THE INTERNATIONAL JOURNAL OF HUMANITIES & SOCIAL STUDIES

Interpersonal Communication and HIV and AIDS Self-Protection among the Youth in Secondary Schools in Nairobi County, Kenya

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Abstract:
This study sought to investigate how young people use interpersonal communication to anchor their self-protection from possible risks of HIV infection. Social Construction Theory guided this study. The study was conducted among students in public secondary schools in Lang'ata District, Nairobi County. Mixed methods research design guided the study. The survey method was used to collect Quantitative data from a sample of 340 respondents. Multi-stage sampling technique was used to select the respondents for the survey. Qualitative data were collected from focus group discussions and key informants. Participants in the FGDs and the key informants were selected purposively. Ten FGDs each with eight participants were held while 10 key informants were interviewed. Descriptive and inferential statistics were used to interpret the quantitative data collected. Thematic analysis was used to interpret the themes in qualitative data. The data collected were triangulated to enhance the reliability and validity of the results. The study found that the youth used interpersonal communication to engage in discoursesth at generate meanings, interpretations and understanding of HIV and AIDS with their peers. The interpersonal discourses generated from a common stock of lay knowledge from which the youth made decisions about their behavioral responses to HIV and AIDS. The study concluded that the HIV and AIDS preventive behaviors are not only the outcome of an individual decision but are "rational" decisions stemming from a blending of lay discourses. Therefore, interpersonal exchange is important in mediating mass media campaigns' influences on people's attitudes and beliefs. The study recommended that media initiatives that are already objects of young people's exchanges be used as channels for disseminating HIV and AIDS preventive messages because they have a greater chance of becoming part of the youth's discourses. The study recommends further research to establish the extent of interpersonal networks among the youth and how these networks impact on their behavior.

Keywords: *Interpersonal communication, youth, HIV risks, self-protection*

1. Introduction

Today, it is estimated that about half of all new HIV infections worldwide are among young people aged 15 to 19 years (UNGASS, 2011). This age group also has the highest rates (over 500, 000 infections daily) of infection of sexually transmitted infections excluding HIV (UNAIDS, 2010) due to their physical, social, psychological and economic vulnerabilities. Every day, 6000 young people become infected with HIV – more than five people every single minute. Often, these young people may not perceive themselves to be at risk (UNAIDS 2010).

According to the 2010 report on the global AIDS epidemic released by the joint United Nations Program of HIV and AIDS (UNAIDS), young people aged 15 – 19 accounted for about 40 percent of new infections. Young people are particularly vulnerable to HIV infection for many reasons, including age, biological and psychosocial development, lack of comprehension to self-risk, social norms that make it difficult for them to learn about HIV and AIDS and reproductive health, and peer pressure which easily influences them in ways that can increase their risk (UNAIDS, 2010).

In our world today, knowledge of AIDS as a biomedical reality is well articulated and ways in which to avoid infection are well known. However, social responses to AIDS are still fearful, moralistic and emotive (Nzioka, 1994). It is this aspect of AIDS rather than its medical reality which problematises AIDS management, and which has to be dealt with if youth-based HIV and AIDS communication strategies will be successful.

In the 1990s, HIV spread rapidly in Kenya – reaching prevalence rates of 20 – 30 percent in some antenatal care (ANC) sites – with major social and economic impact at all levels of society. In 1999, the government of Kenya declared HIV a national disaster and established the National AIDS Control Council (NACC) to implement a multi-sectoral national response by coordinating two five-year strategic plans covering the periods 2000 to 2005 and 2005/6 to 2009/10 (NACC, 2009). Since 1999, the national adult HIV prevalence dropped from 14 percent to about 7.4 percent in 2007 (KAIS, 2007; KDHS, 2008/09).

Overall, the HIV and AIDS prevalence rate is just below that of the sub-Saharan African region, that is, 6.3 percent compared to 7.5 percent (WHO 2010).

The highest rates of infection were initially concentrated among the marginalized and special risk groups but in the last decade the impact of HIV and AIDS epidemic has been mixed; new infections are occurring among the sub-groups hitherto assumed to be safe as well as those considered vulnerable and high-risk groups (NACC, 2010). For instance, in spite of all the efforts – including the social marketing of condoms - there was little behavior change reported among the youth. Young people continued to expose themselves to unprotected sex (KAIS, 2007; KDHS, 2008/09; NACC, 2010).

The trends in HIV prevalence among the youth aged 15 – 19 years was captured by the 2003 Kenya Demographic Health Survey report, the 2007 Kenya AIDS Indicator Survey report and the 2008/09 KDHS report. According to the three national surveys, HIV prevalence in 2003 KDHS report was 1.6 percent, 2.3 percent in KAIS 2007 report, and 1.7 percent in the 2008-09 KDHS report. This trend showed that HIV infection levels increased between the years 2003 and 20098-09 among this age group.

The KDHS report (2008-09) suggested that the youth start engaging in sexual intercourse early, where 7 out of 10 girls and 8 out of 10 boys had engaged in sex by the age of 20, with a median age at first sexual intercourse of 17 years. The youth consequently face many risks and challenges that come with early sexual debut such as struggling to remain in school (NACC, 2010).

Okigbo et al. (2002) pointed out the knowledge – behavior gap in AIDS communication, which they said, was at the heart of the difficulties in containing the epidemic among the youth. Nzioka (2004) noted that early sexual debut and premarital sex among the youth in Kenya exposed them to not only sexually transmitted diseases but also to HIV and AIDS. He observed that despite high levels of knowledge concerning the protective value of condoms and other contraceptives, unprotected sex was still a common feature.

Studies have, however, found that though there were high levels of HIV and AIDS knowledge among students, there was still lack of observable behavior change amongst them (Likoye, 2004; Ochieng, 2005; Nyinya, 2007; Ongunya et al., 2009). The HIV and AIDS education program had not enabled the youth to acquire the readiness and ability to adopt lifestyles that were compatible with prevention attitude and practice in relation to HIV and AIDS prevention (Likoye, 2004). The knowledge, which was envisaged by the current HIV, and AIDS program in schools, therefore had not brought about positive behavior change to the students (Ongunya, et al., 2009).

Scholars say that there is a mismatch between HIV and AIDS program objectives and behavior change among the youth (Ongunya et al. 2009). They state that there is a gap between the objectives and actual HIV and AIDS education program delivery and behavioral changes among the youth in secondary schools. There is a need therefore to address this gap between HIV and AIDS knowledge and behavior among the youth in secondary schools.

1.1. Statement of the Problem

The Kenya National HIV and AIDS Communication Strategy for Youth (NACC, 2008), shows that the majority of the youth have heard about HIV and AIDS but many of them do not believe themselves to be at risk. Further, the youth lack adequate decision – making skills or the ability to adopt safer sexual behaviors. Information alone has not led to behavior change among young people. There is need therefore for greater attention to be focused on addressing the contextual realities faced by young people with regards to the decisions they make about their sexual behavior.

Scholars observe that meanings, perceptions, understandings and knowledge of the world are not pre-given, but rather actively constructed (Burry, 1986; Nzioka, 2004). This is why social discourses and constructions about HIV and AIDS among young people are important in mediating the impact of HIV and AIDS preventive campaigns.

In spite of high levels of awareness of HIV and AIDS among the youth, there is no dramatic change in their sexual behavior (Likoye, 2004; Ochieng, 2005; Nyinya, 2007; Ongunya et al., 2009). Scholars have found that high levels of knowledge of HIV and AIDS among students have not always translated into behavior change. Instead, more and more young people continue to engage in risky sexual practices that might lead to high rates of infection of STIs and HIV. This is the knowledge – behavior gap in HIV and AIDS communication that this study sought to investigate in the context of the role of interpersonal communication.

1.2. Study Objective

The purpose of this study was to investigate how young people use interpersonal communication to anchor their self-protection from possible risks of HIV infection

2. Literature Review

2.1. Self-Protection against HIV and AIDS among the Youth

Peltzer and Promtassananon (2007) carried out a study about HIV and AIDS knowledge and sexual behavior among junior secondary school students in South Africa. The aim of the study was to assess the HIV and AIDS knowledge and sexual behavior amongst the students. The findings indicated a relatively low behavioral response in spite of the high levels of HIV and AIDS awareness. The study also found out that there was infrequent use of condoms and other contraceptives and that a

significant proportion of adolescents had two or more lifetime sexual partners. The findings from their study support those of Ongunya et al. (2009) who found that there was a mismatch between HIV and AIDS program in Kenya's secondary schools and behavior change. As such, the study found that there was minimal behavioral response to HIV and AIDS prevention.

HIV and AIDS knowledge is an important component of HIV and AIDS risk prevention strategies that may influence engagement in high-risk behavior. In their study carried out among the youth in Cape Town, South Africa, Kermyt & Beutel (2007) found that engagement in high-risk HIV and AIDS behaviors (e.g. multiple sex partners, inconsistent condom use) despite knowledge of HIV and AIDS was rampant among the youth. The authors argued that that a more in-depth knowledge about HIV and AIDS was needed among the youth in order to ensure proper protection from the disease and that HIV and AIDS education would be more successful if the audiences were more segmented.

Ongunya et al. (2009) suggest that whereas students believed they had begun exhibiting the expected change of behavior, teachers felt that this was inadequate in enabling them to prevent and control the spread of HIV among the youth. This meant that there seemed to exist a gap between the objectives and actual HIV and AIDS education program delivery and behavioral changes among the youth in secondary schools.

2.2. Communication and HIV and AIDS Behavior Change

To maselli et al. (2002) argued that there was no single example of media campaign that had demonstrably reversed HIV infection trends worldwide, yet such campaigns remained the centerpiece of many government responses. According to the authors, the core of the problem lay in the assumption that knowledge and awareness led to behavior change. They observed that media campaigns achieved objectives of knowledge and awareness but it was the terrain beyond that awareness that was harder to achieve. Accordingly, the contexts which framed HIV pandemic were never understood within a theoretical whole. It was the contextual factors that problematical the notion of behavior change.

Swanepoel (2007) said that mass mediated campaigns formed important components of HIV and AIDS prevention and support programs as they aimed to persuade those at risk to practice safer sex, go for HIV test and utilize the available care and support infrastructure should they test HIV positive. Behavioral indicators suggest, though, that these campaigns are not optimally functional, even if one acknowledges the need for policies and structural interventions to support the required behavioral changes. Swanepoel (2007) argues that there are fundamental problems in the design of the messaging of HIV and AIDS campaigns. One of these is the fact that the design of the message is still very much left to the "gut feelings" of campaign designers and copy writers. Yet, professionally it would be inappropriate to use subjectivity and personal feelings to design HIV campaign messages.

Albright (2007) suggests that researchers must take into consideration the characteristics of their target populations including demographics as well as the specific social and cultural context, in order to advance their understanding. In addition, she says that the circumstances of the particular set of individuals or target audiences must be clearly understood in order to design an information strategy. Another way of looking at this is to consider why people continue to engage in risky behaviors. This can be accomplished through a needs analysis which will identify attitudes, norms, beliefs and perceptions regarding desirable behavior (e.g. safe sex practices) and will help to shape the design of the implementation (Albright 2007).

Albright (2007) says that strategies that are designed to target the identified variables will likely be more successful. For example, people in their late teens are not as likely to respond to fear messages because developmentally at that age they are more likely to be in denial of their mortality (Albright 2007). As Albright puts it, AIDS messages need to be targeted to smaller groups or individuals because of the range of individual information needs and processes through which individuals make sense of their worlds and their realities. A mass media approach designed to change behavior is inadequate to provide incentive for all members of the society (Albright 2007).

HIV and AIDS communication in Kenya has been provided to institutions like schools, religious organisations and health care centres (Kiai, 2009). Several communication approaches have been used or adopted in communicating on HIV and AIDS. Social marketing is a concept developed in the population education sector and has been used widely to promote condoms, particularly among segments of the population who are prone to high risk sexual behaviour.

The concept involves packaging, pricing and presenting a product or behaviour to the target market in an appealing manner and soliciting for the participation of wholesalers and retailers in the distribution and conventional trade promotions. The mass media are utilised to convey the benefits of the desired behaviour for a particular target audience (AIDSCAP/FHI, 1997; Okeyo et al., 1998).

Peer education as a strategy of HIV and AIDS prevention education has gained prominence and been used at workplaces, colleges, universities and social gatherings. The method has been found by some organisations to be practical and cost-effective while reaching a large number of people (Nduati & Kiai, 1996). A modification of peer education is the anti-aids clubs which can be started as extra-curricular activities in schools and in workplaces. The strength of the peer education approach lies in its ability to reach people through their own peers and this has contributed to its success especially in the workplaces (Nduati & Kiai, 1996). It has been recommended, however, that peer educators should be trained in the different communication methods and strategies in order to increase their effectiveness (Kiai, 2009).

Another method which has proved effective in the discussion of sexuality is that of group discussion where peers share information based on their experiences. Being with their peers allows them to openly talk about subjects which would otherwise appear to be taboo (NASCOP, 1998).

Literature indicates that various media have been used HIV and AIDS communication and prevention intervention (NACC, 2009). These media include posters, leaflets, booklets, comic stories, cartoons, drama and poems, including the mainstream mass media. However, as Kiai (2009) suggests, the important concern should be the participation of the target audience in the whole communication process - from the planning to evaluation. This is important given concerns that many information, education and communication (IEC) images in Kenya have presented conflicting messages in the text and visually.

The mass media are important agents in communicating HIV and AIDS messages because they have the ability to influence public opinion and to stimulate debate. In addition, the media can be used for advocacy as they can sustain a topic or theme in the public forum for long periods of time. The main observation has been that the media are useful in raising HIV and AIDS awareness, but this awareness has not translated into behaviour change (Nzioka, 2004; Kiai, 2009; Ndeti, 2011).

According to UNICEF (2003), there is a growing body of evidence that approaches to HIV and AIDS such as information campaigns focusing only on transmission and prevention of HIV and AIDS have resulted in increased levels of knowledge but have had little effect on risk taking behavior patterns and reduction of vulnerability to infection and consequently on the pace of the epidemic (UNICEF, 2003).

Kiai, et al. (2004) sought to critically identify and examine the communication needs, patterns of utilization and their existing strengths and gaps among female adolescents in Kenya in regard to sexuality, HIV and AIDS. The authors posit that previous styles of HIV-related prevention for adolescents have employed individualistic approaches based on theoretical frameworks such as Health Belief Model and Social Learning Theory that emphasize the need to help the young people to acquire accurate information and skills relating to HIV and AIDS. Such approaches, however, the scholars argue, are being criticized for failing to take account of the contextual, environmental and structural factors influencing young peoples' choices, actions and behavior.

In this study, Kiai et al. (2004) point out that effective communication for the youth such as behavior and attitude change is necessary if HIV and AIDS campaign activities are to achieve the desired results. They further add that while attempting to understand the communication needs of the youth in Kenya, it should be appreciated that the adolescent is a product of diverse socio-cultural background and economic lifestyles, which collectively impact on the communication needs. It is thus important to identify the challenges and opportunities created by the diverse socio-cultural realities in our society, so as to design effective communication strategies for the youth on HIV and AIDS.

Sneijder and Molder (2004) have pointed out that an understanding of interpersonal discourses is fundamental in constructing individuals' opinions and attitudes about health, underlining that discourses are not the result of a cognitive process but, rather, are social actions. From this perspective, social interactions produce not only shared norms that individuals integrate but also symbolic meanings that frame individuals' understanding of reality and, thus, their behaviors. It follows that because discourse is considered an action, then changes in discourse might result in changed actions.

Muturi (2005) argues that reproductive health programs have used the mass media and other communication interventions to inform and educate the public about the disease and to promote behavior change and healthy sexual practices. Muturi's research looks at the discrepancy in Kenya from a communications perspective addressing socio-cultural and related factors contributing to the lack of change in behavior and sexual practices. However, the study does not address interpersonal communication discourses of HIV and AIDS among the youth which this study examined.

Obregon (2005) analyzes young viewer relate to health messages dealing with HIV and AIDS and sexuality issues. The study looks at the presence of media effects at attitudinal and behavioral levels and active construction of meaning among young viewers. The study suggests that viewers, both alternately and simultaneously, can negotiate meanings of health issues. These findings have implications for health communication researchers and practitioners who often overlook people's experience of media reception while focusing primarily on the potential existence of message effects.

Researchers have studied the ways in which expert discourse (e.g., physicians' information, mass media messages) becomes part of lay discourse (e.g., everyday communication), how expert discourse is re-elaborated by individuals in their social exchanges, and how these social exchanges eventually influence individuals' versions of reality (Kline, 2003). Several authors have applied this perspective to the study of media messages, claiming that the meanings of the media messages are symbolically constructed by becoming part of individual discourses (Kline, 2003; Kitzinger, 2007). Furthermore, some authors have suggested that media messages themselves are forms of expert discourse that have precise socio-political meanings (Gwyn, 2002).

3. Theoretical Framework

3.1. The Social Constructionist Theory

Berger and Luckmann's (1990) social constructionism has its roots in phenomenology. The scholars argue that all knowledge, including the most basic, taken-for-granted common sense knowledge of everyday reality, is derived from and maintained by social interactions.

In social construction theory, the idea of an objectively knowable truth does not exist. Knowledge is constructed through social interpretation and the inter-subjective influences of language, family and culture (Hoffman, 1990). The basic contention of social constructionism is that reality is socially constructed (Berger, 1967), that is, what we perceive as reality has been shaped through a system of social, cultural and interpersonal processes.

Social construction theory explores an evolving set of meanings that are continuously created from people's interactions. The development of concepts is a social phenomenon, a fluid process that can only evolve within a cradle of communication (Hoffman, 1990). It is only through interaction of the socio-cultural processes with the intrapersonal self (ideas, beliefs, history) that the construction of knowledge is nurtured. Persons are constructors of knowledge in their lives assisted by the prevalent discourses in their societies and cultures, and their own life experiences.

Through social constructionism, researchers can look for diverse meanings of HIV and AIDS within and between social groups (Thomson, 1992). Social construction theorists contend that physically identical sexual acts may have different social and personal meanings depending on how they are defined and understood in their different cultures and historical periods (Vance, 1991). Besides influencing the way individuals define and act on their behaviors, socio-historical constructions also organize and give meaning to collective sexual experience through, for instance, constructions of sexual identities, definitions, ideologies and regulations (Vance, 1991).

According to the social constructionist approach, the world becomes intelligible to us in the way it does only because of the ideas and beliefs we have about it (Bury, 1986). Social constructionists argue that it is human beings who give meanings to diseases (Berger and Luckmann, 1984) so much so that one disease can be experienced differently across and between individuals and communities. The definition of a sign or symptom as illness depends on cultural values, social norms and culturally shared rules of interpretation. Diseases are socially constructed products of cultural and social arrangements (Turner, 1990).

Social constructionist theory was used in this study to explain and understand how the youth construct reality and knowledge around the HIV and AIDS communication and how such constructed knowledge informs their behavioral response.

3.2. Research Methodology

3.2.1. Research Design

This study used mixed-methods design, which utilizes the strengths of both qualitative and quantitative approaches (Creswell, 1997; 2009). According to Campbell et al. (1999), mixed methods are a powerful way to enhance the validity of results. This view is supported by Herbert & Shepherd (2001) who say that mixed methods are used to research the same issue with the same unit of analysis, thus cross-checking one result against another and thereby increasing reliability of the result.

Nachmias & Nachmias (1992) and Nzioka (1994) concur with the scholars above that data produced by combined methods enhances the validity and reliability of research findings. The use of mixed methods in this study was meant to get confirmation of findings through convergence of different perspectives. As a result of this combination, this study benefitted from the advantages of sample survey and statistical methods (quantification, representativeness and attribution) and the advantages of the qualitative and participatory approaches (ability to capture the diversity of opinions and perceptions). Mixed methods were also used to find contradictions and new perspectives, and to add scope and breadth to the study.

3.3. Sample Size and Sampling Procedures

3.3.1. Sample Size

A sample size of 325 respondents was determined using Fisher et al. (1983) as shown below. Other scholars who agree with Fisher (1983) on the sample size of 325 (if the target population is less than 10,000) are Moser and Kalton (1979); Mulusa (1990) and Mugenda and Mugenda (2003).

If the target population is less than 10,000, the required sample size will be smaller. In such cases, the final sample estimate (nf) is calculated using the following formula:

$$nf = \frac{n}{1 + (n/N)}$$

Where:
nf= the desired sample size (when the population is less than 10,000)
n = the desired sample size (when the population is more than 10,000)
N = the estimate of the population size

The sample size therefore was:

$$nf = \frac{384}{1 + (384 / 2163)}$$

$$nf = \frac{384}{1.18}$$

= 325

3.3.2. Sampling Procedures

Multi-stage sampling design was used to select the study sample for the survey. This sampling technique was appropriate because the study sample was selected in stages using stratified and systematic sampling techniques. In stratified sampling, the population is first subdivided into mutually exclusive segments, based on relevant variables. First, the study population was stratified into males and females. Secondly, a random sample was taken from each stratum using proportional stratified sampling. Proportional stratified sampling ensured that the sub-samples of both boys and girls were calculated proportionately to their sizes in the population in each school.

The third stage was to get the exact number of respondents needed from each class in the schools selected. The study proportion (for each school) was multiplied by the number of students in each class, and then divided by the total population of the school, as shown below:

$$\frac{X}{Y} = z$$

Where:
x = the study proportion
y = the total population of the school
z = the intended respondents in each class

In the fourth stage, systematic sampling technique was used to pick the corresponding sample once the number of respondents in each class had been calculated (as shown above). Systematic sampling consists of selecting every ***kth*** case from a complete list of the population (Singleton, 1988). Using class lists as the sampling frame, the researcher divided the total number of students in each class by the number of students needed (from each class) in order to get the sampling interval. The sampling interval is the ratio of the number of cases in the population to the desired sample size.
The researcher then selected a random number between 1 and this value to give the first respondent of the sample. This number would also act as a starting point for the selection of the rest of respondents (Mulusa, 1990). From this point, every KTH entry on the class list was selected using this sampling interval until the selection was completed. This sampling procedure was applied in all the five schools.

3.4. Data Collection Procedures

Data were collected using mixed methods approach with the aid of structured questionnaires, focus group discussions and key informant interviews. Both quantitative and qualitative data were collected concurrently and then the two databases were triangulated to determine if there was convergence, differences or some combination (Creswell, 2009). The purpose of using this strategy was to offset the weakness inherent within one method with the strengths of the other.

The quantitative data were necessary to guarantee a generalization of the results. Complementary qualitative data were collected to ensure consistency with the survey research or comparison. In other words, the qualitative data wereneeded to provide plausible explanations for quantitative data (Cresswell, 2009). Using both the structured questionnaire and the interview schedule to collect data also served as a mutually validating procedure. According to Campbell *et al* (1999), while the survey is useful for measuring the incidence of a specified behavior, it is often unsatisfactory for full investigation of motivations, beliefs and values that may have a major influence on behavior. Alternative approaches, including key informant interviews and focus group discussions can complement large-scale survey methods. This is consistent with the assertion of Lincoln & Guba (2000) that double measure of the same construct enables the researcher to get more accurate data and thus reduce measurement errors. Hence, the mixed methods approach was used to increase the trustworthiness of the conclusions made from this study.

The side-by-side integration of data provided quantitative statistical results, which were followed by qualitative quotes that supported or disapproved the quantitative results. The advantage of mixed methods was that it resulted in well – validated and substantiated findings. The quantitative data were collected from a sample size of 340 students using self-administered questionnaires. Although the desired sample size was 325, an additional 15 respondents were sampled in order to guard against drop out and attrition.

3.5. Survey

The survey method was used to assess incidence of behaviors among the target group. A self-administered questionnaire was used to obtain data from the respondents. The main advantage of the questionnaire method was that it avoided the potential embarrassment of face-to-face dialogue and guaranteed complete anonymity. Campbell *et al* (1999) say that the use of self-administered questionnaires is particularly useful in the collection of data on sensitive topics, such as sexual behavior.

Another advantage of self-administered questionnaires, according to Campbell *et al* (1999), is that they are appropriate methods for obtaining data from literate study populations. In this case, the study population was literate. Since there was no probing, the self-administered questionnaires were short, simple and very easy to follow. The respondents filled the questionnaires in their classrooms. The researcher supervised this exercise assisted by their teachers.

3.6. Focus Group Discussions

Focus group discussions were used primarily to investigate the normative aspects of behavior. They were used in this study to explore the ways in which the youth interacted in their discussions and the extent of agreement in opinion and attitude (Campbell et al, 1999). The advantage of these group discussions was the greater breadth of ideas, opinions and experiences that were expressed by the participants.

Two focus group discussions were held in each school; one with form one and two students combined, and then the other with form three and fourstudents combined. Each FGD consisted of eight students - four girls and four boys drawn purposively from each form. Thus, form one produced 2 girls and 2 boys, and so did form two, three and four. From each school, 8 girls and 8 boys participated in the focus group discussions. In total, 80 students participated in the FGDs.

Attempts were also made to ensure equal representation of boys and girls in each group. Care was also taken to ensure that the groups were as homogeneous as possible in terms of sex, educational background, and other relevant characteristics like familiarity with each other. Familiarity had advantages such as reducing initial tension or embarrassment. Homogeneity also reduced the danger of the discussions being inhibited by considerations of status or hierarchy (Campbell et al., 1999). Each discussion lasted between 60 and 90 minutes and was tape-recorded.

The researcher facilitated all the discussions. He also made some field notes. Each focus group discussion began with an introduction. The researcher then outlined the goals of the research and the reasons for recording the sessions. In order to exploit group dynamics and enhance the quality of data collected using this method, the participants were allowed a free atmosphere to express themselves. Issues that were covered in the focus group discussions included: the meanings and or beliefs associated with HIV and AIDS, how discussions generate knowledge about the youth's understanding of HIV and AIDS, HIV risk perceptions, self-protection against possible HIV infection, and how interpersonal communication influenced behavioral responses to HIV and AIDS among the youth. The researcher only intervened to bring out salient issues, particularly when group participants did not do so.

3.7. Key Informant Interviews

Key-informant interviews were of a conversational style rather than having a question-answer format (Campbell et al., 1999). These were conducted using a semi-structured interview guide. Key informants were mostly the professionals in the schools who had knowledge and experience about HIV and AIDS and the youth. They included two head teachers, two guidance and counseling teachers, two games teachers, one school nurse and three school captains. A total of ten key informants were interviewed.

The in-depth interviews were used to provide insights in understanding the context in which behavior occurred and its broader structural determinants. Other advantages included a greater depth of detail of information; greater opportunity to share and understand the viewpoints of informants, and how their beliefs, experiences and vocabulary related to the wider issues. In this study, two key informants were purposively selected from each school for the key interviews. The researcher encouraged the respondents to talk freely and guided the discourse towards new topics from time to time.

3.8. Data Analysis and Presentation

According to Kombo & Tromp (2006), data analysis refers to examining what has been collected in a survey and making deductions and inferences. It involves scrutinizing the acquired information and making inferences. Descriptive and inferential statistics were used to interpret the quantitative data obtained on variables relevant to the study objectives and hypothesis. Statistical Package for Social Sciences (SPSS) was used to assist in the analysis. Data were presented using tables.

The qualitative data produced from the focus group discussions and key informant interviews weretranscribed and coded into common themes. The themes in qualitative data were interpreted using thematic analysis. A narrative report enriched with quotations from key informants and focus group participants was written and triangulated with quantitative responses in order to capture convergence or differences (Creswell, 2009). Data from the survey, the key informant interviews and the focus group discussions were triangulated to enhance the reliability and validity of the results.

4. Findings

4.1. Knowledge of HIV and AIDS and the Youth's Self-Protection against Possible HIV Infection

The findings of this study showed that interpersonal communication regulated the forms of experience and perception among the youth toward HIV and AIDS communication for behavior change. Consequently, the youth's perceptions and meanings of HIV and AIDS were constructed through available discursive understandings. According to Burry (1996), interpersonal communication restricts and enhances meaning, dialogue and thinking. Burry (1996) observed that diseases

were not merely biological entities but rather they were socially constructed phenomena. Those meanings that the youth attributed to HIV and AIDS were decisive in shaping their responses to this condition.

As earlier observed, HIV and AIDS was an unthinkable disease for the youth. The only way to talk about it was by defining it as a problem that was related only to particular places or segments of the population. For example, in their communication, participants tried to locate the virus propagation in distant areas and among groups such as commercial sex workers. This sort of virus circumscribing discourse allowed the youth to represent HIV and AIDS as a confined and remote problem. Below is an excerpt from a 19-year-old head boy:

"When I think of AIDS, I don't really associate it with the youth. I imagine the prostitutes or far off places like the beaches in Mombasa which are frequented by tourists. I think needle users and gay men are more likely to catch HIV and AIDS than us the youth."

Thus, individuals with HIV and AIDS were perceived as socially undesirable, and HIV was often attributed to the "others." The perception of the divergence between oneself and those who are exposed to the risk of infection seemed o be based on stereotypes about the disease and on the "it-cannot-happen-to-me" syndrome: HIV and AIDS was discussed as something that affects "not normal" people. Participants defined themselves as normal and, thus, not at risk.

HIV and AIDS were defined as something for which individuals were responsible; it was perceived to be a consequence of individual's irresponsible behaviors. It followed that getting HIV was the individual's fault, and it was an object of social blame, as observed by the 17-year school captain:

"I don't want to generalize and say we are all at risk. No. I can't relate HIV infection to real people here. I think it is a lifestyle disease. Unless you are born with it, it is your lifestyle that gets you. I think it is a preventable disease. For me, I am normal, so HIV is not an issue for me."

The KDHS report of 2008/09 indicated that the youth start engaging in sexual intercourse early, where 7 out of 10 girls and 8 out of 10 boys had engaged in sex by the age of 20. The report put the median of first sexual intercourse at 17 years. This early sexual debut exposed the youth to numerous health risks (NACC, 2010).

When the respondents were asked whether they had any knowledge about condoms, 90.6 percent of them said they knew about condoms. This is illustrated in the table below. Only 5.6 percent of the respondents said they had no knowledge about condoms. Another 3.8 did not give any response. These findings are supported by the KDHS reports of 2003 and 2008-09 which suggested that the youth aged 15-19 years had knowledge about condoms and that one could use them for protection against HIV infection.

4.1.1. Knowledge of Condoms

Knowledge of Condoms	n	%
Yes	308	90.6
No	19	5.6
No response	13	3.8
Total	340	100.0

Table 1

As seen in table below, when respondents were asked to state who they had sex with, 69.1 percent of them said they had sex with their friends. This was followed by 25.3 percent who mentioned schoolmates as their sexual partners. Those who said they did not have a sexual partner were 5.9 percent.

During the focus group discussions, participants attributed their sexual activities to peer pressure particularly from their close friends and school mates.

Q: Why do you engage in sexual relations?

P1: There is a lot of pressure from friends. It is difficult to survive in a group of friends without engaging in sex, because that is always the main activity.

P2: And so, you will want to prove a point. That you are capable just like them

P3: The fear of possible consequences will drive you to comply. These guys can beat you up if you don't accept their plans.

Q: Do girls experience such pressure from other girls?

P7: Oh, my! They are worse. If cliques of girls discover that you want to be different from them, they insult, or even organize with the boys to attack you. You have to play ball.

P4: And you can't even report their threats to the teachers. One time, a form two girl reported some girls from her classmates to their class teacher. I wish she was here to tell her story. Imagine her parents had to transfer her to another school, but not before she had Received a thorough beating from people she did not know. And this happened on her way home from church!

The table below shows the responses the respondents gave when they were asked whether they had used a condom the last time they had sex. Those who did not use a condom the last time they had sex were the majority at 80.9 percent

compared to 13.4 percent who said they had used a condom. Failure to use a condom during sexual intercourse is supported by Nzioka (2004) who asserted that unprotected sex was still a common feature among young people in spite of the levels of knowledge concerning the protective value of condoms and other contraceptives being high. This showed a very low risk perception.

4.1.2. Whether They Used a Condom in the Last Sexual Encounter

Used a Condom	n	%
Yes	45	13.4
No	275	80.9
Total	320	94.3

Table 2

While condoms remain one of the best weapons against HIV transmission, studies continue to show limited use of this protective method in sexual intercourse among the youth in Sub-Saharan Africa (MacPhail, 1998; Wodi, 2004). These scholars cite several socio-cultural and religious factors in the limited use of condoms. These findings corroborate earlier studies about condom use and beliefs among the youth in Nairobi (Kiai, 2004; Ongunya et al., 2009; Kabiru & Orpinas, 2009; KDHS, 2008-09; APHRC, 2010; NACC, 2010).

From the focus group discussions, it emerged that a condom was an important prevention strategy in theory, but in practice it was not in neutral action: it implied specific relational meanings that made its use less frequent:

Q: Do you use condoms during sex for protection against HIV infection?
P5: Condoms? No, I don't because I am in a serious relationship with my partner. I believe we are healthy.
P8: I don't use them because the level of trust between us is very high. As such, I am not worried at all.
P3: The problem is, what kind of world do we live in if you cannot ever trust the person you are with?
Q: Supposing they cheat and put you at risk?
P1: Yes, they can slip, but it is always difficult to ask your partner to wear a condom.... I mean, where do you begin?
P2: Buying condoms is also embarrassing for young people coz it means that you are having sex. And remember you don't want people to label you lose!
P5: Condom use is only common in casual intercourse or at the beginning of a relationship.

As noted in the above discussion, participants pointed out that long – term relationships were perceived as not risky, and thus using condoms seemed unnecessary. Moreover, participants said that asking a long – term partner to wear a condom would imply not trusting in his or her commitment to the relationship and fidelity.

Sometimes this discourse of trust between partners was issue even at the beginning of a relationship. The decision to have sex with a new partner was often contemplated seriously and was based on the individual's perceived honesty and reliability. Asking a new partner to use a condom would mean not being totally confident in the correctness of the partner's previous behavior. Girls, in particular, declared their shyness in negotiating condom use and their concern about meanings implied by this request.

Another problematic aspect related to the discourse of condom use was the discourse of birth control pills. Preventing unwanted pregnancies was the main concern of sexually active youth. This tended to lessen the relevance and urgency of HIV and AIDS prevention in their sexual relationships. Since young people's main preventive concern in relation to sexual activity was avoiding unplanned pregnancies (rather than preventing HIV and AIDS), girls who were using birth control pills felt protected and were not concerned about the risk of HIV and AIDS:

P5: With birth control becoming relatively reliable, many people I know, myself included, don't pay as much attention to the secondary reasons for wearing a condom.
P8: When I think of using a condom, I think of preventing a pregnancy, not preventing AIDS.

MacPhail (1998) suggested that much of the research had shown that the youth had high levels of knowledge about the transmission of the HIV virus and were fully cognizant of the value of barrier contraception, such as condoms in preventing HIV transmission. Despite the high profile given to HIV, few adolescents were able to translate their knowledge into adopting safe sex behavior. Jemmot (2000) also observed that most sexually active youth did not consistently use condoms although their use may reduce the risk of sexually transmitted diseases.

Data from the KDHS reports of 2003 and 2008-09 showed that there had been a marked improvement in knowledge of HIV prevention methods among adolescents aged 15-19 years. For instance, 75 percent of adolescents knew that someone could reduce the risk of getting the HIV virus by using a condom every time one had sexual intercourse. This knowledge of condom use increased from 67 percent in 2003 to 75 percent in 2009 (KDHS, 2003; 2008-09).

The respondents who supported the use of condoms argued that they considered this as the only option of self-protection since they found it very difficult to abstain. However, they were uncomfortable with condoms since they reduced sexual pleasure.

P1: It is not easy at all to abstain. Sex is very much addictive.

P3: It is just like smoking. Once you start smoking, it becomes very hard to stop the same.

P7: By the way, girls want favors, gifts, money, outings, shopping, among other niceties. Which girl will not fall prey to a man ready to provide these things? And if such a man wants sex, they insist on unprotected sex anyway. How can you refuse?

P8: I would advice those who are still virgins to try, yes, try coz it is not easy, to remain so. But I can tell it is not easy. I tried it will little success before I finally gave in.

The respondents were asked if they thought they could protect themselves from HIV infection by abstaining from sex. The table below shows that 86.2 percent of the respondents agreed that they could abstain from sex as one way of protecting themselves from HIV infection. Only 13.8 percent of the respondents said they were not able to abstain.

Protection from HIV infection by abstaining from sex

Ability to Abstain from Sex	N	%
Yes	293	86.2
No	47	13.8
Total	340	100.0

Table 3

However, the respondents stated that owing to the influence and pressure from their friends, it was hard to practice abstinence. They said that only those who had not involved themselves in sexual relations could be encouraged to abstain, if that were possible. When the respondents were asked whether they discussed HIV with their friends, 91.7 percent of the respondents said they did while only 8.3 percent of them said they did not.

From these discussions, it was established that students talked about HIV and AIDS though others felt that it was a taboo to engage in sex-related discussions. Some of the observations raised during these discussions supported the UNFPA report (2008) which stressed the fact that discussing sex was taboo in many countries, and this denied a large number of people especially the 15 – 19 age group the necessary information to negotiate for safe sex (UNFPA, 2008). The report supported the need to develop a culturally sensitive educational intervention program.

A few of the participants during the focus group discussions noted that talking about HIV and sex was embarrassing to them. However, the majority of the participants observed that talking about HIV and AIDS among friends was not unusual. They argued that though HIV and AIDS was in itself "boring" and "sad", discussion of sex-related topics was perceived to be easier with one's sexual partner. In other instances, the participants argued that talking about the disease and its prevention implied a lack of trust in one's partners' past sexual behaviors, and so some participants avoided it for this reason.

Furthermore, participants categorized sexual relationships as acceptable or promiscuous. Among those in acceptable relationships, the participants considered themselves not at risk and noted that HIV was a mentionable topic but still was seldom discussed, even at the beginning of a relationship. The consequences of HIV and AIDS were not a young person's concern.

Q: Is it difficult to talk about HIV and AIDS with your partner?

P3: Yes, it is very difficult to bring it up sometimes. All I say is.... let's make sure you will not kill me with some horrible disease. It's not very romantic.

P8: It may be a bit awkward to bring it up, at first, but it has to be done.

P1: Talking about HIV and AIDS is not always the first thing in my mind, so it doesn't arise naturally. But we end up talking about it anyway.

When the respondents were asked whether they discussed how to protect themselves against HIV infection, the majority of them (83.2 percent) said they didn't. Only 16.8 percent said that they discussed HIV protection with their friends.

4.1.3. Whether Discussed HIV Protection

Whether Discussed HIV Protection	N	%
Yes	57	16.8
No	283	83.2
Total	340	100.0

Table 4

From the focus group discussions, it emerged that having sex with a partner whom the young person knew well, in the long-term relationship, for instance, was not a deplorable behavior for participants. It was considered acceptable, at least among the youth and not an example of a risky behavior, in their view. The only sexual relationships that the youth viewed as risky were the same-sex relationships and casual intercourse. These were classified as promiscuous relationships and were more likely to be the object of social blaming among the peers.

Furthermore, because promiscuous sexual relationships were not considered acceptable or socially desirable, they could not be part of the social conversations, and thus the risks, such as HIV and AIDS, could not be communicated. Participants reported that HIV and AIDS prevention seemed to be an issue only in promiscuous relationships. This has important consequences for attitudes regarding the use of condoms in sexual intercourse.

Within the discourse of HIV and AIDS knowledge, information about self-protection from the key informants and the focus group discussions complemented the findings of the survey about self-protection against HIV infection. Both data indicated that most young people did not bother with self-protection against possible HIV infection, even when they knew the risks of unprotected sex.

4.2. Summary of Findings

4.2.1. Knowledge of HIV and AIDS and the Youth's Self-Protection against Possible HIV Infection

The study found that 80.9 percent of the students did not use a condom the last time they had sex. This response shows a very low risk perception. This finding supported Nzioka (2004) who suggested that unprotected sex was still a common feature among young people in spite of the high levels of knowledge concerning the protective value of condoms and other contraceptives.

Students pointed out that they did not perceive long – term relationships as risky and thus using condoms seemed unnecessary. Moreover, participants said that asking a long – term partner to wear a condom would imply not trusting his or her commitment to the relationship and fidelity.

The decision to have sex with a new partner was often contemplated seriously and was based on the individual's perceived honesty and reliability. Students observed that asking a new partner to use a condom would mean not being totally confident in the correctness of the partner's previous behavior. The study found that in particular, girls declared their shyness in negotiating condom use and their concern about meanings implied by this request.

The discourse of birth control pills also came to the fore. The youth observed that preventing unwanted pregnancies was their main concern. This perception tended to lessen the relevance and urgency of HIV and AIDS prevention in their sexual relationships. Since young people's main preventive concern in relation to sexual activity was avoiding unplanned pregnancies (rather than preventing HIV and AIDS), girls who were using birth control pills felt protected and were not concerned about the risk of HIV and AIDS.

However, the respondents stated that owing to the influence and pressure from their friends, it was hard to practice abstinence. They said that only those who had not involved themselves in sexual relations could be encouraged to abstain, if that were possible.

Students said that HIV and AIDS were not easy to talk about given the social taboo surrounding its main method of transmission: sexual intercourse. Participants referred to the difficulty of talking openly about sex and sex-related topics with friends. In a conservative culture such as that of Africa, sex before marriage is not accepted, and sexually active unmarried youth are always part of a blaming discourse especially by adults. This observation supported the UNFPA report (2008) which stressed the fact that discussing sex was taboo in many countries, and this denied a large number of people especially the 15 – 19 age group the necessary information to negotiate for safe sex (UNFPA, 2008).

The report supported the need to develop a culturally sensitive educational intervention program. It was found that talking about HIV and sex was considered embarrassing. Participants noted that talking about HIV and AIDS among friends was unusual, not because of its link with sex but because it was perceived to be too "boring" and "sad" to discuss. Furthermore, participants categorized sexual relationships as acceptable or promiscuous. Among those in acceptable relationships, the participants considered themselves not at risk. The only sexual relationships that the youth viewed as risky were the same-sex relationships and casual intercourse.

The study found that most young people did not bother with self-protection against possible HIV infection, even when they knew the risks of unprotected sex.

5. Recommendations

Based on the findings of this study, the following policy recommendations are made:

- Young people should be adequately involved in the planning, design, implementation and evaluation of communication interventions that target them.
- There is need to involve the youth in the design and dissemination of HIV and AIDS messages. Furthermore, because of lack of engagement of the youth in health communication messages, retention of knowledge is minimal and this leads to lack of acceptance of the message. It is important to listen to what young people think and believe in order to ensure acceptable and appropriate interventions.
- The youth should participate in HIV and AIDS campaigns by way of writing poems, plays or skits with HIV and AIDS messages. Here, the students may have the opportunity to enact their own feelings and by extension, own the process of developing HIV and AIDS media messages. This can be done during the schools and colleges drama festivals held every year.

- The Ministry of Education should make HIV and AIDS education syllabus examinable like other subjects. It is not enough to teach HIV and AIDS as an integrated subject. Making it a stand-alone subject will demonstrate the seriousness of the content therein.
- There is need therefore to revise the HIV and AIDS curriculum with a view to meeting student's needs. It should focus more on life skills such as decision – making and interpreting social settings.

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