

# THE SOCIAL CONTEXT OF PERCEPTION OF AIDS RISK AND SEXUAL BEHAVIOUR IN KENYA



*Ukweli juu ya ukimwi - The Truth about AIDS*

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*PAIA*

# 1 INTRODUCTION

While remarkable efforts are being made to minimise the spread of HIV and its impact, the AIDS pandemic has continued unabated and has claimed millions of lives the world over, particularly in developing countries and more specifically, in sub-Saharan Africa (SSA). The rising prevalence rates and the rapid spread of HIV/AIDS suggests that the epidemic has not reached its equilibrium in most of SSA, hence the need for continued research and interventions into ways of minimising its spread and the social and economic impact.

At the onset of the epidemic, research and interventions for HIV/AIDS prevention largely focused on bio-medical consequences of the disease and ignored the varying geographical, behavioural, socio-cultural, and economic contexts underlying the course of the epidemic in SSA. Similarly, previous studies predominantly targeted groups considered at high risk of HIV infection thus leaving out a large group of people potentially at risk. The diffusion of HIV/AIDS from “core groups” to the general population is evident in widespread infections among most populations of SSA countries. The increasing spread and devastating socio-economic impact of the epidemic have stimulated a shift of research priorities from a bio-medical and “core groups” focus to the societal context of sexual behaviour and HIV/AIDS. The last two decades have seen a rise and a broadening of studies on HIV/AIDS and the antecedent sexual behaviour from epidemiological contexts to include population-based surveys, as well as small-scale qualitative studies focusing on attitudes and behaviour facilitating the spread of the disease. This study examines how people assess their risk of contracting HIV at the community level and how they relate their sexual experiences to the risk of HIV infection.

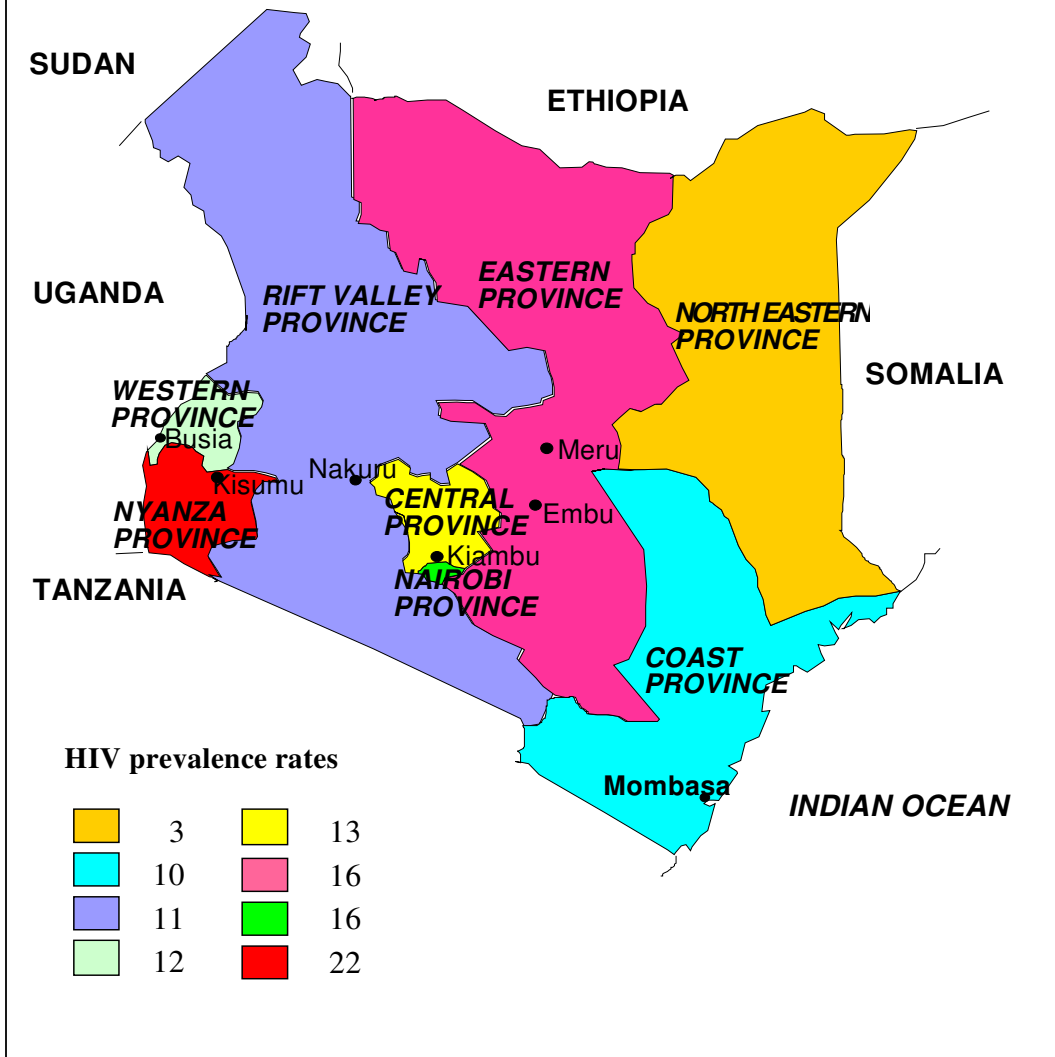
## **The HIV/AIDS Situation in Kenya**

Kenya, situated in East Africa, is one of the countries in sub-Saharan Africa most affected by the AIDS epidemic. The country is culturally diverse, with over 40 ethnic groups. The diversity in culture makes it difficult to implement AIDS prevention campaigns, as no single programme would be appropriate for all cultural contexts. The major groups are Kikuyu, Luo, Luhya, Kamba, Kalenjin, Mijikenda, Meru, Embu and Kisii. These groups are concentrated in specific regions in Kenya. Kikuyus are predominant in Central Province, Luos and Kisii in Nyanza province and, Luhyas live in Western Province, Kambas, Merus and Embus in Eastern Province and Kalenjins inhabit the Rift Valley Province.

The population of Kenya is approximately 30 million. About 80% of the population lives in rural areas. Kenya is characterised by a young population. Almost 50% of the population is aged less than 15 years. Kenya has experienced one of the most rapid fertility declines in the recent past that has been largely attributed to increases in contraceptive use and improvements in other socio-economic aspects. The total fertility rate declined from about eight births per woman in 1978 to 4.8 in 1998. The population growth rate is estimated to have dropped from 3.8% in 1979 to about 2.5% in 1998. Contraceptive prevalence rate increased from 17% in 1984 to 39% in 1998 (NCPD, CBS and MI, 1999). The decline in fertility and population growth rates was initially accompanied by a decline in mortality rates. But these positive gains are currently being reversed by the increasing deaths attributed to AIDS. It is projected that by the year 2010, life expectancy will fall to about 40 years in Kenya, meaning a loss of 20 years attributed to AIDS (GOK/ACU, MOH and NACC, 2001; Cohen and Trussell, 1996). Population projections indicate that AIDS will have reduced the population of Kenya by over 2.1 million by 2005 and 4 million by 2010 (CBS, 1996).

HIV/AIDS prevalence rates in Kenya have risen sharply since the 1990s, with up to 14% national prevalence rate in the adult population aged 15-49 years in 2001 from 5% in 1990 (GOK/ACU and NACC, 2001). Figure 1 shows that prevalence rates are high in most parts of Kenya. HIV/AIDS prevalence rates have been invariably high in urban than rural areas. The current estimates are 17% to 18% in urban areas and 12% to 13% in rural areas, although, the absolute number of people infected is larger in rural than urban areas since 80% of the population lives in rural areas. The rising prevalence rates are worrying because it suggests that HIV prevention campaigns are not being translated into safer sexual behaviour and that there is a built up momentum of people living with HIV. It also means that there is a high likelihood of encountering a sexual partner that is infected when levels of HIV prevalence are high because any sexually active adult linked in a sexual network with other non-monogamous men and women will be at high risk of infection themselves particularly for adolescents initiating sexual activity. Heterosexual transmission accounts for about 80% of new infections hence, young people are at risk of getting the disease as soon as they initiate sexual activity. The large number of young people entering their sexual and reproductive lives are a potential AIDS reservoir who should form a priority group for AIDS research and prevention activities because their behaviour will determine the future course of the AIDS epidemic.

**Figure 1: Map of Kenya showing regional HIV prevalence rates, 2001**



Many studies, using both quantitative and qualitative methods have looked at the sexual behaviour of Kenyan people (Idele, 2002; Nzioka, 2001; Bauni & Jarabi 2000; Futures Group, 1999; Habema et al., 1999; Fapohunda and Rutenberg, 1999; Ndinya-Achola et al. 1997; Barker and Rich, 1992; Ajayi et al., 1991). Data is also regularly collected by DHS, UNAIDS and through sentinel surveillance systems and STD clinics in Kenya. All these sources of data point to the prevalence of risky sexual behaviour and the heightened risk of HIV infection among young people. Young people are more likely to have multiple and casual sexual partners, to perceive low risk of HIV infection and to use condoms irregularly.

Sentinel surveillance data indicates striking age and sex differences in infection levels. Infection rates are generally higher for young women than young men, but the reverse holds for older men and women. About 75% of the AIDS cases occur in the age group 20-45 years, peaking at ages 25-29 years for females and 30-34 years for males. Young women in the age groups 15-24 years are 2 to 3 times more likely to be infected than males in the same age. More AIDS cases occur in children under five years than in age group 5-14 probably because most of them are infected through their mothers (GOK/ACU, MOH and NACC, 2001).

Since 1987, the Kenyan government, international and local non-governmental organisations (NGOs) and development partners (World Bank, DfID, USAID, UNAIDS among others), have been addressing this major challenge to the country's development. The President declared AIDS a National Disaster in November 1999, culminating in the establishment of the National AIDS Control Council (NACC) in the same year. The AIDS campaigns in Kenya emphasise change in sexual behaviour (abstinence, condom use, monogamy and reduction of sexual partners). Indeed, the Kenya Demographic and Health Surveys (KDHS) of 1993 and 1998 show high awareness of AIDS. Over 99% of respondents were aware of AIDS in 1998 (NCPD, CBS, MI, 1999). Similarly, over 96% of both women and men knew that AIDS could be transmitted through sexual intercourse. In addition, over 80% know that HIV can be transmitted from mother to child and that a healthy looking person can have the AIDS virus. According to the KDHS of 1993 and 1998, the number of people with misconceptions about AIDS has decreased over the last few years. In 1998, only 8% gave incorrect responses when asked about modes of transmission, while in 1993 over 50% did so. Similarly, the number of people who reported that they knew someone sick of or who had died of AIDS increased from 4% in 1993 to over 70% in 1998, thus reflecting the advancement of HIV/AIDS spread in Kenya.

Although ignorance is no longer the issue in Kenya, attitudes and behaviour change are. Feelings of invulnerability and risky sexual practices are rife among different population sub-groups. In the 1998 KDHS about a third of both women and men felt they were not at risk of HIV/AIDS. Risky sexual behaviour persists even though there is high knowledge of AIDS. In the 1998 KDHS, 16% and 60% of married and unmarried men respectively, reported having more than one sexual partner in the 12 months before the survey. For women, the proportions were 2% and 40% for married and unmarried respectively. About 7% of married men with



extramarital partners reported having had two or more sexual partners in the last year while less than one per cent of married women reported the same. Comparably, 50% and 14% of the sexually active unmarried men and women respectively reported having had two or more sexual partners in the last year before the survey. The differences indicate that Kenyan men are more likely than women to engage in extramarital sexual relations or to have multiple sex partnerships, thus they are more at risk of contracting HIV and infecting their partners.

Condom use is low in Kenya and is confined to only certain types of sexual liaisons, although use is common with non-regular than with regular partners. In the 1998 KDHS 7% of men and 3% of women reported condom use among spouses respectively, compared to about 42% of men and 15% of women during sex outside marriage. Low use of condoms in extramarital relations heightens the risk of HIV and classical STDs in conjugal unions that would otherwise reduce risk if partners were faithfully monogamous.

It remains unclear how knowledge of AIDS is translated into safer sexual behaviour at the community and individual levels. It is also not clear how perception of risk influences or is influenced by sexual behaviour as the association between the two variables can work both ways. The strong influence of the socio-cultural environment may explain the observed inconsistency between what Kenyan people claim to know and their beliefs and risk-taking behaviour associated with increased risk of HIV infection.

This summary report is drawn from findings of focus group discussions (FGDs) and in-depth interviews (IDIs). The study complemented results obtained from the quantitative analysis of the correlates of perception of risk and sexual behaviour using the 1998 KDHS data. The report describes briefly the data sources. It then describes the study communities, outlining social, cultural and economic differences between them. The report goes on to examine evidence for the success of AIDS prevention strategies: What do people know about HIV and how to avoid it? How do people learn about AIDS and sex in their communities? The community norms, beliefs, practices and discourses surrounding sexual behaviour and perception of AIDS risk are then described. The report looks at the challenges people face in instituting preventive measures. The implications of the social context of perception of risk and sexual behaviour on AIDS messages and behaviour change are summarised.

## **2 METHODOLOGY**

### **2.1 Methods**

Focus groups discussions and IDIs were held with women and men aged 15 to 45 years in the month of March 2001. The study was undertaken in two study sites, in rural Kisumu district, Nyanza Province, and a peri-urban area of Kiambu district, Central Province, Kenya (see also Figure 1). Gender, marital status, and ethnic affiliation/region of residence were used to stratify FGD participants in order to explore views of people exposed to different sexual experiences and cultural contexts. The focus groups for unmarried women and men comprised both the sexually experienced and inexperienced. Fourteen focus group discussions (6 in Kisumu and 8 in Kiambu) were conducted with 122 participants as follows:

- Six groups among unmarried women and men aged 15-24 years
- Four groups among recently married women and men aged 15-30 years (marital duration of 5 years or less)
- Four groups among older married women and men aged 31-45 years (marital duration of 6 years or more).

FGDs allow a small group of participants with similar characteristics to discuss subjects of common interest with the guidance of a facilitator or moderator, in which participants do not necessarily need to reveal personal information. FGDs are important in exploring common attitudes, norms and practices of social behaviour. FGD guides or question routes were used in this study to explore a range of topics. The final versions of the FGD question routes are given in Appendices 3.1 and 3.2. More details about using focus groups in Social Research are described in Hennink and Diamond (1999).

Anonymity is important when discussing personal and sensitive topics such as sexual behaviour of respondents, where they may have to admit to behaviour socially disapproved, such as extramarital or premarital sex. IDIs were held with 29 respondents drawn from the focus group participants, using pre-designed question guides given in Appendices 3.3 and 3.4. IDIs explored the more personal and sensitive issues of how people perceive and interpret their individual vulnerability to HIV at two stages of their sexual lives: during sexual initiation and at later sexual partnerships, rather than to obtain detailed sexual histories. IDIs provide opportunity for probing respondents for greater depth and further explanation or clarity on their answers (Hennink, 1997). In-depth respondents were purposely drawn from FGD participants in order to understand how individual perceptions and opinions conformed or diverged from what was expressed in the group discussions.

Only individuals who reported ever having sexual intercourse were selected for IDIs because this group was most suited to address the research problem. The respondents for IDIs were identified after the FGDs by administering a short questionnaire that collected basic socio-demographic characteristics and sexual experience of participants. IDIs focused on the first and recent<sup>1</sup> and/or current sexual partnerships were in order to minimise recall errors. It is assumed that the first sexual intercourse is a memorable event, the circumstances surrounding which are unlikely to be forgotten. Similarly, activities in a recent or current partnership can easily be remembered compared with events of intermediate partnerships. Due to the small number of participants (29 respondents interviewed in-depth), the characteristics of sexual behaviour and the subjective criteria of risk assessment are examined and not necessarily the prevalence of specific behaviour across sub-groups.

All research instruments were originally developed in English but translated into Luo and Kikuyu, the dominant languages spoken in Kisumu and Kiambu respectively.

## **2.2 Data Collection**

Fieldwork started in Kiambu, then Kisumu. Two research assistants of the same sex (one as a moderator and the other a note taker) conducted the FGDs and IDIs. Eight research assistants, four females and four males, well acquainted with the local languages (Luo and Kikuyu), in addition to being fluent in English and Swahili were recruited. Experience in conducting qualitative research in social sciences, and the ability to transcribe and translate interviews from a local language to English was another criterion used for recruiting research assistants. Understanding the subject matter was also crucial. Two of the research assistants had first degrees in Sociology and six had Masters degrees in Population Studies or Anthropology.

Research assistants underwent intensive training for six days to familiarise themselves with the research questions, ways of conducting focus group discussions and in-depth interviews, roles of the moderator and note taker, transcription and translation techniques, and the contents of the question routes. The training included role-playing and a pilot testing in a location in Kiambu district.

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<sup>1</sup> The sexual partnership is considered recent if it terminated in the last 12 months before the study; and is current if it is still ongoing or involves a marital union.

FGDs were conducted in the morning and in-depth interviews in the afternoon. The number of participants for most FGDs was 10-12. All interviews were tape-recorded and notes taken by the note taker to ensure that all discussion was captured. All FGDs and IDIs varied in length but generally took about one and a half to two hours for FGDs and 45 minutes to one and half hours for IDIs.

### **2.3 Data Processing and Analysis**

Qualitative research generates large amounts of textual data requiring a systematic method of segmenting the data into meaningful units or themes. Tape-recorded discussions were transcribed and translated verbatim to English. Both the moderators and note takers did the transcriptions and compared notes to ensure quality and consistency. The transcripts were then typed and thematic or content analysis was undertaken. The analysis of qualitative data in this report was based on the concepts of *Grounded Theory* (see Strauss and Corbin, 1990). Thus, themes that emerged during the discussions rather than the confines of formal health behaviour models, guided the analysis. Analysis involved developing a system of indexing the data into sets of categories or codes that provided structure to the data based on the research objectives and the topics included in the question guides. Thus, each code represented a core topic or theme. Different levels of codes were developed to enrich the analysis process. For example, a parent code (e.g. sexual behaviour) was developed and then sub-categories (e.g. premarital, extramarital, commercial) were used to represent different types of sexual behaviour. QSR Nudi\*st (QSR, 1997), a qualitative software was used for textual data analysis.

### **2.4 The Study Sites**

The two areas, Kisumu in Nyanza Province and Kiambu in Central Province, were purposely selected in order to reflect differences in social and cultural beliefs and practices, variations in access to AIDS knowledge and services and HIV/AIDS prevalence rates. Figures 1 showing the regional HIV prevalence rates in Kenya indicates the location of Kisumu and Kiambu districts in Kenya (the study sites). The two areas are meant to be illustrative of the social context of AIDS risk among people in Kenya and not to be statistically representative. Thus, no attempts are made to generalise the results of this study to the wider Kenyan population.

The Luo ethnic group predominantly inhabits Kisumu district. The catchment population for this study was from Kisumu rural, drawn from all the four divisions that constitute Kisumu district. Kiambu district is a peri-urban area close to Nairobi, largely inhabited by the Kikuyu ethnic group. Two locations were selected in Kiambu district, one for pilot testing and another for the actual fieldwork. The Luo and the Kikuyu have markedly contrasting economic and socio-cultural belief systems that tend to shape people's daily behaviour.

Kiambu district has an estimated population of 744,000 people and Kisumu has 517,317 people. HIV prevalence rates in Nyanza Province have been consistently high compared to rates in Central Province. At the end of the year 2001, 32% of people in Nyanza were estimated to be living with HIV/AIDS compared to 12% in Central Province. At the district level, estimates from sentinel surveillance data indicate that HIV prevalence rates in Kisumu and Kiambu are 26% and 17% respectively (ROK/ACU, MOH and NACC, 2001). Socio-economic, cultural and behavioural factors may explain the observed HIV prevalence rates. The age-sex distribution of HIV prevalence rates is similar to the national levels in both study sites. For example, in Kisumu HIV prevalence rates among adolescents aged 15-19 years are estimated at 22% for girls and 5% for boys, suggesting that girls are four times more likely to be infected than boys (MOH/Kisumu District Health Profile, 2000).

The quality and quantity of public services and infrastructure vary considerably between the two communities. Kiambu is well served by a network of tarmac roads; the majority of homes have electricity; there are public telephone booths and most homesteads have private water supplies. Newspapers are easily accessible in Kiambu. In Kisumu, almost all the rural roads are subject to closure during the rainy season, most rural homesteads have no electricity, public telephone booths are non-existent, and people depend upon local rivers and ponds for water supplies.

The two study sites are further differentiated by access to health and reproductive health services. Kiambu is well served by both public and private health facilities and Nairobi is within easy reach. There are two well-equipped private hospitals, a government hospital, and a number of health centres and private clinics. Proximity to Nairobi enables people in Kiambu to benefit from most AIDS prevention initiatives. The study site in Kiambu is served by one private hospital, one health centre, and three private health facilities attached to tea factories.

Services at the factory health facilities are free to non-workers. There are four primary and five secondary schools in the study site, most within walking distance.

Kisumu is typically a lowland area bordering Lake Victoria. The district is vulnerable to flooding and prone to water and vector-borne diseases such as malaria and diarrhoea. The district has 48 health facilities offering basic health services. The majority of the health facilities (23) are private enterprises and situated in Kisumu town. Generally, utilisation of health services is poor in rural areas because of poor infrastructure, long distances to facilities and inadequate distribution (MOH/Kisumu District Health Profile, 2000). Both Kisumu and Kiambu districts have benefited from a range of AIDS prevention initiatives, the common one being a nation-wide World Bank funded STI control project. However, consistently high HIV prevalence rates in Kisumu, and Nyanza province in general, have attracted the attention of several international donors and NGOs focusing on AIDS prevention, care and support activities. A major initiative has been the HIV/AIDS prevention and care (HAPAC) project funded by DfID and managed by Futures Group Europe. Futures Group Europe oversees activities of NGOs and private sector institutions targeting AIDS awareness, prevention and care activities in Nyanza Province, including Kisumu district. Despite all the AIDS initiatives, Kisumu ranks among areas with high HIV prevalence rates.

Economic activity is more diversified in Kiambu than in Kisumu district. Kiambu is a tea and coffee production zone and so most people are employed in farms and factories. Tea and coffee picking, planting, horticulture and vegetable growing are the main socio-economic activities of the people. Kiambu attracts many labour in-migrants from other parts of Kenya, particularly Nyanza and Western Provinces. Integration of people from different cultural backgrounds is likely to influence people's way of life. For purposes of this research, only people of the Kikuyu ethnic group settled in the area were selected. Another section of the population of Kiambu earns its living by working in Nairobi because of its proximity (on average, less than 1 hour by public transport). In Kisumu, most economic activities are confined to smallholdings utilising family land. The largest town, Kisumu is situated about 30 kilometres or more away from the rural communities (MOH/Kisumu District Health Profile, 2000).

The cultural beliefs and practices vary considerably between the two communities. In Kisumu, the practice of widow inheritance, a belief in witchcraft and '*chira*'<sup>2</sup>, and polygyny are entrenched components of the Luo culture which have been associated with the rapid spread of AIDS in the area (Kenya *et al.*, 1998; Ocholla-Ayayo, 1976). The Luo community does not traditionally practice male circumcision. In Kiambu, widow remarriage has disappeared and circumcision of boys and girls, a common cultural feature among the Kikuyu, has shifted from the more traditional form of seclusion to the modern hospital environments (Price, 1995). Polygyny is more widely practiced in Kisumu than in Kiambu. In the 1998 KDHS, about a quarter of women respondents in Nyanza Province reported having co-wives compared with 3% of women in Central Province. Similarly, 18% of men in Nyanza Province and 3% in Central Province reported being in polygynous unions.

The significance of the lineage system has declined markedly in Kiambu but it is a strong element of people's lives in Kisumu. Traditionally, the Kikuyu are a matrilineal society, in which the lineage is traced through female members of the family, though the husbands do not necessarily move to reside in the wife's home. Women in Kiambu have a stronger control in reproductive decisions than men since children belong to the woman (Price, 1995; Gage and Njogu, 1994). In the 1998 KDHS, twice as many women in Central Province (2%) as in Nyanza (1%) reported marriage dissolutions perhaps reflecting differences in lineage systems. Women in Kiambu can also inherit property from their fathers or husbands (Price, 1995).

In contrast, the Luo of Kisumu is typically a patrilineal community where the lineage system is drawn through male members. In a patrilineal society, women at marriage must leave their families to live with their husbands'. Payment of bride wealth to the woman's family transfers the woman's reproductive capacities and other benefits from her own lineage to that of the husband. Such a society might have higher rates of polygyny than others, suggesting that men are more dominating. In patrilineal communities, son preference for inheritance and continuation of the lineage tree has a strong influence on the number of children a woman bears for her husband's family (Gage and Njogu, 1994). Kiragu and Zabin (1995) observe that patrilineal societies in some parts of Africa condone premarital sexual relations for boys and not girls. Traditionally, Luo women do not inherit property (Ocholla-Ayayo, 1976).

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<sup>2</sup> '*Chira*' is a Luo term for a body wasting illness that is believed to afflict people who break cultural taboos.

### **3 KNOWLEDGE AND SOURCES OF SEXUAL AND AIDS INFORMATION**

#### **3.1 Introduction**

This study used a range of questions to explore the levels of sexual and HIV/AIDS knowledge and attitudes, particularly regarding the causes of HIV/AIDS and its prevention (See Appendices 3.1 and 3.2). FGD participants were asked about the sources from which they learn or hear about matters concerning sex, contraception, STDs and HIV/AIDS, mentioning the nature and type of information acquired. It was not the intention of this study to examine the role of the various public awareness messages or community level networks, but rather to understand what is learnt from different sources. It is apparent that the type of sexual information people gather from different sources may have varying influences on their attitudes and behaviour.

#### **3.2 Knowledge of AIDS**

In both study sites, people were well informed about AIDS. When asked how HIV is acquired, not only did the FGD participants chorus “*sexual intercourse*”, but they also added that it was unprotected risky sexual contact, in particular, that was a problem. Multiple partnerships, casual and extramarital sex, sex between young and older people, and sex for monetary and material favours without use of condoms were explained to elevate a person’s risk of getting HIV. Married women implied that men’s infidelity was the major cause of HIV infection among partners, and that married women were less likely than their husbands to have extramarital sex. A few participants demonstrated deeper knowledge by stating that HIV could be transmitted even with use of condoms since they can burst or that some individuals intentionally pierced them, a concern strongly expressed by women. Details about condom use are discussed in section 6.3.

Participants asserted that blood is a channel of HIV transmission saying, “*What we have been told is that blood contact is the major mode of transmission*” (Kiambu, FGD, older married males). The main sources of blood infection mentioned include transfusion of infected blood, sharing of contaminated injections or syringes, and sharing of cutting or shaving instruments such as razors and circumcision knives. Discussants also had plausible explanations of how the HIV virus could be transmitted through blood by contact with saliva and other body fluids especially if cuts, sores, or dental bleeding are present.



Participants' misconceptions about AIDS were negligible. They agreed that sharing of eating utensils, beds, and shaking hands could not transmit HIV, suggesting high levels of accurate knowledge. Only older married women in Kisumu believed that one could get HIV through caring for an infected person and sharing food, fears that could be reflecting their sources of AIDS information and the high HIV prevalence rate in the region that places the burden of caring for the sick on women.

Younger participants in both study sites spontaneously mentioned mother to child transmission, while older participants were probed. However, all discussants expressed clear understanding of the mechanism of mother to child transmission stating a mother could pass infection to the child either during childbirth or breastfeeding.

Participants were aware that certain cultural practices such as widow inheritance, polygyny, belief in witchcraft and “*chira*” (or a curse that results from breaking of a taboo), marriage and fertility goals, could place them at risk of HIV infection. These are discussed in detail in section 5.2.

### **3.3 Sources of Sexual and HIV/AIDS Information**

#### **3.3.1 The Mass Media**

There was evidence from FGDs of the penetrative influence of the mass media. Apart from the formal sources such as the radio, television and newspapers, people are also exposed to an array of other communication channels such as films, magazines, books, and videos. The HIV/AIDS communication appears to emphasise AIDS prevention through condom use, abstinence, monogamy and fidelity. All the participants reported receiving much information on the radio. They stated:

*R4: For instance the radio talks about those infectious diseases...like gonorrhoea... diseases like that...<sup>3</sup>*

*R4: It is the KBC radio, which talks about these things.*

*R1: All the radio stations...nearly all the ten of them talk about AIDS.*

*R1: Radio programmes especially the channel KAAYU (local Kikuyu dialect radio) that highlights the dangerous impact of AIDS (Kiambu, FGD, unmarried male).*

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<sup>3</sup> Quotations are indicated in reference to the place, method of data collection, and category of respondents. For example, an ending of the format (Kiambu, FGD, unmarried female) indicates that the source of the quotation was from a focus group discussant that was an unmarried female in Kiambu site. Where applicable, ‘M’ stands for moderator or interviewer and ‘R’ for respondent.

*“Through the radio we get information on how STDs spread. Through programmes like ‘Ushikwapo Shikamana’ (government-sponsored), we get important information on sexual matters and diseases” (Kisumu, FGD, married male).*

*“From the radio and also TV. For example radios advertise ‘Trust’” (a brand of condoms) (Kiambu, FGD, unmarried female).*

*“They show us such programmes on TV. They show us how people fall in love; how they get AIDS and how it makes people look and how AIDS orphans are taken care of” (Kisumu, FGD, married female).*

*“We also get information from radios about AIDS and how to avoid risky sex” (Kiambu, FGD, married female).*

The television was said to be more informative because of the audio-visual effects likely to have lasting impressions, though the participants acknowledged that the TV is expensive and is affordable by only a few people.

The discussions also revealed the influence of ‘role models’ as depicted in films, videos and sometimes TV programmes:

*“When young boys go to films and video shows within the community they acquire sexual information by seeing how actors behave” (Kisumu, FGD, unmarried male).*

The print media (newspapers, magazines, books, and posters) were mentioned as sources of information on AIDS statistics, personal life experiences, and other information as illustrated by these discussants:

*“Yes, you read or see a photo of someone who died of AIDS or you find statistics of a given area showing the number of people affected” (Kisumu, FGD, married male).*

*“Also magazines, you read and get ideas e.g. Parents Magazine which gives stories about people’s experiences” (Kiambu, FGD, unmarried female).*

*“...Maybe you read...how a girl got pregnant and was just left alone by a boyfriend” (Kiambu, FGD, unmarried female).*

*“You can read about new family planning methods or forms of contraceptives launched in the market” (Kiambu, FGD, unmarried male).*

### **3.2.2 Community-Level Networks**

**Friends and peers.** Much discussion about sexual matters was reported to occur among friends or peers because *“it is people of your age group...they are the ones you can talk with without ...feeling shy or embarrassed” (Kiambu, FGD, unmarried male).* The context of such

learning may be at school or at home, but usually people considered friends or acquaintances as major sources of information. Discussions between same-sex groups were reported to be the commonest and mixed-sex discussions were rare. Same-sex group discussions are usually with acquaintances and other peers, in which individuals acquire information about sexual matters (both correct or incorrect) from group members with more sexual knowledge and experience. Information exchanged in the group often emanates from an array of other sources already mentioned. A discussant stated:

*“One can learn from discussions that take place in groups... As you talk you can pick one thing at a time. You get something from here, then from another place and the another tomorrow. In the end you have acquired all those things” (Kiambu, FGD, married male).*

Group discussions are more common among men than among women. The group talks seldom address the issues of HIV/AIDS or pregnancy, but matters regarding physical attraction and sexual experiences with the opposite sex as expressed by several unmarried male participants in Kisumu district:

*M: How do boys like you know about matters concerning sex and HIV/AIDS?*

*R2: ...Friends. Most of the time we are together with these people. We even sleep together with them in common houses...We exchange views about sex and listen to their sexual experiences, which we are then influenced to adopt.*

*R1: Peer groups influence people to adopt different sexual habits and acquire different types of sexual information. When we are in groups, most of the things we discuss are sexually related. We mainly dwell around topics concerning girls.*

Married discussants suggested that they sometimes exchanged information related to doubts and suspicion about their spouses and misunderstandings that occurred in marital sexual relations. One male participant in Kiambu alleged that it was difficult to talk about marital sexual relations with one's friends, but this was quickly refuted by other discussants: *“...there is no difficulty in talking to a friend. You can tell a friend very private issues with much ease” (Kiambu, FGD, married male).*

The one-to-one discussion may involve a close, trusted friend of the same sex or a sexual partner and, is used to discuss more serious and intimate issues that surround relationships such as the use of contraception, fears regarding STIs or pregnancy and issues to do with misunderstanding between partners.

*“From your girlfriend... She may request you to use contraceptives, especially when she fears unwanted pregnancy. Sometimes she may request some few coins to buy the pills” (Kiambu, FGD, unmarried male).*

The one-to-one level of communication is the most common form of discussion among women as expressed in these dialogues with unmarried women in Kiambu:

*M: What questions do you ask friends concerning sexual matters?*

*R1: Let us say that you love a boy who is giving you a lot of problems so you go to a girlfriend like Wanjiru (a girl's name) and ask her how to resolve it.*

*M: What things would you then talk with Wanjiru?*

*R5: Like if he is disturbing you so much you can ask for advice from other people and they tell you what to do, and so you can only go to a friend in that case.*

*M: Anything else?*

*R3: May be he is "double dealing" you with another person. You see you talk to a friend to advice on what steps to take.*

*R3: Boyfriends give you advice on how to prevent diseases or pregnancy.*

One group of married men in Kisumu pointed out that they hardly broached the topic about AIDS with their partners because of the fear of being suspected of unfaithfulness. They prefer women to raise such matters since they are considered more trusted.

**Parents and Siblings.** Almost all groups acknowledged that there was little discussion about HIV/AIDS and other sexual matters. The involvement of parents in communication is limited to giving warnings to their daughters or sons about the risks of pregnancy and infection. This is prompted by the children's behaviour such as coming home late at night and being drunk. Parents also caution their children when they send them out on errands. Sometimes the discussion of sexual matters with parents is considered disrespectful or taboo.

*"Parents advise on not moving around and to avoid having many friends" (Kiambu, FGD, unmarried females).*

*"Talking with parents about sexual matters is very difficult as sex is considered something that should be treated with much privacy...Moreover, there should be respect maintained between parents and children such that issues like sex cannot feature as subjects of discussion...When such a discussion starts you may find one of the parties (parent or child) going away" (Kisumu, FGD, married males).*

*"It is not easy to discuss these issues with parents, as it is taboo to discuss issues related to sex..." (Kisumu, FGD, unmarried males).*

Some participants observed that the home environment, such as the sleeping arrangements in which parents share bedrooms with their children, expose children to sexual matters early in life. It was alleged that this is the case for rented premises, a common feature in urban and peri-urban areas.

On the other hand, some parents that talk to their children, though the breadth and depth of such talks appeared to be limited and one-sided. The parents give the instructions with little or no parent-child discussions; "...*We tell them to take care about moving around and having many sexual partners*" (Kiambu, FGD, married female). Parents are prompted to talk to their children by media messages, the prevalence of AIDS deaths and sex education at school that exposed children to facts about AIDS, though parents expressed being shy and embarrassed. The following excerpt from married women in Kiambu sums the views of many:

*M: Do you find it easy or difficult talking about these issues (sexual) with your children?*

*R4: ...These days we don't find it hard...It has become easy because of the many people that have died of AIDS. Yes, there is no shame now.*

*R2: Because even the radio talks about it when the family is together. You won't switch the radio off because there are children...Though you as a parent you may be ashamed, but because these things are now being talked about there is no way you will have a problem with it.*

*R6: ...Children will still...narrate how at school they were taught about AIDS and even shown a video.*

The educated parents were said to have greater openness when discussing sexual matters with their children. Perhaps this is because educated parents are less likely to adhere to the traditional communication structure of strict distinctions between parents and children, consequently having a more open attitude towards sex.

Siblings were also mentioned as sources of sexual information. Like the parents, discussions of sexual matters between siblings appear to be rare. Learning from siblings involves observing the behaviour of an older brother or sister with members of the opposite sex as this respondent said, "*We learn through an older brother; through his actions such as the way he relates to girls*" (Kisumu, FGD, unmarried male).

Married discussants reported discussing their marital problems with their siblings, whereas one unmarried woman in Kiambu dismissed the whole idea saying, "*We have never talked with our brothers and sisters*". IDIs showed a few cases where older siblings warned their younger kin about sexual risks, and also provided the younger siblings with contraceptives. For example, an in-depth interview with an unmarried female respondent indicated that her older sister gave her a packet of contraceptive pills after realising she was sexually active. When the respondent ran short of pills, she got pregnant and dropped out of school.

**Clinic/Health workers and community-based organisations.** Information from health sources is obtained through health talks given to patients at maternal and child health and family planning clinics (MCH/FP), posters, and community health workers (CHWs). The CHWs liaise with women groups to organise AIDS awareness seminars, though women groups also provide an opportunity for “gossiping” about sexual relations. Female discussants, more than the males, mentioned health workers as sources of sexual and AIDS information. Perhaps this is because women are more likely than men are to visit MCH clinics since it is women who go for antenatal care or take children to health clinics.

Women said that they learn little from health talks and posters at health facilities. They stated that health workers are rude and do not give patients time to ask questions. When unmarried males in Kiambu were asked if they get any information from hospital, they simply said “*we do not go to hospital; we rely on herbal medicine*”. The negative attitude of health workers appears to limit the communication dynamics of sexual matters with patients and this deters people from asking questions or seeking STI treatment.

Evidence suggests that government leaders were actively involved in AIDS awareness campaigns. The leaders inform the public at funeral gatherings that usually draw huge crowds, as well as during community leaders’ meetings such as celebrations to mark public holidays.

*“Also through funeral ceremonies. The Assistant Chiefs advise the youth not to have sex because of the HIV prevalence” (Kisumu, FGD, unmarried female).*

*“...In funerals it is announced if somebody has...been found to have died of that disease (AIDS)” (Kiambu, FGD, married female).*

**Schools.** Female participants were more likely than the males to mention schools as a source of information. The topics covered in school include puberty, pregnancy, HIV/AIDS and other STDs and sexual abstinence, with emphasis on menstruation.

*“In schools we are taught and get information on how to prevent diseases and pregnancy” (Kiambu, FGD, unmarried female).*

*“They (teachers) tell us that we can get diseases like gonorrhoea, HIV and syphilis if we get involved in sexual activities” (Kisumu, FGD, unmarried female).*

*“...We get information about AIDS and human physiology from teachers in schools” (Kisumu, FGD, married male).*

Evidence from older women suggests that AIDS education is now offered at school and children talked about being taught and shown videos regarding AIDS. However, it appears that AIDS education is being imparted without consideration for the student's age and so information is likely to be misinterpreted by young students as illustrated in a view expressed by a married woman in Kiambu:

*M: What about learning, is there anywhere they are taught?*

*R: In some schools they learn. Like mine is in standard five (about 10 years) and she came to tell me about it at home... They were shown a video at school so even when the radio mentioned it she told her father too (Laughter). She said to him, 'father have you heard? We were shown a video but for me I want to get educated. I will live alone (no marriage) because I don't want to die' (Laughter).*

*M: So she took it that if she marries she would die of the AIDS disease?*

*R: Yes, she is still young for advice but she knows that if you have sex with a man you will get AIDS. That is what she knows...*

**Churches.** Churches are actively involved in communicating AIDS information in the form of either sermons or youth seminars revolving around the dangers of AIDS and the value of abstinence outside marriage and fidelity within marriage. Almost all the groups talked about church-organised AIDS awareness seminars. The nature and extent of the talks were considered not valuable because “...they use idioms, they pass a long route before they deliver the message” (Kiambu, FGD, unmarried male). The findings attest to the fact that talking about HIV/AIDS issues in church is constrained by the need for church leaders to abide by existing church doctrines concerning sexual matters. The Catholic Church was singled out as being non-supportive of condom use, which made it difficult communicating AIDS prevention messages in the church, suggesting a preference for value-laden messages that may not be practical for the majority of sexually active youth.

### **3.4 Summary**

It is apparent that AIDS knowledge is high. People gather sexual information from different sources, which may also have varying influences on their perception of AIDS risk and sexual behaviour. The widespread knowledge and sources of AIDS information among the participants under study may be attributed, in part, to the success of the countrywide AIDS awareness campaigns. There was no evidence from the discussions to suggest that there is HIV/AIDS communication related to voluntary HIV counselling and testing, gender relations, sexual decision-making and negotiation skills.

## **4 THE SOCIO-CULTURAL CONTEXT OF SEXUAL RELATIONSHIPS**

### **4.1 Introduction**

Studies in sub-Saharan Africa have documented the important role of cultural practices and behavioural factors in the spread of AIDS (Cohen and Trussell, 1996). To gain an understanding of the social context of sexual behaviour likely to heighten the spread of AIDS in the communities, FGD participants were asked if premarital and extramarital sexual relations were common in the local communities and their opinions on such relationships. Unmarried participants in both FGDs and IDIs were asked about the motivations for premarital sexual activity. These are described below.

### **4.2 Premarital Sexual Activity**

The opinions expressed in FGDs and IDIs concurred that premarital sex is a pervasive sexual culture in the study communities; most unmarried women and men were sexually active. All except two male FGD groups in Kiambu mentioned that more men than women were sexually active. However, the IDIs suggested that unmarried women were about the same as unmarried men to engage in premarital sexual intercourse, as all married participants interviewed in-depth were not in union with their first sexual partner. Similarly, information collected from FGD participants at the end of the discussions showed that out of 30 never married men who participated in the FGDs, only one stated that he had never had sexual intercourse. And out of 21 unmarried women only five said they had never had sex.

Participants stated that both boys and girls start sexual activity at an early age, but the girls started much earlier than the boys because they mature faster and “*men notice girls when they are young and can easily be cheated*” (Kiambu, FGD, unmarried females). All FGD participants in Kisumu cited much lower ages for sexual initiation than the Kiambu groups. In Kisumu, the range was nine to 12 years for girls and 10 to 15 years for boys, and in Kiambu it was 10 to 20 for girls and 10 to 22 for boys. Perhaps among the Kiambu participants, traditional circumcision practised for both girls and boys may promote delay in sexual debut. There are no initiation ceremonies in Kisumu. Except for the women, ages at first sex reported in IDIs by men did not reveal striking differences from those reported in FGDs. The age at sexual debut reported in IDIs by young women ranged from 13 to 22 years with most citing 16 years, and for the men the range was 10 to 20 years with most reporting 15 years.



Among all male FGD participants in Kiambu, initiation of sexual intercourse for boys was linked to the time immediately after circumcision, said to take place at the age of 15 to 18 years or when they complete primary school. For the girls in the same area, sexual initiation was reported to occur when they are in standard 5 or 6 (level of primary education where most children would be aged 10 to 13 years). A discussant in Kiambu said of the boys:

*“It is mostly around 16 years of age. Because that is when they get circumcised after say leaving class 8” (Kiambu, FGD, unmarried male).*

The age that was considered appropriate for initiation of sexual activity was 18 to 20 years because at that age “... you are learned and know about good and bad” (Kiambu, FGD, unmarried female). Nonetheless, all married participants advocated abstinence till marriage. The married discussants considered 18 to 20 years as ages in which people are both physically and mentally mature to start a family, stating that currently the age at which girls and boys start having sexual intercourse was too early because they cannot manage a family.

*Both girls and boys should start having sex when they are ready for parenthood” (Kisumu, FGD, married male).*

These views could be linked to AIDS awareness campaigns in Kenya that promote the delay of sexual debut. In addition, most boys and girls in Kenya complete secondary school around the age of 18-20 years. After secondary school, one is considered marriageable.

When FGD participants were asked if premarital sex is acceptable in the communities, all discussants acknowledged that it was unacceptable and that “*even the government does not approve of it*” (Kisumu, FGD, married females). Although not sanctioned premarital sexual activity is implicitly tolerated and accepted. The increase in premarital sexual activity was attributed to the collapse of traditional restrictions and sanctions that regulated premarital sex. A group of married men in Kiambu stated that among the Kikuyu, traditional circumcision ceremonies for girls and boys used to be marked by a period of seclusion, in which initiates were taught about sexual matters. Similarly, among the Luo who did not traditionally circumcise, literature suggests that grandparents played a major role in teaching adolescents about responsible sexual behaviour that emphasised premarital virginity (Ocholla-Ayayo, 1997; 1976).

*“In the past, virginity was highly valued than nowadays. Nowadays almost all girls are not virgins” (Kisumu, FGD, unmarried female).*

The married males in Kisumu stated that traditionally, those found to engage in premarital sex were punished through a curse. A man said:

*“Previously the punishment given to those who engage in premarital sex was by placing a symbol of an outcast within the house they were sleeping. These people shall be treated as outcasts such that they do not live a normal life. All their children are believed to die in future” (Kisumu, FGD, married male).*

### **4.3 Motivations for Premarital Sex**

Motivations for premarital sex could be strong enough reasons to preclude adoption of strategies to reduce the risk of HIV. Young unmarried participants in FGDs, as well as in IDIs, were asked why young people have sex. The reasons for premarital sex showed high agreement between FGDs and IDIs. The broad reasons were: socio-cultural norms, peer influence and pressure, economic reasons, and media influence. Participants frequently mentioned the first three reasons and media influence was less reported.

**Socio-cultural Norms.** Men’s sexual activity appears to be driven by the desire to experience unprotected penetrative sexual intercourse in order to prove their manhood and to be like other men. To that end, young men took advantage of opportunities that arose to accomplish their motives. Almost all men expressed the same reasons for having sexual intercourse, and were supported by views expressed by women:

*“You expect to prove to people that you are capable of having a girlfriend. In case a girl has been rebuking you as being useless and incapable of having sexual intercourse you can lure her into sex to prove to her that you are a real man” (Kisumu, FGD, unmarried male).*

*“Some want to know whether they are mature or not e.g. by making a girl pregnant” (Kisumu, FGD, unmarried female).*

For men, sexual activity is considered a natural reaction that is difficult to control. This fact was even supported by women. An unmarried woman in Kiambu interviewed in-depth said that she had sex because *“it is the normal thing for men.”* Young unmarried men in Kiambu believed that it is natural for men to have sex or else retained sperm can make a man ill.

*“There comes a time that when the back begins to pain ... I am talking about something that I have experienced ... it reaches a point, after staying longer without having sex, that your back begins to give you problems” (Kiambu, FGD, unmarried male).*

For women, the ultimate aim for having sex was to have a marriage partner and to raise children in a family environment. Some men also supported these views. When asked why

she had unprotected sexual intercourse with her current partner, an unmarried woman in Kiambu said: *“Because I want to be married. I love him and he loves me.”* Other participants said:

*“Looking for a husband; you want to get married” (Kiambu, FGD, unmarried female).*

*“Friendship is for marriage. This especially applies to girls from distant places e.g. in-laws who you can eventually end up marrying” (Kisumu, FGD, unmarried male).*

Unmarried women stated that they preferred to have serious long-term relationships that culminate in marriage, but men who engaged in casual and concurrent partnerships curtailed this. Unmarried women reported that they are forced to terminate their partnerships once they realise that the partner is *“double-dealing”* (has concurrent sexual partners). Consequently, women end up in short-term serial monogamous relationships whereas males tend to have short-term concurrent partnerships.

Although FGDs with unmarried women also suggested men often had two sexual partners; *“one for the future (for marriage) and another one for sex”*, findings of IDIs did not support this claim. Almost all women and men interviewed in-depth reported to have had serial monogamous relationships, except one woman and man who reported to have had concurrent sexual partners. The limitations of self-reported behaviour could explain this difference.

Men felt a sense of great achievement and contentment at first sexual intercourse and this was evident on how it was readily and explicitly discussed with friends. Unmarried men in Kiambu and Kisumu said:

*“I felt good. I felt I was a man...I talked to my friends at school about what went on and other experiences I had” (Kiambu, IDI, unmarried male).*

*“... I felt very happy and relieved because I had scored the goal...I talked to a friend of mine who was of the same age. We talked about the girl I had slept with. I was very excited about my first sexual encounter” (Kisumu, IDI, unmarried male).*

On the contrary, for nearly all women, first sexual intercourse evoked feelings of hatred and regret. When women were asked how they felt after first sexual intercourse, some said:

*“I felt pain. I felt I would never do it again. I hated sex...I did not talk to anyone about it” (Kiambu, IDI, unmarried female).*

*“...I felt like I had done a bad thing... I never told anyone” (Kisumu, IDI, unmarried female).*

**Peer influence and Sexual Pressure.** Conformity to the normative behaviour plays a significant role in young people's sexual behaviour. Individuals would want to do what others do so as to feel a sense of belonging to their circle of friends.

*"Friends also have that habit (have sex)... And if you want to fit with them, you have to do what they do" (Kiambu, FGD, unmarried male).*

*"I had sex because of the influence from my friends. They kept on saying stories about their girlfriends. It was also because of my age, I just started feeling like I wanted to have sex" (Kisumu IDI, unmarried male).*

Men compete to outnumber each other on the number of sexual partners they have and they boast about their sexual prowess.

*"...You also engage in sex due to peer competition. Age mates would like to outdo one another or prove their manhood; that they are mature. You also engage in sex to match your peers or confirm that you are still active. If so and so has a girlfriend and also tells me how he has sex why should I also not engage in sex or have a girlfriend" (Kisumu, FGD, unmarried male).*

*"To feel great by setting a record based on the number of partners one has" (Kiambu, FGD, unmarried male).*

It was a common belief among all participants that true love must involve sex. Some said:

*"Yes, I had sex in order to make the girl remain mine because...without sex, there is no love...." (Kisumu, IDI, unmarried male).*

*"For you to have true love you must have sex" (Kisumu, FGD, unmarried male).*

*"To trust you and to believe that you love him you must have sex" (Kiambu, FGD, unmarried female).*

Sexual pressure was evident either as a form of forced/coerced sex from a male partner (and to a lesser extent a female partner), or from peers. The views that pressure from boyfriends, influences many girls to engage in sex were common among both young unmarried men and women.

*"Some girls have sex due to pressure from boyfriends who have been giving them money for sometime. In this case they are easily influenced" (Kisumu, FGD, unmarried male).*

Forced or coerced sex was a recurrent theme among women interviewed in-depth, particularly in first sexual intercourse, and to a lesser extent, in recent/current relationships, and also in FGDs. Almost all women interviewed in-depth reported that they did not want sex the first time compared to men who all said they wanted to experience sex. It should be acknowledged

that women might have reported that their first sexual experience was unwanted simply because of a need to give a culturally acceptable response, rather than the “truth”. Responses to subsequent probing attest to this fact. When asked why they had sex when they did not want to, most women alleged that they agreed to have sex because the men insisted and they did not want to annoy them. Some women expressed having acquiesced in sexual intercourse for fear of termination of the relationship and sometimes because sex is synonymous with love and is therefore used to please men. One said, *“I did it because I loved him” (Kiambu, IDI, unmarried female).*

Results from IDIs imply that most women engaged in first sexual intercourse not because they wanted to but because they felt obliged to do so. In addition, the opinions expressed suggest that coercion is gradual; in which a woman is persistently manipulated and pressured to a point she relents to sexual intercourse:

*“ ...I didn’t know anything...He told me we go to his place. Then he did it (had sex with her). I really didn’t know anything. I was then 18 years old and he was 21. He cheated me into it. I didn’t know that is what he wanted. I went to his place innocently (Kiambu, IDI, unmarried female).*

Four women interviewed in-depth stated having been forced/raped during first sexual intercourse, and alleged that they did not resist because of being in an isolated environment and the fear of repercussions of being sexually uncooperative. In addition, the secrecy of the affair made the women remain silent about the rape and, as alleged by one woman, because nobody would have believed. An unmarried woman said:

*“ No! He forced me to. We were in his home attending a birthday party. Most people had left and finally we were left alone... He suggested it and I refused. He dragged me to one of the bedrooms and raped me (Kiambu, IDI, unmarried female).*

Situational factors far outweigh the risk of HIV infection in influencing premarital sexual activity. Typically, the IDIs revealed that sexual intercourse appears to occur spontaneously by a man creating situations (e.g. asking the girl to visit him at his house or a friend’s, meeting at an isolated field or place) that would easily end up in the woman agreeing to have sex even if this was not in her mind in the first place. Women appear to agree to the invitations, not knowing that consenting to the boy’s proposal is likely to lead to sexual intercourse. Premarital sexual activity takes place out in the fields or ‘green lodges’, in the men’s houses (own house or a friend’s), referred to as ‘cubes’ or ‘simba’, in boarding schools, at the back of classrooms, at discos, parties, funeral gatherings, and in rented places (lodges).

Both the FGDs and IDIs reiterate the subtle manipulative process men employed in sexual intercourse. Evidence from IDIs suggests that men always played the leading role in deciding when, where and how sexual intercourse took place. When asked who decided that sex should take place, most men simply said, “*it is me*”, or “*I did*”, and some men expressed how they persuaded the woman:

*“I had to struggle. It wasn’t easy...She lacked self-control, and I took advantage of that” (Kisumu, IDI, unmarried male).*

Some men said they negotiated with their partners or that the woman decided: “*Me. It is a man’s responsibility to do so*” (Kisumu, IDI, unmarried male).

The desire to explore and to experiment with different partners influences premarital sex and for some, sex is for pleasure and fun. An unmarried woman in Kiambu said:

*“I had not done it before so I wanted to try in order to know how it feels” (Kiambu, IDI, unmarried female).*

Another woman remarked that though she was scared and felt pain at first sex, she did not mind having sex and so “*after all the touching I actually started enjoying it and so I allowed him to go all the way*” (Kiambu, IDI, unmarried female).

**Economic Motives.** Receiving money and material favours was a common theme cited by all FGD groups and by some women interviewed in-depth as a reason for premarital sex, and usually linked to the rising poverty levels in the communities. An interview with an unmarried woman in Kisumu illustrates both elements of manipulative sex, as well as, the allure of monetary and material gain for women:

*R: The first one (boyfriend) was due to influence because the guy was too powerful for me. He had that convincing power that I wasn't going to resist because I loved him*

*M: Why did you have the relationship then? How did he convince you?*

*R: By telling me that he would give me school fees.*

*M: What else was he offering?*

*R: Help, like buying me lotions and such like things.*

*M: Anything else that made you agree to the relationship?*

*R: Only those.*

The theme of sex for economic motives is discussed in detail in section 5.3.

**Media Influence.** This was commonly mentioned in FGDs and IDIs in Kiambu. A discussion with unmarried males in Kiambu indicated that young people learn about sex from watching films or printed literature.

*R7: It is psychological issues, after probably watching a movie or reading a magazine. You tend to experiment as watched or read.*

*R6: You could be watching TV with her and you are tempted to have sex.*

*M: Anything else*

*R2: Adult films.*

An in-depth respondent said:

*“... I thought I should adventure now. I have been reading magazines, watching movies...I wanted "to experience it" and do everything as instructed in the magazines to make her satisfied. So I never looked at it as a serious relationship, it was use and dump” (Kiambu, IDI, unmarried male).*

Sex education at schools was mentioned to influences girls and boys to learn about sex and to experiment at an early age. A participant said:

*“We shouldn't forget that due to education more young unmarried people are indulging in sexual activities. The introduction of sex education explains this where even the innocent children are exposed to sexual matters and many of them go ahead to have sex out of curiosity” (Kiambu, FGD, unmarried male).*

Discussions with unmarried men in Kiambu indicated that condoms are believed to promote premarital sexual activity, because people believed that they fully protect against HIV infection.

*“The use of condoms. People look at condoms as absolutely safe. They therefore engage in sex anyhow. Condoms have made some people believe that there is no HIV/AIDS” (Kiambu, FGD, unmarried male).*

The context of condom use is discussed in detail in section 6.3.

#### **4.4 Extramarital Sexual Relations**

The FGDs with married women and men were asked about their opinions on extramarital sexual relations. All married participants in the two study sites were unanimous that extramarital sex is common though not acceptable. Further discussions suggested that the men more than women, perpetuate extramarital relations.

Interestingly, the IDIs with married women and men did not suggest that extramarital relations are common. None of the IDI participants admitted being in an extramarital relationship. The reason for the discrepancy in FGD and IDI results could be related to the small number of participants of IDIs or the reticence of people to talk about individual sexual experiences particularly if it is not the normative behaviour. Participants said extramarital

sexual relations are frowned upon and “*it is something that the community strongly condemns...*” (Kisumu, IDI, married female). Alternatively, it might just be that none of the IDI respondents had engaged in extramarital sexual activities in the last year before the study.

When asked why married women and men have partners outside marriage, men ascribed their extramarital affairs to their wives’ behaviour, whereas women linked extramarital sex with poverty or economic motives and lust. Some men and women said:

*“Lack of sexual satisfaction from the wife. Hostility from the wife can also result to a man having an extramarital affair”* (Kisumu, FGD, married male).

*“...Another thing that makes a man have a partner outside marriage is disagreements between him and his wife. She may become stubborn”* (Kiambu, FGD, married male).

*“If the woman lacks money in the house, she will look for someone”* (Kisumu, FGD, married female).

*“It is both men and women. Rich women take on young men, and the rich old men take young girls out. So you cannot say it is some people only, it is both ways”* (Kisumu, FGD, married female).

Some married men attributed extramarital sexual relations to the special care and personal attention given to them by the non-regular sex partners. Such care is reported to be lacking at home because wives are always nagging and cruel. A group of married men in Kiambu concurred that some women are “*cold because they have used contraceptives over a long period*” (Kiambu, FGD, married male). Some married women in Kisumu mentioned that men engage in extramarital sexual activity because of the need for variety since some “*cannot eat ‘sukuma’ (type of vegetable) everyday*” (Kisumu, FGD, married female).

#### **4.5 Summary**

The results described above suggest that premarital sex is common in the study communities and although considered not acceptable it is implicitly tolerated. The need to prove manhood, peer influence and pressure, economic motives, and media influence were reported to influence risk-taking behaviour among unmarried women and men in the study communities. It is interesting to note that both women and men tended to blame their partners for infidelity. Poverty and the sugar daddy/sugar mummy culture, lust or promiscuity, work away from home, spousal conflicts, revenge for a partner’s sexual infidelity, and lack of care and concern by spouse were given as reasons for extramarital sex.



## **5 PERCEPTION OF AIDS RISK**

### **5.1 Introduction**

Focus group discussions and IDIs were used to explore the extent to which participants thought AIDS was a threat to their community and the reasons for their fears. The FGD participants were asked: To what extent do you think HIV/AIDS is a risk to this community? Participants in IDIs were asked two questions regarding their perception of personal risk of HIV infection. The questions were: “In your opinion, do you fear that your sex life might have put you in danger of getting AIDS?”, and “Would you say currently you are in danger of getting AIDS?” The reasons for perceiving or not perceiving risk were sought. Individual in-depth interviews (IDIs) were used to explore the more personal and sensitive issues of how people perceive, interpret and respond to their personal vulnerability to AIDS under different contexts and stages of their sexual lives, that would otherwise not be possible in FGDs. Unlike opinions raised in FGDs, it was not easy to simply categorise IDI participants into those who perceive and those who do not perceive themselves at risk since respondents interpreted their own risk in a range of ways, sometimes with contradictions, so that a person could both acknowledge and deny risk at different points of the interview.

### **5.2 The Worry About AIDS**

When FGD and IDI participants were asked in general what sexual risks they worry about, HIV/AIDS appeared to be a distant concern. Married participants worried more about having too many children to be able to care for properly, shame, embarrassment, and sometimes divorce due to marital infidelity. Unmarried women and men worried most about pregnancy, abortion, and school dropout for girls as illustrated by these segments of dialogues with unmarried men in Kiambu:

*M: What do young men fear most about sex?*

*R1, R4: Pregnancy.*

*R1: It is pregnancy. None of you is willing to take the responsibility. She may opt for abortion. If she dies the police will come for me. I will be imprisoned as well as pay for the damages.*

*R5: You know AIDS takes long to kill but abortion is a fast killer.*

*M: What of girls?*

*R2: Pregnancy.*

*R8: Sometimes her parents ...would not like their daughter to be married off before completing her studies.*

*R7: Also you have made her life miserable by losing her education.*

Interestingly, when specifically asked whether they feared the AIDS disease, all participants then acknowledged the severity of AIDS, stating the fatality of HIV infection as the most worrying consequence of AIDS. Thus, asking about AIDS in a more direct and personal manner brought the reality of AIDS closer to home and made participants suddenly realise its enormity. An unmarried man in Kisumu summed the views of many when he said:

*“AIDS is a risk and is very common in this community. Very many people already have the disease as reflected by the number of orphans who end up being street children (referred to as ‘ninjas’). The number of widows is also on the increase. Most of their husbands have died of AIDS but some people who are the traditional die-hards do not accept this. When knowledgeable people are dying within the community, this is a sign of risk to the community. Indeed, AIDS is a threat to the community” (Kisumu, FGD, unmarried male).*

All FGD groups recognised that AIDS is decimating families, the old and the young, married and unmarried, the educated and uneducated, so *“it is a problem to everyone; the infected and the affected” (Kiambu, FGD, married male).*

Participants worried about social and economic impact of AIDS to families. All groups and individuals mentioned orphaned children as a major effect of AIDS to the families. The death of parents was described as leaving children to fend for themselves or under the care of the elderly and other relatives who may be unable properly to care for them. Families were reported to incur loss of earnings through household expenditures for medical expenses and funeral costs when the breadwinner dies. It was also frequently mentioned that AIDS has led to the disintegration of the family unit. There was strong evidence of stigmatisation and ostracism of HIV infected individuals and affected children and families of people who got sick of or died of AIDS. Some participants said:

*“They (children) are stigmatised by people because of fear of contracting the disease. People tell their children not to mix with them because they fear their children can get infected” (Kiambu, FGD, married female).*

*“I am most worried about the AIDS disease...When you have AIDS it is coupled with much social stigma. Community members do not want to associate with you. You always feel guilty” (Kisumu, IDI, married male).*

Some FGDs alluded that poverty has escalated due to the reduction in labour productivity, attributed to the time spent caring for the sick or seeking for care. Participants suggested that AIDS has led to low levels of development in the communities since the disease kills people in the economically productive ages and causes children to drop out of school.

### 5.3 Reasons for Participant’s Perception of AIDS Risk

The reasons mentioned are summarised in Table 1 below and, are broadly classified as behavioural, economic, socio-cultural, environmental, and to a lesser extent, attitudinal and bio-medical factors. Participants clearly indicated a mix between the social construction of risk and the contemporary bio-medical explanation as to what constitutes risky and non-risky behaviour. While acknowledgement of high risk was unanimous in FGDs, respondents interviewed in-depth employed varying subjective measures of HIV risk, often acknowledging and denying at the same time. Interpretation of AIDS risk at the personal level was seen as distant – perhaps an illusion of personal invulnerability -“*it can’t happen to me*”.

Table 1: Summary of participants’ reasons for perceiving or not perceiving AIDS risk

<b>Perceive risk:</b>	<b>Do not perceive risk:</b>
<p><i>Behavioural factors</i></p> <ul style="list-style-type: none"> <li>• Prevalence of risky sexual behaviour e.g. premarital, casual, extramarital and multiple sex partners, non-use of condoms and condom failure, rape</li> </ul> <p><i>Economic factors</i></p> <ul style="list-style-type: none"> <li>• Sex for exchange of monetary and material favours</li> <li>• Cost of HIV testing</li> <li>• Labour migration</li> </ul> <p><i>Socio-cultural Factors</i></p> <ul style="list-style-type: none"> <li>• Widow inheritance</li> <li>• Marriage patterns and reproductive goals</li> <li>• Denial and fatalism, belief in witchcraft, and “<i>chira</i>”(a curse against breaking a taboo)</li> </ul> <p><i>Environmental Factors</i></p> <ul style="list-style-type: none"> <li>• Increase in AIDS orphans and widows</li> <li>• Difficulty of knowing the infected and deliberate transmission</li> <li>• Stigma related to HIV testing</li> <li>• Alcoholism and idleness among young people</li> </ul> <p><i>Bio-medical factors</i></p> <ul style="list-style-type: none"> <li>• Blood-related mechanisms mainly contaminated cutting instruments and needles.</li> </ul>	<p><i>Behavioural factors</i></p> <ul style="list-style-type: none"> <li>• Young/virgin partners</li> <li>• Trustworthiness and fidelity</li> <li>• Familiarity/proximity with partner</li> <li>• Use condoms</li> <li>• No casual and multiple partners</li> <li>• Marriage goals</li> <li>• Abstaining</li> </ul> <p><i>Bio-medical factors</i></p> <ul style="list-style-type: none"> <li>• Had HIV test</li> <li>• Would be sick by now</li> </ul>

#### Behavioural Factors

Focus group discussants and in-depth interviewees were aware of the role of risky sexual intercourse in HIV transmission, and all strongly believed that individuals who engage in unprotected risky sexual behaviour are vulnerable to HIV infection. Risk was constructed as having sex with certain categories of people considered “high risk”. FGD participants were asked about the people considered at high HIV risk. Prostitutes, bar maids, alcohol and drug users, truck drivers, bus drivers and touts, widows, orphans, policemen, urban dwellers, and business or rich people were mentioned. Others were the poor, subordinate women,

schoolgirls and boys, and religious people who consider themselves invulnerable as God protects them. Risky sexual behaviour cited by participants is described below.

***Extramarital sex, casual and multiple partners.*** The theme of unfaithful partners was strongly exemplified by married women and men, though it was also recurrent among unmarried participants. The main cause of worry was that though individuals may remain faithful in their relationship, the behaviour of their partners could put them at risk of HIV.

*“...Even here one can sleep with a woman knowing that she is someone’s girlfriend or wife. That is a fact. Adultery is everywhere. Again this place is like a settlement scheme. There are many tribes here because of the tea plantations” (Kiambu, FGD, unmarried male).*

*“Yes, I am in danger since we are both sexually active. My wife could decide to engage in sex outside the family. In case she contracts the disease, I will also get it” (Kisumu, FGD, married male).*

Although women and men were suspicious of their partners’ fidelity, almost all felt they were exempt from the risk of HIV. Generally, both women and men took trust as being personal, stating that they, themselves, did not engage in extramarital or casual sex but that they had doubts about their partners. For most participants, it was not an outright statement but rather as a supposition that their faithful partner could have been (or maybe) unfaithful. The women and men alike qualified their statements and placed emphasis on their partner’s behaviour as their main source of worry. Some participants said,

*“I don’t know whether my wife can cheat on me or not. I am sure that I can’t cheat on her but I don’t know about her since I can’t judge her” (Kiambu, FGD, married male).*

*“Yes, especially for the woman, because when her husband moves outside, he might have different people ...it is especially the men who bring AIDS” (Kiambu, FGD, married female).*

*“You can be faithful as a woman but your husband is unfaithful. He can make you get AIDS (Kisumu, FGD, married female).*

One group of married men in Kisumu purported that a woman could engage in extramarital sexual relations in retaliation to her husband’s infidelity that could make both partners vulnerable to HIV infection.

Most participants associated the high vulnerability of young unmarried people to casual and multiple partnerships. The opinions expressed in FGDs indicated that most of the partnerships

are of a casual and serial monogamous nature, although unmarried participants alleged that men tend to have multiple concurrent partners, commonly referred to as “*hit and run*” or “*use and dump*” type. Perhaps, this is because of men’s non-restricted movement outside of the community in which they live. If a community is much more mobile there is greater opportunity for having concurrent partners than in a somewhat cohesive community.

Participants interviewed in-depth perceived themselves at HIV risk due to their own past risky sexual behaviour. But this acknowledgement of risk was readily denied as some individuals alleged that AIDS was not present at the time or that they had recently modified their behaviour.

*“Yes, there are times I had sex without a condom” (Kisumu, IDI, unmarried male).*

*“Yes, I would be dead by now. Even after I got married, we had problems because my husband was violent...This made me leave my matrimonial home to go back to my parents. Here, I got a boyfriend even though I loved my husband. We had this affair for about one month but I didn’t like. By then AIDS was not so prevalent; that was in 1994” (Kisumu, IDI, married female).*

**Rape.** Though not a common theme, a group of married men in Kisumu said that rape places many young girls at risk of HIV. This is not surprising given that findings from IDIs suggested that some women were manipulated/coerced or forced into sexual intercourse (see section 4.3).

**Premarital sex.** All participants, regardless of age and marital status, acknowledged that premarital sex was common and believed to heighten young people’s vulnerability to HIV. Young unmarried people were said to have “*hot blood*” or high sexual urge because they are “*agile and active*” and this makes them highly vulnerable to HIV infection. Some said:

*“They are sexually active but they do not have steady partners...” (Kisumu, FGD, married male).*

*“This is because young people at times have many sexual partners and this is the method that spreads it (AIDS) most” (Kisumu, FGD, unmarried females).*

### **Economic factors**

**Sex for exchange of material and monetary favours.** All participants in the two study sites repeatedly admitted that poverty motivates people to have sex in exchange for favours or money, making them vulnerable to HIV/AIDS.

*“You see as a married woman you may be in a financial problem and so get an outside partner who may infect you with AIDS” (Kiambu, FGD, married female).*

*“Sugar daddies look for young girls and also sugar mummies look for young men” (Kisumu, FGD, unmarried female).*

*“A boy for instance may not discriminate. If there is an elderly promiscuous woman, ...this boy will sleep with her as long as he can get some little money for himself” (Kiambu, FGD, married male).*

An IDI with a woman in Kisumu suggested that abstaining is difficult under the influence of peers and that sex for money or material favours occurs between young women and men. She stated:

*“We are told to abstain, but I can’t abstain. Peers influence me. They are bought gifts by their boyfriends, so even me, because my boyfriend assists me financially” (Kisumu, IDI, unmarried female).*

When married women were asked if young unmarried people are at risk of AIDS, all admitted that they are at great risk because they had multiple partners and could contract AIDS from older partners with money and spread it to their younger partners. Some women said:

*“It is worse for them because if parents are poor and a girl meets with somebody with money she will accept him and he might be infected. She will also have a boyfriend at school and they all get it” (Kiambu, FGD, married female).*

*“The young men like sugar mummies who are sometimes infected. They say that these women especially the married ones don’t disturb them” (Kisumu, FGD, married female).*

Older men and women were said to lure young girls and boys using their wealth. On the other hand, older men prefer relationships with younger inexperienced girls, referred to as “ripe oranges”. An older married man in Kisumu said: *“I think they (men) go out with women who make them happy; who satisfy them, like the young ladies. For example, like I am 45 years. I will not go for a woman of 45 years. I will go for one of 18 years.”* Though the older men go for younger women, it seems obvious that the allure for material and monetary favours, a practice made common by the rising poverty, influences the pattern of age mixing in sexual relationships. In communities where poverty is high and unemployment rising, most young women and men would fall prey to older men and women’s pursuit of sexual pleasure, putting them at high risk of getting AIDS. Some said:

*“Poverty...You may find that in secondary schools, some girls have so much shopping and you don’t. If you find some rich man somewhere, you will use your body to get whatever you want” ( Kisumu FGD, Unmarried female).*

*“Some girls engage in sex for money especially girls from poor families such that the only source of livelihood is sex” (Kisumu, FGD, unmarried male.*

Both women and men alluded to the prevalence of sugar daddies and sugar mummies, and this seems to be generally taken as the norm or the typical prevailing sexual culture. Sexually experienced older men act as a bridge in HIV transmission as they were alleged to infect young women who in turn infect young men. During IDIs, most women reported to have had first sexual intercourse with someone five or more years older. Men reported slightly younger partners or someone of the same age.

Although commercial sex was mentioned as a high-risk factor, it was linked to the increasing levels of poverty in the communities rather than as a prime motive for sex.

***Cost of HIV testing.*** The cost of HIV testing as reason for perception of HIV risk was less discussed except in two FGDs among married women in Kisumu and unmarried men in Kiambu and, in one IDI with an unmarried man in Kiambu. The cost of an HIV test was alleged to deter people from going for the test. The cost of the test within government facilities in Kenya differs according to whether it is voluntary counselling and testing (VCT) or for medical reasons. A VCT costs between Kenya shillings 50 to 100 (\$0.7-\$1.3) and for medical or diagnostic reasons is shillings 450 to 500 (\$7). Within private health facilities, the cost ranges from shillings 800 to 1,000 (\$11-\$13). In addition to the cost, the stigma attached to the HIV test is a constraint to some people who want to undergo the test as implied by an unmarried man in Kiambu:

*M: Have you ever had HIV test?*

*R: No, I haven't gone because of financial difficulties. If you can offer me a free AIDS test now, then I can go for it but it has to be very private; only between you and me. I would not want anybody to know that I have gone for a test as this would lead to stigma (Kiambu, IDI, unmarried male).*

***Labour migration.*** Migration due to work-related reasons was mentioned in only one FGD among unmarried women in Kisumu and by one married woman interviewed in-depth.

*“Separation of partners due to work. The man goes to work leaving the wife at home. Both may get sexual urges which they satisfy with other people who are not their spouses and this is risky” (Kisumu, FGD, unmarried female).*

## **Socio-cultural Factors**

The role of cultural practices was strongly echoed among participants in Kisumu.

***Widow inheritance (or “Tero”)***. This is a common practice of the Luo of Kisumu, and is considered a major agent of HIV transmission in the community. Among the Luo, widows sometimes have sexual intercourse with a male relative of the deceased as ritual “cleansing” before she can be inherited or remarried. Women in Kisumu expressed their fear of the practice of widow inheritance, which they seemed to have no control over. A married woman summarised the fears of other vulnerable women when she observed:

*“Customary practices. If my husband dies even if it was AIDS and my son also dies, I will have to be inherited first, so that my daughter-in-law can also be inherited according to the Luo custom” (Kisumu, FGD, married female).*

Both married women and men in Kisumu added that according to the culture of the Luo, most social activities have a sexual connotation. However, it is not simply sexual intercourse that is the concern, but the fact that sex has to be unprotected for it to be considered traditionally appropriate. Men in Kisumu shared these fears as if to express the dilemma in which they find themselves:

*R7: Most of the Luo culture, our culture goes with sex...If I am a man, the first born and I don't have a wife I will be forced to look for a woman to open the way for the others.*

*R9: If you are in your home sexual practices also guide many activities. If you are to start ploughing you have sex; planting also requires that you have sex. Harvesting cannot take place without sex. All these are finished with sex (Kisumu, FGD, married males).*

***Marriage patterns and reproductive goals***. This was a recurrent theme among participants in both sites, but more so, in Kisumu. Polygyny was considered common among the Luo in Kisumu and was a source of worry of HIV risk. Participants reckoned that a polygynous man could influence his wives to have extramarital sex as he might not be able sexually to satisfy all the wives or he may abandon older wives for younger ones. This makes the whole family vulnerable to contracting HIV.

An unmarried woman in Kisumu singled out marriage by abduction as another reason for high-perceived risk of AIDS. She expressed her fear as though the practice is long gone and as if only men could infect women and not vice versa:



*“Marriage by abduction; in the traditional days, people used to abduct for marriage. An infected man may abduct you” (Kisumu, FGD, unmarried female).*

When asked if the practice is still common, she added, “yes, in some parts half of the community abduct.”

Some married female discussants in Kisumu alleged that cases of infertility in marriage might indirectly increase a woman’s vulnerability to AIDS because the husband can allow the wife to sire children with her brother-in-law or anyone else. The women who maintained that the practice still happens discounted a woman who attempted to say that the practice no longer existed.

The societal expectation for marriage and reproduction seemed to be an overriding factor in perception of risk for a few unmarried female and male participants in both Kiambu and Kisumu. Adulthood in Kenya is almost synonymous with marriage. The participants alluded that the social expectation to get married may put pressure on individuals who may end up marrying somebody already infected. Worry of this kind appears oblivious of the role of HIV testing in determining the sero-status of prospective marriage partners. An unmarried woman and man said:

*“Because you want a husband and do not know his past and may be he had it (AIDS). You will give birth to children who also die because they are infected” (Kiambu, FGD, unmarried female).*

*“...I am also in danger because I am supposed to marry. In case I get a woman already infected, then I will automatically get infected” (Kisumu, IDI, unmarried male).*

***Sense of denial and fatalism, witchcraft and “chira”.*** All participants in Kisumu and Kiambu stated that young people do not take AIDS seriously because of the belief that AIDS does not exist or does not affect them. Some FGD participants in Kisumu perceived themselves at risk because some people denied the reality of AIDS arguing that AIDS is witchcraft or “chira” (a curse due to breaking of a taboo) and not a disease. This form of denial means that some people may not be motivated to change behaviour:

*“The youth don’t believe that AIDS exists. They end up engaging in sex not knowing that there is some risk behind it. They are ignorant so they are hard to convince” (Kisumu, FGD, unmarried female).*

The fact that some people were alleged to deny the existence of AIDS is difficult to explain given the evidence of high level of knowledge about AIDS. Perhaps it reflects misinformation acquired from an array of sources or simply indifference to AIDS.

Some participants indicated that fatalistic attitudes are used to rationalise death and many people said they would die anyway and there is nothing they can do about it. Such beliefs make individuals more vulnerable to HIV infection because of a perceived lack of the need to change behaviour. Such expressions were common in both study sites:

*“Yes, there are those who say it (AIDS) is just a cold. And that AIDS is the same. That death from an accident and from a disease is the same. There is nothing like a different death.” (Kiambu, FGD, married females)*

### **Environmental Factors**

***The increase of AIDS orphans and widows.*** Children orphaned and women widowed by AIDS were considered as high-risk groups in the communities as they were alleged to use sex as a survival strategy.

*R6: This thing can happen even because of orphaned children who don't have parents but have sugar daddies to depend on. If he has AIDS, she will get it because they lack guidance.*

*R2: They have no one to care for them so they look for men to satisfy them sexually and for money (Kisumu, FGD, married females)*

*“And probably this woman going with young boys was widowed a long time and is very much in need of sex...And the boy will get it (AIDS) from her and pass it over to his young girlfriend” (Kiambu, FGD, married male).*

***The difficulty of knowing the infected and deliberate transmission.*** All participants appeared to concur that anyone is at risk of getting AIDS and so it is difficult knowing “...who has it and who does not” (Kiambu, FGD, unmarried female). There was evidence that some infected people were not aware of their HIV status and so continued to spread the disease unknowingly, making most people vulnerable. Yet, most groups maintained that some people spread the disease deliberately in order not to die alone. The issue of deliberate transmission of HIV was a recurrent theme in most groups.

*“HIV has really spread, unfortunately...we do not know who has it but it spreads fast. Again those who live here are not aware...Those who have it continue to have sex because they are not aware and this really spreads it” (Kisumu, FGD, married male).*

*“Another way it spreads is that infected people say that they will not die alone so they deliberately move around to spread it” (Kiambu, FGD, married female).*

***Stigma related to HIV testing.*** Both FGDs and IDIs indicated that there was a lot of stigma surrounding HIV testing and this deterred people from getting the test. Almost all FGD participants made it clear that they would not like to get the HIV test because they might be rejected by their partners, family, and friends if found to be infected. The issue of confidentiality seemed to be an overriding factor in the participants' fears about getting tested, and was related to misconceptions and the silence surrounding the disease. Some said:

*“This is because when you get your girlfriend and you move ahead to have sexual intercourse, none of you is willing to open up and inform each other about his/her health status. In fact many people will probably go for a test after they have had sexual intercourse...”* (Kiambu, FGD, unmarried male).

*M: Have you ever had HIV/AIDS test?*

*R: No. I have not felt the need for AIDS test. The impact of the result can be difficult for the family* (Kisumu, IDI, married male).

Although FGD participants stated they were unwilling to be tested for HIV, 13 of the respondents interviewed in-depth admitted to have had the HIV test, whereas those who had not were willing to do so (see section 6.5). The difference in FGD and IDI results support the importance of using IDIs in studying sensitive and personal issues. Participants may have chosen not to discuss HIV testing in FGDs because of the need to avoid being stigmatised.

Alcoholism and idleness among young people was mentioned as AIDS risk factors in two FGDs with unmarried males in Kiambu. There was no much discussion on these issues to warrant fuller description.

### **Bio-medical factors**

Blood-related modes of HIV transmission were rarely mentioned as risk factors in FGDs, but a few IDI participants alleged they were at risk because of the likelihood of infection through non-sexual or blood-related sources. Most married people assertively ruled out the possibility of risk from sexual intercourse as they claimed to have changed their behaviour to maintaining trusting, faithful and monogamous relationships, stating non-sexual forms of HIV transmission as their only possible risk source. None of the unmarried people raised this concern:

*“I fear in case a doctor may use unsterilised needles for injecting me. In other words I worry about the non-sexual modes of transmission”* (Kiambu, IDI, married male).

#### 5.4 Reasons for Participants Perceiving No Risk of HIV

Denial of risk was rife among IDI participants who stated a range of reasons to justify their own sexual behaviour as safe, often ignoring more risky sexual aspects of their own or partners' sexual lives. The criteria for denying risk (see Table 1) are described below. Denial of HIV risk was in most cases attributed to safety based on a partner's or one's own sexual behaviour.

*Partner was young or a virgin* was a popular allegation among men who argued that they knew the partner was inexperienced, hence safe.

*“For one thing, I knew she was a virgin. I had got the information from a reliable source. I knew about how she lived in her village” (Kiambu, IDI, unmarried male).*

*“...We trusted one another. We were still young and did not think that we would have any disease” (Kisumu, IDI, married male).*

Whereas men perceived young women as safe, women did not consider young age in judging the safety of their male partners. Moreover, FGDs with unmarried women revealed that young women prefer to partner older men because such men are considered mature and responsible.

*Trustworthiness and fidelity between partners.* Some participants argued that they felt safe because their partners were faithful or that they trusted their partners. This was a recurrent theme among IDI respondents. Only in one FGD amongst young married men in Kiambu was denial of HIV risk so explicit. They argued that they were faithful and trusting to their partners. Some IDI participants said:

*“As per now I don't doubt her faithfulness” (Kiambu, IDI, married male).*

*“Because I trust him very much” (Kiambu, IDI, unmarried female).*

The following dialogue with an unmarried male in Kiambu outlines the different ways in which HIV risk was assessed based on trust, and the contradiction between AIDS knowledge and behaviour:

*M: Did you talk to your first sexual partner about her past sexual experiences?*

*R: No, The lady was trustworthy. Her movements could not be doubted. Her life was not promiscuous. The lady asked me if I had another girlfriend but I told her that I did not have another girlfriend.*

*M: Did you seek information about your sexual partner from anyone?*

*R: Yes, I sought information from friends who knew the lady and they encouraged me very much. I enquired both from girls and boys. All the same, it did not require many enquiries because the girl was my sister's friend. I therefore trusted her.*

*M: Did you use any form of contraception the first time you had sex with your first sexual partner?*

*R: No, I did not. We both trusted each other and we believed none of us could get sick. We did not even fear pregnancy.*

*M: After first sex, in which you did not use contraception, did you consider using any form of contraception later in you relationship with your first sexual partner?*

*R: No, I did not use any contraceptives in later sex.*

*M: Why do you think you never used contraception at all with your first sex partner?*

*R: I was serious with the girl. I did not therefore fear making the girl pregnant because I was ready to marry her. I was ready to accept her.*

*M: Did you talk about contraception with your first sexual partner?*

*R: Yes, we talked about contraception and condoms but we arrived at an agreement that none of us had a disease. We were both fine.*

*M: Who initiated the talk?*

*R: The lady, my partner. She talked about disease prevention and this was just before sex.*

*M: Can you remember how the subject was started?*

*R: The lady was from the rural area while I stayed within the town centre. She did not know my lifestyle in town and she therefore decided to talk to me about condoms. She had the mentality that those from the shopping centre were promiscuous.*

In the above excerpt, both partners were aware of the risk of unprotected sex but they did not act on such knowledge basing their judgement on trust.

***Familiarity/proximity of a partner.*** Some participants argued that they were not at risk because they have/had known their partners for a long time. Even knowing that a partner had other partners was ignored. Women and men argued that because they had grown up with the partner in the same neighbourhood or even gone to the same school, they knew that their partner had not been promiscuous and did not have other partners, or else someone could have told them:

*M: Did you talk to your first sexual partner about her previous sexual experiences?*

*R: No. Of course I had known her all the time. I had been in the relationship with her for almost one year and three months. I had all the time known her. Also, I was a school prefect and other boys feared her since she was 'pushing' with a prefect (Kiambu, IDI, unmarried male).*

The results suggest that people gather information on a partner's sexual history either directly from the sexual partner or through informal networks, relatives and friends or what can be termed as "gossip". However, knowing a partner's sexual history was not consideration for being at risk of HIV infection and often not a serious aspect as one unmarried man in Kisumu claimed, "I just used to ask jokingly." Individuals seemed to be more concerned about the numbers and general character of partners than about the risk of exposure to HIV from a

partner's past sexual experiences. Surprisingly two women who reported that their partners had had sexually transmitted infections (STIs) still argued that they trusted their partners and considered them safe from infections. Even among individuals who had initiated sexual intercourse in what could be termed the "AIDS era", the fact that AIDS has a long latency period was not applied when sexual histories were used to assess risk, so that knowing that a partner has had other partners was somewhat ignored:

*"Because I knew those other relationships were not serious" (Kiambu, IDI, married male).*

**Using condoms.** Some unmarried participants admitted that they consistently used condoms with partners they did not trust. However, one man admitted having had a lapse, and as if to exonerate him from blame, he alleged having not used a condom because *"the lady insisted so much on having sex"* (Kiambu, IDI, unmarried male). Another said,

*"No, I protect myself fully. I use condoms with those I do not trust" (Kiambu, IDI, unmarried male).*

Some people reported that they used condoms only in casual sex or at the beginning of the relationship and once trust was established condoms were disregarded. Other people reported reliance on natural forms of contraception because of the fear of side effects of the clinical methods.

All married participants reported relying on trust, faithfulness and monogamy for AIDS prevention or when they knew their HIV status, and so other methods such as the pill, the injectable or natural contraception methods were used to prevent pregnancy. Some participants were simply concerned more about unplanned pregnancy than AIDS because they had the assurance of safety based on their partner's characteristics:

*"I used the calendar method. I was afraid of getting pregnant. I could not support a baby..." (Kiambu, FGD, unmarried female).*

Most older male respondents and a few young people simply admitted to having been ignorant because they were young at first sexual intercourse, so they did not know much about sexual risks and had not heard about condoms or AIDS. This might be a reflection, in part, of the time and context in which first sex took place. AIDS was not a serious threat in Kenya till late 1980s. Thus, older people in the study may have not been particularly aware of AIDS at the time of their first sexual intercourse. Among young people, sex education in Kenya has long been a contentious issue; so most of them could have been ignorant of sexual

and AIDS diseases. Besides, for most respondents first sexual activity was almost spontaneous and not planned, so it would have been difficult for partners to initiate condom use at the time. A man who had first sex with his cousin's partner who was visiting illustrates this fact:

*R: The room of my cousin had condoms but I never thought of it...I was overwhelmed. I cannot say I was carried away because if she never accepted I could not have done it...*

*M: Are you saying you never talked about contraception with your first sexual partner?*

*R: There was no time to talk. I think she thought if she asks me I would have told her let's not do it (have sex)" (Kiambu, IDI, unmarried male).*

And for some, the fun of having sex overrides the concern of AIDS risk, "...I didn't even think about the risk involved in unprotected sex because I was having so much fun" (Kiambu, IDI, unmarried female).

**No casual, multiple or extramarital partners.** Most respondents also argued that they were now safe because they were sticking to only one sexual partner or were not having extramarital sex.

*"In my opinion I think I am well placed. I think I am not at risk unless I get other partners. I can only fear if I have many partners" (Kisumu, IDI, unmarried female).*

*"Since I began taking the issue of AIDS seriously, I do not take any risks. In fact, I have completely refrained from extramarital sex" (Kisumu, IDI, married male).*

**Abstinence.** Abstinence was a common theme among some unmarried respondents for denying being at HIV risk, though for others the risk of HIV infection from previous sexual partners was often ignored. Some people abstained after having HIV test:

*"I am not in danger now because I went for a test and it turned out to be negative. I now don't have a sexual partner" (Kisumu, IDI, unmarried male).*

*"We are currently not engaging in sex" (Kiambu, IDI, unmarried female).*

**Marriage goals.** A few men stated that they had marriage intentions and so did not fear pregnancy or diseases. Similarly, some women alleged that their partners did not use condoms because they intended to marry them. Although claims of marriage intentions were mentioned, none of the married IDI respondents reported having married their first sexual partners. Women, more often than men, perceived their first sexual partner as serious because, with sexual intercourse, the relationship was thought to entail elements of emotional

attachment, faithfulness, trust, and marriage intentions. The women's ultimate goal was marriage until they realised that the partner did not think of the relationship in the same way.

***Had an HIV test.*** Thirteen people said they had been tested for HIV and were quite clear that they were not infected. Some participants even claimed to do the test frequently.

*“ Let me say that I usually go for medical tests including my wife. And we have been found to be uninfected” (Kiambu, IDI, married male).*

***I would be sick by now.*** Some individuals alluded to seriously falling sick as a sign of being HIV infected and so did not worry because they had not experienced serious illness.

## **5.5 Summary**

It is apparent from IDIs that the context and patterns of sexual intercourse preclude protective sexual intercourse. HIV risk was perceived differently in FGDS and in IDIs. Whereas perception of risk was high and unanimous in FGDS, individuals tended to deny it. Perception of risk of HIV was mainly attributed to the possibility of infection from a partner's infidelity, self-engaging in unprotected casual sex, risky cultural practices (e.g. widow inheritance), and to a lesser extent, non-sexual modes of HIV transmission. The partners' characteristics or one's own sexual behaviour informed denial of personal risk of HIV. Partners' young age, familiarity of a partner, and trustworthiness were used to judge partners as being safe from HIV. Others argued they were safe from contracting HIV because they were abstaining, using condoms, had had an HIV test, and were trusting and faithful to their partners.



## **6 PREVENTIVE BEHAVIOUR AGAINST THE RISK OF HIV INFECTION**

### **6.1 Introduction**

This section considers the methods that the participants reportedly use to avoid the risk of getting HIV/AIDS and, the social and cultural impediments to their attempts at maintaining low-risk sexual behaviour. FGD participants were asked the question: In your opinion, what are married women/men (or boys/girls) in this community doing to reduce their chances of getting STDs/HIV/AIDS? The IDI respondents were asked: What have you done to reduce your chances of getting STDs/HIV/AIDS? The strategies of monogamy and avoiding multiple partners, trust and fidelity, HIV testing, abstinence, and condom use, and to a lesser extent, communication with partners, becoming religious, and stopping widow inheritance (mentioned in Kisumu only), were mentioned. But through probing, contradictions raised in FGDs and IDIs revealed the gulf between what respondents knew about AIDS prevention and what they believed they could realistically do to influence safer sexual behaviour. These are discussed below.

### **6.2 Trust, Fidelity, Avoiding Multiple Partners and Monogamy**

The participants repeatedly declared that monogamy, trust and fidelity within or outside marriage was the best protection against HIV infection, though they were aware of the tendency for partners to be unfaithful. Married women in particular were emphatic that they preferred trusting and monogamous relationships, but it was difficult to control men's behaviour. A married woman discounted the prevention strategy of trust and faithfulness and spoke as if assenting to fate:

*“In my opinion it is difficult. Your husband can be unfaithful. So there is no way we as women can prevent the disease” (Kisumu, FGD, married female).*

FGDs and IDIs with unmarried participants suggested that the concepts of trust, fidelity and monogamy were interpreted to mean serial monogamy. Individuals believed that so long as they maintained one partner at a time, they were safe from the risk of HIV. No link was made between serial monogamous relationships and the number of partners and the risk of getting infected.

The problem of how to handle promiscuous partners, particularly spouses, drew more interest among married women than any other group. In the end women did not really settle on any

one strategy to deal with unfaithful men since they were assumed too difficult to change. Yet, the some women said clearly that men have now started changing their behaviour because of the threat of AIDS. Some women claimed they trusted their husbands and could vouch for their fidelity.

Refusing sex was an alternative suggested by women if a partner was suspected to be unfaithful though this was seen to be unrealistic within marriage. The issue of refusing sex is discussed in detail under abstinence in section 6.4.

Avoiding multiple partners was a less cited AIDS prevention strategy, perhaps because of the overlap with other strategies such as monogamy and fidelity. Analysis of IDIs, indicated that most individuals maintained serial monogamous relationships, not multiple concurrent partners, and that the majority of men were more likely to have short-term relationships than women were. Nonetheless, the FGDs alluded to the prevalence of multiple concurrent partnerships. It is difficult to tell whether opinions expressed in FGDs indeed reflect reality or past sexual behavioural patterns in the communities under study.

### **6.3 Condom Use**

All FGD participants mentioned the use of condoms as a strategy for protecting against HIV, yet only seven unmarried IDI respondents reported they currently used condoms. The IDIs indicated that the estimation of HIV risk associated with particular partners played an important role in determining condom use. This discussion is limited to the male condom since not much was said about female condoms in either FGDs or IDIs, though some participants claimed to have heard of them.

The timing and choice of contraceptive methods was also used to gauge how individuals assessed AIDS risk. When IDI respondents were asked if they used any form of contraception during the first sex, almost all women and men mentioned that they did not use or even think of contraception at first sex, though some individuals reported they later adopted hormonal (pill and injectable) or natural (withdrawal or periodic abstinence) methods of contraception for preventing unplanned pregnancy. Most respondents reported that they did not use condoms because they loved their partners or did not want to annoy them as condoms connote

promiscuity and mistrust, and reduced sexual pleasure. A few women stated they did not use a condom at first sexual intercourse because they were manipulated/coerced, forced or raped.

On the contrary, all unmarried IDI respondents in Kisumu reported having used/using condoms in their recent or current relationships (for dual protection against disease and pregnancy) as compared with only two males in Kiambu. Participants in Kiambu reported to have resorted to trustworthiness, fidelity and getting tested for HIV as precautions against AIDS, so they used hormonal or natural contraception to prevent pregnancy.

All respondents interviewed in-depth in Kisumu admitted having discussed contraception with their recent/current sexual partners, particularly condoms for fear of pregnancy and STIs. On the contrary, the discussions about contraception and AIDS noted among some Kiambu respondents were often limited and did not include talking about condoms, as these were considered to connote mistrust and promiscuity. Some remarked:

*M: Did you talk about condoms?*

*R: No, we did not...I was scared of suggesting them to him” (Kiambu, IDI, unmarried female).*

*“I told her that I hate them (condoms)...And she knows I don’t like them and she also told me they are not comfortable for her...I told her that she should forget about condoms in our love life. So I made a declaration which she supported” (Kiambu, IDI, unmarried male).*

Discussions of condom use in FGDs invariably stimulated vigorous debate regarding their acceptability, their effectiveness for HIV prevention, women’s ability to negotiate their use, and the responses of partners when they were suggested. All participants acknowledged that condoms protect against pregnancy and sexually transmitted infections, but some raised concern on the effectiveness because “a condom can burst and therefore is not a 100 per cent safe”. A few feared that HIV could also be transmitted through saliva and doubted that condoms would be sufficient protection. A larger number of participants questioned the possibility of condoms having small holes and the rumours that condoms are laced with the HIV virus. Others alleged that condoms can disappear in the woman’s womb and could result in death.

Initially participants advocated condom use as one of the risk prevention strategies but almost all people in every group later reversed their opinion and talked of the disadvantages of

condoms. The opinions expressed in FGDs and IDIs suggest that the major deterrent to condom use is attitudinal in nature. All individuals perceived that condoms reduced sexual pleasure, though this attitude was particularly strongly expressed by men. The question “*Are women/men (boys/girls) willing to use condoms?*” elicited a range of negative attitudes from both women and men FGDs as illustrated by these segment of a FGD among unmarried men in Kisumu:

*R1: Some of them.*

*R4: Very few boys are willing to use condoms. Very few girls are willing to use condoms. They claim that the condom makes them to have pimples. Boys do not want to use condoms as this reduces the sweetness involved in sex. Girls do not want to use condoms, as they fear that retention may result in death.*

*R11: The majority of boys are willing to use condoms because of HIV. When boys get strangers whom they do not know, they use the condom to have sex. It is evident that the disease (AIDS) is real yet blood screening is very costly. They would rather use the condoms to avoid getting the disease.*

*R6: Boys are willing to use condoms more than girls are.*

*R7: The lady will feel that you do not trust her. If she is sick, she will be alarmed and worried.*

*R1: She might suspect HIV infection.*

*R5: Some will agree to usage comfortably without getting annoyed while others will refuse to have sex with you once you suggest condom use.*

And married women in Kiambu said:

*R2: A man cannot accept a sweet in a wrapper! Few women can.*

*R4: He will think you don't trust him.*

*R6: Yes, he will suspect you of unfaithfulness.*

*R9: They refuse - you can only just pray.*

*R9: You have to be very tactful about how you ask and pray about it. Without God you cannot manage.*

*R2: I would not personally accept because if you accept to use, he will be free to use with other women. Some men also insist that they burst.*

*R9: Yes, they can puncture it at the tip and you end up getting pregnant.*

*R2: There is no one who will accept. They think women will suspect they are infected or they were with someone else and ask a lot of questions.*

*R1: They refuse even when they are told in hospital. I have seen a case of a man at a clinic who was told to go for treatment with his wife. He refused and went to another clinic where he bought pain killers and goes on with life uncured.*

*R2: They will even deliberately use them the wrong way.*

Women and men were more concerned about their partner's response to a suggestion to use condoms. Both women and men stated that suggesting to a partner to use a condom would provoke him or her to accuse the partner of infidelity or a sexual disease, the only reason, they might allege, that the partner would make such a demand. Women asserted that men could

never accept that they had other partners so that they should use a condom but instead turned the blame on them.

Surprisingly, participants revealed a lot of contradictions in their attitudes to condoms. The same people who advocated condom use in risky sexual encounters later strongly rejected the idea of using them in their own relationships. There was little differentiation in opinion within or across groups. Individuals tended to start by agreeing that women or men have a right to protect themselves from AIDS but qualified their views by outlining restrictive conditions under which condom use is acceptable. Some women were outright that men did not want to use condoms. Similarly, men said the same concerning women.

All participants agreed that condom use is acceptable with casual or extramarital partners and prostitutes but not for women and men in long-term serious relationships or conjugal unions. Some male participants seemed to view their double standard of multiple relationships as if it were acceptable. They often prefaced their remarks with “if” clauses: *“If I must go out, I think I’ll use condoms to reduce my chances of getting the disease” (Kisumu, FGD, married male).*

Despite their reservations and negative attitudes towards condom use, all FGD participants advocated the use of condoms if a partner is promiscuous. Following a hypothetical story of Fagia, a promiscuous man who lived in town and his partner, Kazuri, a faithful female partner who lived in their rural home, participants were emphatic that Kazuri should not have sex with Fagia without condoms, or else she should move out. Like abstinence, women suggested strategies for convincing Fagia to use condoms to include tactfully persuading the man (frequently mentioned by married women) or direct demand (commonly cited by unmarried women):

*“Personally I would advise her to be patient and pray to God so that he will understand and able to talk in a way that he will not make noise at her. She should talk to him politely and God will intervene” (Kiambu, FGD, married female).*

*“You can tell him that you don’t trust him and so he needs to use a condom” (Kisumu, FGD, unmarried female).*

Some women suggested they could convince promiscuous husbands to use condoms under the guise of family planning since this is less threatening than directly confronting the issue of preventing AIDS:

*“I can tell him to use it as a family planning method to space children” (Kisumu, FGD, married female).*

While it was apparent that men got their way in decisions regarding condom use, there was some evidence that young unmarried women are becoming more assertive in negotiating condom use. When asked who decided that condoms should be used, some unmarried women said,

*“I did. I was in my unsafe period so I asked him to use condoms” (Kiambu, IDI, unmarried female).*

*“I decided that we use the condoms...It not only prevents STDs but also AIDS...I always use condoms” (Kisumu, IDI, unmarried female).*

Similarly, some unmarried men alluded to their partner’s active role in the decision to use condoms.

*“We both decided. I raised the issue and she supported me” (Kisumu, IDI, unmarried male).*

Access to the condoms did not appear to be major factors affecting condom use. All participants agreed that condoms are easily available and could cite a range of sources from where they could be obtained free, such as in health facilities, at lodgings and hotels, and from community based distributors or health workers (CBDs/CHWs). Condoms can also be bought in shops.

#### **6.4 Abstinence**

Practicing abstinence was the most common AIDS prevention strategy amongst young unmarried respondents. There was an indication from the FGDs and IDIs with young unmarried people that abstinence is being initiated voluntarily as a response to the threat of HIV infection. Abstinence in the context of HIV/AIDS prevention could either refer to the delay of initiation of sexual intercourse (primary abstinence) or a choice made to forego further sexual relations for a period of time (secondary abstinence). This study did not explore the extent of the practice of primary abstinence in detail because the IDIs focused on those with sexual experience. The FGDs may have captured the element of primary abstinence since the participants included the sexually inexperienced, though this is difficult to disentangle from group discussions. Some respondents interviewed in-depth reported to have adopted abstinence after having an HIV test.

There were often heated arguments in the FGDs amongst married participants regarding abstinence. Some recommended abstinence for the unmarried people only citing that condoms promote sexual promiscuity. Others argued that it was better to give young unmarried people condoms if they could not abstain or else they might have unprotected sex. A group discussion with married women in Kisumu revealed their attitudes about what they felt as appropriate protection measures for young people:

*R8: We should just teach them to abstain from sex. They may not know how to use condoms and in the process hurt each other.*

*R7: Just tell them to abstain from sex but if they have to have sex then they should use condoms.*

*R5: I wouldn't tell them to use condoms. Rather, they should abstain because condoms are not 100% effective.*

*R2: If you tell them not to use condoms, then they will have sex without it and this is risky. It is better to tell them to use condoms.*

*R3: These sugar daddies cheat them not to use condoms after giving them money.*

The married women also suggested abstinence as a solution to preventing infection from a promiscuous spouse, particularly if he declines to use condoms. However, despite suggesting abstinence in a marriage relationship, the same women reversed their position when they argued that it was an unrealistic solution and even a frightening option that could lead to worse repercussions. Thus, women recognised that though they had a right to refuse sex for fear of AIDS, in reality their ability to refuse sex was not under their control. In fact, when women suggested refusing to have sex with their partners, it was usually a matter of deception rather than direct confrontation with a promiscuous partner. Women suggested many ways of refusing sex with an errant partner, namely feigning illness, fatigue, pretending to be menstruating, not being in the mood, and fear of pregnancy. Married women understood that deceptive strategies of refusing sex could only be temporary because it was not possible to refuse to have sex forever within marriage. In addition, tactics like pretending to be menstruating could backfire if the man decided to ascertain for himself as illustrated by a remark of a woman in Kisumu:

*"It depends, if you tell him you are in your periods (menstruating), he will check (laughter)" (Kisumu, FGD, married female).*

Married women feared that refusal to have sex could be interpreted as meaning that they were unfaithful or infected with a sexual disease. Married women worried that suggesting abstinence could lead to physical abuse and the risk of making it easy for the man to contract AIDS from a relationship outside marriage. Unmarried women expressed similar fears. All women feared that their partners could find somebody more compliant if they refused to have

sex, and for the unmarried women this spelt loss of a potential or future marriage partner, their ultimate goal in life, as most seemed to suggest. For unmarried women the need to hold onto the relationship overrode the AIDS risk. Married men never suggested abstinence as a strategy they used to avoid getting AIDS. Men expressed opinions that concurred remarkably with women's views on the difficulty of women protecting themselves against HIV infection from promiscuous partners. Most men appeared to agree that a woman had no right to refuse sex and said that they (the men) would use persuasion or force to have sex.

## **6.5 HIV Testing**

The uptake of HIV testing as an AIDS prevention strategy was most frequently cited among respondents interviewed in-depth but not in FGDs, supporting the importance of using IDIs for the more sensitive issues. Participants who reported having had the HIV test said they did so to allay fears of an infection and as an antecedent behaviour for adoption of other AIDS prevention strategies such as abstinence, monogamy and fidelity. Reporting of HIV testing was definitely more pronounced among Kiambu participants than in Kisumu. Out of the 17 participants of IDIs in Kiambu, 11 (five women and six men) reported that they had undertaken HIV test for various reasons – to know their HIV status and therefore maintain monogamous relationships, for medical or pregnancy reasons, and employment/study-related purposes. In comparison, of the 12 IDI participants in Kisumu only two men reported having had an HIV test; an unmarried man who wanted to know his own HIV status and decided to abstain from sex, and another for marriage purposes. Curiously, none of the women in Kisumu reported having taken an HIV test despite the fact that it is a sentinel surveillance site. Care was also taken to establish the truth of the HIV testing claims because of the likelihood of misinterpreting the random anonymous testing conducted in selected sentinel surveillance sites in Kenya. People could have thought that they had been tested for HIV just because of having given out blood for other medical reasons, when in fact they had not. A number of hospitals in Kenya now require that pregnant women undergo HIV testing during the antenatal period.

Respondents who alleged knowing their HIV status alluded to having changed their sexual behaviour; that they were trusting and faithful to their partners. For unmarried individuals, HIV testing usually preceded abstinence or monogamy and fidelity in relationships. Some married people alluded to getting tested as a basis for maintaining fidelity and monogamy



within marriage. Six of the men and women who had not had the HIV test stated that they had considered having one (three in Kiambu and three in Kisumu), and nine expressed that it was not necessary and so never thought of a test, as exemplified by a woman in Kisumu:

*“I haven’t just thought about it; perhaps if I fall seriously ill then maybe I could go for an HIV test.” (Kisumu, IDI, married female).*

Only one unmarried woman in Kiambu alleged that she was scared of going for the HIV test and that she did not know where to go for it.

## **6.6 Communication and Change in Cultural Practices**

Communication about AIDS was a less mentioned AIDS prevention strategy, but commonly cited by married women. The women opined that talking to the man about the threat of AIDS might convince him to give up risky behaviour, though a few women discounted the idea of discussions because it could be misconstrued as a sign of unfaithfulness. Some FGD participants stated that they have stopped adhering to risky social and cultural practices such as widow inheritance in Kisumu. Some Kiambu participants alleged that circumcision is now performed at hospitals or special medical clinics. However, some male participants maintained that circumcision for girls is still practiced traditionally. Female circumcision is outlawed in Kenya and it is possible that girls are undergoing the rite secretly, and most likely using traditional methods.

## **6.7 Summary**

The participants mentioned the following preventive measures: using condoms, abstinence, fidelity and monogamy, uptake of HIV testing, and to a lesser extent, communication with partners and avoidance of risky cultural practices. Nonetheless, various contradictions and barriers to behaviour change were cited that reflected a mismatch between knowledge, intentions and behaviour. Among all participants, condoms connote mistrust, promiscuity and exposure to a sexual disease, as well as decreased sexual pleasure. Women stated abstinence, faithfulness and monogamy are beyond their power to effect. Participants stated that use of condoms and abstinence were unrealistic behavioural change options for married people or those in stable relationships. Condom use is also hindered by fears and misperceptions to include: they can slip into the woman’s womb and could cause death; they have holes that allow sperm to pass, and they are laced with the HIV virus.

## 7 Conclusions and Policy Implications

### 7.1 Conclusions

The objective of this study was to explore the socio-cultural environment in which people conceive and assess their risk of HIV, the common norms and discourses surrounding sexual behaviour and the risk of AIDS in the community, and the options for and barriers to behavioural change to avoid AIDS at the community and individual levels. This objective was achieved using focus group discussions (FGDs) and in-depth interviews (IDIs). The key findings from the FGDs and IDIs are summarised below:

- Awareness of both biomedical and socio-cultural mechanisms influencing HIV transmission was high in the study communities. Knowledge of sexual ways of preventing HIV infection was also widespread.
- Premarital and extramarital sex was reported to be common in the communities. The need to prove manhood, peer pressure, economic motives, and negative attitudes towards condoms were reported to influence risk-taking behaviour among unmarried women and men in the study communities.
- All the FGD participants were unanimous that AIDS was a great risk to the communities, and they acknowledged its socio-economic impact. High perception of risk was informed by the prevalence of risky sexual behaviour, mainly attributed to the escalating poverty and to people considered as “high risk” (e.g. truck drivers, business men/women, policemen and people in the armed forces, sugar daddies and sugar mummies, young girls and boys, AIDS orphans and widows). Young unmarried people were considered to be at greater risk of AIDS than the older and married ones. Some risky cultural practices, such as widow inheritance, polygyny, a belief in witchcraft and “*chira*” (a curse from breaking a taboo) and marriage and fertility goals were, reported to heighten the risk of HIV infection in the communities, particularly in Kisumu.
- On the contrary, denial of risk was rife among all IDI respondents; AIDS was not necessarily perceived to be great. Individuals who perceived themselves at HIV risk mainly attributed it to the possibility of infection from a partner’s infidelity, self-engaging in unprotected casual sex, risky cultural practices (e.g. widow inheritance),

and to a lesser extent, non-sexual modes of HIV transmission. The partners' characteristics or one's own sexual behaviour informed denial of personal risk of HIV. Partners' young age, familiarity of a partner, and trustworthiness were used to judge partners as being safe from HIV. Others argued they were safe from contracting HIV because they were abstaining, using condoms, had had an HIV test, and were trusting and faithful to their partners. Serial monogamous relationships are not necessarily considered as risky. Individuals feel invulnerable because they maintain sexual loyalty at a given point in time.

- Use of condoms, abstinence, fidelity and monogamy, uptake of HIV testing, communication with partners, and avoidance of risky cultural practices were mentioned as options adopted to prevent HIV infection. Nonetheless, various contradictions and barriers to behaviour change were cited that reflected a mismatch between knowledge, intentions and behaviour.
- For both women and men, condoms connote mistrust, promiscuity and the presence of a sexual disease, as well as, decreased sexual pleasure. People hold fears and misperceptions about condoms that include: they can slip into the woman's womb and could cause death; they have holes that allow sperm to pass; they are laced with the HIV virus, and that they can burst. Women stated abstinence, faithfulness and monogamy are beyond their power to effect. Similarly, all participants stated that use of condoms and abstinence were unrealistic behavioural change options for married people or those in stable relationships.
- The cost and the social stigma of undergoing an HIV test appear to hamper the uptake of these services.

## **7.2 Policy and Programme Implications**

There is no doubt that the findings from FGDs and IDIs raise a number of programme and policy issues likely to influence AIDS prevention activities in Kenya. Findings suggest that messages that people hear may not be addressing their needs as behavioural change communication has been promoted at the expense of social contexts. The findings showed that the majority of people appear to embrace distorted perceptions of risk, while ignoring

more risky aspects of their partners' or one's own sexual behaviour. IDI results showed that people relied on social networks for information about their partners' sexual histories. AIDS prevention messages need to highlight that the idea of 'knowing' a partner is deceptive. Messages need to emphasize to people the importance of using reliable measures of risk such as taking an HIV test. Thus, programmes need to reinforce the idea of equal vulnerability ("*it can happen to me*") among both women and men in order to dispel illusions of invulnerability ("*it cannot happen to me*"). The emphasis in AIDS messages needs to be placed on explaining biomedical information in lay language.

Perception of invulnerability may stem from the fact that an admittance of vulnerability would also mean being immoral. Thus, to rationalise the threat of AIDS, individuals may consider other people as vulnerable and not themselves. Sex workers, truck drivers, sugar daddies and sugar mummies, policemen and so on, were mentioned as high-risk groups – the groups identified by policy and programmes for targeted interventions. This deflection of vulnerability to others might appear, in fact, to have led to both a greater fervour in self-denial as noted in IDIs and a stigmatisation of the infected and affected evident in FGDs. Stigmatisation and discriminatory practices may lead PLWHA to conceal their infections in order to be accepted in their communities. Perhaps, the concealment of one's HIV status might explain the rampant fear of deliberate transmission of HIV in the communities. This calls for the government and other advocacy groups to create a supportive environment for the PLWHA through legislation and public education. The uptake of VCT services need to be popularised and de-stigmatised so that people can know their HIV status in order to dispel fears related to the possibility of deliberate transmission.

Misperceptions that condoms are unsafe and ineffective may be related to a lack of correct knowledge of use. Condoms not worn properly will slip or burst and this could be the real problem. In addition, trust and familiarity are analogous to safety and condoms to infidelity, mistrust and having a sexual disease, perhaps because of the way AIDS messages are interpreted. AIDS messages in Kenya have often emphasised that individuals should trust their partners and use condoms with partners that are not trusted! The implication is that where you lack trust, consider using condoms, hence the connotation of condoms with promiscuity. Condoms were also considered unnecessary in marriage and stable relationships, and suggestion of their use is taken to connote mistrust, unfaithfulness and the presence of a

sexual disease. Moreover, individuals have a choice, to stick to one partner or else have multiple partners and use a condom. Likewise, the role of condoms in AIDS prevention has been a matter of many public debates in Kenya, which have highlighted misperceptions and discredited the efficacy of condoms in preventing HIV infection. Programmes have to strive to improve the image of condoms as an effective and safe prophylactic against infections and pregnancy. Clearer AIDS messages need to be devised in order to reverse the negative perceptions about condoms and promote use in a more positive way; the emphasis on “use with a distrusted partner” should be stopped and replaced with use for dual protection. The need to promote condoms as a responsibility for both women and men is paramount if the negative perceptions about them are to be reversed.

The study revealed the challenges men and women face in AIDS prevention strategies. Behavioural change is hindered by gender differences and negative attitudes and misperceptions. For example, behavioural change options of fidelity, monogamy, and abstinence seem to be unrealistic among women living with promiscuous men. For married women, these are not within their power to bring about. And for many girls, the possibility of sexual assault or rape is a reality. These are all aspects that policy and interventions should strive to address through legislation and life skills improvement programmes.

AIDS prevention strategies might need to address the normative component of behaviour change, with an aim of changing entrenched risky cultural beliefs and practices influencing the spread of HIV/AIDS and other STDs. Programmes need to encourage people to discard risky practices, but at the same time, provide alternatives that will improve people’s sexual health. Such programmes need to focus both at the societal and individual levels, and to address people’s lived realities and experiences. For example, AIDS policies and programmes must reconcile socio-culturally driven fertility goals vis-à-vis their biomedical health concerns. Programmes can utilise the prevailing fertility scripts to encourage both men and women to be sexually responsible for their own health and that of their partners if they must have healthy children, and the continuity of their lineage.

The social paradigm of proving manhood and showing male prowess among young men needs to be targeted before boys reach their sexual maturity in order to reduce risks at sexual initiation.

Finally, the frequency with which poverty was linked to paid sex in FGDs needs particular attention in AIDS prevention efforts. The findings suggest that poverty may still fuel the AIDS epidemic in resource-poor contexts like in Kenya. AIDS prevention strategies must acknowledge and address poverty, which is alleged to make the women, particularly young girls, and to some extent men, resort to sexual survival strategies, consequently heightening their risk of HIV infection. For the majority of people in Kenya, as the rest of sub-Saharan Africa, their concerns are basic needs of food, shelter, etc. Essentially, unless interventions address these basic needs of target populations, the AIDS messages of HIV prevention may not translate into behaviour change. Most people have greater survival problems that supersede the looming danger of HIV infection. The social structure that favours men means that without support, women cannot avoid engaging in paid sex. Thus, behaviour change initiatives need to have a component of income generation and life support skills to address poverty, which could be a cause and effect of risk-taking behaviour in Kenya.

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**APPENDICES**

**QUESTION GUIDES**

## **Appendix 3.1: Focus Group Discussion Guide For Unmarried Women And Men**

### **Introduction to FGD Sessions**

We would like to thank you all for coming today. My name is \_\_\_\_\_. My colleague(s) is/are called \_\_\_\_\_ and \_\_\_\_\_. We are from the University of Nairobi. We are conducting a study on sexual health matters in this community. Some of the topics we are going to discuss concern sexual relationships between men and women and HIV/AIDS. We are particularly interested in how people get sexual health information, how women and men behave sexually, and what people think about the relationships between women and men. We feel by talking to people like you we can best find out about practices, opinions and feelings about these issues in order to help us improve sexual relationships between men and women and health services in our country.

There are no wrong or right answers. We are interested in your views, so please feel comfortable to say what you honestly feel. I have a list of topics I would like us to talk about but please feel free to bring up any other issues you feel are relevant.

During the discussion \_\_\_\_\_ will be taking notes to keep track of what has been covered, and to remind me if I forget to ask certain things. However, so that s/he does not have to worry about getting every word down on paper, we will also record the discussions on tape. Please, do not let that worry you. The tapes and written material will be kept safe and not shared outside the research team. After writing our report, all the tapes and written notes will be erased, so no one will know who said what.

Regarding the language, we want you to feel comfortable throughout the talk, so please just use the language that you use when you chat with friends. Finally, please try to let everyone have a turn at saying something, since all your views are important, and please try to keep the talk within the group. The discussion is confidential. Are there any questions? Please may we begin.

### **Ice-breaker**

Ask each participant to introduce themselves (first names only) and what they do.

#### **A. Knowledge and sources of sexual and HIV/AIDS information**

Q1. How do girls/boys like yourselves know about matters concerning sex, contraception, STDs, and HIV/AIDS? (Explore **what** issues are talked about with different people; Formal and non-formal sources - friends, siblings, parents, other relatives, teachers/school, church, medical, media – magazines/newspapers, films, radio).

#### **Probes:**

- a) Do you find it easy or difficult to talk about these issues with the people you have mentioned? Please explain.
- c) In your opinion, which is the most important source of sexual information? Please explain.

Q2. What do girls/boys like yourselves want to know about sexual matters? How would you like to get this information?

#### **B. Sexual relationships**

Q3 At what age do you think boys and girls in this community start to have girl/boy friends?

Q4. At what age would you say boys and girls in this community start having sexual intercourse? (Probe for motivations for sex, proportions pre-maritally sexually active; opinions about premarital sex, sexual pressure, coercion)

Q5. A) (**FOR GIRLS ONLY**). If a boy feels like making love with his girl and the girl does not want to, what can the girl do? How does the boy react? What reasons might be there for a girl to refuse to have sex with her partner?

B) (**FOR BOYS ONLY**). If a boy feels like making love with his girl the girl does not want to, what can he do?

**C. Perception of risk of HIV/AIDS, risk-aversion strategies and sexual decision-making**

Q6. In your opinion, what can happen to boys/girls like yourselves as a result of sex? (Awareness of sexual risks). **Probes:** a) What risks are girls/boys likely to worry about? b) Who should be responsible for protecting against these risks? (**Explore** gender differences for preventing different types of risks)

Q7. As far as you know, how do people (in general) get AIDS?

Q8. To what extent do you think HIV/AIDS is a risk to this community? Please explain? (**Explore** risky sexual practices and/or cultural beliefs and practices). What are the consequences of this disease for the family? In your opinion are boys and girls of your age in danger of contracting AIDS? Why/why not?

Q9. In your opinion, what are boys/girls in this community doing to reduce their chances of getting STDs/HIV/AIDS? **Probe:** Do you think there are some people (in general) who know that they can get HIV/AIDS and are doing nothing to prevent it? What kind of people are they? What are the reasons for their risk-taking behaviour?

Q10. In your opinion, what does practising 'safer sex' mean? (Sexual modes of STI/AIDS prevention).

**Story for discussion**

**Facilitator/moderator:** Kazuri is a girl who has a boy friend called Fagia who works and lives in town. Kazuri stays in the village and Fagia regularly goes to see her. But Kazuri is worried because she has heard that Fagia has other girl friends in town. She does not know what she should do about their relationship. She does not want to leave Fagia, but she is also afraid he will give her AIDS.

Q11. What do you think Kazuri should do? (Probes: If Kazuri does what you are saying, how do you think Fagia will react? What are your opinions on condoms? What are the advantages of condoms? What are the disadvantages of condoms? (**Explore** uses and beliefs about condoms; When is condom use acceptable? With whom should condoms be used?)

**Probes:**

**FOR GIRLS ONLY:** Can a girl suggest to her boy friend using condoms? How can she ask him? How will he respond? We have heard that not all girls can suggest to their boy friends using condoms? What can you tell us about that? c) If the boy does not want to use condoms, can the girl convince him? How? In general are girls willing to use condoms? What about boys? Please explain. Where can a person get condoms? Is it easy or difficult for you girls to get condoms?? Please explain.

**FOR BOYS ONLY:** Do you need your girl friend's permission to use condoms? Why not? b) In general are boys willing to use condoms? What about girls? Please explain. c) Where can a person get condoms? Is it easy or difficult for you boys to get condoms? Please explain.

Q12. Do you think that a girl/boy should talk to a boy/girl about the fears she/he has of contracting AIDS? How can she/he bring up the subject? How will he/she react?

Q13. You girls/boys know what AIDS is about. Do you believe you have a responsibility to protect yourselves? To protect your partners? Probe: Would you inform your partner if you had STD? Why/why not? How about AIDS? Why/why not?

**E. Conclusion**

We are reaching the end of the discussion. Does anyone have anything to add or say before we switch off the tape recorder? Do any of you have any comments on how you feel it went? Before you came, did you expect anything like this?

Just before you go, could you fill this short questionnaire (we have few questions to ask each one on their own). This gives us some basic information on who takes part in these discussions. We do not need to know your name as it is anonymous, confidential.

END: Thank you very much for participating in this discussions.

### Appendix 3.3: Focus Group Discussion Guide For Married Women And Men

#### A. Knowledge and sources of sexual and HIV/AIDS information

Q1. How do married women/men people like yourselves know about matters concerning sex, contraception, STDs, and HIV/AIDS? (Explore **what** matters are talked about with different people; formal and non-formal sources - friends, siblings, parents, other relatives, teachers/school, church, medical, media – magazines/newspapers, films, radio).

**Probes:** a) Do you find it easy or difficult to talk about these issues with the people you have mentioned? Please explain. c) In your opinion, which is the most important source of sexual information? Please explain.

Q2. What do married women/men like yourselves want to know about sexual matters? How would you like to get this information?

#### B. Sexual relationships

Q3. Do you think married couples make plans to have sex? **Probe:** Who decides when to have sex?

Probes: In your opinion, would married couples discuss anything sexual before having sex? What sort? Why not? (Probes: contraceptive use, STD/sAIDS). Who starts the discussions before having sex? Can a woman suggest to her husband to have sex? Please explain?

Q4. **(FOR WOMEN ONLY)** If a man feels like making love with his wife and the wife does not want to, what can wife do? How does the man react? What reasons might be there for a married woman to refuse to have sex with her husband?

**(FOR MEN ONLY)** If a husband feels like making love with his wife and the wife does not want to, what can the husband do?

Q5. What is your opinion on extramarital sex? Probes: Is having an extra-marital sexual partner among married women/men acceptable or not acceptable in this community? Is there punishment for extra-marital sex? Are there differences between men and women? In your opinion what makes married women/men have outside partners? What type of married men/women are likely to have extra-marital sex? What type of people would they have extra-marital sexual relations with?

Q6. Do you have any views on sex between unmarried couples? **Probes:** a) At what age would you say young people in this community start having sex? In your opinion, do you think this is too early, too late or about right? Please explain? b) What proportion of young men/women in this community do you think are sexually active? Is having a sexual partner among unmarried boys/girls acceptable or not acceptable in this community? Is there punishment/reward for pre-marital sex? Are there differences between boys and girls?

#### C. Perception of risk of HIV/AIDS, risk-aversion strategies and sexual decision-making

Q7. In your opinion, what can happen to married women/men like yourselves as a result of sex? (Awareness of sexual risks). **Probes:** a) What risks are married women/men more likely to worry about? b) Who should be responsible for protecting against these risks? (**Explore** gender differences for preventing different types of risks)

Q8. As far as you know, how do people (in general) get AIDS?

Q9. To what extent do you think HIV/AIDS is a risk to this community? Please explain? (**Explore** risky sexual practices and/or cultural beliefs and practices). What are the consequences of this disease

for the family? In your opinion are married people of your age in danger of contracting AIDS? Why? As far as you know, are unmarried girls and boys in this community in danger of contracting AIDS? Why? How do you think you might help young people avoid getting AIDS? If you knew they were sexually active, would you advise young people to use condoms? Why not?

Q10. In your opinion, what are married men/women in this community doing to reduce their chances of getting STDs/HIV/AIDS? Probe: Do you think there some people (in general) who know that they can get HIV/AIDS and are doing nothing to prevent it? What kind of people are they? What are the reasons for their risk-taking behaviour?

Q11. In your opinion, what does practising 'safer sex' mean? (Sexual modes of STI/AIDS prevention). **Probe:** Would you say it is easy or difficult for married men/women in this community to adopt 'safer sex' practices? Are there differences between men and women in what you are saying?

### **Story for discussion**

Facilitator/moderator: Kazuri is married to Fagia who works and stays in town. Kazuri stays in the village and Fagia regularly goes to see her. But Kazuri is worried because she has heard that Fagia has other sexual partners in town. She does not know what she should do about their relationship. She does not want to leave Fagia, but she is also afraid he will give her AIDS.

Q12. What do you think Kazuri should do? Probes: If Kazuri does what you are saying, how do you think Fagia will react? What are your opinions on condoms? What are the advantages of condoms? What are the disadvantages of condoms? (**Explore** uses and beliefs about condoms; When is condom use acceptable? With whom should condoms be used?)

### **Probes:**

**FOR GIRLS ONLY:** Can a wife suggest to her husband using condoms? How can she ask him? How will he respond? We have heard that not all wives can suggest to their husbands using condoms? What can you tell us about that? c) If the husband does not want to use condoms, can the wife convince him? How? In general are wives willing to use condoms? What about husbands? Please explain. Where can a person get condoms? Is it easy or difficult for you women to get condoms?? Please explain.

**FOR MEN ONLY:** Do you need your wife's permission to use condoms? Why not? In general are married men willing to use condoms? What about married women? Please explain. Where can a person get condoms? Is it easy or difficult for you men to get condoms? Please explain.

Q13. Do you think that a woman/man should talk to her husband/wife about the fears she/he has of contracting AIDS? How can he/she bring up the subject? How will he/she react?

Q14. You married women/men know what AIDS is about. Do you believe you have a responsibility to protect yourselves? To protect your partners?) Please explain what you have said. Probe: Would you inform your partner if you had STD? Why? How about AIDS? Why?

### **D. Conclusion**

We are reaching the end of the discussion. Does anyone have anything to add or say before we switch off the tape recorder? Do any of you have any comments on how you feel the discussions went? Before you came, did you expect anything like this? Just before you go, could you fill this short questionnaire (we have few questions to ask each one on their own). This gives us some basic information on who takes part in these discussions. We do not need to know your name as it is anonymous.

END: Thank you very much for participating in this discussion.

### **Appendix 3.3: In-depth Interview Guide for Unmarried Women and Men**

#### **Introduction to in-depth interview session (for unmarried, with sexual experience)**

My name is \_\_\_\_\_. I am from the University of Nairobi. We are conducting a study on sexual health matters and relationships between men and women in this community. Some of the topics we are going to discuss concern sexual relationships between men and women and HIV/AIDS. We are particularly interested in how people form sexual relationships, how women and men behave sexually, and what people feel about sexual health services. We feel that by talking to people like you we can best find out about practices, opinions and feelings about these issues in order to help us improve sexual relationships between men and women and health services in our country.

I have a list of topics I would like us to talk about but please feel free to bring up any other issues you feel are relevant. Some of the questions that I am going to ask on sexual behaviour and relations may be sensitive. I assure you that the interview is completely anonymous. Your name will not be written on this form and will never be used in connection with any of the information you tell me. You do not have to give me an answer to any questions that you do not wish to respond to and you may stop this interview at any time. However, your honest responses to these questions will help us to understand better what people think, say and do with regard to relationships between men and women and sexual health matters.

During the discussion I will be taking notes to keep track of what we have covered, and to remind me if I forget to ask certain things. However, so that I do not have to worry about getting every word down on paper, we will also record the discussion on tape. Please, do not let that worry you. The tape and written material will be kept safe and not shared outside the research team. After writing our report, all the tapes and written notes will be erased, so no one will know what you said.

Regarding the language, I would like you to feel comfortable throughout the talk, so please just use the language that you use when you chat with friends. Once again this discussion is confidential. Are there any questions you wish to ask? Please may we begin.

IN-DEPTH INTERVIEW ICE BREAKER: BACKGROUND INFORMATION–UNMARRIED WOMEN AND MEN

<b>I will start by asking questions about yourself</b>			
		Categories	Codes
Q1	District	Kisumu Kiambu	1 2
Q2	Division		
Q3	Location		
Q4	Sub-location		
Q5	Sex	Male Female	1 2
Q6	How old are you now?	15-19 20-24 25-29 30+	1 2 3 4
<b>I would like to ask you about your marital status</b>			
Q7	Have you ever been married or lived with a man/woman as if you were married?	Currently married Ever married Never married	1 2 3 <b>TO 10</b>
Q8	How long have you been married/were you married?	Less than a year 1-3 years 4-5 years 6+ years	1 2 3 4
Q9	<b>Never married:</b> Have you ever had sexual intercourse?	Yes NO	1 2
Q10	Have you ever attended school	Yes No	1 2
Q11	What is the highest level of school you attended?	Primary Secondary University	1 2 3
Q12	What is your religion?	Catholic Protestant Seventh Day Adventist Muslim Other None	1 2 3 4 5 6
Q13	What do you do for a living?	Salaried/wage employee Business person Farmer Domestic work Student Other (specify)	1 2 3 4 5 6

**In-depth interview Guide**

**A. Sexual relationships: Nature and process**

Please tell me about your general sexual experiences. How many sexual partners have you had in your life? Have you had sex in the last 12 months? With how many partners? Have you had sex in the last 4 weeks? With how many partners? (Probe: casual or serious; concurrent or serial monogamous; sex for exchange of money/gifts/favours).

**First sexual Intercourse**

Now I would like to ask you about your first sexual intercourse. At what age did you first have sexual intercourse? Was this someone of the same age?



- Q1. Did you have sexual intercourse with your first boyfriend partner? **If not, what person did you first have sex with?** How long after starting your relationship did you have first sex? What sexual activities did you engage in before having first sexual intercourse?
- Q2. At the time did you consider this relationship to be serious or casual? Why? Do you think he/she considered the relationship as serious/casual? Why?
- Q2. Did you want to have sex when you had it the first time? Please explain. (**Probes:** what influenced you to have sex the first time?. At what place did you have sex the first time? Who decided that you have sex?
- Q3. In general, how did you feel after your first sexual intercourse?
- Q4. Did you talk to your first sexual partner about his/her previous sexual experiences? Did your first sexual partner ask you about your previous sexual experiences?
- Q5. Did you seek information about your first sexual partner from anyone? Where from and what about?
- Q6. Did you use any form of contraception the first time you had sex?  
**Probes: (If yes)**, which method(s) of contraception did you use? How did you get them? Who decided that you use that method? Why did you use that/those methods during your first sex and not another method?
- Q7. Did you continue to have sexual intercourse with your first sexual partner? How long did the relationship last? **Probes:**a) (**If contraception used at first sex?**) Did you continue to use contraception all the time you had sex with your first sexual partner? b) What methods did you use? How did you get them? c) Why did you use that/those methods and not another method?
- Q8. (**If contraception not used every time**) Why do you think you did not use contraception every time you had sex with your first sex partner?
- Q9. (**If didn't use contraception at first sex**) After first sex in which you did not use contraception, did you consider using any form of contraception later in your relationship with your first sexual partner?  
Probes: a) Can you remember why you started using contraception? Who decided that you use contraception? b) What methods did you use? How did you get them? c) Why did you choose to use that/those methods during sex and not another method?
- Q10. **If never used contraception at all**) Why do you think you never used contraception at all with your first sexual partner?
- Q11. Did you talk about contraception with your first sexual partner?  
Probes: a) (**If yes**) Who started the talk? Can you remember when you talked about it, was it some time or just before sex, during sex, after sex or perhaps not on the first time but afterwards during or in a later occasion of sex?  
b) Can you remember how you or your first sexual partner started the subject of contraception? What were some of the things you both said? Did you talk about condoms? What did you talk about condoms? c) (**If not talked**) Can you remember if there was any reason(s) you did not talk about condoms with your first sexual partner?
- Q12. Did you ever talk with anyone about your first sexual experience? What type of person did you talk to and what did you talk about?

**If respondent has had more than one sexual partner in her/his life time and has had had a partner in the last 12 months, ask about the current or most recent sexual partner**

Now I would like to ask you about your current/most recent sexual partner? Is this someone of the same age?

Q13. How long after starting your relationship did you have sex with your current/recent partner?

Q14. Do/did you consider this relationship to be serious or casual? Why? Do you think he/she considers/considered the relationship as serious/casual? Why?

Q15. Do/did you always want to have sex when you have/had it with your current/recent partner? Please explain. (Probes: What influences/influenced you to have sex with your current/recent partner?). Where do/did you usually have sex? Who decides that you have sex?

Q16. Do/did you talk to your current/recent sexual partner about his/her previous sexual experiences? Did your current/recent sexual partner ask you about your previous sexual experiences?

Q17. Did you seek information about your current/recent sexual partner from anyone? Where from and what about?

Q18. Do/did you use any form of contraception with your current/recent sexual partner? Probes: (**If yes**), which method(s) of contraception do/did you use? How do/did you get them? Who decided that you use that method? Why do/did you use that/those methods and not another method?

Q19. How long have you had/did you have the relationship with your current/most recent sexual partner?

a) Do/did you continue to use contraception all the time you have/had sex with your current/recent sexual partner?

b) What methods do/did you use? How do/did you get them? Why do/did you use that/those methods and not another method?

Q20. (**If contraception is/was not used every time**) Why do you think you do/did not use contraception every time you have/had sex with your current/recent partner?

Q21. (**If does not/didn't use contraception**) Do/did you consider using any form of contraception later in your relationship with your current/recent sexual partner? Why? What methods? How will you/did you get them? Why would you /did you choose to use that/those method(s) and not another method?

Q22. Have you (did you) talked about contraception with your current/recent first sexual partner? Probes:

a) (**If yes**) Who started the talk? Can you remember when you talked about it, was it some time or just before sex, during sex, after sex or perhaps not on the first time but afterwards during or in a later occasion of sex?

b) Can you remember how you or your current/recent sexual partner started the subject of contraception? What were some of the things you both said? Did you talk about condoms? What about did you talk?

c) (**If not talked**) Can you remember if there was any reason(s) you have not/did not talk about condoms with your current/recent sex partner?

## B. Perception of risk and risk-aversion strategies

Q23. Looking back since the time you became sexually active up to now, what risks are you likely to have faced as result of having sex?

Q24. What are you more worried about? Why? What makes you take these risks?

Q25. In your opinion, do you fear that your sex life might have put you in danger of contracting AIDS? Why? Would say currently you are in danger of contracting AIDS? Why? Have you ever talked to any of your sexual partners about the fears you have of contracting AIDS? Who started the subject? What did you talk about? How did your partner react?

Q26. What have you done to reduce your chances of getting STDs/HIV/AIDS? Have you ever had HIV/AIDS test? ? **If yes**, what made you have a test? **If not**, have you ever considered having one? Why? Do you personally feel that it has been easy or difficult for you to protect yourself against getting HIV/AIDS? Why? Is there a difference between you and your sexual partners in what you are saying, or feel?

Q27. Do you feel your partners have had other sexual partners? Why? How do you feel about this?

Q28. Would you say that you have ever been pressured into sex? What sort and how?

Q29. **(If has ever used condoms)** Has your use of condoms changed since hearing about HIV/AIDS? **Probe:** more or less regularly? When did the change occur? What made you change? **If has never used condoms:** Are you considering using condoms in future?

Q30. Can you suggest condom use to your partner? Please explain. a) If your partner does not want to use condoms, can you convince him/her? How? b) In general, are you willing to use condoms? Why? c) Is your partner willing to use condoms? Why?

Q31. Would you inform your partner if you had STD? Please explain. How about AIDS? Please explain.

### Conclusion

We are reaching the end of our discussion. Do you have anything you would like to add or say regarding sexual behaviour and HIV/AIDS? Do you have any comments on how you feel it went? Before you came, did you expect anything like this? Thanks so much for your time and responses.

## Appendix 3.4: In-depth Interview Guide for Married Women and Men

### IN-DEPTH INTERVIEW ICE BREAKER: BACKGROUND INFORMATION – MARRIED WOMEN AND MEN

<b>I will start by asking questions about yourself</b>			
		Categories	Codes
Q1	District	Kisumu Kiambu	1 2
Q2	Division		
Q3	Location		
Q4	Sub-location		
Q5	Sex	Male <b>Female</b>	1 2
Q6	How old are you now?	15-19 20-24 25-29 30+	1 2 3 4
<b>I would like to ask you about your marital status</b>			
Q7	Have you ever been married or lived with a man/woman as if you were married?	Currently married Ever married Never married	1 2 3 <b>TO Q10</b>
Q8	How long have you been married/were you married?	Less than a year 1-3 years 4-5 years 6+ years	1 2 3 4
Q9	<b>Never married:</b> Have you ever had sexual intercourse?	Yes NO	1 2
Q10	Have you ever attended school	Yes No	1 2
Q11	What is the highest level of school you attended?	Primary Secondary University	1 2 3
Q12	What is your religion?	Catholic Protestant Seventh Day Adventist Muslim Other None	1 2 3 4 5 6
Q13	What do you do for a living?	Salaried/wage employee Business person Farmer Domestic work Student Other	1 2 3 4 5 6

### In-depth interview Guide

#### A. Sexual relationships

Please tell me about your general sexual experiences. How many sexual partners have you had in your life? Have you had sex in the last 12 months? With how many partners? Have you had sex in the last 4 weeks? With how many partners? (Probe: casual or serious; concurrent or serial monogamous; sex for exchange of money/gifts/favours).

## First sexual Intercourse

Now I would like to ask you about your first sexual intercourse. At what age did you first have sexual intercourse? Was this someone of the same age?

Q1. Did you have sexual intercourse with your first boyfriend partner? **If not, what person did you first have sex with?** How long after starting your relationship did you have first sex? What sexual activities did you engage in before having first sexual intercourse?

Q2. At the time did you consider this relationship to be serious or casual? Why? Do you think he/she considered the relationship as serious/casual? Why?

Q2. Did you want to have sex when you had it the first time? Please explain. (**Probes:** what influenced you to have sex the first time?. At what place did you have sex the first time? Who decided that you have sex?

Q3. In general, how did you feel after your first sexual intercourse?

Q4. Did you talk to your first sexual partner about his/her previous sexual experiences? Did your first sexual partner ask you about your previous sexual experiences?

Q5. Did you seek information about your first sexual partner from anyone? Where from and what about?

Q6. Did you use any form of contraception the first time you had sex?

**Probes: (If yes)**, which method(s) of contraception did you use? How did you get them? Who decided that you use that method? Why did you use that/those methods during your first sex and not another method?

Q7. Did you continue to have sexual intercourse with your first sexual partner? How long did the relationship last? **Probes:**a) (**If contraception used at first sex?**) Did you continue to use contraception all the time you had sex with your first sexual partner? b) What methods did you use? How did you get them? c) Why did you use that/those methods and not another method?

Q8. (**If contraception not used every time**) Why do you think you did not use contraception every time you had sex with your first sex partner?

Q9. (**If didn't use contraception at first sex**) After first sex in which you did not use contraception, did you consider using any form of contraception later in your relationship with your first sexual partner?

Probes: a) Can you remember why you started using contraception? Who decided that you use contraception? b) What methods did you use? How did you get them? c) Why did you choose to use that/those methods during sex and not another method?

Q10. **If never used contraception at all**) Why do you think you never used contraception at all with your first sexual partner?

Q11. Did you talk about contraception with your first sexual partner?

Probes: a) (**If yes**) Who started the talk? Can you remember when you talked about it, was it some time or just before sex, during sex, after sex or perhaps not on the first time but afterwards during or in a later occasion of sex? b) Can you remember how you or your first sexual partner started the subject of contraception? What were some of the things you both said? Did you talk about condoms? What did you talk about condoms? c) (**If not talked**) Can you remember if there was any reason(s) you did not talk about condoms with your first sexual partner?

Q12. Did you ever talk with anyone about your first sexual experience? What type of person did you talk to and what did you talk about?

**Ask the respondent about the current spouse.**

Now I would like to ask you about your spouse. Is your spouse of the same age? How long after meeting your spouse did you get married?

Q13. Do you always want to have sex when you have it with your spouse? Please explain. Do you plan when to have sex with your spouse? Who decides when to have sex, you or your spouse?

Q14. Before or after marriage, did you talk to your spouse about his/her previous sexual experiences? Did your spouse ask you about your previous sexual experiences?

Q15. Did you seek information about your spouse from anyone? Where from and what about?

Q16. Do you use any form of contraception with your spouse? Probes: (**If yes**), which method(s) of contraception do you use? How do you get them? Who decided that you use that method? Why do you use that/those methods and not another method?

Q17. Do you use contraception all the time you have sex with your spouse? What methods do you use? How do you get them? Why do you use that/those methods and not another method?

Q18.. (**If contraception not used every time**) Why do you think you do not use contraception every time you have sex with your spouse?

Q19. (**If does not/didn't use contraception**) Do you consider using any form of contraception later with your spouse? Why? What methods? How will you get them? Why would you choose to use that/those methods and not another method?

Q20. Have you talked about contraception with your spouse? **Probes:** a) (**If yes**) Who started the talk? Can you remember when you talked about it, was it some time or just before sex, during sex, after sex or perhaps not on the first time but afterwards during or in a later occasion of sex? b) Can you remember how you / or your spouse started the subject of contraception? What were some of the things you both said? Have you talked about condoms? What have you talked about condoms? c) (**If not talked**) Can you remember if there is any reason(s) you have not talked about condoms with your spouse?

**Perception of risk and risk-aversion strategies**

Q21. Looking back since the time you first became sexually active up to now, what risks are you likely to have faced as result of having sex? What are you more worried about? Why? What makes you take these risks?

Q22. In your opinion, do you fear that your sex life might have put you in danger of contracting AIDS? Why?

Would you say currently you are in danger of contracting AIDS? Why? Have you ever talked to your spouse about the fears you have of contracting AIDS? Who started the subject? What did you talk about? How did your spouse react?

Q23. What have you done to reduce your chances of getting STDs/HIV/AIDS? Have you ever had HIV/AIDS test? **If yes**, what made you have a test? **If not**, have you ever considered having one? Why/why not? Do you personally feel that it has been easy or difficulty for you to protect yourself or your spouse against getting HIV/AIDS? Why? Is there a difference between you and your spouse in what you are saying, or feel?

Q24. Do you feel your spouse has outside sexual partners? Why? How do you feel about this?

Q25. Would you say that you have ever been pressured into sex by your spouse? How? By anyone else? What sort and how?

Q26. **(If has ever used condoms)** Has your use of condoms changed since hearing about AIDS? **Probe:** more or less regularly? When did the change occur? What made you change? **If has never used condoms:** Have you considered using condoms in future?

Q27. Can you suggest condom use to your spouse? Please explain. a) If your spouse does not want to use condoms, can you convince him/her? How? b) In general, are you willing to use condoms? Why? c) Is your spouse willing to use condoms? Why?

Q28. Would you inform your partner if you had STD? Why? How about AIDS? Please explain.

### **Conclusion**

We are reaching the end of our discussion. Do you have anything you would like to add or say regarding sexual behaviour and HIV/AIDS, particularly among married couples? Do you have any comments on how you feel it went? Before you came, did you expect anything like this? Thanks so much for your time and responses.