecting HIV/AIDS transmission and acquisition in a population. There is substantial evidence suggesting that male circumcision is a preventive measure against HIV/AIDS. Circumcision is believed to reduce the risk of ulcerative STDs (Bailey, 2001). An analysis of studies examining the relationship between male circumcision and the risk for HIV/AIDS infection among males in sub-Saharan Africa concluded that uncircumcised men are twice likely to be infected as compared to circumcised males.

Objective three was to find out the perception of students towards selected Kipsigis cultural practices.

What traditional Kipsigis taboos are still practiced that may promote the spread of HIV/AIDS?

Table 16 is giving the opinion of the students as to whether the taboo of touching the male sex organ is a taboo.

**Table 16.
Touching Male Sex Organ**

		Frequency	Percent
Valid	Yes	2	22.2
	No	7	77.8
	Total	9	100.0

Only 2 groups (22.2%) of the 9 groups interviewed concluded that this taboo of touching a male sex organ still holds while 7 groups (77.8) think the taboo is no longer observed. The responses to this question were very low. This could be explained by the fact that students may not know that there is such a taboo since most taboos are no longer tenable. Table 17 was meant to establish whether this taboo of touching male sex organ could influence the effectiveness of the condom.

Table 17.
Does the Taboo of Touching Male Sex Organ make Condom Use a Failure?

		Frequency	Percent
Valid	No	2	22.2
	No response	7	77.8
Total		9	100.0

22.2% of the groups think that the taboo of touching male organ does render the condom use a failure while 77.8% did not give their opinion possibly because they were lacking the necessary background information on the subject.

Table 18 and table 19 are addressing the taboo of a man not sleeping with a wife until a baby is weaned and how a man met his sexual needs. This taboo was functional in the traditional society since most men were polygamous.

Table 18.
Restricting a Man from Sleeping With the Wife Until the Child Is Weaned

		Frequency	Percent
Valid	Yes	2	22.2
	No	7	77.8
Total		9	100.0

Table 19.
How do men meet their sexual needs?

		Frequency	Percent
Valid	Cheat	1	11.1
	Faithful	1	11.1
	Total	2	22.2
	No response	7	77.8
Total		9	100.0

22.2% of the groups interviewed concluded that it is a taboo for a man to sleep with the wife until the child is weaned while 77.8% did not respond. It is indicative that the students did not give their view because they do not know the taboo maybe because it is no longer tenable in the society.

Table 20 is addressing whether the practice is practical even to the women. 33.3% indicated that this is not practical however 11.1 think that the taboo is practical. A majority of the students (55.6%) did not give their opinion.

Table 20.
How practicable is this among the women?

		Frequency	Percent
Valid	Yes	1	11.1
	No	3	33.3
	Total	4	44.4
	No response	5	55.6
Total		9	100.0

The results indicate that the majority of the groups concluded the practice is no longer tenable among the Kipsigis community.

From the findings of this study there were two major taboos that were considered. One was the taboo of touching a male organ and whether it affected the condom use. The respondents reported that the taboo did not render the use of a condom useless because the man can still put

on a condom without the lady touching the organ. However it should be noted that the failure could only arise in a situation where the male did not want to use a condom and therefore can pretend to put it on but remove hence compromising their safety. The other taboo was whether the man stays away from the wife until the child is weaned. Even though few respondents gave their opinion, the few indicated that the practice is no longer tenable within the Kipsigis community.

Objective four was to investigate the student’s level of awareness of preventive measures used to curb the spread of the HIV/AIDS.

Which preventive measures are preferred by students and why?

Table 21 gives the various ways in which students protect themselves from infections. The various ways in which one can protect himself include condom use, abstinence, or being faithful to one partner amongst others.

Table 21.
What should students do to protect themselves from infection?

		Frequency	Percent
Valid	Use a condom	27	6.8
	Abstain	330	82.5
	Be faithful to one Partner	13	3.3
	Avoid sharing sharp Objects	18	4.5
	Total	388	97.0
	No response	12	3.0
	Total	400	100.0

82.5% of the respondents indicated that the best way to avoid getting infected with HIV/AIDS is to abstain from sex. 6.8% indicated that they could protect themselves using a condom while

4.5% said they could avoid contracting the disease by avoiding sharing sharp objects with others. Only 3.3% said they could avoid infection by being faithful to a single partner.

Table 22 is trying to get information as to whether the students use the condom to protect themselves from infection. The other reason for using a condom is to prevent pregnancy or just experimenting.

Table 22.
Why do you use a condom?

		Frequency	Percent
Valid	To avoid infections and Pregnancy	262	75.3
	Avoid pregnancy	49	12.3
	Experiment	5	1.3
	Total	355	88.8
	No response	45	11.3
Total		400	100.0

Majority of the respondents indicated that they are using a condom purposely to protect themselves from infection and to avoid getting pregnant (75.3%). 12.3% use it purposely as a contraceptive to avoid getting pregnant and only 1.3% used for experimentation while 11.3% did not give their opinion.

Table 23 is trying to get information on what they think students should do to avoid HIV/AIDS infections. This can give information on the feeling of the students as to how they should be assisted as concern sexual matters.

Table 23.
What advice do you give to secondary school students to avoid infections?

		Frequency	Percent
Valid	Education on safe sex and Abstinence	198	49.5
	Guidance and counselling	79	19.8
	Introduce aids Programmes in schools	36	9.0
	Set up single sex schools	36	9.0
	Testing and isolating the Infected	13	3.3
	Total	362	90.5
	No response	38	9.5
Total		400	100.0

Majority of the respondents recommended that schools should come up with sex education programmes (49.5%) to teach learners about safe sex and inform them of the dangers involved in the activity of pre-marital sex. 19.8% recommended for guidance and counselling of students as a first step in the fight against the pandemic. Only 9% recommended for the establishment of single sex schools to avoid situations where learners are tempted into experimenting/trying out sexual activities with their fellow students. Only 3.3% recommended for testing and isolating victims to avoid situations where promiscuity is used as a way of spreading the disease.

Can sensitisation on the mode of HIV/AIDS transmission change the behaviour pattern among the Kipsigis people?

Sensitisation plays a big role in reducing the spread of HIV/AIDS. Awareness can work to reduce the likelihood of infections by developing values and attitudes that say yes to life and no to premature, casual or socially unacceptable sex and sexual exploitation.

What underlying belief system make the Kipsigis people adhere to some cultural practices?

The following misconceptions among the Kipsigis should be discarded, as they are known to Spread HIV/AIDS:

- i. The belief that the use of one knife during circumcision will unify the initiates.

- ii. The belief that multiple marriages will bring new relationships between families and give status to the society by increasing the members.
- iii. The belief that a barren woman can perpetuate her lineage by marrying another woman.
- iv. The belief that widows should be inherited by close relatives for social and economic wellbeing of their families.

Inheritance of widows and children is a common occurrence after death of husbands from HIV/AIDS. It has been noted that psychosocial distress following death in the family is exacerbated by stigmatisation of the bereaved by the community and more so by relatives (UNAIDS, 2000).

CHAPTER FIVE

SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND IMPLICATIONS

5.1 Introduction

This chapter contains a summary of the major findings and conclusions from the study of the level of HIV/Aids awareness and the role played by cultural practices in the spread of the pandemic to educators, researchers and policy makers.

5.2 Summary

From the findings, the researcher found out that the level of HIV/AIDS awareness among the Kipsigis students of Belgut Division is high. Their responses indicated that cultural practices such as circumcision, clitoridectomy and wife inheritance among the Kipsigis contribute significantly to the spread of HIV/AIDS and that taboos are no longer tenable.

The researcher also found out that the majority of the students opted for abstinence in the prevention of the pandemic because there is no cost incurred, the use of condoms is not 100% safe and due to the lack of trust in their partners.

However, the researcher noted that sensitisation plays a big role in reducing the spread of HIV/AIDS. Awareness can work to reduce the likelihood of infections by developing values and attributes that say yes to life and no to premature, casual or socially unacceptable sex and sexual exploitation.

The researcher found out that some beliefs among the Kipsigis should be discarded, as they are known to spread HIV/AIDS. These are: the beliefs that the use of one knife during circumcision will unify the initiates, that multiple marriages will bring new relationships between families and give status the society by increasing the members, that a barren woman can perpetuate her lineage by marrying another woman and that widows should be inherited by close relatives of their husbands for social and economic well being of the family.

5.3 Conclusions

The high level of HIV/AIDS awareness among students is an indication that the inclusion of HIV/AIDS lessons in the school curriculum has had positive impact. Education can do the

following to mitigate the impact of HIV/AIDS. There are three levels where HIV/AIDS related interventions are needed:

- i. When the individual is still free of HIV/AIDS.
- ii. When the individual has become infected and eventually suffer from AIDS related illness.
- iii. When HIV/AIDS has resulted in death.

In the first case, the objective is to preserve one's self from infection. In the second case the major objective is to live positively and productively; and in the third case the objective is for the family members to adjust to the changed psychosocial and economic circumstances occasioned by the death.

HIV/AIDS impact negatively on educational planning and management. The development of education sector is a demanding activity which requires the ministry of education to be firmly in charge of policies on strategic implementation at all times. This is a challenge, more so when there is a risk that HIV/AIDS may decimate key human resources. To minimise its impact on the ministry's activities key, aims should be put in place to prevent further HIV/AIDS infections in the work force and to help those already infected to live positively. While the ministry must show double concern for the students, teachers and those working in schools and colleges, it should be equally diligent to extend similar concern on its own immediate staff- senior officials as well as other employees in finance, planning and personnel divisions. All these personnel are at risk and they stand in need of the ministries guidelines and directives that will strengthen their determination to avoid HIV infection and that will enable them to live and function positively should they become infected.

5.4 Recommendations

The following is a list of recommendations to educators. Education has the potential to:

- i. Inculcate skills that will facilitate self-protection.
- ii. Promote behaviour that will lower the risk of infection.
- iii. Enhance the capacity to help students to protect themselves against the risk of infection.
- iv. Integrate sexual health and HIV/AIDS education into the curriculum at all levels of education.
- v. To extend its mission to include counselling and care of the members (students, teachers and parents) and promote compassion for those infected with HIV/AIDS.

5.5 Implications

From the findings it is indicated that the students are aware of the dangers of HIV/AIDS this implies that the students have access to information about the pandemic, however the school/teachers need to play a more significant role in imparting this information. This is because the students seem to be getting more information from the media and the peers hence a risk of misinformation. It is also implied that the students need to be sensitised on the dangers posed by some cultural practices. There is need for the school, particularly the guidance and counselling department to expose the dangers associated with these practices. The teachers also have a responsibility to encourage young people to avoid contracting the infection or transmitting it to others. The school should also create an environment that does not discriminate against the infected or affected. The school should also establish linkages with community based organisation and non-governmental organisations so that they can assist in giving correct information about the pandemic. These organisations together with a functional guidance and counselling departments will help break the stigma among the students by bringing those infected but living positively with the virus to talk to the students.

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APPENDICES

APPENDIX A: Student's Questionnaire

- I. In answering this questionnaire, please bear the following in mind:
- (a) The Questionnaire is not a Test and therefore no grade or mark will be awarded.
 - (b) Your individual identity will not be known and your answers will be treated with utmost confidentiality.
 - (c) Answer every question in accordance with instructions.
 - (d) Please read every question or statement carefully before answering.
- II. This questionnaire is designed to gather general information on HIV/AIDS awareness, cultural practices and sexual behaviour. Confidentiality will be maintained in dealing with your responses. Please indicate the correct option as honestly and correctly as possible by putting a tick (✓) on any of the provided options. For the item that requires your opinion, please fill in the blank spaces provided (-----). You are kindly requested to answer all the items.

A. Personal Information

1. How old are you (years)
- (1) 11 – 13 (3) 17 – 19
(2) 14 – 16 (4) 20 – 23
2. What is your sex?
- (1) Male (2) Female
3. Name of your school _____
4. What is your religion?
- (1) Roman Catholic (2) Traditionalist
(3) Protestant (4) Non-believer
(5) Muslim (6) Other (Specify)_____

5. How important is religion in your daily life?

- (1) Very important (4) Least important
(2) Not important (5) None of the above
(3) Important

6. How often do you participate in religious activities?

- (1) Once a week (4) Never participate
(2) Once a month (5) Other (specify) _____
(3) Once a year

7. How often do you move from your place of residence to the nearest town/trading centre?

- (1) Once a week (4) Do not move at all
(2) Once a month or more (5) others (specify)
(3) Once a year

Please give reasons for your visits

8. Where do you live?

- (1) Village (2) Town (3) Others (specify) _____

B. HIV/AIDS KNOWLEDGE

1. What is AIDS

2. What is HIV

3. In what ways does a person get AIDS? (Tick the correct

Choice) [Yes] [No] [Don't Know]

1. Sharing clothing with an infected person [Y] [N] [DK]

2. Witchcraft [Y] [N] [DK]

3. Sleeping in the same room with a person suffering from AIDS [Y] [N] [DK]

4. Having sex with an HIV infected person [Y] [N] [DK]

5. Being bitten by mosquitoes, bedbugs which have bitten a person previously

- suffered from AIDS. [Y] [N] [DK]
6. Being in the same room as a person with AIDS [Y] [N] [DK]
7. By coughing and sneezing [Y] [N] [DK]
8. Sharing utensils with someone who is HIV Positive [Y]
- [N] [DK]
9. Using unsterilized needles and syringes which have been previously used by infected persons [Y] [N] [DK]
10. Poor health and bad nutrition [Y] [N] [DK]
11. Receiving blood which has been infected [Y] [N] [DK]
12. A woman who has AIDS virus can pass it To the baby. [Y] [N] [DK]
13. Sharing toilets [Y] [N] [DK]
14. Other (specify)_____

4. From what sources have you learnt about Aids? (tick all that apply)

- (1) [] Friends (7) [] Leaflets/pamphlets
- (2) [] Radio (8) [] Community
- (3) [] Posters (9) [] Meetings
- (4) [] Television (10) [] Newspapers
- (5) [] Drinking place (11) [] School
- (6) [] Church/mosque (12) [] Other (specify)_____

5. Does a person with HIV infection have characteristics, which can be used to identify him/her? YES/NO

If yes, how can you tell who has HIV?

.....

.....

6. If a person contracts the virus that causes AIDS, how long will it be before the signs show up?

- (1) [] Less than a week (4) [] At least six months
- (2) [] At least one month (5) [] At least one year
- (3) [] At least three months (6) [] At least five to ten years
- (7) [] I don't know

7. What are some of the signs, which show that a person is suffering from AIDS? 1 2 3

- (1) Diarrhoea for more than one month [Y] [N] [DK]

- (2) Fever for more than one month [Y] [N] [DK]
 (3) Pus discharge for more than one month [Y] [N] [DK]
 (4) Vomiting for more than one month [Y] [N] [DK]
 (5) Visible rash [Y] [N] [DK]
 (6) Cough for more than one month [Y] [N] [DK]
 (7) Others (specify) [Y] [N] [DK]
8. Can AIDS be cured? 1 2 3 [Y] [N] [DK]
9. If yes, do you think that AIDS can be cured by a:
 (1) [] Doctor (3) [] Others (specify).....
 (2) [] Herbalist
10. The spread of HIV can be prevented by: 1 2 3
 (1) Eating good food [Y] [N] [DK]
 (2) Always using condoms during sex [Y] [N] [DK]
 (3) Having sex with only one person/partner [Y] [N] [DK]
 (4) Having a few boyfriends (2-4) [Y] [N] [DK]
 (5) Avoiding casual sex [Y] [N] [DK]
 (6) use of protective witchcraft medical person [Y] [N] [DK]
 (7) A void injections by unqualified medical person [Y] [N] [DK]
11. Do you think that there are people in your area with AIDS or HIV infection?
 1 2 3
 [Y] [N] [DK]
12. Have you ever seen anyone with AIDS? [Y] [N] [DK]
13. (1) Do you think that you could get AIDS? [Y] [N] [DK]
 (2) Why?
 (3) Are you doing anything to protect yourself against AIDS? [Y] [N] [DK]
 (4) If yes, How?:
14. What should student do to protect themselves against contracting?
 HIV/AIDS?.....
15. Who should care for a person suffering from AIDS?
 (1) [] His/her family members

- (2) Health workers
- (3) Friends with same illness
- (4) Religious persons
- (5) Friends
- (6) Relatives
- (7) Others (specify)_____

16. What steps should the government take to minimize the spread of AIDS? (Tick the correct choice)

- (1) Mass screening and isolation of victims
- (2) Encourage people to seek a mutual faithful sexual relationship.
- (3) Promote condoms
- (4) Chase all barmaids and prostitutes from towns.
- (5) Test blood of all people coming into the country and deport the ones with HIV.
- (6) Promote religious morals.
- (7) Confine all AIDS patients in hospitals
- (8) provide sex education for children and youth
- (9) Encourage virginity before marriage
- (10) Other (specify)

17. If there were voluntary counselling and testing centres (VCT) at your place would you go for a test?

- (1) Yes (2) No (3) Not sure

18. Would you like to know the results of your test?

- (1) Yes (2) No (3) Not sure

19. If you found results of your blood test to be HIV positive or Negative. What would you do?

- (1) I would commit suicide
- (2) I would tell my family
- (3) I would tell my friends
- (4) I would announce publicly

- (5) I would keep quiet
- (6) I would spread the disease by being more promiscuous.
- (7) Other (specify) _____

C. Condom Use

1. Have you ever heard or do you know anything about condoms?

- (1) Yes
- (2) No

2. What was your source of information on condom? (Tick all that apply)

- (1) Parents/Guardians
- (2) Relatives
- (3) Teachers
- (4) Friends
- (5) Books/magazines
- (6) Radio/TV/Video
- (7) Doctor
- (8) Family planning clinic
- (9) Women's group
- (10) Women's group
- (11) others (specify)

3. Have you ever used a condom during sex?

- (1) Yes
- (2) No

4. Why do you use a condom?

- (1) To avoid infection with STDs and AIDS
- (2) To avoid pregnancy
- (3) To experiment it
- (4) Others (specify)

5. How often do you use a condom?

- (1) Always
- (2) Frequently
- (3) Sometimes
- (4) Rarely
- (5) Not at all

(b) Explain your answer _____

6. What has been your experience of using condoms?

.....

7. When you use a condom, who suggests its use?

- (1) Me
- (2) My partner
- (3) Any of us
- (4) my peers
- (5) others (specify) _____

8. Who provides it?

- (1) Me (3) Any of us
(2) My partner (4) Other (specify) _____

9. Has your sex partner ever refused to use a condom?

- (1) Yes (3) Other (specify) _____
(2) No

10. Where can one get/buy condoms?

- (1) Shop/Drugs shop
(2) Hospital/Health Centre
(3) private clinic
(4) Family Planning Clinic
(5) other (specify) _____

D. Sexual Behaviour

1. How many regular sexual partners have you had in the past?

Number of regular a partner(s) []

2. How many regular partners do you have now?

Number of regular partner (s) []

3. Does your partner have any other sexual partners (s) a part from you?

- (1) [] Yes
- (2) [] No
- (3) [] Do not know
- (4) [] Least interested
- (5) [] Other (specify)

4. How long have you been with your current partner?

- (1) [] Days
- (2) [] Weeks
- (3) [] Months
- (4) Years
- (5) Other (specify).....

5. How long ago is it since you last had sexual relationship with any one?

- (1) [] Day ago
- (2) [] Weeks ago
- (3) [] months ago
- (4) [] Years ago
- (5) [] Other(specify)

6. How old were you when you first had sexual intercourse?

(1) [] Age years _____

7. For how long had you known this partner before having sexual intercourse?

- (1) [] Days ago
- (2) [] Weeks ago
- (3) [] Months ago
- (4) [] Years ago
- (5) [] Others (specify).....

8. Would you be able to do the following with a first or a new partner:

- (1) Ask how many partners he/she has had [Y] [N] [DK]
- (2) Discuss using condoms before having sex [Y] [N] [DK]
- (3) Ask him/her to be tested for HIV before having sex [Y] [N] [DK]

9. What do you think needs to be done to control the spread of AIDS in secondary schools?

APPENDIX B: Interview Schedule for Students

1. What type of circumcision is practiced among the Kipsigis:
 - (a) Traditional circumcision () Clitoridectomy ()
 - (b) Religions (church) circumcision () Clitoridectomy ()
 - (c) Modern (Hospital) circumcision () Clitoridectomy ()

2. Which of these cultural practices are still practiced among the Kipsigis people, and why?

	Practices	Age when practiced	Why	Tool used	Sterilized	Unsterilized
A	Circumcision					
b	Clitoridectomy					
c	Dental extraction					
d	Scarification					
E	Wife inheritance					
F	Ear to be piercing					
g	Epiglottis					
h	Traditional midwifery					
i	Clean hair shaving					

3. Who attends to expectant mothers during delivery and the tools used
 - (a) Traditional birth attendant () Tool used Sterilized
 - (b) Nurses () Tool used Sterilized
 - (c) Any other () Tool used Sterilized

4. When somebody dies in the family, do you still practice the use of ‘clean head hair shaving?’
 Yes () No ()

5. Does the community practice betrothal marriage (marriage of girls below 10 years)
 Yes () No ()

6. Who takes care of Aids orphans in your community?

- (a) Brother or Sisters
- (b) Distant relative
- (c) Community
- (d) The government

7. Is wife inheritance practiced in your community?

- (1) Yes (2) No (3) Do not know (4) Rare
- (5) Other (specify) _____

8. Does the traditional taboo that prohibits the touching of male sexual organs still exist?

Yes () No ()

If yes, does this make the use of condoms a failure? Comment

.....
.....

9. Does the Kipsigis habit of restricting a man to sleep with the wife until the child is weaned after delivery still practicable?

Yes () No ()

If yes, how do men meet their sexual urge?

.....
.....

In reality, is this practicable among the women?

.....
.....

Among the discussed cultural practices in Q.2, which of these have major, minor or no effect of AIDS transmission? Put a tick (✓) .

	Practices	Major	Minor	No effect
A	Circumcision			
b	Clitoridectomy			
c	Dental extraction			
d	Scarification			
E	Wife inheritance			
F	Ear to be piercing			
g	Epiglottis			
h	Surrogate			
I	Traditional midwifery			
J	Clean hair shaving			

10. Is the burial rite of an AIDS victim different from other deaths?

(1) Yes (2) No (3) Other (specify) _____

11. Are there any beliefs for people suffering from AIDS?

(1) Yes (2) No (3) Not sure

(4) Other (specify) _____

12. How are the rape or incest victims viewed by your community?

(1) With respect (2) No respect (3) Least respect

(4) Don't know (5) Other (specify) _____