INTRODUCTION

Primary School Action for Better Health (PSABH) is a school-based HIV/AIDS prevention programme whose goal is to provide a learning environment conducive to:

- The integration of HIV/AIDS prevention within schools and communities;
- The successful uptake and implementation of HIV/AIDS prevention by teachers;
- A change in student related HIV/AIDS knowledge, attitudes and behavior.

Developed within the existing cultural, political, and economic infrastructure, PSABH is an attempt to provide an integrated prevention program which enables schools and communities to work towards HIV/AIDS prevention for youth. The curriculum itself focuses on abstinence and condom use, in that order.

The programme is currently being tested in 160 schools in Nyanza Province, Kenya. In November 2001, students and teachers completed baseline surveys. These surveys sought to assess:

- Student HIV/AIDS related knowledge, attitudes and behaviours;
- Teacher knowledge, attitudes and readiness to implement the PSABH curriculum.

In March 2002, interviews and focus groups were conducted in 16 communities. The purpose of these was to:

- Clarify ambiguities discovered in quantitative surveys;
- Either confirm or disconfirm quantitative results;
- Provide a better understanding of the context in which the curriculum is being implemented;
- Identify factors which are either facilitating or hampering PSABH programme implementation and success

This is the second report on data collected as part of the Monitoring, Evaluation and Research component of PSABH. The report is based primarily on the interviews and focus group discussions with results from surveys with teachers and students integrated to:

- Provide an integrated picture of the lives of students, teachers, and their respective communities in 16 qualitative interview sites as they relate to HIV/AIDS.
- Supplement and enrich the quantitative results.
- Pursue in greater depth, issues raised in quantitative analysis.
- Identify major themes arising from both the qualitative interviews and focus group discussions that either facilitate or hamper HIV/AIDS prevention efforts.

RESEARCH METHODS

This report is based on

- Data collected by Steadman Research in two self-completion questionnaires administered to students and teachers in 160 schools in Nyanza Province, Kenya in November, 2001 and reported in Primary School Action for Better Health: Self Completion Survey, Pre-Programme Vols 1 and 2.
- Data collected by Steadman Research in qualitative interviews conducted with teachers, community leaders and students in 16 of the 160 study sites.
- Data collected by Zonal Inspectors on pregnancies among students in the 160 study sites.

Selection of 16 Sites for Qualitative Study:

Sixteen schools were chosen for in-depth qualitative data collection in a manner that ensured equal representation across target and control groups, ethnicity, and schools whose pupils tended to score at the top and bottom of standard academic evaluations. The 16 schools comprised:

- 8 target and 8 control schools
- 8 Kisii and 8 Luo schools
- 8 top and 8 bottom performing schools

Beyond this breakdown, schools were selected to maximize diversity and with attention paid to feasibility of access. To be eligible for selection schools had to:

- have enough boys or girls in standard 7 and 8 to provide at least 5 boys or 5 girls for a focus group discussion;
- be accessible to the research team which had to transport equipment from a central location to the school.

In each school semi-structured, in-depth interviews were conducted with:

- 1 head and 1 senior teacher with an attempt made to insure at least one interview was with a senior female teacher;
- the chief or assistant chief and the head of the women's group or otherwise recognized influential woman in the community served by the school.

A focus-group was conducted with either 5 boys or 5 girls in each community. Participants for focus groups were selected on the advice of teachers based on their willingness to talk about issues related to HIV/AIDS and sexuality.

Transcripts from a total of 32 interviews with teachers, 32 with community leaders and 16 focus groups were analyzed with the assistance of the qualitative analysis software N5 (Scolari).

In-Depth Interviews

The in-depth interviews were designed to further explore and elaborate on key issues raised by questionnaire results. All interviews addressed issues related to AIDS awareness and the key prevention messages of waiting to engage in sex until some later time, (ideally marriage), and using condoms when engaging in sex. In addition, interviews with teachers explored concerns expressed by teachers with respect to teaching shy students, their own comfort with teaching about sex and AIDS, concerns about parents' views of what they were teaching, and how and what they taught.

Focus group discussions with students focused on areas where survey results required clarification because of inconsistent answers and weak associations where strong ones were expected. Students engaged in discussion around relationships between boys and girls, the scripting of sexual encounters, how they learn about sex, their views and what they had been told about abstinence and condoms, whether these expectations could be realized and the ways in which they were or were not realized.

Interviews with community leaders were the first time their opinions and views were collected in this project. The focus here was to elicit from male and female community leaders their views on AIDS in their community, the vulnerability of youth, the role of the school and community in prevention, their own views on prevention (particularly abstinence and condom use), whether, from their experience, they felt youth were acting to reduce their own risk, and what they felt should be done.

Analysis

Analysis of textual data was facilitated by N5 Software. There were five steps in the analysis process:

(1) All textual data was read and coded based on the original interview/focus group questions.
(2) Sections from all interviews dealing with the same topics were read to develop an understanding of the topics from the perspective of different community members.
(3) Summaries based on these topics were prepared.
(4) As cross-cutting themes began to emerge from the data, text was re-read and re-coded into thematic groupings and the themes and connections between them were elaborated.
(5) Once the qualitative data had been 'mined' in this way, it was compared to results from surveys with teachers and students.

The textual materials provided insights into the meanings behind survey responses. These insights were of several types:

- at times they challenged the earlier interpretations of these responses (e.g. forced sex and sexual scripts, AIDS awareness);
- at times they confirmed those interpretations and provided the reasons behind them (e.g. shy students);

- at times they raised issues that had not been fully explored in the surveys but might warrant further attention (e.g. voice of religion);
- at times they suggested the survey responses needed to be examined differently than they had been (e.g. condom knowledge and attitudes).

The results of these analyses were compiled into the text of this report.

Finally, a preliminary profile was constructed of each of the 16 communities included in the qualitative data collection using survey, qualitative and pregnancy data. Additions will be made to this profile once the Community and School Responsiveness Surveys have been analysed. It will form part of the basis for a community-level analysis of the effects of the PSABH programme. These profiles can be found in Appendix A.

Presentation of Results

Results of this analysis have been grouped by themes. Interpretations and conclusions based on the data are supported by direct quotations from the text of interviews. Unless a particular interpretation applies only to one group of individuals (e.g., only to teachers, only to Kisii), quotations are drawn from interviews with different groups of people from different types of communities. Each quotation is identified as coming from an interview with community, teacher or pupils, as from a male or female and by the line number of the text in the interview. No communities or individuals are mentioned by name in order to protect the confidentiality of participants and groups.

AIDS AWARENESS

Every country and region of the world has had to deal with the reactions of defensiveness and fear with respect to AIDS. This is understandable, as AIDS essentially threatens the social and economic fabric of nations as well as the lives and well-being of their people. Such a threat instills fear not only into individuals but into national leaders as well. For developing nations, which have been working hard to improve the social and economic conditions of their populations and which are dependent on the confidence of wealthy nations in their stability and progress, the reality of AIDS poses an exceptional threat. For populations where employment is hard to find, where there is no guaranteed access to education or health care, and where the livelihood and survival of an entire family is dependent on their place in the community, the ability of AIDS to threaten each of these is a strong motivator for defensive reactions which frequently include outright denial. Thus, the unwillingness to openly express that AIDS affects 'my' nation, 'my' region, 'my' ethnic group, people like me and my family, is a worldwide response to the fear of what AIDS can do. However, the consequences of such a defensive reaction work against prevention and care efforts and provide a niche for AIDS to spread its devastation even further.

In surveys, both teachers and students indicated a high level of awareness that AIDS is present in their communities:

- 82% of teachers do not think AIDS has been made into too big a problem.
- 90% of students have heard of AIDS.

This suggests that it is a minority who may be expressing denial around the presence, extent, or seriousness of AIDS in Kenya. However, a somewhat different picture became apparent from reading the text of the qualitative interviews. What was evident was a considerable degree of discomfort with addressing the existence of HIV/AIDS, invisibility of people who are infected and affected by it, and, to some degree, the expression of denial that it is of immediate concern to the interviewee.

Defensiveness around the existence of HIV/AIDS.

Discomfort in addressing the topic of HIV/AIDS was apparent even from a cursory reading of the interview transcripts. Despite the fact that interviewees were aware of the topic and interviewers asked questions using the term AIDS, there was still a tendency among interviewees to refer to AIDS using something other than its rightful label. Specifically, there were two interviews where the very word *AIDS* was never used by the interviewee and many others where interviewees seemed more comfortable simply referring to HIV/AIDS as "that disease".

> *Unless she becomes very careful, straightaway she will get that disease because now it seems it is everywhere* (Community10_F:196-198).

> *Yes they should be told, so that they know the consequences of getting the disease* (Community3_M:118-119).

> *Now you find the teacher who will come when he / she is teaching CRE* [Christian religious education] *what she will tell you, you take care not to be infected with this disease* (Boys6:1500-1503).
>
> *So they do not ruin their lives. Because of the "big" disease* (Girls4:570).
>
> *They should be taught the meaning; particularly of this dreaded disease* (Teacher6_M:179-180).
>
> *They should be taught how to prevent, how to manage living with the disease and how to behave in order to avoid this* (Teacher9_F:275-277).
>
> *...tell them how bad this disease which has come is, how bad it is* (Teacher15_M:305-306).

Many interviewees acknowledged that AIDS was a problem with comments such as:

> *It is a big problem now that we are having* (Community 12_M:82-82)

Some spoke of a shift in the open recognition of the presence of AIDS.

> *When this disease came they* [community members] *did not take it as something that can destroy life...But as time goes by, they have come to prove that it is a dangerous disease and a problem in this community* (Community2_M: 51-55).
>
> *But these days they have known because of education and many people now understand how people have died, there is this deadly disease called AIDS, that is what is killing people* (Community26_M:63-67).

However, in a few communities there appeared to be discomfort about acknowledging the existence of HIV/AIDS.

> *I swear I have never heard that this community of ours has that disease called AIDS. I have never heard* (Community32_F:94-95).
>
> *...but others brush it off saying that AIDS is not real* (Community8_F:628).
>
> *...they* [the students] *have got to know first that AIDS is real* (Teacher19_M:25-26).
>
> *What is happening here, which I have said is that even some of the teachers whom you think should actually believe there is AIDS, some of them have not believed* (Teacher23_M:336-338).

Even when AIDS was mentioned, some failed to see the disease as more severe than other

diseases. For them, AIDS was a disease like many others.

> *For me I have heard that AIDS is just like any other disease* (Girls5_F:1283).

The 11.1% of the teachers who, in the quantitative survey responded "definitely yes" to the statement "I don't think HIV/AIDS is as big a problem as its made out to be", suggests that even among those who are educated, some may still be unwilling to openly express the extent to which AIDS has had an impact on their communities, their families and themselves.

Among Luos who were interviewed, defensiveness around the presence of HIV/AIDS was transposed into a traditional understanding of disease and its relationship to breaking taboos. Thus, according to some interviews from Luo communities, AIDS continued to be referred to as "chira".

> *Well, according to this disease, we tell them so many things, because some people believe that, that there is no disease like that. They believe that AIDS, is 'chira' AIDS is 'Chira'* (Community21_M:125-127).

> *... you tell them there is AIDS, they say no there is nothing like AIDS ... they will say it is 'chira'* (Community5_F:273-277).

> *This is AIDS, though most people think that AIDS is not really a disease, they think it is what we call here 'chira'. They think it is witchcraft* (Community6_M:289-291).

> *You know in the Luo community when a person dies thin they said may be it is chira and so forth because they have done a taboo of the community* (Teacher6_M:158-160).

> *The kind of disease is counted like a curse because of the origin* (Teacher1_F: 556).

> *The only thing that there is still some confusion between AIDS and traditional beliefs...Like maybe "chira" that is when you die when you are so thin they believe that its "chira". But in the real sense its AIDS* (Teacher21_M: 299-308).

Invisibility of those infected and affected by HIV/AIDS.

Defensiveness around the existence and impact of HIV/AIDS was supported by the unwillingness of many people within the communities to openly identify those who were infected and/or affected by the disease. In fact, it was frequently suggested in the interviews that when people have HIV or have died of AIDS, those closest to them are reluctant to reveal this information, even at the funeral. Despite the silence, knowledge about AIDS led others to believe that this was the real cause of death.

> *You know they die sometimes they hide they don't talk that AIDS is the one that*

killed the person or the person has died of AIDS. But we know it is the one (Community10_F:109-112).

In this community there is AIDS. But if somebody dies people never say the truth. But from our observations, the symptoms are clear, there is AIDS (Community11_F:91-93).

But there is nobody who has ever come up in any funeral to say that this man died of AIDS. It was AIDS, please take care (Community27_M:380-381).

When one dies there is no one who comes out clearly and say this is AIDS. You get a number of reasons, he died of this one and that one, this is what goes out and HIV does not come out clearly (Teacher23_M:57-60).

They don't say you will only hear them whispering but they don't say that this is a victim of AIDS (Teacher31_F:772-773).

In fact some of them [the students] *have been infected although they don't know. Although they don't know what really happened to their parents* (Teacher6_M:21-23).

At the same time, interviews suggested that it was not only those closest to the infected and affected who concealed the truth. Rather, there was a general sense that openly identifying those infected or affected by HIV/AIDS went against community norms.

Somebody from outside cannot come to say that it is AIDS that has killed the woman or the husband (Community10_F:118-119).

Even doctors do they really say? They just write the disease that can be cured … I don't know, AIDS makes people get very angry. So if you say for example, someone's kid has died of AIDS, someone will come and ask you: How did you know? and Where were you? Were you there? Are you the one who gave her that AIDS? (Community7_F:172-180)

There are situations when you teach, particularly those ones of us who make the mistake to mention a few cases. It becomes very difficult because if you touch such cases, even when we have such cases people fear talking about it openly because they fear being harassed by even parents, even relatives of those ones to the deceased (Teacher30_M:87-91).

The high rate is there but you cannot know the exact thing, which is making them to die, you just hear somebody is sick and you know in rural, no one can reveal the type of the disease (Teacher29_F:160-163).

Some suggested that this imposed invisibility of AIDS was particularly problematic because, in some ways, it helped to perpetuate the spread of the disease.

The problem is although in the funerals of the victims people have not come openly to talk about it [if they could talk about it] *openly it will assist and the kids will see the need to wait* (Teacher1_F:305-308).

You see, first of all they have to believe that there is this disease AIDS,...there are some who have never seen AIDS in their homes. So even if you try to tell them they cannot believe (Community5_F:325-330).

Some of them [the students] *they have not seen somebody who is affected. some of them they have seen and they have not believed it is a normal disease. So in controlling it, it's becoming a problem* (Teacher15_M:62-65).

Another one I think is ignorance because some people believe in that theory that seeing is believing. So when we teach them theory, theoretically they feel that they've never seen, practically they've never seen an AIDS patient (Teacher19_M:42-46).

For some of those interviewed, this invisibility made it all the more difficult to recognize that any potential partner might have HIV/AIDS.

They should be educated because the disease has spread a lot so when someone is still alive you can't tell whether she/he has AIDS (Community18_F:157-159).

They just tell us how they are used [condoms] *but truthfully maybe you have a friend of yours who you feel you know does not have the disease and you do not use Trust when playing sex, then you get the disease* (Boys8:1571-1574).

They don't know if the person has AIDS or not. Now, she can not know. And if you get person has played sex with many people, she can't know when she got the disease (Girls5:1290-1293).

Understandably, silence and invisibility around the presence of AIDS is problematic for communities. Community leaders recognized this and admitted to making a concerted effort to bring the topic of HIV/AIDS out into the open.

Last year the assistant chief organized a meeting and talked about AIDS. He called a meeting for the union and told the doctors if someone has died of AIDS let them say its AIDS... (Community7_F:437-440).

We have got forums and open air meetings and we can talk to the community. We have also schools and through these ones we can influence the community against AIDS (Community21_M: 476-479).

We have really talked. The elderly men have also talked strongly (Community22_M: 500-502)

> *I have met several barazas in my area and talked about sex, the illegal sex and HIV/AIDS. I have also invited other leaders especially the chief, the local counselors and other departmental heads who have talked about the dangers of this disease* (Community23_M: 401-405).

Teachers, who are often from outside the community and have been given one of the better opportunities to learn about AIDS through materials provided by the Ministry of Education, were able to identify practical reasons for this silence surrounding HIV and AIDS. Those thought to be infected, including their family members, could find themselves isolated or judged as immoral.

> *...others may see a boy suffering from a different disease not AIDS. They may even isolate him [saying]," this one is a victim of AIDS* " (Teacher12_M:302-304).

> *That person is taken as a very immoral person in the community therefore naming after that person who has died is difficult. That's not an honourable kind of death* (Teacher1_F:557-559).

> *Yeah and even association like a person who is suffering from AIDS and symptoms have started to show. A person doesn't talk freely and people start gossiping about the person openly. So the person goes like. "I'm not acceptable in the community"* (Teacher1_F:563-566).

> *...children associate AIDS with shame so they are not free to talk about it* (Teacher14_M:43-44).

> *...they* [the students] *are afraid of AIDS patients* (Teacher21_M:42-43).

At the same time, it is important to note that the teachers themselves also suggested that they participated in passing judgement around HIV/AIDS. In fact, 34.5% of respondents agreed at least a little with the statement that "HIV is God's punishment for wicked behaviour."

These judgements may even be expressed by family and friends as they attempt to distance themselves from those who are dying of AIDS.

> *These people should not be ignored in the family. They should be cared for because there are some that are suffering from this AIDS in our homes and they are just left there to die* (Community16_M:697-700).

> *If you come and you are ill, I'm not ready to take care of you because every evening I always tell you there is a problem I have and you know the problem yourselves...You will die and if you die I don't care* (Community10_F:250-259).

In fact, 22.4% of the students surveyed stated that they would not help to care for a family member who had become sick with AIDS.

Assigning Blame

Defensive reactions to the presence of HIV/AIDS included not only expressions of denial around the existence of the disease within one's community, family, or circle of close associates, but also a projection of HIV/AIDS onto other groups. Thus, people in Nyanza, as have people worldwide, looked outside their communities for the source of HIV/AIDS and for those who had inflicted HIV on their people.

> *...we are bordering* [another] *district and* [this other] *district seems to be the most affected. Now you see if you are bordering people who are affected even we can't miss being affected* (Community26_M:69-73).

> *The* [other people] *they are our neighbour. So these people they used to be very free so the disease has taken a lot of people* (Teacher15_M:308-310).

> *In fact I feel comfortable when talking about it because the way we have seen this disease killing a lot of people even around, you know we have been hearing a lot of it in* [a city] *and some other major towns. But now it has come to the reserve areas* (Teacher20_M:151-155).

They also looked to assign blame to those participating in *deviant behaviours*, particularly when they had violated community norms of sexual morality. Based on the overwhelming number of teachers (88%) who agreed strongly with the statement "Having sex with someone out of marriage is wrong", as well as the strong connection to faith expressed by teachers in the section on the Voice of Religion, it is clear that abstinence and fidelity are among the sexual norms of these communities, and those who violate it are blamed for their own misfortune.

> *...there is a necessity of avoiding illegal sex before marriage for it can as well avoid the disease of AIDS killing our people* (Community23_M:395-397).

> *What happens if boys don't follow these expectations of the community?*
> *Mostly they contract disease like HIV/AIDS* (Community9_M:235-237).

> *I see that women or men can easily get infected with AIDS depending on how you take care of yourself. If you are not careful you can contract AIDS. If you do not stick to one partner meaning you have sex from more than one partner then you can get AIDS* (Community8_F:79-83).

> *My view is that if they start to play sex early he/she may spoil his/her future life. Being infected with AIDS and lose life* (Boys6_M:185-186).

> *We have been telling them that if you do sex you might get the disease and which can ruin your life* (Teacher32_M:85-86).

Given the view, in most societies, that prostitution is a form of sexual deviance, prostitution has

taken on considerable blame for the spread of AIDS. The concern over the role of prostitution in the spread of the disease was echoed in the communities represented in these interviews.

> *They usually go, when they get a few shillings they go to a prostitute and play sex with the prostitute and that is one way of how they can catch the AIDS disease* (Community6_M:357-360).

> *You know people say AIDS is a disease of prostitution* (Girls10:1843).

In addition, a moral code has been established which assigns blame to men and women believed to be intentionally spreading HIV.

> *...the men who like to meet with the virgins are the people we have found out they are the people who have been affected by AIDS and they want to spread the AIDS through virgins* (Community16_M:378-381).

> *And others, when they know they have a disease they will go and infect somebody else with it and say, "Let it continue spreading"* (Community28_F:431-432).

> *Like there is a woman whose husband is dead. And most of the people around know she has that disease so they do not want to meet with her. So for her she will also have a sexual urge. She will look for a young boy to rape so he can get the disease* (Boys8:274-278).

> *...like today economically you may find these boys need money and you might find widows luring them to infect these boys* (Teacher7_F:728-730).

> *Again, if it's a girl who has AIDS she decides she is not going to die alone, "I will give a lot of people I die with them"* (Girls10:1277-1279).

> *If I am a man and I want to give that disease to you what I do I can cut it* [a condom] *or I cut then I put away and if I sleep with you, I know I've given you* (Community10_F:164-167).

> *Like now there was a person who had AIDS, he was very highly tempered and people came to learn about him because most of the women he went out with died, mostly those who slept with him. He used to use a lot of money to give women to go and sleep with him while cheating them that he has used a condom but in reality he wasn't using a condom* (Community27_M:302-307).

> *...he tells you he is using the condom and then he makes a hole in it. Now you know that one can't be used because you know he can cheat you, he knows he has AIDS and he wants to spread it to you* (Community7_F:236-239).

When forced to confront AIDS within their own community, blame was assigned to the infected for their carelessness or for having gone astray. It is this same attitude that is echoed in the

teachers' quantitative survey where 36.6% of the respondents suggested that they agreed at least a little with the statement "People who get AIDS have only themselves to blame".

> *To me, for one to get AIDS should not be a surprise because it is that person's fault* (Boys11_M:760-762).

> *I think that is one way I told you there is some young generation who have gone astray, that is one way of going astray because you know there is a killer disease AIDS* (Community16_M:497-499).

> *So many are now affected, which means they are careless* (Community5_F:324-325).

At the same time, one of the significant implications of HIV/AIDS for many communities in Africa is the number of children left orphaned. This issue was raised in 15 of the interviews, many with the implication that parents with AIDS should be blamed for leaving their children orphaned and disrupting society.

> *...if only their parents were better citizens without getting this disease sickness then such a thing would have not happened* (Community5_F:76-78).

> *It is the major problem here, because we have so many orphans who are left, in fact some of them have got nowhere to feed, so this is the major problem we have here with AIDS* (Community20_M:40-42).

> *Yes some get spoiled more than those who have parents because when the parents are dead they are left alone, have freedom to do whatever they like get* (Community4_F:536-538).

Essentially, AIDS is never an affliction of ordinary people engaging in the activities that members of the community teach, endorse and support. The person with AIDS is somehow exceptional and consequently to blame for their sickness and its communal consequences.

Consequences

The implications of this defensiveness, silence, isolation and blaming are significant in terms of program implementation, care for people infected with HIV, and support for affected families. For example, given the association between HIV/AIDS and sexual activity, as well as the prevailing fear that a number of people are deliberately spreading the disease, there are a number of community leaders and teachers who suggested that young people should be cautioned about their relationships. This places the focus on insuring a sexual partner is free from HIV infection. However, reliance on *one AIDS-free partner* is particularly risky in a society where extra-relationship sex is common (as discussed in the section on Sexual Scripts), where the high prevalence of HIV is often concealed, and where people infected with HIV remain relatively invisible. There is a need, instead, to assume any partner may be infected and to take precautions.

Similarly, silence, defensiveness, invisibility and blaming create a fear of being identified with AIDS. This fear seems to be reflected in students' attitudes around HIV/AIDS and sexuality. Thus, only 52% of students surveyed agreed with the statement "If someone thinks they could be HIV positive then they should go for a test." Alternatively, 50.3% of the students surveyed agreed at least a little that they found lessons on HIV/AIDS a bit shameful, suggesting there may be a desire to maintain silence and invisibility around the disease. These attitudes have a further impact upon young people's ability to use condoms. This is seen in the air of suspicion that exists when condoms are introduced into a relationship –which is more fully discussed in the section on Condoms Use.

The blaming and defensiveness also have serious implications for the identification of cultural practices that have a higher risk for spreading HIV, particularly when these are associated with specific groups of people. For example, the traditions of wife inheritance, non-circumcision of males, traditional circumcision practices for both males and females, and premarital sexual initiation (i.e. non-virginity) have all been identified in epidemiological work as contributing to the spread of HIV. It is essential that communities where these practices and traditions exist recognize these risks and find ways to reduce risk. However, since each practice is associated with a particular group of people (widows, uncircumcised males, men and women who have been circumcised using traditional practices, and unmarried non-virgins respectively) there is a strong likelihood, as seen in quotations in this section, that these groups, rather than the practices, will be identified as the causes of HIV in the community. Alternatively, when the practice is widespread – e.g. no males are circumcised in some ethnic groups – there is particularly strong denial of the association of the practice with HIV fostered more by the desire not to be associated with HIV than the potential need to change the practice. The effect on group members is illustrated in how several community leaders discussed the practice of wife-inheritance.

> *We warn people not to rush to the widows or widowers left behind because there are many diseases and it might even be AIDS* (Community11_F: 103-106).
>
> *Wife inheritance is still happening in this village the message is still being passed and recently the government ordered that anyone found to be inheriting a woman whose husband has died, both of them will get the disease* (Community18_F:499-503).
>
> *The most at risk I think are parents because* [here we] *believe in wife inheritance. This I think plays a major role in bringing about AIDS* (Community20_M:46-48).

The fear of being identified with HIV/AIDS was also evident in interviews with teachers where it had an impact on their willingness to address the subject in class. This is more fully discussed in the section on Sex and AIDS Education in Schools. In fact, some of those interviewed suggested that to talk about HIV/AIDS is to be identified as someone who has AIDS.

AIDS RISK

It is common to deny or disclaim one's own risk, particularly when the consequences of risk are deadly. As discussed in the section on AIDS awareness, whether speaking of communities, groups or individuals, there is a tendency to ascribe risk to those outside one's group or oneself. Such ascription reduces the likelihood that people will take action to minimize or prevent risk. This is especially applicable in areas where parents control or influence the lives of their children. Unless they acknowledge that their children are at risk, they are likely to resist efforts to address their children's risk. To understand the perceptions that community leaders, teachers and pupils had of risk within their own communities, specific questions related to the issue were asked.

While community leaders identified several segments of the population as being at risk for HIV (e.g. migration workers, widows) they judged that it was youth who were at highest risk.

> *It's rampant among the youth* (Community18_F: 104).

In fact, they were more consistent in evaluating youth at high risk for AIDS than were youth themselves. Nearly a third of youth indicated, in survey responses, that they were at little or no risk. Community leaders and teachers, however, spoke at length about youth vulnerability caused by:

- *Promiscuity*
- *Poverty* [play sex for money]
- *Adolescence* [physical, sexual urges, that begin in adolescence]
- *Ignorance of AIDS and its consequences*
- *Lack of exposure to HIV/AIDS prevention efforts in the community*
- *Unemployment*
- *Use of alcohol and drugs*
- *Attendance at discos and dances*
- *Peer pressure* [their friends are pressing them to play sex]

In focus groups, youth spoke of AIDS as a killer disease.

> *AIDS had killed so many people*…[it] *is incurable* (Boys4: 749-750).

> *I heard that it is a dangerous disease and it can't be cured.*
> *It kills.*
> *It is bad disease.*
> *It infects you. You have wounds all over your body.*
> *It destroys one's body* (Girls4: 726-740).

> *A victim loses hair…gets bony…develops wounds on urinary organs* (Girls4: 872-876).

> *Makes you crave for fancy food…weak…scratch yourself like a donkey that has chewed*

bad herbs (Boys12: 884-888).

It is a disease that kills if you don't protect yourself.
It is a virus disease.
It is spread through sex.
If you use unsterile razor (Boys15: 635-638).

In accordance with quantitative results where 70% of students identified themselves to be at some degree of risk for contracting HIV, focus group participants also acknowledged being susceptible to HIV infection.

Question: Do you think boys and girls your age are at a risk of getting AIDS?
Yes.
Yes, they can just get it.
They can.
Most.
It infects many [girls].
Yes, they get.

At the same time, they made sure to point out that people of all ages were at risk.

AIDS doesn't discriminate, it can infect both old and young (Boys11: 761).

Even a small baby can get AIDS (Boys13: 894).

Consistent with a theory of denial of personal risk however, they explained their risk as non-specific and outside their realm of personal control, occurring by chance, or as a result of trickery. In most cases, they placed responsibility for infection outside themselves.

You might find that she was using a razor blade which a person who had used it was having AIDS. Now by mistake she cuts herself so the virus enters her blood and then she gets AIDS (Girls5: 1324-1327).

The reason why girls in this area are at risk is because there are a lot of cattle so they [girls] *go selling milk at the lakeshore where they meet fishermen who buy them mandazis and demand payback afterwards* (Boys13: 899-902).

An infected man may use money to trick her then sleep with her. She may be treated with unsterile syringe (Boys15: 666-667).

Even a young baby who has been born if the mother had AIDS even him/her will be having it (Girls10: 1249-1251)

Boys often spoke of girls as responsible for putting them at risk.

You might find a fat girl that has AIDS but since many people believe that victims are

always thin one may play sex with such a girl only to get AIDS (Boys11: 767-769).

If a girl has AIDS and she wants to spread it she will give in to sex to any boy who proposes to her thus the boy will contract AIDS (Boys2: 614-616).

While overall scores for knowledge were low in response to survey questions in focus groups, youth identified a number of transmission routes:

- *Transmission from mother to child*
- *Blood transfusion*
- *Sexual intercourse with an infected individual*
- *Sharing clothes with an infected individual*
- *Sharing food with an infected individual*
- *In contact with the wounds of an infected individual*
- *Contaminated razor blades or syringes*
- *Sharing toothbrushes* [if two people have open wounds in their mouths]
- *Sharing underpants*

They recognized sex as being the main route of transmission but also spoke at length of various other ways to contract the virus. In fact, it appeared as if they were more concerned with, and fearful of, contracting the virus in these other ways.

If you go to hospital when you are in a bad condition they may inject you with an unsterilised needle (Boys13: 908-909).

If a boy who has AIDS uses a needle to remove a jigger from the leg injuring himself and blood comes out, and a girl uses the same needle to do the same she will get AIDS (Girls14: 914-916).

They were able to offer a variety of suggestions for minimizing risk:

- *Abstinence*
- *Remaining faithful to one uninfected partner*
- *Having both partners tested for AIDS before marriage*
- *Not using contaminated instruments* [needles or razor blades]
- *Avoiding blood transfusions*
- *Not sharing clothes or toothbrushes with an infected individual*
- *Ensuring that barber scissors are clean and uncontaminated*
- *Using a condom*.

It was rare, however, that they spoke of these behaviours as being personally applicable to them.

Summary

Youth are aware of the presence of risk but their discourse avoids ownership of responsibility or even personal risk. When personal risk is spoken of, most often the source is either nonsexual or through the malicious intent of an unscrupulous partner.