THE SOCIAL CONSTRUCTION OF HIV/AIDS PREVENTION STRATEGIES AMONG ABAGUSII YOUTH-KENYA

Rosana Erick Masese

UNIVERSITE DE PAU ET DES PAYS DE L'ADOUR

Faculté de Droit, d'Economie et de Gestion

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Monsieur Rosana Eric MASESE

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Jury:

M. Joshua J. AKONG'A: Professor of Anthropology Moi University, **Rapporteur**

Mme Anne-Marie MOULIN: Directrice de recherches au CNRS – Paris, **Rapporteur**

Mme Laurence KOTOBI: Maitre de conférences en Anthropologie à l'Université Bordeaux Segalen

M. Abel KOUVOUAMA: Professeur d'anthropologie à l'Université de Pau et des Pays de l'Adour, *Directeur de recherche*

M. Hervé MAUPEU : Maître de conférences en Sciences politiques à l'Université de Pau et des Pays de l'Adour, *Co-directeur de recherche*

M. Christian THIBON: Professeur d'Histoire contemporaine à l'Université de Pau et des Pays de l'Adour

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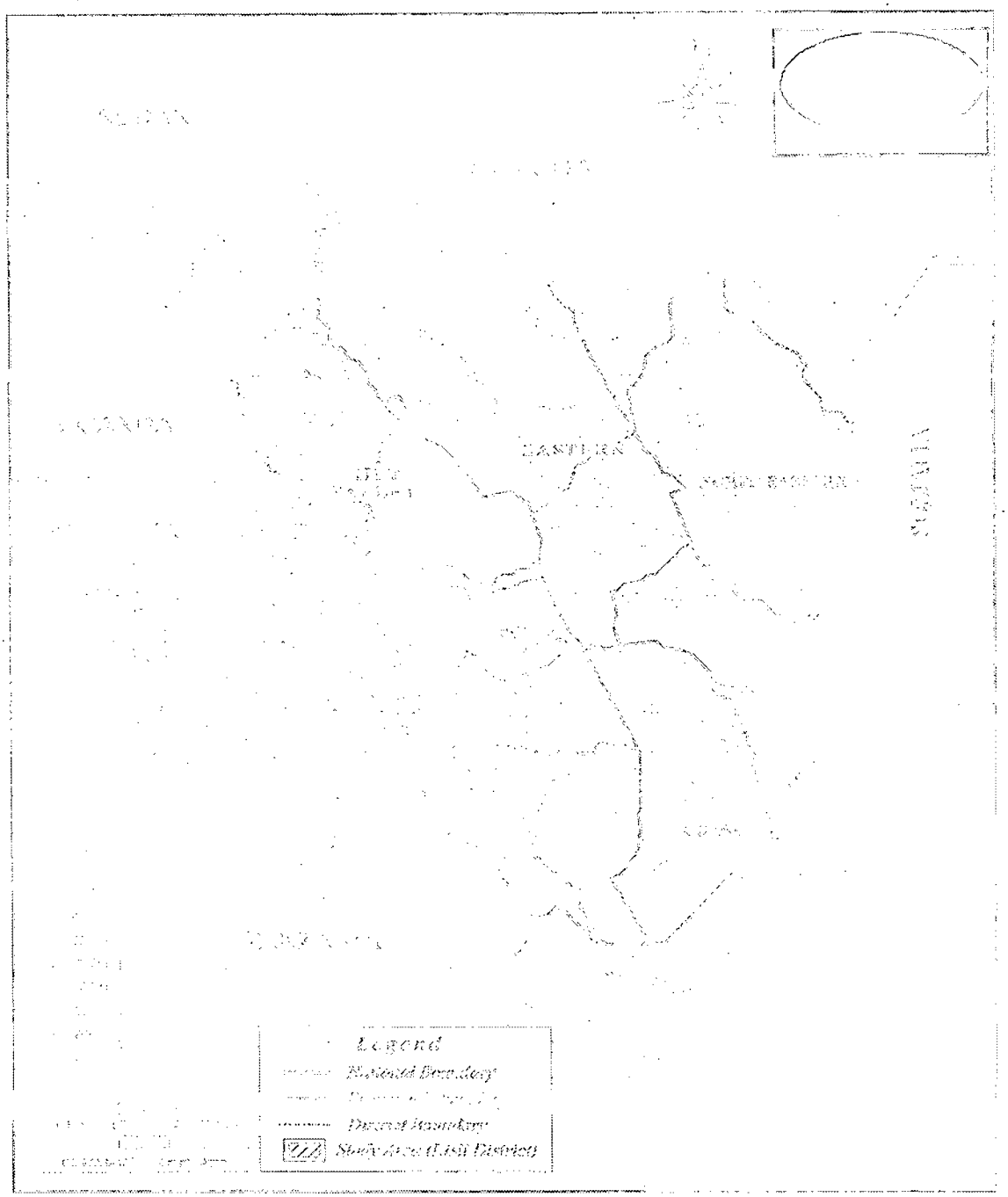
TABLE OF CONTENT

LIST OF TABLES

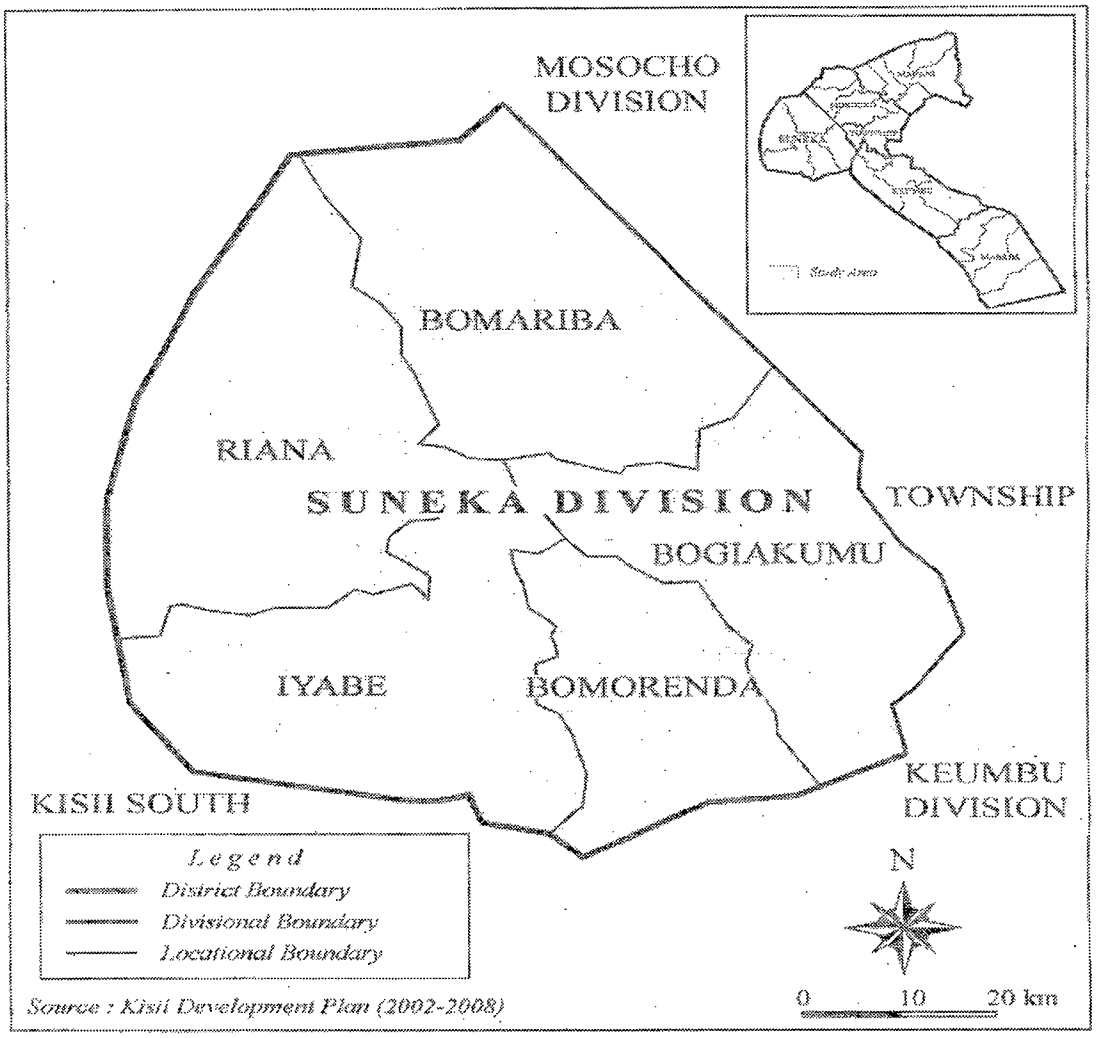
LIST OF FIGURES

MAP 1: Kenya



Map 2: Kisii Central District (Administrative boundaries)

Map 3: Suneka Division (Site of study)



GENERAL INTRODUCTION

Kenya is in East Africa, situated along the equator and bordering the Indian Ocean on the East, between Somalia and Tanzania, Lake Victoria on the South West, Uganda on the West, Sudan on Northwest and Ethiopia on the North. Nairobi is Kenya's capital and the largest city in the country (**See Map 1**).

Internally the country is divided into eight provinces. These are: Rift Valley, Coast, Eastern, Western, North Eastern, Nyanza, Central and Nairobi. Its population is currently over 33 million. Of these 97 per cent are people of African origin, divided into about 42 ethnic groups of which the Bantu (Kikuyu, Luhya, Kamba, and Gusii) and the Luo speaking Nilotics are the dominant. The official language in the country is English while Kiswahili is the national language (The Columbia Electronic Encyclopedia, 2005). The British colonized Kenya for over 60 years. Kenya gained her independence from colonial rule on December 12th, 1963. In 1964, the country became a republic, with Jomo Kenyatta as the first African president.

In Kenya, the first case of HIV/AIDS was diagnosed in 1984 and since then the disease has continued to have a major toll on youths aged 15-40 years. This demographic group constitutes over 51% of the entire population and thus has a significant impact on the societal well-being and future population growth and development. Consequently, keeping this group free from HIV/AIDS infections becomes an urgent priority.

In mitigating the impact of HIV/AIDS among youths, much attention has focused on sexual risk and its consequences. Although in most African societies premarital sex is prohibited, research findings indicate a huge disconnect between the expected and actual behaviour as demonstrated by high levels of premarital pregnancy, unsafe abortion and high prevalence of sexually transmitted infections (Masita, 2007 and Maithya, 2007).

Studies on young people's sexual behaviour in Kenya show that youths continue to face the greatest risk of HIV/AIDS infection. Studies by KIAS, 2007, Masita, 2007; Toroitich-Ruto, 1997; Njeri , 2004 and Erulkar *et al.,* 1998 indicate that youths become sexually active by age of

12 years. They engage in multiple concurrent sexual relationship and most of them have sexual intercourse without condoms. All these become avenues through which HIV/AIDS can easily be spread and therefore this calls for enhanced efforts in making HIV/AIDS intervention methods effective among youths.

HIV/AIDS among youths is spread almost entirely by heterosexual intercourse (KIAS, 2007; Kamaara, 2005 and NACC, 2001). Hence, youths within the sexually active age bear the brunt of the epidemic. Due to this, most intervention or prevention methods have focused on promoting consistent condom use, encouraging partner-fidelity (faithfulness) and abstinences. Included recently also is male circumcision and 'know your status' or Voluntary Counselling and Testing (VCT).

The effectiveness of most of these intervention methods initially relied on empowering youths with knowledge or information in order for them to make rational decisions in preventing themselves from being infected. This approach was premised on the assumption that information or knowledge will empower individuals to make rational decisions on their health by taking into account, *inter alia,* perceived severity of the disease, the level of risk, the cost and benefits of alternative behaviour (Ingham, *et al.*, 1992; Hart, *et al.*, 1992).

However, studies by Rugalema, 2004; Campbell, 2001; Parker, 2001 and Schoepf, 1992 have established that there is no direct link between information or knowledge and sexual behaviour change. This is because more people continue to be infected despite their level of knowledge about HIV/AIDS being good. This implies that HIV/AIDS prevention strategies should not only focus in empowering people with knowledge but should strive to understand how various factors like economic, social and cultural shape an individual's action towards HIV/AIDS (Parker, 2001). This is important because an individual's behaviour is a product of economic, social, cultural and political factors.

In Kenya, the government has been using three approaches to HIV/AIDS prevention. These are: multi-sectoral involvement targeting specific "high risk" group, socio-economic empowerment and awareness raising (GOK, 2000). Multi-sector involvement seeks the active participation in

planning, implementation and evaluation of HIV/AIDS prevention programmes by various local bodies with national planners. The core goal of this participation is to enhance capacity building and sustainability of prevention activities by trying to overcome various structural factors which inhibit the adoption of prevention methods at the local level like initiating income generating activities for vulnerable groups like women.

Awareness raising and targeting of "high risk" groups on the other hand aim at modifying individual sexual behaviour which puts them into risk of infection through information empowerment. Although the government uses these three tier approach to HIV/AIDS prevention, emphasis has been on awareness creation especially among young people (NACC, 2003).

Consequently, prevention discourses among youths have largely been on the notion of sexuality with most of them designed to reshape youths' sexual practices, primarily by categorizing sexual behaviour into either safe or unsafe. In doing so, they advocate Abstinence, Be faithful, and Condom use. As in Napel (Beine, 2003), these strategies in Kenya also are greatly influenced by the Western biomedical models which assume that sexual behaviour carry uniform meaning to all actors regardless of the social, economic, and cultural factors. This is contrary to Bibeau *et al.* (2002), observation that in Africa sexual practices are governed by a corpus of rules and values which determine the relations between sexes. These determinants of sexual behaviour are not only a function of individuals and social but structural and environmental factors as well.

Further, Lyttleton (2002) noted in Thailand; the success of HIV/AIDS campaigns which were based on sexual behaviour depended on the congruence of what the campaigns advocated for and how local people interpreted and made meaning of those messages in relation to their social, cultural and economic context. Similarly, it is the contention of this thesis that HIV/AIDS prevention programmes targeting youths will be more effective if we strive to understand how they make meaning of such campaigns in relation to their day to day life experience.

Although issues of sexuality are widely experienced as a private behaviour that display a personal and private aspect of self, people are socialized to act their sexuality in particular normative manner in various contexts. This is because sexuality and sexual practices are

products of interacting cultures and social practices (Weeks, 1988). In this context, analyzing HIV/AIDS prevention strategies among youths must; therefore, be geared toward an understanding of the meaning attached to sexual behaviour and social practices in the context of the wider social, cultural, and economic environment.

In creating awareness about HIV/AIDS prevention, the government of Kenya has relied mostly on mass media in an attempt to encourage sexual behaviour (Agha S, 2003; Marum E, *et al.* 2008). In most mass media channels both audio and visual, there are many entertainment education programmes (educa-entertainment) dealing with various issues of sexual behaviour. Such programmes include among others, *The Honey that Kills* which discusses various aspects of HIV/AIDS from causation, transmission and management; *Siri* that deals with HIV/AIDS and contraceptive use; *Nimechill* which encourages abstinence among young people until they are married; *Fungua Roho Yako* which encourages open communication among people who are in a sexual relationship to openly discuss about condom use; *Chanuka* which encourages youths to know their HIV status by visiting VCT and *Wachana na Mpango wa Kando* which encourages faithfulness in sexual relationship. Included also in mass media are the use billboards.

Apart from mass media, the government has initiated interpersonal communication programmes such as Straight Talk, peer counselling/education in learning institutions and condom use promotion. Both mass media and interpersonal communication programme aim at creating awareness of Abstinence, Faithfulness, and condom use and "know your status" or VCT among youths.

Supplementing the government efforts in dealing with HIV/AIDS prevention are donors like United States President's Emergency Fund for AIDS Relief (PEPFAR) and religious institutions (PEPFAR, 2005; Kangara, 2004)[1]. In the case of PEPFAR; for instance, only programmes which promote abstinence only until marriage and partner reduction among unmarried people are

[1]Other development partners /donors funding prevention strategies/programmes in Kenya include; World Bank; the United Kingdom's department for International development; the United States Agency for International development; the United Nations; through WHO, UNICCEF, UNAIDS and UNDP; the Belgian Government, the European Union, KFW-Germany, Denmark's DANIDA; the government of the Netherlands; the Japanese International Cooperation Agency; and the Canadian International development Agency (CIDA).

promoted or funded. Promotion of condom use among youths is discouraged or not funded. These conditions on the funding of HIV/AIDS prevention programmes resonate with most religious programmes (Kangara, 2004), but greatly differ with government's programmes which encourages Abstinence, Be faithful and Condom use.

As noted above, prevention messages targeting young people are diverse, confusing and contradictory. This means that for young people to initiate prevention action, they must first interpret and integrate information on prevention into their day to day life experience. However, as Huber *et al.* (1998) note, individuals are not mere consumers of information given to them. Instead they synthesize such information into a common shared knowledge as it exists in their institutions, every day language, shared meaning and understandings. This common shared knowledge is constructed through socialization as a result of social interaction, negotiation and power.

Logically, youths will construct their own realities about the various prevention strategies advocated by different actors. The constructed realities may or may not be accurate translation of what the specific strategy espouses, though they will guide their action. Of critical importance is the fact that these constructed individual realities are influenced by both cultural and historical factors (Blurr, 2003). This in essence means that individual knowledge which will guide action in the prevention of HIV/AIDS will not only be determined by specific cultural factors but also the prevailing social, economic and political circumstances.

The ABC strategy, though widely used in dealing with HIV/AIDS prevention among youths, a number of criticisms have been levelled against it by health practitioners especially in Sub Saharan Africa (Cohen, 2004). Central to this criticism is that the strategy focuses on an individual as an agent of sexual behaviour change and therefore they are only effective in changing an individual's knowledge, attitude and belief towards HIV/AIDS but not sexual behaviour (Swanepoel, 2005; Yzer, 1999). This is so because as Airhihenbwa and Obregon (2000) observe, this approach fails to address the social, cultural and economic factors that may inhibit an individual's ability to make decision at an individual level regarding HIV/AIDS prevention.

Further, given the fact the ABC approach touches on individual sexuality; and human sexuality is a social construction (Vance, 1991), it is therefore important to understand this approach within the wider context where sexuality is practiced. Due to this, it is the thesis of this study that HIV/AIDS prevention among youths will be effective if there is a clear understanding on how sexual behaviour are shaped within the context which they are enacted and how this determines an individual's prevention action to HIV/AIDS. To appreciate this, let us briefly consider the song titled *"Nyaboke*[2]*"*.

The song *Nyaboke* was first composed in 1945, immediately after the Second World War. At this time most Abagusii young men who had taken part in the war in Addis Ababa (Ethiopia) were returning home. However, most of them were suffering from sexually transmitted infections. The song was thus composed to warn young women of marriageable age not to fall in love with the men lest they themselves get infected.

At the time this song was composed, the Abagusii as a community were facing myriad social and economic problems. Economically, the community was experiencing the worst drought ever which had led to crop failure, strange cattle diseases which killed most of their cattle[3] and famine. Related to this; socially, the community was facing the problem of young people not getting married[4] because they won't afford to pay bride wealth as it had gone high (Shadle, 2006). Due to this, most men opted to remain bachelors. This meant also that young women remained unmarried as they won't find spouses.

In the midst of these problems, a new disease[5] comes in and touches the core aspect of young people's sexuality. Worse still, the carriers of this disease were young men who had served in a

[2]" Nyaboke" is a narrative song on the impact of sexually transmitted infection in the Gusii community. Though the song was composed by women in 1945 warning of the impending danger of the new disease, the song has been redone by Ontiri Bikundo in 2008 using both modern and traditional music instruments to create awareness of the dangers of HIV/AIDS. The song has retained most of all the wordings and themes as the original song.

[3] Cattle at this time were a symbol of wealth and were the only means of paying bride wealth which solemnized any marriage. The source of bride wealth was what was received from marriage of a daughter or sister.

[4] Marriage gave men and women a chance to achieve the status in the society or to be considered as an adult. For women, it also enabled them to access resources. It was thus stigmatizing for young people especially women not to be married once they attained marriage age.

[5] The Gusii people had no history of sexually transmitted infection until 1945. The disease was brought to the community by young men who had taken part in the Second World War in Addis Ababa (Ethiopia).

war far away from the community. The young men were not only of marriageable age, but also had resources from their military service which enabled them afford bride wealth, putting the young woman Nyaboke in a dilemma.

Nyaboke's dilemma oscillated between meeting the stipulated community's social and cultural aspects of sexuality as a young woman and being infected by the new disease. The social and cultural aspects of sexuality entailed that she must be married so as to attain adulthood (proper identity) and thus avoid being stigmatized. Also through marriage, she will secure rights of access to resources like land and meet the cultural role of getting bride wealth for her elder brother to enable him marry. All this puts Nyaboke in a dilemma of making a choice between risks of infection of new disease and meeting the social and cultural aspects of sexuality. The song *Nyaboke* is all about this dilemma.

The Song Nyaboke

Nyaboke *nagokania x2*	Nyaboke I cautioned you x2
Nyaboke *nagokania aee omoyo*	Nyaboke I cautioned you, oh my dear
Nyaboke *nagokania x2 ndero*	Nyaboke I cautioned you x2 now
Omomura o'miritari x2	The young military man x2
Omomura o'miritari nare n'oborwaire	The young military man has a disease
Nare n'oborwaire arusia Atisababa	He has a disease he brought from Addis Ababa
Omoyo ogakania x2	My dear you warned me x2
Omomura o'miritari nare n'oborwaire	The young military man has a disease
Nare n'oborwaire arusia Atisababa	He has a disease he brought from Addis Ababa
Omoyo omomura o' miritari ee omoyo	My dear, the young military man, my dear
Omomura o'moritari nare nenibo	The young military man has wealth
Nare nenibo tindokwa ritinge	He has wealth so that I may not be a concubine
Nyaboke *nagokania x2*	Nyaboke I cautioned you x2
Nyaboke *nagokania aee omoyo*	Nyaboke I cautioned you, oh my dear
Nyaboke *nagokania x2 ndero*	Nyaboke I cautioned you x2 now
Omomura o'miritari x2	The young military man x2
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Omoyo ogakania x2	My dear you warned me x2
Omomura o'miritari nare n'oborwaire	The young military man has a disease
Nare n'oborwaire arusia Atisababa	He has a disease he brought from Addis Ababa
Omoyo omomura o' miritari ee omoyo	My dear, the young military man, my dear
Enibo ya, omomura o'miritari omoyo x2	Wealth from young military man my dear x2
Omoyo, negere torutwa omware omoyo	It will help you get married my dear

Let us briefly consider the narrative content of this song and try to relate it to some of the themes this thesis will be pursuing by beginning with the young woman of marriageable age - Nyaboke. Nyaboke is being warned not to fall in love with young military men who are labelled as carriers of sexually transmitted infection. However, the power of the young military man (who is labelled as carrier of infection) in terms of helping Nyaboke meet her socially and culturally sanctioned obligations of sexuality such as getting married makes invisible the risk of getting infection. Although the young woman demonstrates that she is aware of the danger of falling in love with the young man, this risk becomes secondary in comparison of meeting the socially and culturally stipulated roles. This demonstrates that risk perception is shaped by culture, society and history. This puts into question the relevance of knowledge alone in preventing risk.

In the song a person is understood as being constituted by relations with others, produced through kinship and other forms of substantial relatedness, and through flow of substances that link one person with others and the environment. For example, in the song Nyaboke values the culturally and socially defined relationship with others as more important than risk to infection, *"The young military man has wealth, He has wealth so that I may not be concubine"..... "Wealth from young military man my dear x2 It will help you get married my dear."* This understanding of personhood tend to value relation between people over boundaries around them, and regard the person as composite and overlapping with other persons rather autonomous and indivisible. This is contrary to Western understanding of personhood which often emphasizes individualism and boundaries. Therefore, these observations from the song *Nyaboke* convey a message concerning perceptions of risk: if one does not understand the person as a bounded, autonomous individual, a crucial condition of the notion of risk-perception as individual choice between avoiding and approaching a potential threat is not given. If the person is not the central locus of control and agency, adversity is not experienced, anticipated and countered in relation to single persons, but to a network of social relations. This can lead to an emphasis on different threats (for example, threatened relations like being a concubine rather than threatened bodies through infections) and different counter-measures (for example, those aimed at meeting cultural and socially prescribed obligations rather than disease prevention).

Evidently, it is clearly from the foregoing that non-individual model of personhood have implication for how people understand their bodies. An idealized individual body in this context is an autonomous and indivisible organic unit, which depends for its wellbeing on completeness and boundedness. Therefore in the song *Nyaboke* sickness is understood in terms of blocked pathways or infringed boundaries, which is countered by taking different actions which aim at re-establishing firm boundaries around the body and person. As noted in the song *Nyaboke* re-establishing of boundaries may not take risk to infectious disease as priority. For example, Nyaboke is aware of the disease and how it's transmitted, but she has other priorities than risk-avoidance, such as production of person and sociality.

In the song, the disease is construed as of a foreign origin and for a particular group of people, "*.... The young military man has a disease... He has a disease he brought from Addis Ababa...*" This construction makes people who do not identify themselves with the risk group to have some sense of security against infection. Thus, the general counsel of avoiding risk is by not associating with the risk group; "Nyaboke, *I caution you, the young military man has a disease.*" However, as noted from the song being aware of the risk group alone does not curtail an individual from taking risk. Instead the context an individual is in determines which action to take as regards risk. Similarly, it is the contention of this thesis that the ways youths will make sense over HIV/AIDS prevention strategies will depend on their cultural, social and economic context at a particular time and space.

In dealing with this disease as evidenced from the song, action takes a gender perspective and action towards prevention depends on how one situates himself/ herself to risk; *"Nyaboke I cautioned you, oh my dear, Nyaboke I cautioned you x2 now..."* Despite the fact that the disease is associated with young military men, it is young women like Nyaboke who are warned to protect themselves from being infected. The young military men who are the carriers of the disease are not urged to take any action from spreading it. Also Nyaboke's brother who actually represents the male folks does not identify himself with the disease but takes it to be the problem of the sister. This is in essence makes this sexually transmitted infection a woman issue thus endangering protection. Thus in examining the ABC approach among youths, this study takes

into account gender rules, values and norms governing sexuality and try to examine how they influence individuals' action.

Lastly, the song brings forth the changing nature of sexuality. Due to prevailing socio-economic factors, Nyaboke realizes that she can use sex to enable her meet socially and culturally prescribed roles. In pursuit of this, she stops being passive in initiating sexual relationship – a role which was conventionally meant for men among the Abagusii. By taking an active and prescribing new role to sex, Nyaboke shows how the construction of sex is contextual. Now how does this construction of sex influence *"Nyaboke's"* action in protecting *"herself"* from being infected by sexually transmitted infection "HIV/AIDS"?

Statement of the Problem

Youths in Kenya continue to face severe threat to their well being. More than two decades into HIV/AIDS pandemic, vast majority of Kenyan youths continue to face the wrath of this pandemic (Kamaara, 2007; KIAS, 2007; Shueller *et al.*, 2006). Although many youths have good knowledge about HIV/AIDS, many still continue to be infected (UNAIDS, 2007). This has raised questions on the relevance of empowering people with information alone as a strategy of mitigating the impact of HIV/AIDS (Rugalema, 2002, Campbell 2002, Parker, 2001). This questioning has therefore prompted a call to investigate the contextual factors driving the pandemic (UNAIDS 1999).

Consequently, in Sub Saharan Africa studies focusing on the context of sex practice have focused on structural factors. Studies by Madise *et al.*, 2007; Cradock, 2004; Hunter, 2002 and Baylies *et al.,* 2000, for example, have shown that people engage in risky sexual activities because of socio-economic factors like meeting their basic needs. Other studies also attribute this to cultural factors like proving their fertility by having unprotected sex before marriage (Mba, 2003). Other studies by Gupta, 2002; Silberschmidt, 2001; Vagra, 2003; Wilton, 1997; Blanc, 2001; Campbell *et al.,* 2001 have also attributed women vulnerability to HIV/AIDS to gender power imbalance which characterizes most African societies .

Apart from structural factors, recent studies investigating why individuals engage in sexual risk-taking, despite their awareness of HIV/AIDS, have focused on meanings of sex, sexual practices and social norms in various cultural contexts. Studies by Chitando (2008) and Hunter (2004) for example have shown that men engage in sexual risky because of cultural beliefs about sex. That is they believe that sex enhances their health and is away of proving their manhood. However missing in these studies is the processes on how meanings which influence sexual behaviour are generated despite providing vital information on how contextual factors enhance risky sexual behaviour. Consequently, this study focused on the structures and processes of meaning formation with regard to sex and HIV/AIDS, and how the meanings generated through these processes influence the interpretation and adoption of HIV/AIDS prevention strategies among Abagusii youths in Kenya

To attain this goal, this study therefore focused on emic understanding of HIV/AIDS prevention strategies such Abstinences, Being Faithful, Condom use and Knowing one's HIV status (VCT) among Abagusii youths in their lived experiences. In specific the study examined how the social meanings of sex and HIV/AIDS influenced the interpretation and action towards "ABC" and "VCT" HIV/AIDS prevention approaches.

The Study Objective and Research Questions

The main objective of this study was to determine how the Abagusii youths make sense of cultural meaning offered by HIV/AIDS prevention messages such as Abstinence, Being Faithful, Condom use and knowing ones HIV status through Voluntary Counselling and Testing ((VCT) from their cultural perspective. Using the social construction theory, the study specifically investigated how youths' constructions of sex informed the meaning and action with regard to HIV/AIDS prevention in various contexts.

Research Questions

The research sought to answer the following questions

1. How do youths access HIV/AIDS prevention strategies?
2. What is the impact of HIV/AIDS prevention strategies on meaning formation with regard to sex and HIV/AIDS prevention?

3. How do youths interpret the cultural meaning offered by HIV/AIDS prevention text such as ABC and VCT?
4. How do youths' construction of sex influence the interpretation and action towards ABC and VCT?

Justification of the Study

The importance of examining how youths understand HIV/AIDS prevention strategies cannot be overemphasized given the fact that there is no cure for the disease yet. By using a social constructionist approach to frame this study, there is an understanding that there are multiple ways in which HIV/AIDS prevention strategies are understood by various individuals in different contexts. This understanding may impede or facilitate HIV/AIDS prevention among a given population. By recognizing that there is no collective and universal way of understanding of HIV/AIDS prevention strategies and the importance of individual context, findings of this study are important in making HIV/AIDS interventions more effective to different groups' especially youths. This is because meaning which form a basis for an individual's action stems from an individual context.

Sexuality as a social construction is influenced by social, economic and cultural factors. These factors affect the way individuals define, perceive, feel and act their sexuality in various contexts. Among the Abagusii, youth's sexuality is influenced by their way of socialization, culture and socio-economic factors. However, to the knowledge of this researcher, there is no study which has tried to examine how Abagusii youths' construction of sex influence their interpretation and action towards HIV/AIDS prevention messages such as Abstinence, Being Faithful, Condom use and knowing your status (VCT). This study sought to fill this gap.

According to Global HIV Prevention Working Group (2004), HIV treatment offers great opportunities for HIV/AIDS prevention as it increases HIV testing and reduces stigma. However as Mukherejee *et al.,* (2003) observe, HIV treatment may alter people's perception of HIV/AIDS and this may lead to increased risky behaviour. As accessibility to treatment continue to improve specifically in developing countries, there is need to examine how this development affects various group response to prevention messages which specifically target behaviour change. This

study appreciates this given the fact that the success in HIV/AIDS intervention depends on both treatment and prevention. Without reducing the incidence of HIV/AIDS infection, the goal for treatment is unattainable. For example, the WHO/UNAIDS initiative of having 3 million people on treatment by year 2005 has not been achieved given that 5 million infection occur every year.

The findings of this study put into focus the problem of about 73% of the population which is composed of young people (Ndeda, 2000). The danger of not intervening in helping this population overcome the danger of getting infected by HIV/AIDS will have enormous negative implication especially on socio-economic development of this country. As a distinct stage of life characterized by changing roles and increasing freedom, youths are equally faced with enormous challenges from the effect of globalization and changing traditional way of life. All this changes have an impact on youths' way of interpreting of HIV/AIDS prevention messages. This understanding is critical given the fact they face the greatest wrath of HIV/AIDS. This study; therefore, offers enormous opportunities in coming up with policy recommendations on how to adjust HIV/AIDS prevention messages in order to have some impact on youths' health-related behaviour towards HIV/AIDS in various contexts.

Definition of Concepts

Youths: The term "youths, young people and adolescent" are variously defined. The US centre of disease control defines adolescents as ages between 13 and 16 years and 20-24 for young people. Paediatric centre for adolescents and medicine defines young people as aged 13- 31. WHO refers to people between age 10 to 19 as adolescents and the larger group 10-24 as young people (WHO, 1986). Harrison (2005) defines youths as a broad category of both men and women aged between 10-30 years. In this study I will define youths as persons aged between 12 – 40 years. This is because among the Abagusii it is a transition period between childhood and adulthood. The term youths and young people in this study will be used interchangeably.

Sexual behaviour: This refers to the society shared / learned knowledge, attitudes and practices about young people's sexuality. In this study, it will refer to the adoption of behaviours that reduce the risk of HIV/AIDS infection like use of condoms, Being faithful, reduction of sexual partners and knowing HIV status.

Prevention: This will refer to various ways in which youths use HIV/AIDS prevention discourses to protect themselves from HIV/AIDS in their day to life experience.

Discourse: This study will adapt Burr (2003: 6) definition of discourse as "A set of meaning, metaphors, representation, images and statements which produce a particular version of an event."

Organization of the Thesis

This thesis is divided into two parts. Part one covers chapter one to chapter five. Part two covers chapter six to chapter nine which draws the arguments to conclusions.

Part One

In **chapter one**, I provide the theoretical and empirical ground for my study. Using social construction theory, the chapter argues that HIV/AIDS prevention is more of a social than a medical problem. Therefore, the challenge facing the society in managing it depends upon the social and symbolic meaning in specific cultural context. This way, the chapter critiques HIV/AIDS prevention interventions which aim at empowering people with information only as ineffective. Instead the chapter shows that understanding how people make sense of HIV/AIDS prevention interventions in particular cultural contexts will aid in mitigating the impact of HIV/AIDS.

Chapter two is devoted to the critical review of wider social, political and economic framework in which HIV/AIDS has been managed in Kenya. In particular, the chapter examines the social construction of HIV/AIDS in Kenya and its current prevalence rate. The chapter further examines various government policies and how they have been applied in the national HIV/AIDS control programmes. The chapter notes that, while the Kenya government has addressed itself to the problem of HIV/AIDS, policies have been developed within social, political and economic frameworks which have brought about various meanings to HIV/AIDS prevention strategies. These meanings in this thesis are taken as critical in shaping individuals' behavioural responses to HIV/AIDS prevention policies.

Chapter three provides the background information on Abagusii. In particular, the chapter discusses their history, social organization, beliefs about illness, and gender and sexuality. The chapter underscores the fact that Abagusii's way of life especially on issues of illness and sexuality are greatly influenced by the values and knowledge as found in their social system. This chapter therefore lays ground for understanding different constructions of persons as shaped by culture and society and how they shape individual responses to health or illness. This understanding is important because it is the contention of this thesis that risk and risk-reducing interventions like in the case of HIV/AIDS are shaped by culture, society and history. Lastly the chapter discusses the challenges of doing ethnographic research as an insider.

Chapter four examines the role of various contextual factors namely: historical, political, economic and socio-cultural factors in the spread of HIV/AIDS. The chapter argues that the prevalence of HIV/AIDS in many communities in Sub Saharan Africa cannot be accounted by focusing only on people's sexual behaviour (sexuality). Instead, such focus should incorporate various contextual factors which influence people's behaviour and sexuality. Therefore this chapter critically discusses how cultural, social, economic, political and historical factors affect people's responses to HIV/AIDS interventions. However, the chapter appreciates that there is a missing link on how meanings which are vital in influencing sexual behaviour in relation to HIV/AIDS interventions are generated in different cultural contexts. Lastly, using ethnographic data; the chapter discusses the socio-economic impact of HIV/AIDS on individuals and households in Gusii.

Chapter five explores the methodological processes, theories and practice that guided this study. The chapter discusses how the social construction framework informed methodological choices and decisions made in the course of the study. The chapter also discusses the approaches and methods used in the study which included: case study approach, sample selection and sample size, snowball sampling technique, use of in-depth conversational interviews, focused interviews, tape recording of interviews and field notes. Further, the chapter discusses various ethical dilemmas encountered in the course of the study and how they were overcome.

Part two

Chapter six analyses various HIV/AIDS campaigns strategies that are used in the fight against HIV/AIDS among Abagusii youths. It examines how youths access information about HIV/AIDS prevention and the nature of information they have access to. The chapter, in particular, focuses on the use of both the media and interpersonal communication channels which are used to encourage sexual behaviour change and the extent to which youths are involved in HIV/AIDS activities. The chapter further discusses the impact of HIV/AIDS prevention campaigns especially on youths' perception about HIV/AIDS and sexual behaviour. In a nutshell, the chapter observes that youths' access and response to HIV/AIDS prevention campaigns is influenced by social, cultural, economic and political factors.

Chapter seven discusses youths' interpretation of Abstinence, Be Faithful, and Condom use and know your status (VCT). The chapter further discusses the social construction of sex among youths. In doing so the chapter notes that youths interpret HIV/AIDS preventions strategies in relation to their social meanings of sex in particular cultural context.

Chapter eight examines the interplay between youths' social construction of sex and adoption of prevention strategies namely: Abstinence, Be Faithful, and Condom use and know your status (VCT) in their daily experiences. In particular, the chapter discusses the strategies youths use in protecting themselves against HIV/AIDS and meeting the social meanings of sex. The chapter observes that these strategies are in conformity with youths' social meanings of sex.

Chapter nine deals with interpretation and discussion of key results based on the theoretical assumption of the study. In this chapter, the meaning generated by young people with regard to sex, HIV/AIDS and HIV/AIDS prevention texts such as Abstinence, Be Faithful, and Condom use and know your status (VCT) are examined in relation to social construction theory in order to understand why HIV/AIDS prevention do not seem to influence youths' sexual behaviour. The chapter then summarizes the key findings and draws conclusions.

CHAPTER ONE

THE SOCIAL CONSTRUCTION OF HIV/AIDS PREVENTION

Introduction

In this chapter I try to legitimate my identification of HIV/AIDS prevention as a social problem. While acknowledging the fact that HIV/AIDS is a medical problem with devastating consequences for the individual health, I argue that the challenge facing the society in managing its impact relies on the social and symbolic meaning associated with it. This means to understand how people manage HIV/AIDS, it is important to appreciate the cultural, social and economic contexts in which people experience it.

By treating HIV/AIDS prevention as a cultural, social and economic process, I am not denying the ontological existence of HIV/AIDS as a medical problem with biomedical strategies of preventing it. Instead my concern is how individuals make meaning of biomedical prevention texts presented to them and how this meaning influence their prevention action in various contexts. This chapter will therefore examine HIV/AIDS intervention approaches and try to underscore the importance of social, cultural and economic factors.

HIV/AIDS prevention intervention: Searching for a solution

The first HIV/AIDS intervention approaches were greatly influenced by biomedical paradigms. This was because, as Mann (1996) notes in Schoepf (2004), first, the desire by medical professionals wanting to own the problem by keeping the discourse of HIV/AIDS at a medical and public health level. To them, the problem was purely medical and required medical understanding and intervention. Second, the medical professionals wanted to avoid the inevitable accusations that they were meddling in societal issues which go beyond their scope and competence. At this time, most biomedical research focused on behaviour correlates of risky groups like homosexuals, drug addicts and sex commercial workers. It was assumed that understanding these risky groups will enable medical personnel to intervene effectively.

The classification of the population into risky and not risky groups, however, had its implications. First, it created a false sense of security among those who were not in the risky group category and second, most efforts were devoted in dealing with the risky group thus

neglecting the general population. This approach was nevertheless found to be ineffective in HIV intervention strategies as even those people who were not in risky groups were found to be infected. Due to this there was an urgent need to move from understanding risky groups to risky behaviours (McGrath *et al.*, 1993).

In support of this shift from risky group to risky behaviour, Schoepf (1993) and Larson (1990), urged that focus of HIV/AIDS intervention should be more on behaviours which are risky, like having unprotected sex other than particular kind of relationships that put people into risk. Further, targeting only risky groups also led to stigmatization of these groups creating a false sense of security on those groups not classified as risky.

Consequently, most intervention strategies started focusing on risk related behaviours and changing knowledge, attitude and beliefs about sexuality that might be associated with risk of HIV/AIDS infection. In this case, most social scientists working under the biomedical paradigm started doing surveys on individuals' sexuality. Data collected in these surveys included the number of sexual partners, the frequency of sexual practices, previous experience with sexually transmitted infections and any other issues that were understood to contribute to the spread of HIV/AIDS infection (Parker, 2001). The aim of these surveys was to help in designing prevention policies and intervention programmes to reduce behaviours associated with increased risk for HIV infection.

The data which was collected from sexuality surveys were linked with Health beliefs model, reason action model or the change stage model to design prevention policies and intervention programmes for changing behaviour that was associated with increased risk of HIV/AIDS infection (Parker, 2001). The programmes advocated empowering people with knowledge about HIV/AIDS and how to protect themselves from infections. It was assumed that information will empower people to arrive at health relevant decisions which will take into account *inter alia* perceived severity of the condition, the level of risk, the cost and benefits of alternative behaviour (Ingham *et al.*, 1992; Hart *et al.*, 1992).

At this time most HIV/AIDS prevention intervention strategies centred on information supply in various cultural settings. However, the effectiveness of these intervention strategies started being questioned by anthropologists (Parker *et al.*, 1991). This questioning arose from the practicability of adopting universally HIV/AIDS intervention strategies in diverse social and cultural settings with different understanding of sexual expression and practices.

Further, research findings from various studies (Herdt *et al.*, 1991; Clatts, 1999) also indicated that behavioural intervention strategies based on information and reasoned persuasions were ineffective in HIV/AIDS risk reduction. Instead the structure of risk in every population group was found to be mediated by social, structural and economic factors (Parker, 1988; Obbo, 1988; Schoepf *et al.*, 1988).

As a consequence, focus on HIV/AIDS prevention intervention strategies shifted from information empowerment to interpretation of cultural meanings as central to fuller understanding of both the sexual transmission of HIV in different social settings. This shift, according to Treichler (1999), was aimed at coming up with culturally appropriate prevention programmes. At this time also there was increasing concern with the impact of structural factors in shaping vulnerability to HIV infection as well as conditioning the possibilities for sexual risk reduction in specific contexts (Farmer, 1992; Treichler, 1999).

Findings from researches on interpretation of cultural meanings (Farmer, 1992; Treichler, 1999; Schoepf *et al.*, 1988) identified cultural factors as important in understanding social dimensions of HIV and AIDS. This understanding also brought into fore the limitation of traditional behavioural research approach to public health, particularly to the development of HIV/AIDS prevention and intervention activities (Herdt *et al.*, 1999).

With the influence from interactionist sociology and interpretative cultural anthropology, attention turned to the broader set of social representation and cultural meanings that could be understood as shaping or constructing sexual experiences in different contexts (Daniel and Parker, 1993). Influenced by social constructionists concern, focus on HIV/AIDS prevention interventions researches shifted from earlier focus on individual psychology and individual

subjectivity to intersubjective cultural meanings related to sexuality (Parker *et al.*, 1991; Parker and Aggleton, 1999).

Informed by anthropological approaches to other cultural phenomena, such as religion and beliefs, social construction emphasized shared or collective meanings to sexuality in specific cultural contexts. In this regard research on HIV/AIDS prevention intervention started focusing on what sexual practices mean to an individual and the significance of contexts in which sex takes place. Consequently, research on sexuality in relation to HIV/AIDS moved from focusing on behaviour to cultural setting symbols, meanings and rules that organize it (Lyttleton, 2000; Paiva, 2000; Setel, 1999).

This shift of research from individual behaviour to cultural meanings drew attention to socially constructed and historically changing identities that structure sexual practices in everyday life. On this basis, it became apparent that HIV/AIDS prevention intervention approaches which emphasized behavioural change were not effective. This was because HIV/AIDS prevention interventions were found not to function at the level of behaviour, but rather at the level of social and collective representation (Parker, 1996a). As a result of this any new knowledge or information about perceived sexual risks was argued by social constructionist to be synthesized in the context of pre-existing system of meaning in order to inform action. In this context action was understood as socially constructed and fundamentally collective in nature. Therefore research on HIV/AIDS prevention intervention moved from the notion of behaviour to ethnographically grounded descriptive and analytical research on the social and cultural construction of sexual meanings in relation to HIV/AIDS.

Ethnographic researches on social and cultural construction of sexual meanings have provided insights to the representations shaping HIV related risks. These insights are crucial in developing culturally sensitive and culturally appropriate community-based HIV/AIDS prevention programs. With time, however, it became evident that the social construction of sexual experience was not influenced by cultural factors only but also by structural, political and economic factors. Therefore research on HIV/AIDS intervention started to focus on the role of structural factors in the spread of HIV/AIDS and prevention intervention programmes (Farmer,

1992; Farmer, 1999; Schoepf, 1991; Schoepf, 1995; Singer, 1994). This new focus on structural factors brought forth how diverse political and economic processes and policies create the dynamics of the epidemic and impact on intervention programmes (Long, 1997; Kammerer *et al.*, 1995; Porter, 1997; Farmer *et al.*, 1996).

In appreciating the growing importance of structural factors in shaping sexual experience and vulnerability to HIV infection, anthropologists' attention started focusing on the ways in which societies structure the possibilities of sexual interaction between social actors. That is, the ways societies define sexual partners and practices, as well as the rules and regulations governing sexual behaviour among various actors, like with whom one must have sex, in what ways, under what circumstances and with what specific outcome (McGrath *et al.*, 1992; Rwabukwali *et al.*, 1994). This focus was necessitated by the fact that sexual behaviour is governed by implicit and explicit rules and regulations imposed by the sexual culture of specific communities as well as the economic and political power relationships that underpin sexual cultures.

This awareness of the ways social order structure sexual behaviour has led anthropologists to focus their interest to socially and culturally determined differentials in power, particularly between men and women (Farmer *et al.*, 1996; Gupta and Weiss, 1993; Ward, 1991). Because different societies organize sexual inequalities in specific ways, social and cultural rules and regulations place specific limitations on the potential for negotiation in sexual interaction. These rules and regulations in turn influence sexual inequalities, patterns of contraceptive use, sexual violence and negotiation and HIV/AIDS reduction strategies. Consequently, the dynamics of gender power relations have thus become major components of research focusing on reproductive health and rapid spread of HIV infection among women.

Studies by Farmer *et al.* (1996), Gupta and Weiss (1993) and Ward (1991), for example, have demonstrated the importance of cultural analysis in relation to sexuality and HIV/AIDS. In these studies also issues related to gender and power have been noted as central in understanding the importance of structural factors in organizing sexual relations and HIV/AIDS related vulnerability. This has given impetus for other ethnographic researches that are attentive to cultural, political and economic factors, like among mountain tribes of Northern Thailand by

Kammerer *et al.* (1993), Hmong in North Thailand by Symonds (1998) and among women in Kinshasa in Zaire by Schoepf (1992c).

In researching about power, attention has, however, not focused on gender only but also on poverty, especially in developing countries context (Farmer, 1992,1995,1999; Farmer *et al.* 1996; Farmer *et al.*, 1993; Schoepf,1991; Sobo,1993). These studies have also demonstrated that gender and poverty have enormous effect in shaping the nature of HIV/AIDS related risk.

From the foregoing it is clear that meaning as conditioned by structural factors is important in reframing research on sexuality and HIV/AIDS intervention. The potential implication of this understanding for HIV/AIDS prevention intervention strategies is crucial in making them effective in different social, cultural, economic and political contexts.

Understanding HIV/AIDS prevention through social constructionism

The way one comprehends, conceives, voices and makes meaning of phenomena transpires through discourse, language and interactions that are discursive. Thus meanings, perceptions, understandings and knowledge of phenomena are not pre-given, but rather actively constructed (Blurr, 1996). Therefore meaning does not occur naturally; it is suctioned by language and culture. In this regard language determines how an individual makes meaning and understands certain sets of knowledge in his/her everyday life experience (Blurr, 1996).

Discourse therefore regulates forms of experience and perception. This is because discourse represents the beliefs, attitudes, values, language and behaviours which in turn determine how policies, rules and regulations are held in societies. Consequently, one does not understand, perceive and know oneself in any way one chooses but rather one's perception and understanding are constructed while simultaneously being limited by available discursive understanding. In this case discourse both restricts and enhances meaning, dialogue and thinking (Parker, 1992; Blurr, 1996).

According to Foucault (1980), discourses are, however, held in place by complex network of power relationships which are always vulnerable to resistance and change. The tension

governing these power relationships determines how individuals make sense of various discourses. In this case what may look normal or obvious to implementers of certain policies may not be necessarily so to the people they want to influence. This is because most people are so embedded in their societal belief systems that they neither question their society's dominant values nor realize how much they themselves are naturalized into them. Therefore, certain behaviours which some policies want to change are seen as normal and functional. For example, due to unequal gender power sex relations in South Africa (Shefer and Foster, 2001) note that women do not challenge the risky behaviour of their male partners. Instead they strive to maintain the status quo of their sexual behaviour.

In making sense of discourse individuals may exercise different levels of power depending on their role in social interaction. However, the way societies work militates against the success of individual power to resist dominant views. Due to this individuals will internalize and normalize their unchallenging behaviour or attitudes as a form of self regulation (Foucault, 1980). In this case individuals will exercise some form of self control to their behaviour as if they are being watched from an imagined, all-seeing gaze. By policing themselves in this way individuals take away their will to resist by internalizing a "common sense" certain rules and norms. Therefore discourses define what is normal and what is normal is then seen as in need of normalization or conformity to the norm (Ramazanoglu, 1993).

The self-surveillance is held in place through institutional structures, conditions and hierarchies where individuals oversee each other. People believe they must conform because they believe in the expectations of their conformity, so that the system is: ''taking away their wish to commit wrong ...mak[ing] people unable and unwilling to do so'' (Ramazanoglu, 1993: 154). The family, for example, is an institution through which sexuality discourses are enacted for economic or other socially relevant purposes. The body and sexuality are tools for an expression of power relationships.

Suffixing from above discussion it is clear that our ability to change discourses relies on our understanding of how they are set up in the first place and how they function on a daily basis.

This understanding is important in knowing why and how individuals behave the way they do in relation to behaviour changes messages geared towards reduction of HIV/AIDS infection:

> *Ascertaining the sexual culture of any such community is a central research task for effective health education, because all communities are differently structured* (Dowsett, 1999: 228).

In support of this view, Low-Beer & Stoneburner (2004: 10) argue that communications from within communities, in addition to formal HIV interventions, is crucial in ensuring behavioural change occurs in ways that are "engaging rather than disrupting its values and structures". However, this first entails identifying the meanings embedded in different cultural contexts (Dowsett, 1999).

In Kenya, the Gusii people are still relatively homogeneous and behavioural ties are strong and bound by their discourses. Therefore external interventions, like those advocating sexual behaviour change in relation to HIV/AIDS prevention, do not occupy the position of neutrality as assumed by implementers in this context. Instead they are, first and foremost, perceived as foreign discourses which aim at sustaining certain power viewpoints due to their top-down approach which does not take into account people's social, cultural, economic and political contexts.

Consequently, individuals will first of all synthesize these external interventions in relation to HIV/AIDS prevention into their common knowledge as contained in their society's discourse to guide action. However, Foucault (1980) observes that this kind of knowledge rarely receives political status. It is often subjugated and disregarded as deligitimated knowledge, local and without authority. The subjugated knowledge and discourses are what this study is unearthing. This study therefore examines these discourses from the rationale and context of the Abagusii youths in Kenya in relation to sex and HIV/AIDS prevention strategies, namely ABC (Abstinence, Be Faith faithful, Condom Use) and VCT. In so doing the study reveals why HIV/AIDS prevention strategies which aim at behaviour change are not effective.

In understanding how youths make sense of HIV/AIDS prevention strategies the construction of HIV/AIDS and sexuality is important as hereafter discussed:

HIV/AIDS

Since the first case of HIV/AIDS was discovered, knowledge about its cause and how it can be avoided has greatly improved. With no cure yet, HIV/AIDS can still be managed by available therapies to considerable relief to the affected person. This has made the disease from being regarded as fatal to chronic.

Despite this development, the social response to the disease still remains fearful, moralistic and emotive (Nzioka, 1994). This social aspect of HIV/AIDS rather than its medical reality makes its management problematic. As a social construction, HIV/AIDS has led to many responses among many communities. These responses are mostly determined by an individual's knowledge and experience (Farmer, 1992). Individual knowledge and experience emanate from the social, cultural and economic contexts which provide explanatory models on which any illness is interpreted understood and managed (Farmer, 1993; Mattingly *et al.*, 1998).

In non-Western communities, when HIV/AIDS first emerged it was interpreted and understood in the already existing explanatory models. This gave HIV/AIDS both social and symbolic meaning which informed people's response to it. Among the Luo, Gusii and Luhya in Kenya, HIV/AIDS was seen to be identical with *Chira, Shira* and *Okoragerigwa* respectively (Ogot, 2004). These illnesses affected individuals who failed to observe certain taboos relating to sexual practices. Those who were affected experienced severe diarrhoea, loss of body weight and death. All these symptoms are identical to HIV/AIDS illness. The management of these conditions involved the observation of sexual practices taboos, sacrifices to the ancestors to appease them and sexual cleansing which was made possible through wife inheritance. All these management practices differed with biomedical practices.

Accordingly, HIV/AIDS is not mere biological entity but rather a socially constructed phenomenon. Therefore the ways HIV/AIDS facts have been constructed and reconstructed play a significant role on how HIV/AIDS is understood and acted upon (Horton and Aggleton, 1989).

This, however, does not negate the fact that HIV/AIDS exists as medical a phenomenon with known scientific strategies of intervention. Instead it appreciates that since HIV/AIDS was first discovered it has come to take a host of meanings dominating politics, economics and society.

Similarly, Treichler (1989) appreciates that while it is crucial to understand the disease as medical problem, it is equally important to understand its meaning and significance in different social and cultural contexts. This understanding is essential in framing different constructions of HIV/AIDS which are important in its intervention.

In the medical terrain, HIV/AIDS uses a particular language to define itself and set its boundaries. For example, one can learn that HIV can be contracted by having unprotected sex with HIV infected person. This knowledge defines then how one gets HIV and how one can avoid contracting HIV. HIV/AIDS is also seen as "a disease" like any other "disease" although perhaps in greater prevalence. It is an "illness" that insists on precautions in order to avoid it. Failing to avoid it leads to consequences such as medical treatment, hospitalization, prognosis and death. These consequences are, however, experienced in discursive accounts of stigma, morality, panic and fear which transcend medical explanations and experiences.

In exploring HIV/AIDS within the normative discourses of health and illness, the epidemic enters the discursive patterns of myriad human behaviours and conditions, such as sex, death and identity. These conditions embody a set of powerful social meanings that are manifested by and through social arena and generated by social practices (Plummer, 1988). Concurringly, Crimp (1988) thus suggests that we conceptualize HIV/AIDS through the social practices that represent and respond to it.

Since the onset of HIV/AIDS, language has been critical to its social representations. Powerful linguistic metaphors were mobilized around HIV/AIDS which reinforced stigmatization and discrimination. Kopelman (2002), for example, argues that HIV/AIDS from its advert was perceived as something happening to "others" resulting to naming and blaming pattern of disease attribution. This made HIV/AIDS related stigma to fit onto pre-existing system of stigma such as homosexuality, prostitution and intravenous drug use. In turn, this construction of "other" has

provided an explanation for the disease whereby those who do not fail under the construction of "other" feel secure from HIV/AIDS infection. This construction, however, fails to explain why some people who do not fall under the construction of "others" contract HIV/AIDS. Instead it legitimizes, and reproduces existing stigmatizing, discriminatory, and othering processes which negatively affect prevention interventions.

Similarly, Gilman (1988) explains that early conception of HIV/AIDS came to view it as "gay" disease. This in turn structured the understanding of AIDS in a very marked manner. Consequently, People with AIDS (PWA) were stigmatized as carriers of infectious disease as well as located within a very specific category of sexual orientation. Gilman (1988) therefore notes that HIV/AIDS was understood as a sub-set of sexually transmitted diseases, as well as a disease which afflicted gay individuals as a result of their sexual practice and lifestyle.

Sontag (1991) adds that because HIV/AIDS is an infectious disease, which is principally transmitted through sex, it puts at greater risk those who are sexually active. This easily makes HIV/AIDS to be viewed as a punishment for those who are sexually active. Thus those infected with the disease experience shame and isolation. In addition, Miller (1998) also notes that the meaning that an infected individual gives to Seropostivity influences this person's sense of self. Often individuals with HIV/AIDS infection are unable to discern between their sense of self and the virus, in turn self-labelling as "diseased", "infected" or "contaminated." This perception may create a sense of isolation and non-belongingness

Patton (1990) also observes that HIV/AIDS language and its accompanying metaphors highlight the power and social discrimination within dominant discourses. That is, through some constructions of HIV/AIDS some sections of society are rendered less powerful than others through discourses that stigmatize specific groups or behaviour. This has made popular responses to the disease to be characterized by fear, which in most cases necessitates the need to attribute blame. For example, the language "killer disease" and "gay plague" served to perpetuate the initial fear associated with HIV/AIDS and the need to attribute its existence to marginalize the "deviant" social groups (Sontag, 1989).

In addition, the epidemic has also been represented through discourses of silence wherein HIV/AIDS is not perceived as real or tangible (Strebel, 1993). This reinforces stigmatization of both the disease and those living with HIV/AIDS. This discourse facilitates denialism and apathy in response to HIV/AIDS and drives the epidemic underground which exacerbates vulnerability to infection and negates prevention efforts.

The discursive construction of HIV/AIDS epidemic also intersects with pre-existing discourses related to gender, race and class (Wilton, 1997). As such, HIV-related stigmatization is compounded by these intersecting identities. For example, in the gendered construction of HIV/AIDS, women's subordination to men is reflected in and reinforced through representations. Also the "othering" of those perceived to be transmitters of the disease are feminized. Globally also, due to the "white racist imaginary" of the North, HIV/AIDS in Sub-Saharan Africa was represented as a result of pre-existing abnormalities, failure or pathologies among the (black) indigenous population (Wilton, 1997:5). Due to this HIV/AIDS acquired racial dimensions whereby social perception of a rampant epidemic among promiscuous African people has been further reinforced through attribution of viral origin to parts of Africa (Patton, 1990; Fassin, 1996).

In medical discourses, HIV/AIDS has been individualized as a disease of lifestyle and choice (Alcorn, 1988). In this case contracting HIV/AIDS is perceived as the responsibility of the individual devoid of context and socio-cultural circumstances. This understanding of HIV/AIDS is reflected in public prevention campaigns like Abstinence, Be Faithful and Condom Use which emphasize individual behaviour and lifestyle change as the central mechanism for HIV/AIDS prevention. Thus they tend to place an individual as unit of intervention and emphasis on knowledge, attitudes, belief and practices on sexual behaviour. This approach individualizes and decontextualises the epidemic and assumes that individuals have rational control over their sexual behaviour and related decision-making.

The individualization of HIV/AIDS, especially in linking the notion of risk and individualized responsibility for the disease, is due to the fact "medical discourse" is concerned with symptoms with depersonalized seropositives (Seidel, 1993). In this case risk groups are typically

represented as prostitutes, "promiscuous" people and gay people, all of whom are socially constructed as core disease transmitters. Discourses of high risk groups therefore capture the link between HIV infection and specific lifestyles or social identities. The focus on risk groups as opposed to risk behaviours facilitates the stigmatization of those perceived to be part of specific groups and confuses messages for individual behavioural change.

Similarly, Plummer (1988) observes that biomedical understanding of HIV/AIDS locates its cause in the body which draws on technical and diagnostic terms to identify, interpret and understand it. In contradiction, discourses that further the stigmatization of HIV/AIDS locate causality along social rather than medical dimensions, allowing for moral, political and theological explanation for existence of HIV/AIDS. These constructions shape HIV/AIDS responses that are othering, discriminatory and exclusory. As such, both biomedical and moral discourses co-exist offering up varying understandings and responses to the disease.

The manner in which individuals make sense of the disease is partly determined by their cultural context. Existing beliefs and presuppositions shared by a cultural community regarding illness play a significant role in shaping understanding and response to any illness. In this regard illness experience can be argued to be an interpretative exercise which is constructed in social situations according to the premises of culture. Therefore, the way one experiences HIV/AIDS is mediated by culture. Although this experience may be private, Horton and Aggleton (1989) argue that the form which meaning takes on is influenced by one's participation in a specific culture.

In addition, Webb (1997) notes that community perception and individual perception of HIV/AIDS incorporate culturally specific beliefs relating to the origin and aetiology, risk perception and attitudes towards those infected. Therefore the nature of one's response to HIV/AIDS is in part conditioned by the cultural context.

HIV/AIDS and Sexuality

HIV/AIDS prevention has focused on sexual behaviour change as a way of mitigating the impact of HIV/AIDS. This focus has thus made research on sexuality central in the discourse of HIV/AIDS. HIV/AIDS epidemiological surveys, for example, have been used to in social

research typically focusing on knowledge, attitudes and practices (Lear, 1997). These surveys have been used in a number of different social and cultural contexts and have paid attention to patterns of social relationships and safer sex practices.

However, with many researches focusing on HIV/AIDS, it has become evident that quantitative surveys offer limited insights to complexity of social and cultural meanings that shape sexual behaviour. Hence, there has been a movement towards qualitative studies to investigate sexuality within social and cultural contexts (Parker *et al.*, 1998). This, however, does not make quantitative data inferior nor does it advocate its substitution with qualitative data. Instead qualitative data is taken to have the potential to explore social and cultural meanings that may be associated with behaviour. This type of research is crucial in this study because it appreciates the nature of social meanings within different social and cultural settings as a contributing factor to sexual behaviour and its relationship with HIV/AIDS prevention strategies.

As noted earlier in this chapter, a lot of research on HIV/AIDS especially by social scientists has focused on sexuality. This is because of the fact that mitigating the impact of HIV/AIDS requires effective strategies for helping people to alter high risk sexual behaviour. However, in HIV/AIDS prevention strategies, sexual desire has been assumed to be universal and immune to social and cultural factors shaping sexual experiences. This assumption, according to Parker and Aggleton (1989) makes these researches ineffective in steering sexual behaviour change. Accordingly, research on HIV/AIDS and sexuality should focus on meaning systems in order to understand individual and social patterns of sexuality. This is important because other researchers have demonstrated that sex is not merely a biological phenomenon but also a culturally informed experience (Parker *et al.*, 1998).

Consequently, HIV/AIDS and sexuality research should be more concerned with culturally sensitive knowledge of sexual beliefs and practices in order to understand the pattern of HIV/AIDS transmission on different communities so as to come up with intervention strategies which are more effective. In this regard, Parker, *et al.* (1998) opines that sexuality should be conceptualized through the discourse of "sexual culture", that is, the systems of meaning, of knowledge, beliefs and practices that structure sexuality in different contexts.

However, most researches focusing on HIV/AIDS and sexuality often overlook culture because they view it as static and thus a barrier to adoption of biomedical strategies (Airhihenbuwa, 1995). Yet, culture shapes individual sexuality through roles, norms and attitudes within particular social groupings or institutions and at the same time it contributes to the reproducing of the collective or community. This implies that interaction between society and the self is responsible for educating one about sexuality and depending on the type of society; one has a different experience of sexuality. In a "restrictive society", for example, sexual activity for the youth is strongly discouraged and engaging in sexual activity often results in punishment. On the other hand, in a "semi-restrictive society" sexual activity for the youth is discouraged but if one engages in sexual activity, one is not punished (Steinberg, 2002).

Arising from above discussion, it is clear that the terrain of HIV/AIDS research locates sexuality as a context in which much can be learnt about sexual beliefs and practices and ways it contributes to the effectiveness of HIV/AIDS prevention strategies. It is in accordance with this that the construct of sexuality becomes central to this study and is conceptualized as socially constructed.

According to social constructive perspective sexuality is given meaning in social relationships. Various elements influence an individual's identity and sexuality. In other words, understanding of meaning within our world and of ourselves, is mediated by social artefacts, history, culture, and interaction between people (Gergen, 1994). In suggesting that sexuality is socially constructed it does not deny the significance of biology either (Weeks, 1986).

Fundamental to this perspective on sexuality is firstly that sex is not an independent realm free of social interactions that reproduced it. Secondly, it is accepted that there are variances in sexual beliefs and practices. Thirdly, sexuality should not be looked at as a set of dichotomies – that is, for example, society is "sexually repressed" and therefore needs to be "liberated".

Sexuality has numerous histories and is produced by society through complex patterns of negotiation and struggle between those who have power to define and set boundaries and those who do not and attempt to resist (Weeks, 1986). Interaction is vital to this understanding of

sexuality, and understanding that interaction as involving complex negotiations between individuals is equally important. It also points to the significance of the discursive position as an approach to understanding sexuality (Parker & Easton, 1998). It is by looking at discursive accounts of sexuality that it is possible to see how constructions of sexuality are produced and reproduced to constitute meaning (which, in effect, affects sexual beliefs and sexual behaviour). It is from this understanding that this study examined how the Abagusii youths make sense of HIV/AIDS prevention strategies.

The social construction of meaning/reality

The need to understand how individuals make sense of phenomena has generated a huge debate across various disciplines over the years. This debate has led to the development of a wide range of paradigms of understanding, ranging from essentialism to post-structuralism. Post-structuralism, also known as postmodernism" rejects the idea that the world can be understood in terms of grand theories and metanarratives, and emphasizes instead the coexistence of multiplicity and variety of situation-dependent ways of life" (Burr, 2003:12). Social constructionism is believed to have developed out of the works of 20th century scholars in the field of the sociology of knowledge, who were interested in understanding how socio-cultural forces influenced the construction of knowledge (Burr, 2003).

In 1966, Berger and Luckmann published *The Social Construction of Reality: A Treatise its the Sociology of Knowledge*, in which they argued that whatever members of the public perceived as a social reality was, instead, a construction to which each member contributed through knowledge accumulated from "the reality of everyday life" (Berger & Luckmann, 1966). According to Berger and Luckmann, meaning is *intersubjective*, which means that the meanings of different individuals in a society relate to, and are to some extent dependent upon, the meanings of others. Berger and Luckmann's theory drew heavily on Mead's (1934) concept of symbolic interactionism, in which individuals are conceived as constructing their own and each other's identities through daily encounters with each other in social interactions (Burr, 2003; Mead, 1934).

Burr (2003) acknowledges the difficulty of defining what exactly social constructionism is. Nonetheless, she draws on Gergen's (1985) work to suggest four main features that characterize a social constructionist approach. First, she argues that social constructionists undertake a critical perspective towards the taken-for-granted assumptions of knowledge by questioning those assumptions. Secondly, they perceive all ways of understanding as specific to particular cultures and historical moments. Thirdly, social constructionists conceptualize knowledge as a process of social interaction between peoples in their daily lives and, finally, that there are several possible constructions of the world which invite different kinds of social action from the human beings.

Burr further distinguishes between two types of social constructionism: the Micro Social Constructionism and the Macro Social Constructionism. Micro Social Constructionism, also referred to as Discursive Psychology, is concerned with how people construct their worldviews through language use in everyday interactions. Macro Social Constructionism, on the other hand, "acknowledges the power of language but sees this as derived from, or at least related to, material or social structures, social relations and institutionalized practices" (Burr, 2003). The concept of power is central to Macro Social Constructionism which draws heavily on the works of, amongst other scholars, Michel Foucault. Burr, thus also refers to Macro Social Constructionism as Foucauldian Discourse Analysis.

Whilst my own study will draw from both levels of social constructionism, it leans heavily towards the Macro level of Social Constructionism (Foucauldian Discourse Analysis). The concept of discourse in this case is used to refer not just to show the way language is used in particular contexts, but also show how that language "[sets] limits upon, or at least strongly channel, not only what we can think and say, but also what we can do or what can be done to us" (Burr, 2003). This approach, as Burr points out, goes beyond just examining the language to include practice. The study, therefore, adopts Burr's definition of discourse as:

> *A set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events. It refers to a particular picture that is painted of an event, person or class of persons, a particular way of representing it in a certain light* (Burr, 2003: 64).

Therefore using social constructionist approach, this study investigated the social meaning of Abstinence, Be faithful, Condom Use and VCT, and social meaning of sex among the Abagusii youths. This was achieved through an analysis of language used, statements, explanations and narratives that were generated from in-depth conversational interviews conducted with a sample of youths involved in this study.

In this study, however, narratives were not conceived as participants' personal perceptions, but as "manifestations of discourses, of representations of events upon the terrain of social life (which) have their origin not in the personal private experience, but in discursive culture that they (youths) inhabit" (Burr, 2003). They are seen in this study to constitute the discourses that represent the way young people make sense of their sexual behaviours and the HIV prevention options, and may serve to explain the discordance between the sexual behaviour and the knowledge, attitudes and beliefs.

The use of social constructionist approach in this study had many implications on the way core issues of the study, like HIV/AIDS, HIV/AIDS prevention strategies and sexuality, were viewed. Firstly, HIV/AIDS is constructed in many ways, one of them being biomedical construction. Similarly, topics like HIV/AIDS prevention strategies and sexuality are also viewed as being constructed in many ways. For example, sexuality, which is core to HIV/AIDS prevention strategies, is socially constructed and therefore focus will be on how social and cultural system shape sexual experience in relation to HIV/AIDS prevention strategies.

Secondly, and most important to this study, is the crucial place of context. For example, historical and cultural viewpoints, while not the focus of the study, become primary when viewing how youths makes sense of HIV/AIDS prevention strategies (ABC and VCT) in relation to their sexuality. Lastly, in using a social constructionist position to frame this study, there is a reflexive awareness that it is not the only way to view a topic such as the construction of "HIV/AIDS prevention strategies among the youths". Instead there are multiple ways in which to talk about HIV/AIDS prevention strategies. Choosing to use a social constructionist position provides a way of talking about HIV/AIDS prevention strategies that recognizes this.

In using this reflexivity, the social constructionist position is seen as being useful in the study of sexuality and HIV/AIDS prevention strategies because it does not view it as collectively agreed upon or universally accessible in the same ways. Hence, the importance of context within the social constructionist position helps to maintain the viewpoint that locating sexuality within a socio-cultural context may be useful in making sense of HIV/AIDS prevention strategies among youths.

Summary and Conclusion

This chapter provides a context for this study and motivates the use of social constructionist framework. Through review of relevant literature the chapter argues that HIV/AIDS prevention is more of social than medical problem. Therefore the challenge of making HIV/AIDS prevention strategies effective lies on the social and symbolic meaning as embedded in various cultural contexts. So intervention strategies which only aim at empowering people on how to avoid being infected are more likely to be ineffective.

CHAPTER TWO

MANAGING OF HIV/AIDS IN KENYA: OFFICIAL POLICIES

Introduction

In this chapter, I look at the social construction of HIV/AIDS in Kenya, and the scale of the epidemic. After this, I discuss the prevalence of HIV/AIDS in Kenya and later critically examine various policies which have been adapted by the government in the management of HIV/AIDS since 1984 (the first case of HIV/AIDS was officially reported) to 2009. In discussing these various policies, the chapter will also examine how social, political and economic factors both local and global, have come to bear on these intervention policies.

Despite the existence of a political framework for managing the pandemic in Kenya, this chapter argues that the relegation of the actual management process to medical professionals, non-government organizations and religious organizations which often had conflicting and competing interests has limited its effectiveness. The Kenyan political leadership also seems to have cultivated a sense of its own invulnerability in a culture of denial for a long time. In the absence of clear government commitment in HIV/AIDS management process, other actors have come forth with myriad interests in the management of HIV/AIDS giving rise to various meanings to the whole process.

Social Construction of HIV/AIDS in Kenya

The first case of HIV/AIDS was officially reported in Kenya in 1984 (Ogot, 2004), but by then local media was flooded with reports of HIV/AIDS in the West and some African countries. This formed the basis for the government to view the disease as a problem of "other countries". This social construction of the disease influenced the government response to the disease for a long time.

Other than the media, the government's social construction of the disease was also influenced by other factors which were either internal or external. In 1980s, HIV/AIDS was perceived as a disease primarily affecting gay population. Gay population in Kenya was perceived as both

foreign and non-African. Therefore, HIV/AIDS was perceived to affect those who were adopting the decadent foreign sexual practices. Given that at this time there were no official reported cases of gay culture in Kenya, the government felt much secure from the scourge.

Besides this, the government at this time was experiencing negative economic performance occasioned by *inter alia* the 1970 oil debacle, failing export prices especially coffee and tea, declining economic concessions which were provided during the cold world war , increased trade protectionism in the west and increasing budgetary deficit. All these factors affected negatively the living standards of the citizens; escalating prices of basic goods, inadequate provision of health and educational facilities.

In addition, the government was forced to start implementing The Structural Adjustment Programmes (SAPS) by Bretton Wood Institutions. These programmes entailed fiscal discipline (limiting budget deficits and cutting down on social spending in areas such as health, education), financial liberalization, privatization of state enterprises, trade liberalization, limitation barriers to foreign direct investment, and elimination of subsidies on consumer items such as food, fuel and medicines. Other policy measures included the deregulation of labour market and tax reforms to broaden the tax rates.

The consequences of these policies were the diminishing performance of most economic sectors which depended on government subsidy like agriculture. This forced the government to entirely depend on tourism to earn revenue for meeting other development needs (CBS, 1993). Given the fact that the tourism industry is very sensitive to sexually transmitted diseases (Kareithi, 2003); the government had to protect this sector from adverse negative publicity of HIV/AIDS.

Related to this was also the geo political war between Kenya and Britain in 1986 and 1987 over HIV/AIDS related mythologies. This war was precipitated when Kenya stated that it was going to boycott Edinburgh commonwealth games over Britain's stand on apartheid rule in South Africa (Ogot, 2004). In reaction to this, Western press, particularly British and Swedish media started carrying articles that HIV/AIDS was rampant in the Kenyan Coastal towns of Mombasa and Malindi. These areas are strategic tourist attraction.

To the government, these media reports were aimed at killing the tourist industry and scare off foreign investment. Thus, this publicity on HIV/AIDS was seen as an economic warfare designed by the western media to destroy Kenya's economy. To this end, the president advised the citizenry to ignore the malicious propaganda emanating from outside the country that AIDS was rampant in Kenya. Ironically, at the same time the president advised Kenyans to abstain from careless sex and uphold good moral behaviour.

Although HIV/AIDS was officially reported in Kenya in 1984, it was until January 1985 when the Standard[6] newspaper carried an article "Killer Disease in Kenya". This report received mixed responses from the public and government authorities. But in May 1985, the Ministry of Health reported the first 20 cases of HIV/AIDS[7]. The government's acknowledgment of the scale of HIV/AIDS was; however, slow and interspersed with interludes of silence, denials of media reports and public cautions by both government officials and political leaders. In between these reactions was a battle of numbers of people infected with HIV/AIDS. At this time, the government press censorship limited press coverage on the extent of HIV/AIDS. The local press gave little publicity to the local situation, but covered more the HIV/AIDS problem in "other" countries. This presented an image of a country that was little affected by this scourge (Fortin, 1987; Vidal, 1996).

Under pressure from the International Community, the government started allowing limited studies; but mostly in slum areas in Nairobi which were regarded as a den of sex workers (Ogot, 2004). Sex workers were regarded as a risky group and most researchers at this time were trying to understand risky groups as a way of mitigating the virus. The inaction of the government and the social construction of HIV/AIDS as a disease affecting certain risky groups, the general public went on with life as though HIV/AIDS never existed.

Despite this, HIV/AIDS was dreaded because of the way it was presented in the local mass media. Information on the disease was patchy, incoherent and inaccuracy. Media coverage of HIV/AIDS placed emphasis on frightening statistics, and pictures depicting AIDS victims as

[6] The Standard Nairobi : January, 15, 1985
[7] The Weekly review Nairobi: September, 13, 1985.

completely emaciated people. This again influenced people's thinking regarding HIV/AIDS identification. People thought you can identify an HIV positive person by looking at the individual's physical orientation.

Since HIV/AIDS was presented as a disease for "other" countries, anyone who had travelled widely acquired an operational definition of being used to refer to movements to where "others had not been". To the rural people it meant those who had gone to the urban areas whereas to urban dwellers it meant the truck drivers and those who had crossed the country borders. This classification created a false sense of security from HIV/AIDS among those who did not fall in the category of those classified risky.

As the HIV/AIDS progressed, the media started carrying reports of isolated cases of HIV/AIDS. Most of these reports dwelt on people arrested following an HIV diagnosis, and others who were either buried in plastic bags and could not be viewed by family members, or those who were buried in urban because they will not be taken to rural areas for fear of spreading the disease (Fortin, 1987).

More information about HIV/AIDS started also filtering into the country from neighbouring countries changing the social construction of the disease. In Tanzania, HIV/AIDS was associated with young promiscuous men who had travelled extensively. This; however, started changing when elderly long distance traders started dying. It came to be associated with Uganda witches who were thought to have strong witchcraft with which they inflicted death on Tanzanian businessmen who had swindled them in trade. Despite appeasing the Ugandans by paying their debts, many Tanzanians continued to die (Thompson and Cowans, 1989).

The HIV/AIDS discourse continued changing as the social, economic and political factors changed. In 1986, when the government wanted to pursue protectionist policy in favour of local textile industry, HIV/AIDS was associated with second hand clothes. The government banned the importation of these clothes most of which were coming from the West (Nzioka, 1994).

As scientists at global level continued haggling about the cause of HIV/AIDS, at the local level, the disease equally provided traditional healers a platform to propagate their theories about disease causation. To them, HIV/AIDS was caused by a worm or insect which invades the body and travelled to different parts of the body invading and destroying certain life sustaining organs such as lungs, liver, heart and the brain. It could be "sucked" out with proper medicine and charms. This ethno medical explanation about HIV/AIDS contradicts the biomedical explanations and to a large extent influences traditional healers' treatment approach to the disease.

With increasing reported cases of HIV/AIDS, the disease took a religious meaning. This was because of its mode of transmission which was seen to contravene God's law on sexuality and sexual behaviour (Ogot, 2004). Thus, HIV/AIDS was seen as God's retribution for the sins of man. Within this construction, HIV/AIDS was constructed as some form of punishment to individual wrongdoers, especially those engaged in sexual promiscuity.

In conclusion, the discourse of HIV/AIDS has continued to growing ever since the disease was reported in Kenya. Social meanings and definitions that reflect the changing construction of HIV/AIDS is ever evidenced each day. This growth affects how both the government and people perceive and respond to HIV/AIDS.

The Current Estimates of the HIV/AIDS Prevalence in Kenya

Since the identification of the first case of HIV/AIDS in Kenya in 1984, reported cases of HIV/AIDS in the country have continued to swell; rising from 2 per cent in 1985 to over 14 percent by 2000 (NASCOP, 2001). This prevalence rate; however, declined to 13 percent in 2005 and further to 5.9% in 2007(UNAIDS, 2005, KIAS, 2007; Wakabi, 2007). Currently, it is estimated that there are 1.4 million adults infected with HIV of which majority are people aged 15-49 years (KIAS, 2007).

Today, HIV/AIDS is a serious health and development problem in Kenya. Over 1.5 million people have died since the disease was first identified in 1984 with majority being those aged between 15- 64 years. Currently, death rates are estimated at about 150,000 people per year

(KIAS, 2007). This high morbidity and mortality rates has undermined the economic stability of the country by cutting labour productivity in many economic sectors, overstretched expenditure in the health sector and has caused a lot of disruption to the society's social fabric (UNDP, 2003; Obel 1995; Mati, 1997; Republic of Kenya, 2002).

In Kenya, the Annual Sentinel Surveillance Survey data are used to measure the prevalence of HIV among the general population. Other data are generated through: voluntary counselling and testing at National AIDS and STDs Control Programme (NASCOP) sites and many others located in Mission and NGO Hospitals; post-mortems; routine testing (for antenatal mothers, in-patients and STD patients); mandatory testing (that is screening of all blood donations); and diagnostic testing on patients. However, in 2003, important data was generated through the Kenya Health and Demographic Surveys. This was the fourth survey in the International Demographic Health Survey program to include HIV testing, and the first that anonymously linked HIV results with key behavioural, social, and demographic variables.

In Sentinel Surveillance Survey, data is collected from expectant women who attend selected sentinel clinical clinics. Sentinel Antenatal Surveillance assumes that HIV prevalence among pregnant women is a good approximation of the prevalence among the general adult population aged 15-49 in both rural and urban areas. Since 1990, Kenya has been using the sentinel surveillance system that provides the basis for estimating the extent and trends of HIV infections.

The HIV sentinel surveillance is conducted annually over a period of three months. In 1990, HIV sentinel surveillance was started with 13 STD clinic sites located in urban centres. During the period from 1991 to 1998, the number of sites declined from 12 in 1991 to 5 in 1998 (Joesoef *et al.,* 2003). In 2000, the number of sites increased to 11 and by 2001, the sentinel surveillance system was operating in 12 urban sites and 8 peri-urban rural sites around the country. By 2005, there were sentinel sites established at 44 health facilities throughout the country to include populations that are more rural (NASCOP, 2005).

These sites monitor HIV infection among pregnant women who present themselves at antenatal clinics (ANC) for routine testing for syphilis and anaemia as part of the national antenatal

services. The remaining blood is anonymously tested for HIV. In addition, patients presented with sexually transmitted infections are anonymously tested for HIV during the three-month surveillance period; normally from May to August every year. In Gusii, there are two sentinel surveillance centres in Tabaka and Kisii town.

According to sentinel surveillance results from 1990 to 2004 indicate that levels of HIV infection were alarmingly high in most parts of the country. In some sites like Busia, Kisumu, Thika, and Meru, more than 20 percent of the women presented at antenatal clinics were HIV positive. However, there was reduction in HIV prevalence from the year 2000 (GoK, 2001; 2005).

The variation in rates of HIV seroprevalence in the sentinel centres was, however, attributed to under-reporting which occurs due to a variety of factors: the fact that not many mothers present at government clinics that have the testing reagents and also double as surveillance sites; the propensity for mothers to visit mission or private hospitals and clinics for better care and better availability of healthcare resources, and these are not surveillance centres; variation in health-seeking behavioural patterns; dissimilarity in healthcare infrastructure and the availability of healthcare resources across the country; and the epidemic commenced late in some areas. Though the HIV seroprevalence rates are not exact, they describe the extent of HIV infection in some parts of urban and rural Kenya.

Of all the sentinel sites, Mombasa is representative of areas that have stable infection levels. While Meru has experienced rapid increases in the number of people infected, Kisumu is an example of where HIV infection rates have been consistently high. Garissa and Kajiado are shown to be experiencing relatively low HIV infection rates. However, this could be due to low levels of testing (few mothers presenting at the antenatal clinic at the district hospital), and the scarcity of healthcare resources considering that these are enormous districts which are sparsely populated by mainly pastoral communities.

Rates of HIV prevalence among pregnant women in Africa closely approximate the rates of HIV infection in the general adult population of between the ages of 15-49. Therefore, sentinel surveillance in antenatal clinics has been used to estimate the HIV seroprevalence, and trends of

HIV infection in the adult population as young women have generally tended to have higher rates of infection than older women.

According to the estimates by NASCOP, the national adult HIV prevalence was at the peak in 2000 with 13.5 percent (Ministry of Health 2001), having been 5.1 percent in 1990. Decreased to 7.5 percent by 2004, and a further decline to 5.9 percent by 2007 (Ministry of Health 2004, 2005; Wakabi 2007). There is; however, variation in prevalence among urban and rural areas.

In urban areas, the average prevalence is currently estimated to be 9.6 percent while in rural areas it is 4.6 percent (Wakabi, 2007). HIV seroprevalence among pregnant women from all four of the Nairobi City council's clinics fluctuated between 15 and 16 percent from 1994 to 1997 (U.S. Census Bureau, 2000). HIV seroprevalence in Kenya remains highest in western Kenya. For instance, while in 1997 the urban areas of Nyanza Province had the highest prevalence at 35 percent among pregnant women (U.S. Census Bureau, 2000); it is currently still high at 13.0 percent (NASCOP, 2005).

Though HIV/AIDS has, for a long time, been perceived to be an urban infection, the seroprevalence in some rural communities in Kenya is quite high. In 1999, rural data from the sentinel surveillance system showed that Siaya and Kombewa, two rural based communities in Nyanza province, had HIV seroprevalence of 40 percent and 29 percent respectively (U.S. Census Bureau, 2000). While there are over 470,000 HIV infected adults in urban areas, there are about 1.5 million HIV infected adults living in rural areas. Even though it appears that the infection rate is higher in urban areas, the absolute total number of people infected is larger in rural areas since 80 percent, out of the total Kenyan populations reside in rural areas, whereas 72 percent of the infected adults live in rural areas.

In 1997, the median HIV prevalence rates among women showing up for antenatal clinics in and outside major urban areas was 15.2 percent and 12.7 percent respectively (UNAIDS, 2000). For every eight adults in rural Kenya, one is infected; while in urban areas, nearly one out of every five adults is infected (Government of Kenya, 2001).

According to 2004 sentinel surveillance indications, it is estimated that 1.5 million people are currently infected with a national adult (15-49 years) prevalence rate of 7.5 percent. Out of these, it is estimated by NASCOP (2005) that the number of people living with AIDS is 1.2 million, comprising 1.1 million adults between the age of 15 and 49 years, 60,000 aged 50 and over, and approximately 100,000 children. Similarly, data presented to NASCOP between 1986 and 2000, of 98,000 AIDS cases, more than 75 percent occur in adults between the ages of 20-45, with the peak for males and females being at 30-34 and 25-29 respectively.

An estimated 180,000 people died of AIDS during the year 1999 (WHO and UNAIDS, 2000) and in the year 2001, it was estimated that about 700 people would die daily due to AIDS, which brings it to about 255,000 deaths a year. Currently, annual deaths are estimated at 150,000 per year (NASCOP 2005). However, the number of deaths due to HIV/AIDS will continue to increase because of the number of people with HIV infections who develop full-blown AIDS each year. AIDS has already increased death rates in Kenya at all ages. It is projected that the impact will be more severe among young people and children under five. The rapid increase in adult death has had serious consequences on economic and social development. Consequently, this has led to a decline in life expectancy by almost 20 years, from about 65 years to about 46 years.

The increase in the number of deaths due to HIV/AIDS has led to the phenomenal increase in the number of AIDS orphans. It is estimated that since the beginning of the epidemic in 1984 to the end of 1999, Kenya has had a cumulative 730,000 orphans (UNAIDS 2000), while current living orphans were estimated to be 546,965 (UNAIDS/WHO 2000). On the other hand, NASCOP (2001) estimated that by the end of 2000 there were nearly 900,000 orphans in Kenya. This was projected to increase to 1.5 million by 2005. HIV/AIDS has also had a negative impact on the infant mortality rates. The estimated infant mortality rate for 2003 would have been 55/1000 for both sexes instead of 71/1000 due to HIV/ AIDS, with Nyanza Province at 135/1000. In fact, all the gains made since independence in the arenas of health and economic development are being reversed by the impact of HIV/AIDS.

The estimated HIV/AIDS prevalence and reported cases should just be considered as the tip of the iceberg. There is gross underreporting, misdiagnoses, and delays in reporting of cases to NASCOP. In addition, intermittent electricity supply, malfunctioning fridges, and lack of laboratory technicians compromise HIV testing. Further, there is lack of testing reagents and scarcity of testing centres. Also, many cases of deaths due to HIV/AIDS take place at home since after a long illness, family members often prefer to seek alternative therapies within the socio-cultural and home milieu. The stigma attached to HIV/AIDS also leads to the misreporting of the absolute cause of death. In the Kisii District Hospitals; for example, most of the deaths due to AIDS related causes were either recorded as having occurred due to tuberculosis, malaria, and / or immuno suppression. There were no deaths directly attributed to HIV/AIDS. The estimate of the actual cases of deaths due to HIV/AIDS related illnesses in Kenya might be; therefore, three times what is reported which represent only about 5 percent of all HIV infections in the country (Forsythe and Rau, 1996).

As discussed above, rates of HIV/AIDS prevalence have been based on pregnant women attending antenatal clinics (ANCs). While these rates might be a reasonable proxy for the level of prevalence in the combined male and female adult population in a number of settings, there are several well recognized limitations in estimating the HIV rate in the general adult population. This is because rates of infection in pregnant women are not expected to be the same to all adult women. For example, pregnant women presenting at ANCS are young with a peak age of 20 to 24 years. This would exclude old women who belief in traditional birth attendants. In addition, ANCS that act as surveillance points are located mostly in district hospitals which are often far removed from the rural population. In view of these inadequacies of the ANC surveillance system for monitoring HIV trends, in 2003 the Kenya Demographic and Health Survey (KDHS) included the testing for HIV infection for the first time. This was aimed to provide a better estimate in the general adult population of men and women (KDHS 2003; NASCOP 2005).

Results from the 2003 KDHS indicate that 7 percent of Kenyan adults are infected with HIV. The HIV prevalence in women of age 15-49 was 9 percent, while for men of 15-49 years; it was 5 percent (Central Bureau of Statistics, 2003). The female to male ratio of 1.9 to 1 is higher than that found in other population-based studies in Africa. The gender dimension of infection rates is

very clear and congruent with other estimates from around the world. Consequently, young women were found to be more vulnerable to HIV infection compared to young men. For instance, 3 percent of women aged 15-19 are HIV infected, compared to less than 0.5 percent of men aged 15-19, while HIV prevalence among women 20-24 years is over 4 times that of men in the same age group (9 percent vs 2 percent). The peak prevalence among women is at age 25-29 (13 percent), while the prevalence rises gradually with age among men to peak at age 40-44 (9 percent). Only in the 45-49 year-old age group is HIV prevalence among men (5 percent) higher than that among women (4 percent).

Urban residents were found to be at a significantly higher risk of HIV infection (10 percent) than rural residents (6 percent). The prevalence in urban women is 12 percent compared to less than 8 percent for rural women. For men, the risk associated with urban residence is even greater; urban men are twice as likely to be infected as compared to rural men (8 percent and 4 percent respectively).

The data from 2003 KDHS indicated that marital status influence HIV prevalence. Women and men in marital union have prevalence rates of 8 percent and 7 percent respectively, Widowers, divorcees, or separated women have significantly higher rates (30 percent) than married women do (6 percent). Women in polygamous unions have a higher prevalence (11 percent) than those in monogamous unions (7 percent). Again, the rates for men are similar (12 percent in polygamous unions and 7 percent for monogamous unions).

The number of adults with HIV infections in Kenya which is estimated using the population projections from the 1999 census and the general population prevalence rates from the KDHS (NASCOP, 2005). Currently, an estimated 1.1 million adults aged between 15 to 49 years are infected with HIV with two thirds being women as shown in **Table 2.1**.

Table 2.1: HIV Prevalence among Adults age 15-49 Years (year 2003)

	Women (%)	Men (%)	Total (%)	HIV infected(no)
Total				1,100,000
Age				
15-19	3.0	0.4	1.6	
20-24	9.0	2.4	6.0	
25-29	12.9	7.3	10.4	
30-34	11.7	6.6	9.4	
40-44	9.5	8.8	9.1	
45-49	3.9	5.2	4.4	
50-54	N/A	5.7	N/A	
Residence				
Urban	12.3	7.5	10.0	410,000
Rural	7.5	3.6	5.6	670,000
Province				
Nairobi	11.9	7.8	9.9	130,000
Central	11.9	7.8	9.9	130,000
Coast	6.6	4.8	5.6	110,000
Eastern	6.1	1.5	4.0	110,000
North eastern	<1.0	<1.0	<1.0	20,000
Nyanza	18.3	11.6	15.1	310,000
Rift valley	6.9	3.6	5.3	180,000
Western	5.8	3.8	4.9	110,000

Sources: Central Bureau of Statistics, Kenyan Demographic and Health Survey, 2003, and NASCOP, 2003.

Information from the sentinel surveillance further suggests that adult prevalence peaked at a level of 10 percent in adults in the late 1990s, and declined to 7 percent by 2003 (NASCOP 2005). It is indicated that new infections in adults have declined dramatically from over 200,000 to approximately 86,000, but deaths increased to 150,000 per year (NASCOP 2005). UNAIDS (2006) also indicates that HIV prevalence rates declined from 14 per cent in 1993 to 6.1 per cent in 2005. This places Kenya as the only country after Uganda to achieve a sustained decline in HIV infection in Sub Saharan Africa.

The age and sex patterns of infection in Kenya are not divergent from those of other parts of the world. Infection rates are high among girls and young women, especially those in the age group of 20-24 years, while for men, the highest infection rate is found in the age group of 30-39 years. Similarly, an analysis of STD patients who participated in the HIV sentinel surveillance from

1990 to 2001 indicated that the overall HIV prevalence in women was higher than in men in all subcategories including age groups, separated, single, urban and rural residence, all levels of education, and the presence or absence of GUD (Joesoef *et al.,* 2003).

The median age at first intercourse is about 17 for women and 16 for men. Also the age at first marriage is 20 years for women and 25 years for men (Kenya Demographic and Health Survey 1998). This means there is significant period of sexual activity before marriage that exposes young people to the risk of infection. In 1990, the highest proportion of sexually active people having at least one sex partner other than a regular partner in the last twelve months were men of 20-24 years of age (56.5 percent compared to 17.7 percent for girls). This group was followed by those aged between 15-19 years (41.3 percent compared to 83.3 percent for girls) (WHO and UNAIDS, 2000).

In Kisumu, the HIV seroprevalence for adult females was highest, 39 percent, for those in their 20s, and for adult males the highest rate of 34 percent was found among those in their 30s (U.S. Census Bureau, 2000). Young women in the aged 15-19 and 20-24 are more than twice as likely to be infected as males in the same age groups. By the end of 1999, it was estimated that the HIV prevalence rate varied from 11.07 to 14.98 percent and from 4.26 to 8.52 percent among females (15-24 years) and males (15-24 years) respectively (UNAIDS, 2000).

In 2007, the government adopted the AIDS Indicator Survey (AIS) for monitoring HIV/AIDS in the general population. The KAIS (2007) was thus the first AIS for Kenya and it provided information on HIV/AIDS and other sexually transmitted infections. The methods and findings of this survey build upon previous population-based surveys from Kenya Demographic Health Survey of 2003 (KIAS, 2007).

According to KIAS (2007), women continue to be disproportionately infected with HIV (9.2%) compared to men (5.8%). Though this pattern is similar to KDHS (2003), there is marked increase in the rate of infection. In KDHS 2003, the infection rate was 8.7% and 4.6% for both women and men respectively. Despite this, there is also marked difference on infection rates across all ages. Among youth aged 15-24, women were four times likely to be infected than men

and age 30-34 had the highest infection rate. However, there was decline in prevalence among women aged 34 years and among men age 44 years.

Geographically, HIV prevalence rate remain highest in Nyanza at 15.3%; which is double the national prevalence estimate of 7%. Other provinces with similar rates or higher than the national prevalence are; Nairobi (9.0%), Coast (7.9%) and Rift valley (7.9%). Prevalence in Eastern province is 4.7% and Central 3.8% of the adult population infected. North Eastern province has the lowest adult prevalence of 1%. However, due to different population sizes across provinces, this prevalence estimate may not provide the complete picture of HIV burden in each province. For example, though the proportion of infected adults in the Coast and Nairobi is higher than the proportion in Rift Valley, the number of infected adults in Rift Valley(estimated 322,000) was greater than in Coast (estimated 85,000) or Nairobi (estimated 176,000) (KIAS, 2007).

The provincial prevalence estimate for HIV prevalence among 15-49 year-old were as follows; Nairobi;9.3 per cent; Central, 4.2 per cent; Coast, 8.1 per cent; Nyanza, 15.7 per cent; Eastern, 4.9 per cent ; Rift Valley, 7.4 per cent; Western, 5.7 per cent and North Eastern, 1.3 per cent. When these findings were compared with KDHS 2003, the provincial prevalence estimates were found to be almost similar with 1 per cent margin safe for Coast and Rift Valley provinces. In Coast province, the prevalence rate had increased by 2.3 per cent and 2.1 per cent in Rift valley both which marked 40 per cent increase HIV prevalence rate since KDHS 2003.

About three quarters of Kenyans live in rural areas of the country. Among those aged 15-64years, 7 per cent are infected with HIV. In urban areas, the prevalence is 9 per cent. In both areas, women are more infected than men, with 10.8 per cent of urban females compared to 6.2 per cent of urban males, and 8.2 per cent of rural women infected compared to 5.5 per cent of rural men. When this data is compared to KDHS 2003, HIV rates among women and men aged 15-49 was found to be declining among urban residents though the decline is not statistically significant. In contrast, rural HIV prevalence was on the rise among women and men. For example, HIV prevalence among rural men increased by 58 per cent (KIA, 2007).

The level of education was found to have influence on HIV prevalence among women aged 15-64. Women with higher education levels have significantly lower HIV prevalence than those

with less education. Those with primary education have prevalence rate of 10 per cent compared to 7 per cent with secondary education and 4 per cent with tertiary education. Prevalence among women who have never attended school is 7 per cent. For men, there is also decrease in HIV prevalence with higher levels of education but the difference is not statistically significant.

Marital status was also found to have some influence on HIV prevalence as shown in **Table 2.2** Those in polygamous unions are more likely to be HIV infected (11 per cent) than those in monogamous union (7 percent). Women who have been widowed, divorced or separated have higher HIV prevalence at 17-21 per cent. Among sexually active men, those who have never been in a union have a prevalence of 2.8 per cent compared to 7.4 per cent among men currently in a union. The relationship between marital status has remained unchanged since 2003 among women. Among men, the rate of HIV among polygamous men had significantly increased to 15.9 per cent in 2007 from 11.9 per cent in 2003. The same trend is found among monogamous union where HIV prevalence increased to 8.0 per cent in 2007 from 6.5 per cent in 2003.

Table 2.2: HIV Prevalence among Kenyans age 15-64 by Sex and Marital Status

Marital status	Female	Male	Total
Marital Status	% HIV Infected	%HIV Infected	% HIV infected
Currently in union	7.8	7.4	7.6
Monogamous	7.1	7.0	7.1
Polygamous	11.2	11.4	11.3
Currently not in union	10.3	3.2	7.1
Currently widowed	20.7	19.3**	20.5
Currently divorced/ separated	17.1	6.4*	13.7
Never in union	4.7	2.2	3.3
Ever had sex	7.3	2.8	4.6
Ever widowed	21.2	NA**	21.0

Source: KIAS 2008. *married or living with partner **< 25 observation ***Men not asked if previously widowed.

In the recent past male circumcision has been advocated as one of the HIV prevention strategies. In this survey, men aged 15-64, 85 percent are circumcised. The highest level of circumcision is in North Eastern (97.2 percent) and the lowest level is in Nyanza (46.7 percent). Nationally, 73 percent of 15-19 year-old men are circumcised; the rate of circumcision increases in older age groups. In all but the youngest age group, HIV prevalence is higher by 3 to 5 times in circumcised men than in the uncircumcised. Among the uncircumcised men 35-39 years of age, 1 out of 3 is HIV infected.

Unlike in the previous population based surveys, KIAS 2007 included HIV testing and treatment. On HIV testing, 36 per cent of adults ages 15-64 have tested at least once for HIV and received results. Nearly two-thirds of the people have never been tested for HIV and therefore are not accessing appropriate HIV prevention, care and treatment. HIV testing is particularly low among older Kenyans age 50-64; among this cohort only 17.5 per cent have tested for HIV. There is a

great disparity on HIV testing between urban and rural areas. In urban areas, 50 per cent of the residents have been tested for HIV at least once as compared to 30 per cent in rural areas. HIV testing was found to be higher among women than men. On treatment, the survey found that there still exist unmet needs for treatment among those who need it due to inaccessibility.

Critically looking all the various methods used by the government of Kenya to estimate HIV prevalence reveal that HIV still remains a major health problem. The disease has affected all people but has a major impact on those aged between 15-49 years with women disproportionately affected. Although the level of knowledge/awareness on the modes of transmission and prevention of infection is high among all people, there is no corresponding behaviour change. Therefore, this calls a critical examination of the various strategies used in the prevention of HIV/AIDS.

Government action and Response to HIV/AIDS

When HIV virus that causes AIDS was first discovered in 1980, it marked the beginning of the fight against the disease in many countries. The fight took the form of prevention or search for a vaccine. In Kenya; however, there was delayed action towards the disease as it was not perceived as a health threat.

A number of reasons have been advanced to account for the initial inaction to HIV/AIDS in Kenya. Among the reasons as argued by Kwena (2002) is the definition of HIV/AIDS by World Health Organization (WHO) in 1986. According to World Health Organization (WHO), for a person to be declared an AIDS patient, he/she must be diagnosed with two major signs and at least one minor sign. These signs were: recurrent herpes zoster, fever for at least one month, generalized lymphadenopathy, severe malnutrition, and oro-phayngeal candidiasis.

Using this WHO definition of HIV/AIDS, few people were diagnosed to be HIV positive. This made the government to view the disease as not a major health problem warranting attention. Other cited reasons for the inaction were the prevailing economic situation the government was in; the social construction of HIV/AIDS as a disease for risky group of people like gay men, intravenous drug users and commercial sex workers, and the culture of silence surrounding issues of sexuality in most African communities (Ogot, 2004; Kwena, 2002; Fassin,2006).

Despite this, the government has exhibited various responses as reflected in its policy documents in the fight against HIV/AIDS. Initially, the response was lukewarm, unplanned and denial. However, as the problem of the disease manifested itself in various sectors of the economy, the government started taking concerted steps to stem its impact especially from 1990. I hereafter discuss the government's policy response to HIV/AIDS in five phases.

Phase 1: 1984- 1987

In this phase, HIV/AIDS was not considered as a major health problem. Although the disease had been officially reported in the country, the disease was still constructed as an external disease. For example, the first case of HIV/AIDS was reported in 1984 in the East Africa Medical Journal by Drs A, Obel; A, Sharif; E, Gitonga and G, Gitau. The report indicated that the HIV/AIDS patient was a 34 year-old unmarried Ugandan journalist who had widely travelled especially in European countries and based in Nairobi (Ogot, 2004).

At this period also, there were so many conspiracy theories about the origin of HIV/AIDS. These theories were not aimed at cultivating action for mitigating its impact, but who to blame. Consequently, in Western countries the disease was seen to have originated from Africa and spread to Europe by sex tourists who had visited the continent. On the other hand, in Africa the disease was thought to have been manufactured in a laboratory in the Western countries to contain the ever-growing population of black people.

However, with time the threat of HIV/AIDS in Kenya became real. The government thus started establishing infrastructure under which all matters and activities pertaining to AIDS control could be coordinated. The first step was the establishment of National AIDS Committee (NAC) in the Ministry of Health in 1985. The role of this committee was to appraise the HIV/AIDS situation in the country and advice the government on strategies to mitigate the problem (Ministry of Health, 1989). The committee started work in 1987 - exactly two years after formation. Soon after this, the government established a diagnostic surveillance and reporting infrastructure. This was entitled with the mandate to screen all blood donated in the country. Before then, blood was only screened for hepatitis and syphilis.

To further strengthen the work of NAC in creating awareness of the disease and its prevention, AIDS Programme Secretariat (APS) was established in the Office of the Director of Medical Services. The role of APS was to coordinate activities among Ministry of Health, donors and Non-Governmental Organizations (NGOs) in creating awareness of the disease.

In 1986, the Ministry of Health through a Legal Notice gazetted HIV/AIDS as a "notifiable" disease (Ogot, 2004). That meant; all medical practitioners will be required to report all HIV/AIDS cases to the Director of Medical Services, all blood for transfusion would have to be screened and no one would be allowed to use unscreened blood, only disposable syringes would be used for injecting patients of any kind, all government hospitals, private and those run by missionaries would be equipped with blood screening apparatus to enable them determine the spread of the disease and a massive publicity campaign would be launched through the media. Community based organizations were to educate people on the spread of HIV/AIDS. In spite of this, no measures were put in place to enforce this amendment to the Public Health Act.

In the same year, the government developed five years Medium Term Plan (MTP) for AIDS control[8]. In developing this plan, the government invited the WHO to assist in the technical advice and in resource mobilization in the fight against HIV/AIDS. This culminated to the launching of the Kenya National AIDS Control Programme in 1987 whose major component included health education, epidemiology, clinical services, and laboratory and blood transfusion services.

With these efforts, success was recorded. These was; 100 per cent of donated blood in national, provincial, district and mission hospital was screened, counselling and nursing procedures, as well as guidelines for protection of health workers were established. HIV/AIDS awareness programmes were broadcasted in eighteen local languages through the radio and awareness enhancement seminars were held across the country to sensitize administrators and opinion leaders. However, the major bottleneck to the planning and implementation of HIV/AIDS

[8] Developing of MTP was a condition given by IMF and World Bank to the government before it accessed any funding in the fight against HIV/AIDS.

programmes was lack of funds and shortage of qualified man-power and lack of testing kits and equipment (Kibaki, 1992).

Phase II: 1988- 1991

At this period, there was some realization that HIV/AIDS was indeed a health problem. However, many people still believed it was not such serious when it was compared to other diseases like malaria which were causing high morbidity and mortality. There were also limited disclosures from those who were already infected because of high stigma as the disease was associated with sexual immorality. The government on the other hand had no surveillance data on the HIV prevalence.

The government was still not enthusiastic about the problem of HIV/AIDS. This was despite the fact that in early 1988, the Ministry of Health through funding from WHO and other foreign governments had launched a campaign to educate people on the dangers of HIV/AIDS at a tune of US$ 26 million. This educational campaign was to be directed by health sub-committee of NAC composed of twenty members most of whom were medical and public health experts as well as media personalities. They were charged with the responsibility of organizing seminars, workshops and conferences for various opinion leader groups such as medical personnel, politicians and the clergy.

During this time, HIV/AIDS pandemic was growing at an alarming rate due to the compounding economic, political and cultural factors. The donors stopped dispersing funds to the government because of what they termed bad governance, and IMF and World Bank imposed harsh conditions which meant that several social programmes; including health ones , were adversely affected. Socially, the high influx of refugees living precarious conditions significantly contributed to the rapid spread of the disease. The high cost of living and uncontrolled inflation turned survival strategies into death strategies as women and young girls tried to make ends meet by engaging in risky sexual behaviour.

By early 1990, HIV/AIDS was already a serious problem for Kenya that required to be addressed with urgency and commitment at all levels, more specifically at the national level. However,

there was no such enthusiasm from the government. Due to this, local and international NGOs continued to play a leading role in HIV/AIDS prevention. To make their role more effective, the consortium of Kenyan AIDS NGOs and religious groups involved in HIV/AIDS prevention formed Kenya AIDS NGO (KANCO) in 1992. KANCO mobilized resources, developed and led prevention programmes across the country.

Towards the end of this phase, the government started to change its position towards HIV/AIDS. It started to embrace a proactive approach to the fight against HIV/AIDS. This shift was occasioned by several factors:

First, towards the end of 1980s, the number of those infected with HIV increased substantially to the extent that the Minister for Health warned that if appropriate measures were not taken to curb the spread of the disease, the numbers of AIDS patients and carriers would be exceedingly high.

Second, was the pressure emanating from a number of NGOs particularly Kenya AIDS NGOs consortium. And lastly, international pressure especially from the key Kenya's development partners such as World Health Organization, World Bank, United Nations Development Programme and International Development Association. These organizations demanded that the government admits the presence of HIV/AIDS in the country and prioritize it as a national issue. They also required the government to mobilize all resources at its disposal to educate society about the horrors of the disease.

Phase III: 1992- 1995

This period witnessed drastic change in government response to HIV/AIDS after it came obvious that the disease was headed to a calamity. The government action was prompted by the release of data on HIV/AIDS related cases. In the report, it was estimated that by 1993, 841,700 people would be HIV positive out of which 30,000 would be children. It was further projected that by 1996 there would be about 1.27 million people with HIV/AIDS and related deaths would rise from 20,000 in 1990 to about 86,000 (Government of Kenya,1993a).

With these statistics, the government realized that HIV/AIDS was turning into a serious economic and health problem. The disease was noted to be reversing the gains the government

had hitherto attained like reducing child mortality and increasing life expectancy. The cost of caring for those already infected was also noted to increase drastically; thus, affecting the Ministry of Health budget. It was noted that these would have negative impacts on the development of the country.

With the impact of HIV/AIDS now real, the government for the first time recognized the disease as a serious development problem. This precipitated the drafting of the whole chapter on the disease in the Seventh National Development Plan and the Fifth District Development Plan for the year 1994-96 (Ogot, 2004; Government of Kenya, 1993b). The chapter listed three main areas for the fight against HIV/AIDS viz. prevention through sex, blood transfusion, and prenatal care; socio-economic support, social and clinical support for those who had been infected. Lastly, mobilization and unification of resources geared towards fighting against HIV/AIDS. In each proposal, the government gave details on how it was going to achieve the stated goal.

In addition to this, the government indicated it would draft a Sessional Paper on HIV/AIDS by setting up a task force to look into laws relating to HIV/AIDS, and thereafter hold a national awareness conference (Government of Kenya, 1993a). All these developments indicated that the government was at long last getting serious with the problem of this disease as it tried to mobilize resources. The only setback was that the government plan only listed priority areas without corresponding financial commitment. For example, the National Development Plan of 1994-96 identified poverty as a major impediment to the control of HIV/AIDS but no resources were allocated for its implementation.

This deficiency was due to the government's over reliance on donor funding on development projects. With economic recession, most western donor countries at this time had reduced the amount of foreign assistance to Kenya. The diminishing funding; thus, compromised most of HIV/AIDS project planning and implementation. Programmes had to be abandoned altogether or managed with reduced budget. For example, in 1991 Africa received only 2.8 per cent of US$ 3.3 billion set aside for the control of HIV/AIDS[9], which was very limited as compared to the reported extent of HIV/AIDS epidemic in the continent.

[9] Daily Nation Nairobi: August 10, 1992.

At this time also, donor aid had assumed political dimensions. As a political tool, such aid was used to put pressure on African governments to adopt western democratic ideals and belief. The amount of aid given was largely proportional to the level of adherence to these beliefs. However, countries like Kenya who were slow in changing their political system, aid cut resulted; compounding the economic hardship at the time. This; consequently, affected the government's financing of HIV/AIDS prevention programmes.

The over reliance on donor funding in the fight against HIV/AIDS had counter effects also. It suppressed local fundraising and management initiatives. Instead of the government exploring possibilities of raising funds locally either from individual companies, religious institutions etc, it continued to depend on foreign aid. Local funding will have represented an initial step toward a national capacity for self-reliance.

In response to HIV/AIDS, the government further formed National AIDS Control Programme (NACP) to coordinate HIV/AIDS activities and programmes. However, these were still limited due to lack of resources and political commitment which affected budgetary allocation. For example, even though the Ministry of Health had declared HIV/AIDS as a health crisis, the ministry's budget allocation remained the same (Ministry of Health, 1992).

In 1992, the government did an evaluation for the first medium plan. In this evaluation, it was noted that a multi-sectoral approach which was proposed to make HIV/AIDS a priority in all sectors was lacking a coordinated national response. Consequently, it recommended the formation of a National Inter-sectoral AIDS Board (NIAB). The chair of this board was to be appointed by the Office of the President with a secretariat in the Ministry of Health. Membership for this board was to be drawn from other government ministries, NGOs and other private organizations.

The following year, the government released its first surveillance data and hosted its first national conference on AIDS in April 1993. In this conference, the government was urged to cater for the welfare of those affected with the disease and formulate a detailed programme to educate people country wide about dangers posed by the disease. The conference further urged

the government to introduce AIDS courses in colleges and schools and screen AIDS films at all market centres to create more awareness about the disease. AIDS was then declared a national health crisis by the Ministry of Health (Ogot, 2004).

In 1993, the government developed the second five year medium term plan (1992-'96) for the fight against HIV/AIDS. In this plan, the government identified promotion of behaviour change to stop the spread of the virus and mitigate the socio-economic effects of HIV/AIDS at the individual, family and communal level as way of stemming its spread. However, this plan drew a lot of opposition from religious institutions especially on the issue of behaviour modification through introduction of family life education for young people and condom use[10]. The Catholic Church specifically saw this proposal as a licence to immorality (Kangara , 2004).

In 1995, the government started to demonstrate its seriousness to the fight against HIV/AIDS when it started drafting parliamentary Sessional Paper on HIV/AIDS. This was in response to the proposal made in the National Development Plan of 1994-96 (Government of Kenya, 1993b). This Sessional Paper was to be both consultative and multi-disciplinary in nature. In this case consultation was to take place at provincial, district and community levels countrywide. Committees were also to be formed both within the Ministry of Health and outside the government to deal with drafting this paper.

Despite this grandiose plan, the government never took part in the first three initial stages. Instead, the work was left with local and international NGOs. Consequently, the NGOs became the guiding force in determining the public debate on various issues concerning HIV/AIDS prevention (Rau, 1997).

Phase IV: 1996 – 2000

The year 1996 ushered in a new era for the fight against HIV/AIDS in Kenya. With the dissemination of data contained in a book titled "AIDS in Kenya: Socio-economic Impact and Policy Implication", the government noted that the disease was indeed a serious economic

[10] The religious stand on condom use and sex (Family life) education made the government to have contradictory stand on their role in curbing the problem of HIV/AIDS among young people. This situation still persists to date.

development and demographic problem which needed urgent mitigating action. Consequently, HIV/AIDS was to be part of the government development policy issue.

Given the high number of HIV/AIDS infections and AIDS related deaths, the government became concerned about the accessibility of care of those infected and affected. It was argued that by making care accessible, the negative economic impact of the disease will be minimized. Another concern for the government was how to reduce the rate of infection among the people. The government thus noted that the response to HIV/AIDS must encompass control over the spread of other sexually transmitted infections. Consequently, the government reformulated NACP into National AIDS and STD Control Programme (NASCOP).

In this period, data from NASCOP indicated that HIV/AIDS was on a drastic rise. For example, in 1996 NASCOP report estimated that there were 1.2 million HIV positive in the country. This number was projected to rise to 1.8 million in year 2000 if no adequate measures are taken. In the year 2000, the total number of HIV/AIDS was 2.3 million justifying the consequences of uncoordinated government policy. In 1997, NASCOP report also estimated that there were 1.5 million HIV positive people with 111 deaths daily from AIDS related illness (Ogot, 2004).

The impact of HIV/AIDS on individuals, families and communities was becoming enormous. This prompted the political leadership especially the president, Moi[11] to start taking a leading role in advocating for prevention through sexual behaviour change as from 1996. This trend continued henceforth from other political leaders, diplomats and media officials as evidenced in the launch of a book published by USAID/AIDSCAP titled "AIDS in Kenya: Socio-economic Impact and Policy Implication". The book presented extensive data, analyses and evidence of the impact of AIDS and implications in various sectors. For a long time the political establishment had not shown any enthusiasm towards the HIV/AIDS problem. This therefore contributed to opening up of debate on HIV/AIDS especially from political establishment which was missing in the formulation of HIV/AIDS policy.

[11] Moi was the second president of the republic of Kenya. He took over power in 1978 after the demise of the first president Mzee Jomo Kenyatta. He ruled as a president for 24 years. His tenure has been described by many authors as autocratic see for example, Chabal, 2005 and Ader *et al* 2001.

To further show political commitment, the government through Ministry of Health published Sessional paper number 4 of 1997 on HIV/AIDS in Kenya (Ogot, 2004). The paper outlined various guidelines and policies on how to control the pandemic. Among the strategy proposed include: laws for protecting those infected and vulnerable groups, prevention of HIV/AIDS through sexual transmission, prevention of HIV from mother to child and reduction of the impact of HIV/AIDS on the society.

The paper further recommended that HIV/AIDS should not be seen as a Ministry of Health concern, but as a developmental issue which requires multi-sectoral approach and political commitment. The government was required to come with institutional framework for effective management and coordination of HIV/AIDS activities. To this end, the paper recommended the establishment of National AIDS Control Council (NACC).

NACC was to expedite HIV/AIDS prevention through; formulating appropriate policies, establishment of institutional framework for multi-sectoral AIDS control programmes, the strengthening of institutional capacity at all levels, the provision of leadership in resource mobilization for AIDS control; including care of people affected, coordination of all actors which include government departments, NGOs, Community Based Organizations(CBOs) and religious institutions. This paper was passed in parliament unanimously on September 25th, 1997. The paper; however, did not see poverty and gender inequality as important in HIV/AIDS prevention.

In April 1997, the Kenya AIDS NGOs Consortium indicated it was ready to work with the government to implement a policy on providing youths with information on HIV/AIDS. In its Policy Advocacy Paper No.1, April 1997, the consortium said it had identified models and programmes that could help government implement its plan to educate young people and children on family life. This was in response to Family Life Education Sessional Paper No.1 of 1997[12] on the National Population Policy for Sustainable Development which had committed the

[12] This Sessional paper recommended appropriate education programmes to help youths handle their sexuality responsibly and most importantly it set out policies on how to tackle youth problems like unwanted pregnancies, drug abuse and HIV/AIDS..

government to increase accessibility, acceptability and affordability of quality family life information/ education for the youth.

The consortium recommended that for the successful implementation of the policy key person within the communities and churches must be identified to work with the youth. Parents and leaders had first to be equipped with basic knowledge on HIV/AIDS and communication skills, while medical personnel needed extra training on youth counselling and STD management. Finally, the advocacy paper said information and education to be provided to the youth and children must be complete, appropriate and culturally-sensitive and should be channelled through institutions like schools, religious set-ups and health centres.

The government and the NGOs dealing with HIV/AIDS seemed to be combining forces in the fight against HIV/AIDS at this moment. However, government commitment to this goal still continued to be ambiguous and contradictory. For example, at the time Sessional Paper No.4 of 1997 on HIV/AIDS was being passed in parliament, president Moi announced that the government had scrapped the contentious sex education from family education syllabus[13]. The president instead proposed religious bodies to guide the youth on all matters of morality and spirituality[14]. The president's actions were due to intense pressure against the bill from religious institutions led by the Catholic Church. The Catholic Church was very vocal in its condemnation describing the bill as "legalizing abortion, homosexuality and lesbianism"[15].

By the end of 1997, it was evident that throughout the country, the recognition of the virus by the government, the National Control Programme and the adoption of Sessional Paper on AIDS, had not made much impact on the reality of the situation. The reports from NASCOP showed the virus continued to spread and the official national prevalence rate was at least 8 per cent of the population. More than 75,000 cases of full blown AIDS had been reported, but owing to the low levels of testing and under reporting, it was believed that the real numbers of individuals with

[13] The president was referring to Family life education Sessional paper NO.1 of 1997 which had already been discussed and adopted by cabinet. The paper was due to be tabled in parliament.
[14] The Daily Nation Nairobi: September 26, 1997.
[15] East Africa Standard Nairobi: October 2, 1997

full blown AIDS was closer to 250,000. There were also an estimated 1.3 million people living with AIDS in Kenya and 78,000 were children.

Regarding regional statistic, NASCOP estimated that almost 30% of death from HIV/AIDS had occurred in Nyanza province, 17 per cent in East province, 10 per cent in Central, 9 per cent in Rift Valley and Western provinces and 5 per cent in Nairobi. Poverty, poor health and culture were blamed for high prevalence rates. Despite this, the government remained silent in many vital issues. For example, on 29th April 1998, the Minister for Education told parliament that the government had no intention of introducing Family Life Education in schools[16].

Despite this hiccups on government policy, the government started from 1997 to incorporate HIV/AIDS into national development. Consequently, substantial finances and human resources were being committed to prevention activities. This to Rau (1997) laid the foundation that will allow effective national response as evidenced in many activities geared towards HIV/AIDS prevention.

In June 1999, the Ministry of Health launched NASCOP third strategic plan for national HIV/AIDS and STD control programme for 1992-2004 (Ministry of Health, 1999). This plan prioritized the promotion of behavioural change, the prevention of blood-borne infections, reduction of STD prevalence, prevention of HIV/AIDS from mother to child (PMTC) and mitigation of socio-economic impact of AIDS. This plan; however, faced financial challenges as most donors like World Bank withdrew their funding.[17]

In August 1999, the Ministry of Health again launched a five year National Health Sector and AIDS Control Plan for 1999-2004. In this plan, the ministry provided the specific budget for the first time in the fight against HIV/AIDS. The plan had six priority areas; malaria prevention and treatment, reproductive health, HIV/AIDS, tuberculosis prevention and management, integrated management of childhood illness, immunization, prevention and control of environmental

[16] East Africa Standard Nairobi: April 30, 1998.
[17] Most donors at this time (started) channeling their development funds through NGOs, CBOs because of the alleged corruption in government bureaucracy.

health related diseases and food safety. The rationale behind this plan was that many people who were HIV positive were dying from these preventable diseases.

The fight against HIV/AIDS was taken a notch higher in November 25th - 30th, 1999 during HIV/AIDS awareness seminar for 224 members of parliament in Mombasa. During this conference, president Moi officially declared HIV/AIDS a national disaster.[18]. At the conference, president Moi announced various emergency measures to curb its spread[19].

He ordered the immediate setting up of a National AIDS Control Council to coordinate the fight against HIV/AIDS. The president announced that to prepare children for the threat of HIV/AIDS, "special lessons"[20] would be given in all schools and colleges from January 2000. All chiefs and assistant chiefs were ordered to form committees of elders to produce solutions to cultural practices and beliefs that help the spread of the scourge. To avoid antagonizing the church, the president did not advocate the use of condoms in the fight against the disease.

During the seminar, the British government pledged to grant Shillings 3 billion per year for the next five years to fight the war against HIV/AIDS in Kenya. The announcement was made by a Senior Health and Population advisor, in the department of International Development who noted that the situation in Kenya remained bleak as over 1.9 million people were infected with AIDS. To this end, the government was urged to make information and knowledge available to all young people so that they can make informed and rational choices.

Immediately after this seminar, National AIDS Control Council (NACC) which was proposed by Sessional Paper No. 4 of 1997 on HIV/AIDS was established as a state corporation. This was done through Legal Notice No.17 on November 26, 1999 under the State Corporations Act under the office of the president. The general mandate of NACC was to coordinate multi-sectoral efforts in the prevention and control of HIV/AIDS in the country.

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[18] This proclamation was, however, not made under the National Disaster Act. Legally therefore this declaration would not bring into use emergency powers in mitigating the impact of HIV/AIDS.
[19] Daily Nation Nairobi: November 26, 1999.
[20] The president was avoiding using Family life education which religious institutions were against.

To achieve its general mandate, NACC had to carry out the following functions: developing policies, strategies, and guidelines relevant to the prevention and control of HIV/AIDS, had powers to mobilize resources, government ministries and institutions, NGOs, CBOs, research bodies to participate in HIV/AIDS control. The establishment of NACC was actually the first step towards the implementation of Sessional paper number 4 of 1999 on HIV/AIDS and more importantly, the formation of the multi-sectoral approach to HIV/AIDS that was lacking previously.

To co-ordinate the multi-sectoral approach to the war against the HIV/AIDS pandemic, NACC aimed to establish and co-ordinate a decentralized institutional framework. With the decentralized structure, the NASCOP provided the much needed technical assistance for the district in the form of policy guidance and resource provision and mobilization. On the other hand, NACC was intended to harmonize the operations of NASCOP and other NGOs, CBOs, and donors to avoid duplication of HIV/AIDS control and mitigation programmes.

To this end each Ministry established an AIDS Control Unit to implement the strategic AIDS plan in every sector, that is, in all projects and services they offered. The units were also responsible for the dissemination of HIV/AIDS education and information to all employees. The eight Provincial Inter-sectoral HIV/AIDS Control Committees (PIACS) were the co-coordinating bodies of the strategic plan at the Provincial level. The committee membership included the government's departments, the civil society, and the private sector and persons living with AIDS. The District Intersectoral HIV/AIDS Control Committees (DICCs) would co-ordinate the implementation at the district and community levels. The membership was to be drawn from the same spectrum as the PIACCs. The Constituency HIV/AIDS Control Committees (CACCs) would facilitate implementation of resolutions passed at the 1999 HIV/AIDS symposium for members of parliament, develop a people-centered set of activities and responses; and co-ordinate all HIV/AIDS activities in 210 constituencies around the country.

Immediately after the establishment of NACC, Members of Parliament (MPs) as per the resolution of Mombasa conference started launching Constituency AIDS Control Committees (CACC). As stated in the NACC Act which brought it into being, membership of CACC were

to be drawn from provincial administration, public health officer, respected elders, a member of a church, a youth leader, a representative with people living with HIV/AIDS (PLWA) or any person the committee may deem appropriate. Failure to define the criteria to be used to identify respected elders, youths, church members etc was openly abused by politicians to reward their support in spite of their competency in handling HIV/AIDS issues. This led to conflict between politicians, NACC and provincial administration affecting the fight against the disease in most parts of the country.

The conflict over the control of CACC reached a critical stage when parliament Health Committee demanded all PACC and DACC to be abolished. The committee termed PACC and DACC as hindrances to effective war against the spread of HIV/AIDS. The committee observed that the two were purely established for bureaucratic reasons which has nothing to do with HIV/AIDS prevention. This conflict led to establishment of parallel CACC in many constituencies[21].

The war on the control of CACC was not about how best the fight against HIV/AIDS was to be implemented but who controls the HIV/AIDS resources (Ogot, 2004). With the recognition of HIV/AIDS as a national disaster, most donor countries and international agencies were willing to provide funds for HIV/AIDS intervention programmes. In this connection there was a scramble for the control of CACC as a means of controlling the anticipated resources. Apart from the control of resources CACC, others like President Moi saw it as a means to be used by the politicians to use AIDS funds to entrench themselves to the electorate[22].

The establishment of NACC in the office of the president instead of the Ministry of health also generated a lot conflict which further consumed a lot of resources. The office of the president was argued lacked technical experts who will lead in the fight against HIV/AIDS, was more prone to corruption practices and thus most likely that resources meant for the disease

[21] East Africa Standard Nairobi: January 27, 2001.
[22] East Africa Standard Nairobi: October 20, 2000

management will be pilfered. This debate created mistrust among various actors which was detrimental to the fight against the pandemic[23].

NACC was also faced with the problem of coordination of actors in the fight against HIV/AIDS. Given that the government had taken a lukewarm approach to the disease, many NGOs sprung up not to manage the disease but to benefit financially from HIV/AIDS funds from donors. This made it difficult to harmonize the intervention strategies of those of the NGOs and the government as many of them operated from "briefcases[24]." And because of the large numbers of NGOs purporting to campaign against the pandemic, there was duplication of roles which again led to unnecessary competition and conflict.

Another significant development at this period was the launch of a five year poverty reduction strategy in October 2000. The government considered the reduction of poverty and enhancement of economic growth will help in the fight against HIV/AIDS. This plan was also to promote behaviour change, preventing blood-borne infection, treating and controlling STD and mitigating socio-economic impact of the disease. Most of the funds for this plan were disbursed to the districts. The plan also depended on donor funding for its implementation.

At the end of this phase, the government started establishing Voluntary Counselling Centres (VCT) country wide. The logic of these VCT was to encourage people to go for HIV tests, stem the prevalence of STD, and ultimately prevent the spread of HIV/AIDS. To this end, the government aimed to have at least five VCT centres in each district by end of 2001.

It's worth noting in this phase that the government kept on giving contradicting signals in the use of condoms and introduction of family life education. During the opening of HIV/AIDS seminar in Mombasa on November 25th 1999, the president did not advocate the use of condoms as HIV/AIDS prevention strategy[25] but few days later he dropped the moralist stand and advocated

[23] East Africa Standard Nairobi: September 20,
[24] A term used to refer to NGOs which are formed by self interest individuals with the` sole aim of getting funds from donors without carrying out the programme//project. The funds got are not benefit the beneficiary of the project/programme but the owner of the NGO.
[25] Daily Nation Nairobi: November 26, 1999

for the use of condoms among the young people[26]. Similarly, in 1999 the ministry wanted to introduce Family Life Education in the learning institutions in the year 2000, but the plan was shelved almost immediately. All these were creating various meanings on the people whom the policies were meant for in the prevention of HIV/AIDS.

Phase V: 2001- To date

This period saw the government continue initiating various policies it had already identified previously. However, most important was the global debate about improving accessibility of treatment to many people who were in need of life prolonging drugs especially in Sub Saharan Africa. At this period, the government started taking proactive role in the fight against the disease as demonstrated by the introduction of various policy documents. These documents were: National Condom Policy and Strategy, antiretroviral therapy guidelines, HIV/AIDS Voluntary Counselling and Testing and government publication of HIV and AIDS Prevention and Control Bill 2006.

At this period, HIV/AIDS infection had stabilized in most places. More so it was now a manageable problem especially with the discovery of various therapies which prolonged life and lessened pain for the infected. This was particularly so in the western countries where many people would afford the cost of treatment. In Kenya and other Sub Saharan countries, this was not the case because of the high cost of drugs.

The accessibility to HIV/AIDS drugs were hindered in most developing countries by the Trade Related Aspects of Intellectual Property Rights (TRIPS) which dealt with patent laws and set some minimum standards such as the number of minimum years for patent protection for pharmaceuticals. Although in certain instances in such public health emergencies or unfair pricing, as notes Ogot (2004), TRIPS allowed for the production of medicines by companies other than the patent holder (compulsory licensing) or importation of medicines from countries other than the country of manufacture (parallel importing).However, in developing countries both parallel importation and compulsory licensing was not allowed. Most of these countries had been pressurized by developed countries to ban parallel importation and compulsory licensing.

[26] Daily Nation Nairobi: December 3, 1999

Instead most developed countries were willing to provide loans to finance the purchase of anti-AIDS drugs. In South Africa, AIDS Treatment Action Pressure group campaigned against any aid from developed countries for the purchase of anti-AIDS drugs, instead they wanted affordable drugs. Pressure on accessibility to affordable continued to gain moment especially after 39 pharmaceutical companies took South Africa to court for breaking the patent law by importing generic anti-AIDS drugs. This pressure continued piling globally until April 19, 2001 when these pharmaceutical companies dropped their case against South Africa.

In Kenya, fear of breaking International patent laws as stipulated by TRIPS refused to accept generic drugs from Cipla, an Indian pharmaceutical company. The company had offered to supply AIDS therapy cocktail to Kenya chapter of *Medicins san Frontier* at US$ 350 a year per patient instead of the actual cost of between US$2,500 and US$ 6,000. These drugs were under patent and the government did not have any legislation to enable it allow them. At this time the government was under pressure to extend its patent protection from seven years to twenty year as per World Trade Organization (WTO) recommendation[27].

All these prompted local and international NGOs, AIDS activists, public health experts to start pressurizing the government to revise its patent laws to enable the country to either produce or access cheap generic drugs. Immediately, after the 39 pharmaceutical companies had dropped a suit against South Africa in April 2001, the government published Industrial Property 2001. The bill was to allow the government to suspend patent rights in times of emergency, license companies to carry out parallel importation of ART, and compulsory licensing of local companies manufacture generic drugs. The bill had provisions to allow the country to import drugs without consent of the patent holder.

In May 3rd 2001, the bill was tabled in parliament for discussion and passing it into second reading. However, due to partisan politics in parliament the bill was defeated by opposition MPs and referred to parliamentary departmental committee for perusal[28]. The action by the opposition was prompted by the fear that the government planned to scuttle debate on the

[27] Daily Nation Nairobi: November 8, 2002
[28] Daily Nation Nairobi: May 4, 2001.

Constitutional Review (Amendment) Bill, which was a legal prerequisite to a much delayed reform which opposition saw as important in safeguarding democracy.

There were mixed reaction to parliament decision to refer the Bill to departmental committee from NGOs, AIDS activists and religious leaders. By referring the bill to departmental committee, it was argued that would make the bill take a long time to be discussed and passed in parliament. This is because parliamentary departmental committees have no stipulated timeline of perusing any bill referred to them. To the pressure groups, this was seen as mischievous and instead accused multi-national pharmaceutical for trying to influence legislators to remove clauses that would allow parallel importation of cheap generic HIV generic drugs and compulsory licensing[29].

Despite this hiccups, the Bill was passed by parliament in June 2001. However, no implementation date was given. This meant that manufacturing of cheap HIV drug or parallel importation will not commence immediately. One of the probable reasons for this was to do with geo-economic politics pitting Kenya and developed countries specifically United States of America (USA). As Ogot, 2004 observes, US at this time was coercing developing countries especially in Africa to enter into trade agreement outside WTO. Countries benefiting from such trade arrangements with US were not allowed to allow companies to manufacture generic drugs. So the government had to choice between economic growth and the health of people who desperately needed treatment.

After one year since the passing of Industrial Property Bill 2001, the government gazetted May 1st 2002 as the day this bill will become operational/ effective. However, in August 2002, it was discovered that the bill was tampered with during the period of gazettement eliminating the possibility of importing generic HIV drugs into the country. [30] The inserted clause in the bill required that importers of HIV generic drugs to seek permission from manufacturers. This again caused uproar as the government was accused of protecting multi-national pharmaceutical at the expense of her people. The clause was removed from the bill. After that, president Moi assented

[29] East Africa Standard Nairobi: May 8,2001
East Africa Standard Nairobi: May 12, 2001
[30] Daily Nation Nairobi: August 13, 2002

to the Act into law thus allowing the importation and manufacture of generic anti-HIV/AIDS drugs into the country in September 2002[31].

Despite the government passing the bill to allow generic anti-AIDS therapy into the country, many people still were not accessible to them. This was because of structural factors like poverty, poor health infrastructure and lack of coordination among those who were to administer these drugs. For example, the German Pharmaceutical company, Boeringer Ingeilhem donated to the Kenyan government free nevirapine® to prevent mother to child transmission in December 2000, but this drugs were not able to reach the target population because of lack of transport and medical experts.

In response to this challenge, the Ministry of Health organized a meeting on September 2001. The aim of this meeting was to bring together experts from public and private sectors, and faith based institutions, teaching hospitals to deliberate, oversee and harmonize antiretroviral treatment implementation. As a result, in December 2001, the Ministry of Health launched the National Clinical Guidelines on Antiretroviral (ARV) which marked the first step towards creating a "standardized" approach between the public and private sectors (Ministry of Health, 2001a).

The major objective of these policy guidelines is to ensure accessibility of anti-retroviral drugs to all those who need them. To achieve this objective, the policy guidelines will be guided by three core principles namely: to ensure universal access to antiretroviral to those in need, to ensure equity in access to antiretroviral service and to create public-private partnership in expanding access in a phased approach. To achieve these principles, seven areas were identified for development. These are: management coordination and policy development, human resource, service delivery, pharmaceutical and related commodities, infrastructure development, strategic information and communication strategy (Ministry of Health, 2001a).

In December 2001, the government launched National Condom Policy Strategy (Ministry of Health, 2001b). This policy was in response to Kenya National HIV/AIDS Strategic Plan

[31] Daily Nation Nairobi: September 11, 2002

launched in December 2000 where behaviour change to minimize risk of exposure to HIV infection and use of condoms to protect against infection were identified as key interventions. However, in this strategic plan, a number of gaps were identified in the area of coordination, supply and distribution of and access of condoms and lack of information regarding the financing of condoms and their cost to users.

The goal of National Condom Policy Strategy is to enhance access to all sexually active Kenyans to high quality condoms at affordable prices and responsive service delivery. The strategy endeavours to heighten risk perception through public education and advocacy with the view of translating knowledge and awareness of HIV/AIDS to risk behaviour avoidance. Subsequently, this would lead to increase of condom use for those who need and want to use them (Ministry of Health, 2001b).

This strategy recognizes the correct and consistent use of condom as key in the fight against HIV/AIDS. Consequently, the strategy aims to increase the demand and use of condoms. This will be achieved by effective publicity as well as multi-sectoral public education and advocacy, development and implementation of a strategy for targeting condoms access by various segments of the population, offering public sector, condoms and social marketing through a wide range of outlets including retail shops, use of dispensers and slot machines; and youth friendly condom distribution system.

The strategy identified poverty as one of the structural factors which may hinder accessibility of condoms to those who may need them. Therefore, in line with poverty reduction strategy (2000), this policy strengthened the system of waivers and exceptions in Mother Child Health (MCH) and sexually transmitted infection(STI) services including provision of condoms free of charge to the most vulnerable groups like the poor and the youth. In this regard, public institutions would be allowed to levy affordable charge for branded condoms through private sector. Also condoms will be made affordable through multiple outlets.

In implementing this strategy, the ministry identified many stakeholders. They include; government agencies, the private sector, NGOs, Local communities and target individuals,

Reproductive Advisory Board, NACC, Kenya medical supplies Agency and National Quality Control Laboratories. The strategy depended on donor funding for its success.

In December 2001 also, the Ministry of Health launched National guidelines for HIV/AIDS Voluntary Counselling and Testing document (Ministry of Health, 2001c). The aim of this document was to set up Voluntary Counselling and Testing Centres to enable people know their HIV status. Voluntary counselling and Testing was premised on the fact that once individuals know their HIV status, they will change their behaviour. From the launch of this document, the government has continued to expand VCT service through the country with assistance from private sector and donors.

In 2003, the new government came into power after successful election of 2001. President Moi did not contest in this election because he was not eligible constitutionally. The new government (NARC) under President Kibaki was keen on the fight against HIV/AIDS. On March 23, 2003, the president declared HIV/AIDS a national crisis which needed urgent intervention[32]. The president; therefore, formed a cabinet committee where he was to be the chair to coordinate the fight against the scourge. The committee was charged with the responsibility harmonizing all sectors of the government and NGOs in the fight against HIV/AIDS. To achieve this, the committee mandated NACC to provide leadership in the fight against HIV/AIDS within "three ones" principles namely: HIV/AIDS framework that provides basis for coordinating the work of all partners, one national AIDS coordinating with broad based multi-sectoral mandates and uniform monitoring and evaluation level system for the country.

In this regard, the government launched the National HIV/AIDS Strategic Plan (KNASP) 2005-2010. This strategic plan was to provide action framework for HIV/AIDS in the context within which all stakeholders will develop their strategies, plans and budget for HIV/AIDS intervention. This was envisaged to create a well coordinated approach in dealing with HIV/AIDS in the country which was previously lacking.

To ensure sustainability of the plan in dealing with HIV/AIDS programmes, the implementing process was linked to the Economic Recovery Strategy for Wealth and Employment Generation

[32] Daily Nation Nairobi: March 24, 2003

(2003-2007) and the Kenya Government Budgetary Cycle. This would enable ministries to budget and allocate resources to HIV/AIDS programmes. The entire strategic plan would cost the government Ksh 45 billon by 2010 with much of the funds expected from the donors.

At this time, the president also launched a campaign dubbed, "Total War Against HIV/AIDS". In this campaign, the religious institutions were incorporated. However, immediately the Catholic Church renewed its opposition to the use of condoms. The church stressed that chastity was the only way to prevent the spread of HIV/AIDS.

Despite enormous political will to fight HIV/AIDS, there were still a number of hiccups. First, the controversy on which ministry should NACC be under, continued (Ogot, 2004). Second, failure to translate formulated policies into action; and third corruption and misuse of funds meant for intervention programmes. For example, 49 per cent of all funds were being used for administration, 39 per cent on staff and only 6 per cent on advocacy[33]. These hiccups were also noted by a study commissioned by UNAIDS titled, "Measuring the Levels of Efforts in the National and International Response to HIV/AIDS: the AIDS Programme Effort Index". The findings of this study were released during the International Community for AIDS in Africa (ICASA) meeting in Nairobi in September, 2003.

In 2006, the government enacted HIV and AIDS prevention and control bill 2006[34] as further efforts of HIV/AIDS intervention. The aim of the bill is to protect from discrimination any person infected or suspected to be infected from HIV/AIDS, protect their human rights and liberties. The bill also aims to promote public awareness of HIV/AIDS especially about the causes, modes of transmission, consequences, and means of prevention. In addressing harmful related HIV behaviour, the bill criminalizes wilful transmission of HIV.

[33] Daily Nation Nairobi: July 2, 2003

[34] National Council for law reporting (2006): HIV and AIDS prevention and control Act 14 of 2006. Available at www.kenyalaw.org: Accessed on September 14, 2009.

Although the bill is good in deterring wilful/deliberate transmission of HIV/AIDS[35], its implementation is difficult. First, there is a problem of proving deliberate infection/ transmission especially where medical records do not exist as required by the bill. This predicament has been experienced by HIV/AIDS by governments of South Africa, Nigeria and Namibia which tried to criminalize wilful transmission of HIV. Second, HIV/AIDS is mostly spread by behaviour which is not criminal. This makes HIV/AIDS transmission more of a public health than a criminal issue. Third, the bill emphasizes consent between individuals to ensure the people in question have agreed to become intimate and are aware of each other's HIV status. This emphasis does not take into account the various contexts which sex take place. In short, whereby legislation approach to HIV/AIDS prevention is essential as there are situations that require law like individual's right to decide with whom and when to have sex, it is important to deal with deliberate transmission as socio-cultural and economic issue.

Conclusion

The chapter reviews the development of government's policy on HIV/AIDS since 1984 when it was officially reported up to now. Initial government response (from 1984-1990) was denial, lukewarm, drift and slow due to fear over loss of investment and tourism which were key to the economy. The policy response by the government at this time was to set up NAC (1985), NASCOP (1992) and NACC (1999), all which developed strategic plans albeit little implementation on the ground. The policy response at this period was ineffective because of pervasive corruption in the government and poor government-donor relationship which affected funding most of intervention strategies of HIV/AIDS. However, starting 2003 when the new government took over power, responding to HIV/AIDS was identified as a top priority for the country and more concrete and coordinated strategies were put place to mitigate the impact of the disease. Also there was great improvement on government-donor relationship which led to substantial funding of HIV/AIDS response activities.

[35] Wilful / deliberate transmission of HIV/AIDS is also dealt with in sexual offence Act No 3 of 2006 see National Council for law reporting (2007): Sexual Offence Act No 3 of 2000. Available at www.kenyalaw.org : Accessed on September 14 2009.

The government policies for a long time were not linked to research. From 1984-1990 for example, most strategies for the fight against HIV/AIDS were based on evidence. The Five Year Strategic Plan launched in 1987 by NACP emphasized awareness and prevention as key to mitigating the impact of HIV/AIDS. This plan also identified four priority areas: sexual transmission, blood transmission, mother to child transmission and disease surveillance. The second Five Year Strategic Plan Of 1992 also reinforced this and included the need to broaden the HIV/AIDS response. On the other hand, the government through the Ministry of Health was producing various policy documents that highlighted the background to the disease, its impact, interventions and policies.

However, from 1993 especially after the release of a report on the impact of HIV/AIDS (Government of Kenya, 1993a), the government started taking the disease as a serious development issue. As a result, a whole chapter on HIV/AIDS was included in the seventh National Development Plan. This was also followed by passing in parliament Sessional Paper No. 4 on HIV/AIDS in Kenya. All these provided a policy framework within which HIV/AIDS intervention activities would be carried out and marked the first time HIV/AIDS policy had been linked to research.

The fight against HIV/AIDS in Kenya has been spearheaded by local and international NGOs due to initial government response policy. Consequently, most prevention, treatment, care and support activities have been implemented by these NGOs. However, there are a number of issues which indicate that these actors have a challenge of linking research and policy on HIV/AIDS. First, there are many NGOs which are dealing with HIV/AIDS programmes. However, many of them are not genuine in their functions as some are established as conduits of accessing donor/government funds on HIV/AIDS. This has created a problem of coordination in the fight against this disease. Secondly, although most religious organizations have joined the fight against HIV/AIDS, many have refused to endorse condoms. They also have divergent opinions on the issue on sex education for young people.

In summary, there has been steady development of government policy on HIV/AIDS. With these policies, there have been great improvement in HIV/AIDS intervention approaches which

has led to decline in prevalence in many parts of the country. However, most critically, the chapter underscores HIV/AIDS intervention policies are affected by prevailing social, cultural, economic and political factors. These factors create diverse meanings which in turn influence individuals' behavioural responses to these policies.

CHAPTER THREE

GUSII: THE LAND, ITS PEOPLE AND SOCIAL SYSTEM

Introduction

Abagusii occupy the three fertile agricultural districts of Kisii central, Nyamira and Gucha in Nyanza province. The area they occupy is collectively known as Gusii or Gusii highlands and the language spoken by them, Ekegusii, is part of the larger linguistically related Bantu cluster of languages. The people who occupy the land, Abagusii are patrilineal and patriarchal delivering their name from that area. Literally, Abagusii means "of Gusii" or "belong to Gusii." They collectively refer themselves as "Omogusii" Mogusii, being their father of all Abagusii. Along with the Luhya, Samia and the Kuria, Abagusii belong to Kenya's Western Bantu cluster.

This chapter provides a background material on the Gusii and the land in which they live. In specific, the chapter discusses the geo-climatic factors of Gusiiland, Abagusii oral history and lineage system, their social organization, gender and sexuality and the concept of illness. In discussing these aspects, I critically examine how various values and knowledge espoused by them influences individuals' sexual behaviour and prevention of illness. Finally, the chapter discusses the advantages and challenges of doing native ethnography as an insider.

Geo-Climatic Factors

Gusii covers an area of approximately 2,196 square kilometres (km) and is situated between longitude 35 30' and latitude 0 30' south. Administratively, Gusii land currently forms part of Nyanza province. It is made up of Nyamira, Kisii and Gucha districts. It borders Kericho district on the north, Bureti and Bomet districts in the east and Trans-Mara district in the south, all within the expansive of Rift Valley. In Nyanza province, Gusii land borders with Rachuonyo and Homabay districts in the west and Migori district in the southwest.

The land is relatively hilly, and the terrain rises in the southern direction to altitude of 7,000 feet and slopes westwards (in the direction of Lake Victoria) reaching an altitude of 4,500 feet at the lowest. The high altitude has a great influence on the annual mean temperature. In the North West, the annual mean temperature is 14 ^{0}C and 18 ^{0}C. On the east, where the altitude is higher,

the mean annual temperature range between 26 ^{0} C and 30 ^{0} C On the west the maximum mean temperature ranges between 26 and 30 ^{0} C. On the eastern sides the temperature ranges between 22 and 26 ^{0}C (Akama and Kandenyi, 2006).

The most prominent rivers that drain Gusii land are Gucha and the Sondu with their several tributaries and streamlets. The Gucha originates in North Mugirango and traverses Kitutu, Nyaribari, Bobasi, Machoge, and south Mugirango locations onwards to Migori District in South Nyanza where it drains into Lake Victoria. The Sondu starts from Borabu/Sotik area, and flows in the northern part of Gusii land, along the boundary with Kericho district. The river enters Nyamache in Kisumu district before draining to Lake Victoria. Gusii land also possesses many swamps in the valley bottom such as Sironga, Riamoni, Nyanturago and Chirichiro. Most of these riparian landforms are situated within Keroka erosional surface that is composed of Pleistocene rock deposits. These formations include black clay, alluvium and silt clay soils that have been eroded from the highlands (Akama and Kandenyi, 2006).

The climatic condition of Gusii is highland equatorial with a modal rainfall distribution. The rainfall distribution is influenced by the Intertropical Convergence Zones (ITCZ). March to June constitutes the long rains seasons while October to December the short rains seasons. Rainfall exceeds 1,500mm per year and is capable to support diverse agricultural activities and animal husbandry.

Relief, drainage and existing rock formation have thus influenced the soil formation in Gusii land. The high altitude areas in the east have dark humic alluvium soil, whereas the low-lying areas in the west consist mainly of mixture of light coloured humic clay soil. On the whole, Gusii land has extremely fertile soils that are suitable for various agricultural activities. In addition, the climatic conditions are ideal for the growing of diverse crops (Akama and Kandenyi, 2006).

The vegetation of Gusii land is mainly influenced by the rainfall distribution and the area's physiography. Prior to the settlement of Gusii people in the early nineteenth century, most of the vegetation of this region was moist montane forest (Ojany and Ogendo, 1988). By the beginning of the twentieth century; however, the intense clearing of the forest to make room for human

settlement and agricultural production had converted most of Gusii land to open Savannah woodlands characterized by small scattered trees and tall grass. The grass type found in this area is kikuyu and star grass.

The kikuyu grass is mainly found in areas with altitude 6,000 ft and above in the east, whereas the star grass is mostly found in areas in lower-lying areas in the west. This vegetation pattern distinguishes the main ecological zones of Gusii land. As Maxon (2003) puts it, the two ecological zones have, on the whole, provided Gusii land with favourable opportunities for the development of diversified and productive agrarian economy.

It is important to note that the ecological differences in the two zones have, over the years, been recognized by the Gusii people who refer to the lower ecological zone in the west as *Chache*, and the higher ecological zone in the east as *Masaba.* Following these ecological differences, land use pattern and population distribution differences have also characterized these zones. For example in Chache, there is high population density as compared to Masaba.

Abagusii Migration and Lineage System

The Gusii oral tradition has it that they originated from a mystical place called "Misri" (Akama, 2006a). They moved from this place (Misri) which is in the North-westerly direction from the present day Gusii land, over eight hundred years ago taking an easterly direction. They settled first near Mount Elgon region in western Uganda. At this time, the Gusii belonged to one family with the Kuria, Luhya, Meru, Kikuyu and Kamba ethnic communities whom the Gusii fondly refer to as "*abanto bamito*" (our people). Interestingly, existing mythology among other Kenyan Bantu communities trace their origin to this mystical site "Misri".

Though most Bantu mythologies trace their origin to Misri, the exact spatial location of this place is not known. One school of thought contends that Misri is the same place as the biblical Egypt in North Africa. However, this appears to be unlikely as there is no collaborative linguistic, archaeological or ethnographical evidence to support this theory (Akama, 2006a). Consequently, it can be argued that although, in all likelihood, this mystical place did indeed

exist, there is no collaborative evidence to support the theory that it is the same place as contemporary Egypt.

From Mount Elgon, the Gusii moved and settled in Kisumu in the middle 16th Century (Akama, 2006a). This place was characterized by unreliable rainfall distribution and unfavourable environmental conditions for growing subsistence crops and animal husbandly. For instance, at this time, this place was hit with severe drought which led to death of large numbers of livestock and extensive crop failure.

Due to this calamity, their stay in Kisumu was short-lived. They moved southerly and settled in the Kano plains. According to Gusii folk history; however, families that eventually settled at Kano plains were initially on hunting expeditions in search of wild animals and fish. Gusii mythology goes further to state that these families were led by people who were highly experienced hunters. During this period (over 300 years ago), it should be noted that Kano plains are said to have been a park-like country that was made up of tall Savannah grassland and acacia trees. These provided a humble habitat for wild animals like gazelles, buffalos and wildebeests.

At the Kano plains, the Gusii came into contact with Luos. Because of pressure on sustenance resources, inter-clan rivalry and inter- ethnic conflicts between Gusii and Luo, it forced the Gusii out of Kano plains. The Gusii predicament at Kano plains was aggravated by the nocturnal raids from the Maasai which was driven by the cultural belief that all cattle wherever they are belonged to them. Due to this, the Maasai staged nocturnal raids, surrounding whole Gusii villages, burning down houses and killing people as they took away the Gusii's cattle (Akama, 2006a).

Akama (2006 a), further postulates that another "push factor" that must have forced Gusii out of Kano plains was the fear of being sandwiched by two dominant non- Bantu communities that is the Maasai and the Luo. In this case, there was eminent danger of socio-economic annihilation and cultural assimilation. For example, the nocturnal attacks by the Maasai were affecting the Gusii's way of life whereas their Luo neighbours, who were numerically superior, were increasingly impacting on their culture and lifestyle. This realization among Gusii people over

the bearing influence of the Luo culture coupled with incessant urge for self-preservation can be postulated as another factor which added their urgency to move out of Kano plains.

Due to these odds against them as a community, various members of the Gusii clans decided to move to high altitude areas of Manga. They moved together as a distinct family unit because of security reasons and were led by distinguished family patriarchal who provided leadership. The first Gusii group to move from Kano plains consisted of members of Abagirango clan and settled at North Mugirango. The Abagirango were followed by members of Abasweta clan who moved past North Mugirango and settled in central parts of Manga. Later, some Sweta families, consisting of the Abasiango and Abasigisa lineage, moved further south to Tabaka plateau in the current Gucha district. Unfortunately, while in Tabaka, they were again discovered by Maasai who started raiding their villages. As a consequence, they made a hasty retreat and eventually settled in south Manga.

At Manga, the Gusii started to experience increased population pressure relative to available resources. As a consequence, several segments of Gusii started dispersing to adjacent virgin habitats in search for a new place to settle. Particularly, several Gusii families moved from Manga and settled in Kipkelion area along the present Bomet/Kericho border.

Due to unforeseeable circumstances, the Gusii settlement at Kipkelion area did not last long. First, the Gusii found the place to be extremely cold and was not thus suitable for human habitation and growing of their staple food crops (finger millet). Consequently, soon there was persistent crop failure leading to severe famine and starvation. Second, the area appeared to be disease prone, as many people were affected by weather elements and started to die from pneumonia and other related respiratory ailments. Lastly, the arrival of Kipsigis raiders in Kipkelion forced the Gusii to move out of Kipkelion. This chain of calamities led the Gusii people to naming this place *"Kabianga"*, which literally translates to "to a place where everything refused".

As a result of this chain of calamities, various Gusii families started to retreat from Kabianga area, most of them taking a southerly direction and eventually settling at in the present Trans-

Mara district, a place called Nyangarora. However, some Gusii families, mainly from Tabori, Gusero and Basi clans, decided to remain in Letein-Sotik area, and they were eventually assimilated into predominant Kipsigis culture.

Soon after their settlement in Transmara; however, the Gusii started experiencing Maasai raids. Though the Gusii tried to protect themselves from Maasai raids by fighting back, they were overpowered when their military leader Ngararo was felled down by Maasai raiders. This forced the Gusii to make a hasty retreat from Trans-Mara, retracing their way back to their original settlement in Manga escarpments. From this area the Gusii continued to expand, covering all present Gusii district.

The Gusii lineage system followed patrilineal principles that entailed tracing one's descent in the male side. Once a woman was married and the requisite customary marriage rites performed, she was supposed to transfer her allegiance to the husband's lineage, *Egesaku*. In this lineage system, the basic social organization was the homestead that was headed by a family patriarch, *Omogaka bwomochie*. An ideal Gusii homestead consisted of the family patriarch, his wives, his married sons and the other unmarried children in the family. The homestead formed the basis of the Gusii lineage ties that extended to sub-clan and clan level and, eventually encompassed the whole Gusii community. Consequently, the Gusii people traced their lineage starting from the homestead, sub-clan, clan, and eventually extending to the broader Gusii community.

A Gusii homestead formed a distinct self-sustaining socio-political and economic entity that generated its own sustenance resources and carried out most of its socio-economic activities independently. In the homestead, the wife and her children could cultivate specific pieces of land that were adjacent to the homestead. In most instances, by clearing and cultivating the land, the wife and her children (sons) established a legal claim of ownership over that piece of land. The family also owned cattle; and usually the male members of the homestead claimed legal ownership of these cattle. The cattle were highly valued in the whole Gusii community as a source of bride wealth, and symbols of family wealth and prestige.

All the children of the same father, whether coming from different wives, considered one another as belonging to the same family and; treated each other as such. Although at face value there always appeared to be a semblance of social and economic harmony in the homestead, in most polygamous families, there were always of petty incidents of jealousy and rivalry between the sons of different wives. These were commensurate to the available family resources (land and cattle) and the ability of the family patriarch to maintain social harmony and tranquillity in his homestead.

The head of the homestead was also in charge of and ensured family obedience and observance of various Gusii customs, norms, traditions and religious rituals. Consequently, by virtue of his role and functions, a family patriarch commanded immense respect and authority that was commensurate to his social status and control of family resources.

After the homestead, the next level of the kinship lineage chain consisted of people who traced their descent to the same grandfather. The descendants of the same grandfather formed a social unit that was referred to as *Riiga.* However, in terms of socio-political functions and economic activities, *Riiga* did not play any significant role. It was a combination of all the homesteads belonging to other related *Riiga* groups that formed the second most significant socio-economic and political grouping of the Gusii people, the clan. Consequently, after the clan level there was no other form of political and administrative structure that bound the various Gusii clans together.

The Gusii clans acted as self-contained independent units. Beyond the clan level what made the Gusii people perceive each other as a distinct cultural and social entity was their similar language, culture and the various social practices. Furthermore, although each Gusii clan was autonomous, the people recognized the important historical factor that they had a common patrilineal founder called *Mogusii.*

Social Organization

Access to property

As a community, the Abagusii consist of seven contiguous, but politically autonomous groups/clans. These groups/clans are Abagirango (North and South Mugirango), Abagetutu, Abanyaribari, Abanchari, Ababasi and Abamachoge. All these Gusii clans identify themselves with four totems. Gusii oral literature has it that the use of totems as a means of identification of people who belonged to the same ancestry started in Kano plains during hunting expeditions. Since then, all main Gusii clans used their respective totem names as a sign of veneration and respect to their ancestors, community and spiritual well being. Thus, the clan totems are perceived as harbingers of good omen and prosperity (Akama, 2006b).

According to Nyamongo (1998), Abagirango relate to *Engo* (Leopard), Abasweta who consist of Abagetutu, Abanyaribari and Abamachoge relate to *Engoge* (Baboon), Ababasi relate to *Echage* (Zebra) and lastly Abachari relate to *Engubo* (Hippotamus). Each of these clans performed its affairs independent of the other clans. Within the clan, members were responsible for clan welfare under guidance of clan elders. Aggression in each group; however, was dealt with within the group.

The indigenous political and social organization was contained within a segmentary lineage system. Traditionally, the Gusii were an egalitarian society and therefore the society was not stratified either by rank or by wealth and the age organization was rudimentary. Descent provided the main political framework and descent groups were the basis of territorial organization. The Gusii had a hierarchy of segmentary descent groups' right from tribe (Abagusii) down to the nuclear family, consisting of one man with his sons. All order of lineage has patrilineal descent as their mode of recruitment which refers to an eponymous ancestor, the ultimate of these being *Mogusii.* Clusters of patrilineal clans lived in clan villages. Clans and lineages were politically significant in that they provided a framework for territorial organization.

Membership to a particular clan gave an individual access to land. This is because social institutions at the clan level determined ownership and access to land. Land belonged to the clan

and, the specific boundaries were usually set-up separating the land controlled by the various Gusii clans. The clan land was further subdivided into portions of family land. Under this customary land tenure system, each Gusii family had exclusive rights to occupation and use of the land that the family holds. The rights to land passed by an inheritable process from father to son. Consequently, all rights concerning land ownership and its usage derived from clan membership by way of inheritance. No individual, even if he was a member of the clan was to use a free hold land *"omogondo"* that belonged to another family for cultivation without express permission from the holder (Masese, 2006a).

Hence, control over land among the Gusii, usually ended at the family level, and never proceeded to specific individuals in a family. This was because, in accordance with the Gusii customary land tenure system, the individual family members had a right of access to and/or the use of family land. However, no member had right of allocation and disposal of the land. An individual in the Gusii community was not supposed to be separated from his lineage especially when referring to proprietary rights pertaining to land ownership. Consequently, each individual's property collectively belonged to his family *(enyomba)*. The "house concept" was firmly engrained in the Gusii psyche that the rights of each individual family member within a specific homestead was mainly determined by birth and was unalienable.

The land allocated to each family member in a homestead belonged to the family patriarch or father who was the custodian and head of the family. The father later allocated his land to different "houses" of his family through the wives, as the Gusii was a potentially polygamous community[36]. Gusii property rights can thus be reduced to the formula; *"from father but through the mother"*[37], meaning that all land allocated to one family belongs to the father as its authority and passes to the different houses of the family through the wives.

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[36] Abagusii practice polygamy although this practice has reduced considerably over years (Le vine, 1966). This reduction is due, first, economic changes all over Kenya accompanied with population pressure on land and shrinking opportunities to earn money off farm has made polygamy unattractive. Second, the relationship between polygamy and political influence/leadership has totally declined. In this case any one regardless of marriage union type can lead.

[37] Hakansson N (1994) calls this as house property principle, that is each wife and children constitute a house which according to customary law, is jurally and economically independent in relation to other houses in the polygamous family.

A Gusii polygamous man was obligated to subdivide his piece of land according to the number of wives he had. Gusii traditions demanded that the first or senior wife had to get a bigger portion than the rest. This was so because in most cases men married additional wives using the bride wealth obtained from the marriages of the daughters of the first wife. In a way, additional wives were treated as "children" of the senior wife. In most cases their pieces of land were of the size as those of the sons of the senior wife. However, first wives were generally entitled to the largest share of land even if additional wives were married using bride wealth from other sources other than the first wife's daughter(s).

In subdividing the family land among his wives, the head of the family had the right of keeping a portion of the land for personal use. This reserved land was called *emonga.* The purpose of *emonga* was to act as a reservoir of food production for the husband's use in cases of famine (Omosa, 1998). Usually, *emonga* was given to the youngest wife besides her land to cultivate on behalf of the husband. This was because the husband spent most of his time in her house. In some cases, men managed their *emonga* using the whole family labour. At the husband's death, *emonga* was equitably subdivided among all his wives.

Family life among the Abagusii was organized along patriarchal lines. Access to property was through male lineage because males stayed within the family unlike females who moved away after marriage. This was done to ensure family property exclusively remained for the family. Consequently, women never inherited any property at their parents' clan. A woman's right to property or land was realized through marriage. She had automatic access to her husband's land. When the husband died, the wife remained the trustee of his land that came to be inherited by her sons. If the sons were minors at the time of her widowhood, she could hold property in trust for them but had herself to be inherited by a close relative of the husband, in most cases a brother or cousin. The latter; however, did not inherit the property of the deceased. Property went to the deceased's sons, including those born out of the new relationship between the widow and the man who inherited her.

Women who had no sons to inherit land were allowed by tradition to "marry" a surrogate wife and chose a mate for her. The woman's "husband" remained the custodian of the children born

out of this arrangement. Thus, the purpose of the woman-to-woman marriage practice was to ensure that family property bestowed to each woman "house" especially in polygamous marriage remained there and for the continuity of lineage. In this regard, it can be argued that the passion of a son by a Gusii wife was more to do with resource control, security and continuity of her lineage (Masese, 2006a).

Inheritance of land by adult young men from their fathers depended on marriage, a sign of having entered adulthood. The size of inheritance was dependent on the father endowment and subsequently on the number of male children to an individual wife and the position of the adult male in the family. For instance, elder sons and last-born sons were allocated a larger share of land than other sons. The rationale for giving the elder and last born sons more land was because among the Abagusii the elder son was regarded as "a father" to other siblings and therefore had more responsibilities like solving family disputes on behalf of the father. The last born son was supposed to take care of the parents during their lifetime.

This social system of accessing community resources influenced women sexuality in two ways. First, women had to depend on men to access resources. The only means of doing so was through marriage which in essence made men to control female sexuality. Second, despite the fact that family resources were governed by house property principle, where women played a critical role, their access to family resources depended on the sons. This means the security of woman to family resources entirely depended on sons. Consequently, the reproductive system of a woman is governed and determined by men as it will also be in this thesis.

The land tenure system; however, has undergone a number of changes. Omosa (1998) notes that since 1940s, due to high population growth, introduction of cash crop economy and colonial government policies, the traditional land system (which was communal) has changed into private land tenure. Like in the traditional land system, this new land system still continues to put women on the periphery as they must depend on men to access the land resource, in spite of a

number of changes in terms of legislation which have come up with the sole aim of empowering women with rights of accessing it[38].

As an agrarian community, any group which controls land policy and its ownership has power to control its use, allocation and most importantly appropriation of social values. Given the fact that land in most rural communities like Abagusii is the only tangible asset, men will continue to perpetuate their values over women. Most of these values which are ingrained in masculinity may have consequences for both women and men on issues of sexuality and risk taking. Hakasson (1994) observes that access to land resource has made many Gusii young women to elope with young men as strategy to gain access to this resource. Given that these unions are not stable or lack security, young women are vulnerable to question their lovers' sexual behaviour. On the other hand, the power of access to resources which young men posses gives them a gateway to have many sexual relationships as they have a superior position with relation to women.

Circumcision

Abagusii practice various initiation ceremonies or rite of passage that marked the transition from childhood to adulthood. Through these rites of passage, an individual earns his/her social identity and a sense of belonging to the community. This identity is important because certain social roles perceived vital in the society like starting a family require an individual to possess certain specific identity as a qualification. And once the qualification has been obtained, the individual is compelled by a set of social sanctions to perform these roles (Monyenye, 2006).

However, many of the cultural values and social meaning of these initiation rites are undergoing drastic change due to the influences of globalization, modernity and Christianity. Despite this, most rural communities like Gusii continue practicing these rites of passage for both girls and boys but now blended with modernity and Christianity[39].

[38] In the 2005 constitutional referendum in Kenya one of the contentious issues was women accessibility to land (women inheriting land from their parents). Most people were against this clause in the draft constitution. The draft constitution was rejected due to this issue of women land inheritance among other reasons.

[39] Circumcision of both boys and girls has been medicalized (done by professional health workers in medical institutions instead of traditional circumcisers). Most of the traditional circumcision rituals have been replaced by

In this community, the most important rite of passage is circumcision for boys and clitoridectomy for girls. During this rite of passage, an individual receives concrete education and training on various aspects pertaining to human sexuality and the various gender specific roles and responsibilities that accompanies the consummation of sex including conception, pregnancy, child bearing and rearing (Monyenye *et al.,* 2006). Through this rite of passage, an individual then receives the status of adulthood and he /she is allowed to take adult responsibilities and duties.

To understand how these rites (circumcision) prepared an individual's identity, status and influence his/ her sexual behaviour, I will discuss the various rituals and activities involved in this rite and their significance to an individual behaviour. By doing so, I will also try to link them to an individual's identity formation and future behaviour. This is important because many studies on why HIV/AIDS prevention strategies have failed have often cited gender and identity as one of the major reasons in Sub Saharan Africa (Baylies, 2000; Wilton, 1997; Blanc, 2001; Campbell *et al.,* 2001). Besides this, recent medical strategies for HIV/AIDS prevention have cited male circumcision as one of the methods of curbing the spread of the disease.

Among the Abagusii, it was a requirement that a boy who wanted to be circumcised will personally show explicit desire and willingness to undergo the rite by voluntarily requesting the parents. This was meant to indicate that the young boy has reached a stage where he can make decisions on his own - a sign of adulthood. Once the parents received such request and consented to it, their first task was to look for "*Omosegi*" (sponsor, tutor) for their son.

Omosegi was normally an old boy who is already circumcised but unmarried. His role was to assist the initiate during initiation period and after. He was also supposed to inculcate various virtues, values, rules and norms associated with adulthood. Given his important role, *Omosegi* was to be a boy who has undergone all initiation rites, unmarried with exemplary character and not exercising restrained behaviour *"Chinsoni"* when interacting with the initiate. The

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Christianity rituals for example traditional songs which were sung for initiates have been replaced by Christian songs.

relationship between the initiate and *Omosegi* was supposed to be intimate, free from any restraints and was to last for a lifetime.

In the case of girls, their willingness or consent to undergo circumcision (clitoridectomy) was not required. It was purely the decision of the parents. It was obligatory that a girl should be circumcised before reaching puberty and/or before she starts having menstruation. Thus the appearance of physical signs of puberty, such as the enlargement of the breasts prompted the parents to have the girl circumcised. In this case, a girl was not supposed to be a decision maker as in the case of boys; she was supposed to be guarded and dependant on issues touching her womanhood – a virtue which was supposed to stay for a lifetime.

On the circumcision day, male initiates were subjected to ordeals which were meant to taste their endurance and create a sense of toughness which was a requisite attribute in manhood. This treatment continued during the entire seclusion period. Girls never underwent these ordeals but just encouraged to be "woman enough" and undergo the rite.

On circumcision procedure, male initiates were usually circumcised under a ritualistic tree away from the homesteads. An individual initiate would be made to stand his back to the tree, his arms grasping the trunk, his legs bent at the knee and held apart and does not look at the traditional circumciser. As the traditional circumciser cuts the foreskin, the initiate was not supposed to show any sign of emotion. The operation lasted about a half a minute. After this, the initiate is given a traditional grass "*ekerundu*"(Malva verticillata) -a common symbol of fertility- to hold in one hand as he holds the penis horizontally by the other hand waiting for the blood to clot (Monyenye, 2006).

The girls were circumcised within the homestead and not in a ritualistic tree. They were circumcised while seated on a small manger or stone that was referred to as *Orotuba.* While seated on the manger, the girl was supported from behind in most cases by her own mother. The girl's back was supposed to rest on the chest of the supporter as the traditional circumciser performed the operation. Emphasis on the initiate's emotions was not important as women were

supposed to show their emotions. Like boys, the female initiates were given "*ekerundu*" (Malva verticillata).

These differences on circumcision procedures between boys and girls were symbolic. By being made to stand alone and not to show any sign of emotions during the operation, the male initiate was meant to be self-reliant, independent and tough. On the other hand, by sitting down and supported by the mother during the operation, the girl was not meant to be self-reliant. Her life would continue to be managed by her mother until she was married. After that, in marriage she would be under the custody of her husband taking all instructions from him. These expectations are further demonstrated even after the operations. Girls are secluded in the mother's house; while boys are secluded faraway from the parents in a special hut "*Esaiga*" until they undergo all initiation rituals and heal (LeVine and LeVine, 1966).

The circumcision ceremony was meant to bestow upon the initiates the status of an adult. However, a girl was never considered an adult until she was married. She was to remain in the custody of the parents and never to take any independent decision in anything before consulting them, especially the mother. But a boy, once initiated, lived in a separate house from that of his parents. He was expected to behave independently like any adult, no control by the parents (Monyenye, 2006).

The different roles for both girls and boys were to take after circumcision were articulated by circumcision songs *"chisimbore(pl)."* Boys' song (**Appendix 1**) emphasized manliness, toughness and change of status. He was expected to defend his community and home, and be a provider to his family "*Omosancha*" (literally meaning one who looks or provides). Girls' song (**Appendix 2**) on the other hand emphasized tenderness, respect to her future husband, be a good keeper of family resource "*omokungu*" and be married to avoid bringing disgrace to the family. In the circumcision songs for girls and boys, values of "*omosancha*" and "*omokungu*" were emphasized. As *Omosancha* a boy must learn to provide for his family for his reputation depended on it. He should not allow himself to be provided by the wife in any circumstance and above all he must be tough, not lorded by the female folk and be the sole decision maker in the family. *Omokungu* was supposed to be loving and caring, eager to meet the future husband's

needs (her success was pegged on how well she makes her husband happy and emotionally satisfied) and she must diligently take care of whatever resource the husband had. In short, the values of masculinity and femininity were instilled during this rite of passage.

To instil the values of *Omosancha* and *Omokungu* to initiates, circumcision rites were characterized by many ordeals. The importance of initiation ordeals can be better appreciated by using two socio-cultural principles, namely: the principle of death accompanied by rebirth and principle of establishing covenant.

In the principle of death and rebirth, it was a recognized fact that an initiate before circumcision rite was not fit to join the adult world. To do so, the pre-circumcised personality must be dismantled and a new one constructed. For this to happen, death of the former personality must happen. The only way for this to happen, pain must be used. Furthermore, death is mostly associated with pain. When the old status has been dismantled through death, a new status/personality was reconstructed during the seclusion period. In seclusion, the initiates were taught the various dos and don'ts of the new status – adulthood. After seclusion, the initiates are reborn into a new status. By subjecting the initiates to ordeals, it was assumed that it will make them value the new status because they endured a lot to achieve it.

The concept of death and rebirth is further signified by the surgical operation involved. The Abagusii believed that for death and rebirth to occur, the organs that help generate life must first be destroyed. Since the genitals are used as a means of perpetuating life, they should be the target of attack if complete destruction and death is to be achieved. Circumcision of boys and girls were then viewed as a way of bringing about this momentous death and the resurrection of the organ in a new form (Monyenye, 2006). This is clearly expressed in circumcision songs *"esimbore."* For boys the song went like this; *"Samokami oirire 'mboro chiaitoX2" (*Circumciser has taken our penis).... *"Mboro chiaito indokore rwekonoireX2"* (Our penis are like a green tree with its park peeled off - a new and better one comes). The song for girls equally demonstrates this transition; *"Omokebi oirire ebisono biato"* (The circumciser has taken our clitoris)..... *"Orenge mokabaisia"* (She was the wife of the uncircumcised boys)..... *"Obeire mokabamura"*

(She is now the wife of the young men).... *"Abaraete egaita"* (She can now pass through the cattle pen gate).

The shedding of blood during circumcision was symbolic in that, like a covenant, it bounded the initiates to abide by the rules, norms and value of adulthood. To show their sincerity in abiding the requirements of adulthood, the initiate had to demonstrate it by taking a solemn oath by shedding their most precious property – blood. By shedding blood signified that the initiate is willing to follow the tribe's traditions; to defend the tribe and to serve it and live as per the expectations of the acquired status. The blood also acted as unifying factor between the initiates and the community. That is why the circumciser continued using only one knife during the operation for all the initiates without washing it. The idea was to let the blood of all the boys mix on that "holy ground", uniting them in a permanent bond[40].

Circumcision rite prepared initiates for marriage and procreation. Every circumcised person was supposed to get married and have children who will carry on the family lineage. This is why immediately after circumcision the initiate was given the traditional grass *"Ekerundu"* (a symbol of fertility) to hold on the hand. The importance of procreation and marriage was also signified before and after seclusion period especially for boys.

Before the male initiate was escorted to the seclusion hut *"Esaiga,"* tradition demanded that all members of his father's lineage would ritualistically sit between the cattle kraal and the main door leading to the mother's house. While they are sitting, the father of the initiate was required to carry a traditional calabash *"egesanda"* or a small pot *"egetono"* containing sour milk to signify the blessing of the initiate to beget many children and abundant cattle.

At the end of seclusion period also, the initiate was supposed to be led to the parents' house for the first time since he was circumcised to receive special blessings. The initiate's parents who are aware that their son is going to visit them, were required to lay on their sleeping bed either having sex or pretending to, ready to give their son the special blessings. While approaching the

[40] This aspect of using a common knife has been abandoned because of the real danger posed by the spread of HIV from sharing the same surgical knife to operate on all the initiates.

parents' house through the main door *"Egesieri kia bweri"* (the door facing the cattle kraal)[41], the initiate would announce his presence to the parents by uttering a standard statement requesting the parents to give him special blessings as follows *"Tata na Baba borania ango?"* (Literally translated, please father and mother talk with each other and give me blessings).

The father, who all this time was in bed with the mother supposedly having/or pretending having sex, retorted *"Ee mwana one borania chiombe na abanto"* (Yes, my child, have the blessings of having a lot of cattle and children). After the father finished giving his blessing to the son, it would then be the turn of the mother to follow suit and utter the same words of blessing after being requested by the son to do so. As already noted, the initiate was supposed to receive parental blessing while standing on the entrance of the main house that faced the direction of the cattle kraal. This implied that the blessings should, appropriately point to ownership of a large herd of cattle which was the ultimate wealth of a Gusii person. Also the blessing by the parents' and the act of having or pretending having sex, implied the ability to beget many children. Thus the son should look forward to marrying in the near future and eventually have a successful sex life and beget several children, just as his parents were doing.

The making of sacred fire as the initiate enters seclusion was also important in signifying procreation and sex life. Tendering of the sacred fire preoccupied the initiate and *Omosegi* (sponsor) throughout the seclusion period. The fire was not supposed to go off during the entire period of seclusion and if it happens, both the initiate and *omosegi* were to be met by supernatural punishment like not able to get children in adult life[42]. This therefore called for total cooperation between the two to at least safeguard their future fertility. Apart from the fertility notion associated with the fire, it also inculcated the virtue of cooperation in the life of an initiate which was essential for the survival of the community.

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[41] The door facing cattle kraal signified family lineage and wealth

[42] In one of the homesteads I visited during my fieldwork period, I found two young couples who have stayed together for six years without a child. They have never gone to hospital for medical check up on their fertility because each of them believes is reproductively okay. After visiting a traditional medicine man, they were told one of them had his/her circumcision sacred fire burn off during seclusion period. If not so, either of them passed through a house where an initiate was secluded and inhaled the last smoke of the sacred fire which had gone off-making him/her a victim. For them to regain their fertility, they were undergoing again the seclusion ritual of circumcision where the traditional sacred fire was made for them which they were to care for at least five day.

To understand the significance of this sacred fire on the initiate's sex life, I will explain how the fire was made and link it to the initiate's sex life. The sacred fire was made by rubbing a dried hardwood stick against grooved softwood that lay horizontally across the floor. Using both palms, the hardwood stick was vigorously rubbed against the grooved softwood stick until sparks of fire were produced. The sparks were hurriedly but carefully put together to make the sacred fire inside the seclusion hut of the initiate.

The hardwood stick which was rubbed vertically by both palms is known as "*ekerende egetwoni*" (male stick) and the one which lies horizontally on the floor and is soft and known as "*ekerende egekungu*" (female stick). The two sticks were conceived to be symbolizing a man and a woman. The act of rubbing the sticks together and consequent friction which cause heat is conceived as the act of coitus between the man and woman. The fire signified the birth of a child who is a product of sexual intercourse between the man and woman. The fire therefore symbolized the fertility of the initiate, which was to be guided and taken care of at all costs.

Sexual prowess among male initiates was highly emphasized. It was a standard mark of who is a real man. It was held by male folk that good sexual performance was the key ingredient for a successful relationship. Any male adult who was unable to satisfy his wife was to be disregarded. So, it was demeaning for any man when his sexual performance was questioned by a woman.

To test the initiates' sexual prowess, a party of young girls will be made to go in the hut where the initiates are secluded. This was done when the initiates have started healing. The young girls would enter the seclusion hut and start to "trouble the initiates" by arousing their sexual desire (*Ogosonia*). The girls would undress and dance in a provocative manner challenging the initiates to have sex with them if indeed they were men enough. The girls did this knowing very well that since the initiates have not fully healed they were vulnerable to have sex with them. The purpose of this was to test whether the initiates had the potential of experiencing normal sexual arousal (having a stiff erection of the penis), which is important in sustaining effective sexual intercourse for the purpose of procreation.

Apart from preparing initiates for sexual life, circumcision rites also prepared them for future economic activities which are essential for their well being. This virtue was inculcated to the initiate by the growing of "*Esuguta*" grass (Pennisetum catabasis) during the seclusion period. Immediately, the initiate starts her/his seclusion period, she/he was asked to plant *esuguta* within the seclusion house. The initiate was to ensure that the grass was well watered, remained ever green and is able to shoot up. This symbolized the good physical health for the initiate. But if it withers it was an indication of ill health. Therefore, the initiate was made to believe that his/ her physical health resembles that of *esuguta* grass. If he/she hoped to be physically healthy during seclusion and thereafter, he/she must tender the grass properly by watering it regularly.

The *esuguta* also symbolized another important aspect of the initiate's adult life. That is his/her physical health will be brought about by cultivation of crops. By being asked to tender the *esuguta* grass very well, the initiate is ritually introduced to adult responsibility/duty of growing crops. The initiate is made aware that his/her physical health and that of his/her family depend, among other things, on the successful growth of crops. The ritual song which the initiate sang while watering *esuguta* grass clearly demonstrates the concept of crop cultivation (LeVine and LeVine, 1966). The song explains how the tilling of land and growing of crops can enable a person to win friends, strangers and even unfriendly people. A person with plenty of food gets many people to visit him/her, thereby enhancing his/her good interpersonal relationship.

The values of circumcision were very important for initiates as they entered adult life. All the teachings they got were supposed to guide them in all their life. The initiates were never expected to regress to their childhood behaviour. To ensure this, initiates especially the male were not allowed to interact freely with uninitiated boys. The initiates were firmly instructed to shoot the uninitiated boys with their blunt arrows whenever they find them. This was to create fear among the uninitiated boys thus reinforcing the social distance with the initiate. Throughout the seclusion period, the male initiate was made to live a life totally different from that he lived prior to circumcision. He was to learn to be self-reliant and independent.

On the other hand, girls were not trained by circumcision rites to be self-reliant and independent. During seclusion, the girls were under the custodian of their mothers who trained them on their

future married life. To achieve this, the mothers assigned the initiated girls many duties they were expected to perform in their houses after marriage. Initiation for girls; therefore, prepared them for marriage and the sexual adult life. That is why all the ceremonies during the entire seclusion period were mostly characterized by sex education. It can therefore be concluded that, while the boys' initiation ceremonies emphasize education for bravery, leadership, independence and self-reliance, those for girls' aimed at giving detailed sex education meant to prepare them for marriage.

Circumcision rites among the Abagusii has undergone various changes in response to various emerging contexts. According Gwako (1992) and Rianga (2007) the age of circumcision has drastically reduced from 10-13 for girls in the nineteenth century to 6-8 years in the late 20th century. This reduction is in response to the declining age of maturity among girls. As noted earlier, girls were supposed to be circumcised before the onset of puberty or the start of menstruation. In the recent past, girls are maturing at a very young age prompting the change in circumcision age. The declining age of circumcision among girls has also been evidenced in communities which practice it like the Meru community in Kenya.

According to Thomas (2003), the declining age of female circumcision among the Meru was also linked to the onset of reproductive age of girls. Like the Abagusii, it was a taboo for a Meru uncircumcised girl to conceive. A child born by such girls was seen as a curse to the family and in most cases (the child was) killed at birth. Besides this, it was a rule that impregnating a girl attracted a fine from the man who did so to the parent of the girl; however, an uncircumcised girl was regarded as a "child" thus no compensation. This is further emphasized by the fact that no man will marry uncircumcised girl as it was regarded as a disgrace. In response to this, the age of circumcision for girls continued to depend on how the girls age of reproduction/ fertility changes in order to avoid a girl conceiving before undergoing circumcision.

The declining age of circumcision has its attendant consequences. Circumcision was meant to make an initiate acquire adult status, be independent and self-reliant especially among boys. However, with circumcision taking place at young age, the initiate just acquires "adult" status by the act of being circumcised but not with required values. This has two immediate effects; first,

young boys who have undergone circumcision would continue depending on their parent to meet their basic needs long after they have been circumcised *"adults with no responsibility"* and second, given circumcision bestows adult status, the parent will not have control over the boy's sexual life as they are prevented from doing so by the social restraint/avoidance behaviour "*chinsoni*" which is applicable between the two. The latter factor was found by Masita (2007), as a contributory factor to poor sexual monitoring between parents and male youths in one of the divisions of Gusii. In her study, poor sexual monitoring was a major cause of male youth's involvement in risky sexual behaviour.

One of the major functions of earlier western religious missionaries was to change what was considered primitive practices which were seen as "ungodly". Most of the African practices were labelled primitive and thus were supposed to be discarded. Among the Abagusii, the protestant churches have been in the forefront in the campaign against those practices which are regarded as ungodly since their coming to Gusii in 1911 (Orvis, 1997). These campaigns especially on circumcision have not focused on discarding it as a whole but doing away with traditional rituals which were involved with it. In this case, these churches advocated the replacement of traditional rituals with Christian rituals. For example, instead of singing circumcision songs, Christian songs are sung.

In the recent years; however, there has been a lot of campaigns against these initiation rites especially from political elites, government officials and civil society concerning the usefulness of such practices in the modern world. Specifically, most of this campaign target female circumcision with most non-governmental organization (NGOs) calling it "Female Genital Mutilation" (FGM). This practice is attacked as a travesty of individual privacy, freedom and a violation of the basic tenets of human rights charter, promotes patriarchy, threatens women's health and deprives women sexual pleasure. Further, the educational value and sense of identity this practice bestowed to an individual is argued as not tenable in the modern world which is increasingly becoming a global village (Monyenye, 2006).

Consequently, since early 1990s, anti FGM eradication campaigns have been intensified. At the international level, various conferences were held with the sole objective of eradicating the

practice. These conferences were 1994 Cairo conference on population and development and 1995 Beijing conference on women (Thomas, 2003). The consequence of these conferences in Kenya was that many organizations came up in the fight against FGM with funding from international donors.

The first approach to the fight against FGM was based on the information/knowledge supply model. It was assumed that by empowering people with the harmful effect of FGM, they will discard it. At the time these anti-FGM campaigns were commencing, HIV/AIDS was a major problem in most parts of Kenya. As part of HIV/AIDS campaigns, FGM was also linked to the spread of HIV/AIDS. The consequence of this linkage came evidently when the government in 1996 wanted to pass a legislation banning FGM. The proponents of the ban in parliament argued that FGM spread HIV/AIDS through the use of unsterilized instruments. The opponent countered this linkage of FGM and HIV/AIDS by claiming that areas where the practice was prevalent had lower rates of HIV/AIDS. At the end of the debate, the legislation for the ban of FGM was defeated (Thomas, 2003).

Among the Abagusii as observed by Rianga (2007), the linkage of FGM and the spread of HIV/AIDS has led to the medicalization of "circumcision of girls."[43] Most parents as she found out took their young girls to medical institutions to undergo the rite. This is because of the social values accrued from circumcision like it makes the girl to be marriageable in future (most men in the community do not like marrying uncircumcised girls), gives the girls some dignity and respect as those who are not circumcised are despised for they are regarded as "kids". Similarly in the community, although male circumcision is neither prohibited nor condemned, it has also been medicalized due to HIV/AIDS.

In 1990s, it came to realization of most actors who were campaigning against FGM that knowledge/information alone was not a factor in the eradication of the practice. This forced them to start taking a more interventionist approach. One of the intervention strategies taken by many

[43] By using the term medicalization I refer to that act of carrying female circumcision rite using modern technologies which are associated with medical facilities/ institutions. Also by using the term "circumcision of girls" instead of "female genital mutilation" I am implying the social value of circumcision as per the people who practice it see the act of circumcision and not as "other outside" actors like civil societies, international bodies which are campaigning against the practice see it.

actors especially the Non-Governmental Organizations (NGOs) was the "*ritual without cutting*." Through this initiative, the national women's organization *Maendeleo ya Wanawake* started working with local community groups to organize a week-long "seclusion" during which girls of circumcision age were taught values of womanhood and family life skills, just like in the traditional female circumcision rituals. After the end of seclusion period, the girls were graduated in a colourful ceremony into adulthood by being conferred certificates.

This intervention approach was hailed by anti FGM actors as culturally sensitive. However, among the Abagusii, Rianga (2007) observed that even after the young girls have undergone the "ritual without cut rite" organized by NGOs, they soon after underwent circumcision. However, unlike in the past where it was a public/community issue, this time it is done very discreetly involving only close family members. As observed during my fieldwork "ritual without cut" was used by the parents of the young girls to protect themselves from any suspicion once they circumcise their girls as of 2001when the government banned the practice. As noted, immediately after the girls finished the "ritual without cut rite" they immediately proceeded to private medical clinics for the actual cut before coming home.

Another intervention came in form of government legislation. In 2001, the government introduced legal provision prohibiting "female circumcision" on those under the age of eighteen years. This provision was section 14 of the children Act. The Children Act aimed to bring the Kenyan law in accordance with 1989 United Nations Convention on the Rights of the Child prior to the President Moi's attendance at a U.N special session on Children, held in September 2001 (Thomas, 2003). The Act was hailed by anti-FGM activists that it would strengthen the fight against the practice. However, even after the passage of the Act, the practice is still alive in most communities which practice it. The only difference is that it has gone discreet and done in medical institutions.

The struggle to eradicate FGM by various actors and the persistence of the practice raises some fundamental questions regarding female sexuality. Who should control female sexuality? Who should be a beneficiary of female sexuality? Is the female agency passive in these struggles?

These questions are critical as it will be seen in this thesis in the prevention of HIV/AIDS especially among females.

Contrary to female circumcision, male circumcision is encouraged not because of its cultural value to an individual but its importance in reducing HIV/AIDS transmission. In this case, male circumcision has moved from cultural significance/meaning to realm of disease prevention. But the question is: can male circumcision be delinked from its social significance especially among the Abagusii young people and taken as a medical strategy from reducing HIV/AIDS transmission only? The best way to go about this question is by examining male circumcision in terms of content, methods and intentions from both socio-cultural point of the community practicing it and the biomedical point of view which see it as a strategy of HIV/AIDS prevention. The congruence of both perspectives will form the basis informing action towards HIV/AIDS.

Marriage

Clan membership also determines sexual relationship formation. Members of each distinct clan had high affinity with one another and a feeling of brotherhood and common destiny, perceiving one another as sister and brother. Therefore, it was a taboo for members of the same clan to intermarry. Consequently, marriage or sexual relationships were done between individuals of different clans (Akama, 2006c). This still stands to date although during my fieldwork in Bomariba village in Suneka, I was told of two cases of young men who have married from their own clan. These two cases were distasted by many people I interacted with. However, it is important to note that sexual relationship among Abagusii young people within the same clan is common today. Such relationships are tolerated as long as they do not lead to pregnancy and marriage as observed during my field study.

Marriage is highly valued and regarded in this community. It not only ensures continuity of the lineage but also provides an opportunity for young men and women to attain adulthood, to access family resources and identity (Shadle, 2006). The value of marriage is further demonstrated by Mayer (1975), "grey hair rule" which prohibited a woman from "acquiring grey hair" (growing old) at her parents' homestead. If such a woman died, she was buried away from the homestead as she is a disgrace to the family. Similarly, Shadle 2006, observation that it was a curse for the

family if a young circumcised man of marriageable age died without a wife. To prevent tragedy befalling the family, the bachelor was buried with a piece of wood by his side *korutwa omware* symbolizing a fulfilment of marital and reproductive goals that he had not attained. *Korutwa omarwe* was something which was feared because of the associated stigma to the family and even to the dead. Although this practice of *o'korutwa omware* is not practiced today due to influence of Christianity, dying a bachelor is still feared and stigmatized by all and sundry.

Marriage was established through payment of bride wealth. Payment of bridewealth was essential as it solemnized marriage and gave the man social paternity to all children the wife gives birth to irrespective of their biological paternity. Bride wealth enables a man to have total control over the wife's social life. For example, the man has the right to order her to perform tasks, decide when to have sexual intercourse and prevent her from using any contraceptives.

On the other hand, bride wealth gives the woman recognized status in her natal home thus enabling her to receive support in times of difficulty. As Hakansson (1994) notes; without bride wealth, women rights at her natal home are weak. Also bride wealth enabled a woman to get assimilated to the man's lineage as a wife and a mother. This assimilation is important as it accords the woman proper identity in the community. This is so because at her natal home, a woman is not recognized as a full member. Once married and bride wealth paid, she is identified with the husband's patrilineage - giving her a proper identity.

In marriage, children were very important. If a woman died without children, the widower could legitimately demand return of his entire bride wealth. Even in a woman's lifetime, her attribute as a successful wife was linked to bearing children (Shadle, 2006). Although all children were important for making a marriage a success, sons were mostly preferred. Sons were essential for a man's future as they preserved his memory and ensured status as a venerated and lineage founding ancestor and a source of social status among peers[44]. Women also attained their

[44] During my fieldwork I was told of a case where a brother killed his own brother for referring him as impotent. The killer had three daughters and the deceased had two sons and one daughter. By referring him as impotent he inferred that the brother is unable to procreate a son who will carry his lineage as all the daughters will one day get married and leave him alone as if he never had children. Through metaphors also some of my respondents were using underscored the importance of sons in marriage. For example, "has no eye" meaning he has no son. "They have no future" meaning their future is uncertain as there is no son to take care of them or inherent their resources.

security in marriage via their sons as demonstrated in these two Gusii sayings; *"esinyo ekoramwa bamura etabwati"* literally translated as the place which is despised is the one with no sons. *"Omorogi omwenenu no'oyore na abamura"* literally translated as a witch who is rude is the one with sons. Witchcraft was normally associated with women and was distasted. In this case "witch" symbolizes a bad woman who does not care about her deeds or behaviour; is the one with sons to protect her.

The premium of having a male offspring in a marriage can be evidenced by the various strategies couples adopt nowadays. Unlike in the past where a man would marry a second wife or a woman get a "surrogate" wife to bear her sons, today a man discreetly indulges in multiple sexual relationships with hopes that he can have a son with any of the sex partners and then marry her or adopt the son[45]. In the case of a woman, she will also secretly indulge in sex with a specific man who must have many sons in his family with hopes he too can sire her son[46]. This in essence puts them at a greater risk of getting sexually transmitted infection and HIV/AIDS.

Abagusii used cattle in payment of bride wealth (Nyamongo, 1998). The use of cattle for bride wealth; however, is almost insignificant although cattle is considered an important component of bride wealth and marriage. At the present, bride wealth has been monetized. The reasons for this are; first, unlike in the past where parents of young men made marital arrangements for their sons, today young men are making their own marital arrangements and they are getting spouses faraway from their homes. As a result, parents have become less involved in establishing such alliances. This has been enhanced by improved communication in the area. Second, opportunities have been created by schools where young men interact with young women. In the past, such interactions were restricted. Due to this, young people are able to establish their own relationships. Lastly, due to job opportunities young people are able to establish relationships with people from far places and more so from different cultural backgrounds where they work. This has made the use of cattle as means for bride wealth uneconomical and unattractive.

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[45] The practice of men indulging in sex with many sexual partners with sole aim of getting a son is commonly refered to as *"gochiensa kamara"* (to play rotary) in the site of study.

[46] This practice by a woman trying to get a son from another man who is not her husband is refered to *"gotema"* (to try).

All these practices are premised on the assumption that the other partner has a biological problem to which prevents him/her to procreate a son.

In the past, young couples were not allowed to stay together before bride wealth is paid. In this case cohabitation was not allowed. Recent studies; however, reveal that young couples are staying longer before bride wealth is paid (Hakasson and Levine, 1997). As Hakasson and Levine note, in 1957-1967, couples on average stayed together for three years before completing bride wealth payment. At this period, 91% completed paying bride wealth before the second year of marriage. A decade later (1969-1974), 68% had made payment by the second year and in 1981-1983, only 28% had done so. The reduction in payment of bride wealth has been caused by structural factors like high unemployment levels and high population growth which has diminished land acreage for cattle rearing.

With drastic reduction in payment of bride wealth, new forms of marriage have emerged; that is, cohabitation and elopement. These new forms of marriage are not formalized and are to the disadvantage of a woman. In formalized marriages a woman has some rights to property, security, and respect in both her natal and husband's home. This enables her have some power to negotiate on issues affecting her day to day life. This is not the case in these new forms of marriage.

Among the Abagusii Hakasson (1994) observes that these new forms of marriage have made men to engage in multiple sexual relationships with multiple partners in the pretext of looking for an ideal partner with no recourse from any person, reduced the age of marriage and led to increase of single mothers. These consequences are further compounded by the fact that despite changes in marriage, no accompanied change took place on the norms and principles which governed payment of bride wealth. Instead, the legality of marriage in terms of traditional rights and obligations are emphasized. Thus cohabitation or elopement provides a woman no right to a man's resources or security in marriage.

Gusii marriage system started undergoing drastic changes from 1930s and 1940s (Shadle, 2006). These changes in marriage system were not unique to the Gusii alone but were also experienced among the Kikuyu (Penelope, 2001). Among the Gusii, these changes were caused by two but interrelated factors which affected bride wealth namely: the nature of Gusii bride wealth and the colonial political economy. Among Abagusii, most men's source of bride wealth cattle was what

was received from the marriage of a daughter or a sister. A father thus had to ensure that what he received as bride wealth will be enough to give as bride wealth. This arrangement worked very well as each father adhered to the "going rate" of bride wealth at a particular time. However, rumours of other fathers asking more than the "going rate" made other fathers to follow suit. This made bride wealth go high to the extent that many men would not afford bride wealth. The consequence of this was that most men opted not to get married.

According to Nyamongo (1998), the high increase of bride wealth can also be traced to abolition of cattle encampment "*ebisarate*" by the colonial government which regarded them as security threat. *Ebisarate* was a village like organization which consisted of circumcised but unmarried young men for herding cattle due to insecurity from neighbouring communities like the Maasai. After herding cattle, these encampments acted as a training institution for young men on issues regarding manhood. Of critical importance, this arrangement delayed young men from getting married at young ages or indulges in premarital sex relationship.

With the abolition of these encampments, young men had nothing to do but get married. This flooded the marriage market with young men wanting to marry. Consequently, fathers started increasing bride wealth in order to gain more from the existing demand market.

The colonial economy is another contributing factor to high increase in bride wealth. The colonial economy was a cash economy with attendant expenses for individuals and families. These expenses were; for example, paying of taxes and meeting of basic needs like clothing. Before 1930 as Shadle (2006) observes, the sales of agricultural produce fulfilled this expenses. However, this was not possible afterward. This forced young men to move out of the community to sell their labour. Wages from the sale of labour was however inadequate.

The introduction of cash economy created two groups of people in the community. The first group consisted of few educated, chiefs and state employees who were wealthy. The second group consisted of the poor masses. Since at this time polygamy was a sign of wealth and leadership status, the few wealthy men started giving bride wealth mostly beyond the "going rate" at a particular time. Following the logic of Gusii bride wealth, other fathers were compelled

to increase their own demands. This pushed up the going rate upwards making it more impossible for the poor young men to get married.

As bride wealth continued increasing, more young men found themselves without enough cattle to marry; consequently, young women found themselves without husbands. As Shadle (2006: xxii) notes, "by early 1950s there were more single women of marriageable age than any time in living memory." Given the importance of marriage among Abagusii, Chief Kirera introduced a bride wealth limit that held long enough for young men to marry. However, with time some fathers started breaking the limit; forcing others to following suit, and again bride wealth started rising.

Before Chief Kirera's ruling on bride wealth, there were other similar rulings on the same. Towards the end of the 19th century, the rate of bride wealth had gone up to over eighteen cows, one bull and several goats. This was beyond the reach of many young men. As a leader, Bogonko of Abagetutu clan summoned a meeting with all leaders of all Gusii clans. In this meeting, Bogonko made a ruling that from then henceforth bride wealth should be reduced to ten cows only. Most of the leaders in the meeting opposed "Bogonko ruling." This prompted Bogonko to issue a magical-religious sanction by performing a ritual involving the invocation of a curse to the effect that "all the people who went against his pronouncement, their cattle will 'become skins" (die). Indeed most Gusii elders attribute the cattle plague of the late 1890s where most of the cattle in Gusii land were wiped out to Bogonko's curse. Ironically, it is interesting to say that the cattle plague eventually brought down the rate of bride wealth during the late 1890s to as low as one cow.

In 1906, the bride wealth had also gone so high beyond the reach of many young men. This necessitated another meeting involving all Gusii clan elders chaired by Ogeto. In this meeting, it was agreed that bride wealth should be reduced from six cows to three cows that is one bull and not more than four goats. To enforce this ruling which came to be known as "*Ogeto ruling,*" all clan elders performed magic-religious rituals binding everyone to abide by the ruling. According to Gusii elders, "*Ogeto ruling*" was adhered to by most clans for a long time.

By 1920s; however, the rate of bride wealth had increased substantially to over eight cows. This again prompted Inchwari, a leader of Abagetutu clan to summon other Gusii clan elders for a meeting. In this meeting, it was agreed by all clan elders that bride wealth should be brought down to three cows and one bull. This ruling was commonly referred to as "*Inchwari ruling.*"

As evidenced from above, the Gusii community was keen to have bride wealth at an affordable limit for all people. Marriage was only solemnized through payment of bride wealth and none was allowed to be married before bride wealth was paid. Although rulings on bride wealth before 1930 were important in maintaining the Gusii marriage system intact, from 1940s this system started undergoing drastic changes in response to high bride wealth.

The immediate response to high bride wealth was that many fathers started forcing their daughters to get married to rich old men in order to get enough cattle to enable their sons to marry. Many young women in such forced arrangement for the first time started defying their fathers on the issue of whom to marry. As a result, most young women started running away from the forced marriage and returned to their home and others eloped with the men of their choice. Those who eloped hoped that with time their father will accept a more reasonable bride wealth. On the other hand, young men who were desperate to marry abducted and raped women with hope that in case an abductee becomes pregnant, her father will accept any bride wealth (Shadle, 2006).

This response to high bride wealth saw the issue of marriage moving from the confines of the family to judicial courts. However, what is important is the debate which arose within the community regarding what marriage meant and what were the father's and young woman's right in issues of marriage. Was the father's right to bride wealth a passport to organize a daughter's marriage and is elopement and abduction a legitimate form of marriage? (Shadle, 2006)

Despite this debate regarding marriage rights and bride wealth, Gusii women still preferred marriage because of the values associated with it. The bone of contention was that they wanted to be part and parcel of the marriage process. This brings into focus the female agency in decision making and action in issues affecting women. In most cases especially in patriarchal

communities, women are depicted as passive and powerless on issues of their sexuality. In this case; for instance, Gusii women were in the fore front in initiating illicit unions when men were hopeless and challenging institutions which curtailed their right of choice especially on whom to marry. All these demystifies the assumption that only male agency is important in understanding women action in issues of sexuality especially among the Abagusii.

In the contemporary Gusii, marriage has undergone drastic changes. Young people are in the forefront in making their own marriage arrangement without involving parents. Traditional marriage ceremonies[47] have been replaced by religious and civil ceremonies and elopement and cohabitation are common and are recognized as a part of the marriage process. Among the Abagusii young people elopement and cohabitation are commonly referred to as "*come we stay*" or "*testing.*" The main reason why young people prefer this form of marriage is that they want to know each other very well before they commit themselves to formal marriage which involves payment of bride wealth.

Despite these changes in marriage, the traditional values, norms and principles governing marriage and bride wealth are still intact and observed. Payment of bride wealth is still recognized as the only means of solemnizing marriage and giving the husband a right to ownership of children.[48] Marriage gives young people status of adulthood and those of marriageable age but not married are scoffed at. It is also through marriage only that women can access land. Most importantly, in any marriage children are important although preference is given to sons.

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[47] For further reading of traditional marriage ceremonies see J.S Akama and R Maxon (Eds) (2006):The Vanishing Cultural Heritage and Ethnography of an African Community: The Gusii of Western Kenya; The Edwin Mellen Press, New York.

[48] During my fieldwork in May 2009 a young man who had eloped and cohabited with a young woman for five years died. In their union, they had three children. Before the young man was buried, his family was made to pay bride wealth to the wife's family. This was to ensure the young woman is formally the wife of the deceased (acquire proper social identity) and her children have a right to inherit the land and property left behind by the deceased.

Principles Governing Social Behaviour

Another important social organization among the Abagusii is the principles governing social behaviour. In this community, social behaviour and group interaction is governed by a moral code of avoidance, "*chinsoni* "(Levine, *et al.,* 1994). The application of this code of social conduct starts at the homestead and it was strictly followed by every member of the family.

The *chinsoni* concept had clearly defined codes of conduct and required behavioural patterns of every member of the family in the homestead. These set of rules, roles and functions guided people's daily way of life. It provided motivation to undertake acceptable avoidance practices and behavioural restraint that was crucial in maintaining appropriate moral and social order at the homestead and in the community at large.

Among the Abagusii, the family was divided into four groups, namely: the parents, initiated sons, initiated daughters, and uninitiated children. In the social hierarchy, parents are in the top of these social group and uninitiated children at the bottom. Sons generally have higher social ranking than their sibling sisters who will eventually get married and move out to their marital home. Each group had its own sets of norms of avoidance. For example, uninitiated children are the least restricted on what they can say before their parents and siblings. This is because it is assumed the uninitiated children are going through a process of learning. When they become initiated, their social part is defined (Akama and Kandenyi, 2006).

Apart from stipulating social ranking in the family, the *chinsoni* concept defined the chain of command in the family or homestead. For example, wives got orders from their husbands; in turn wives gave orders to their children. Married sons gave orders to their wives and children. In each case obedience is required. In fact it is a serious offence to challenge a specific command coming from someone who is in a higher hierarchy. However, it should be noted that there were built in checks and balances that governed the manner in which hierarchical power was exercised. This chain of command with its built in checks and balances ensured social order is maintained in the community (Akama and Kandenyi, 2006).

In the family, avoidance moral code was strictly enforced between children and parents and to people whom avoidance moral code is applicable like aunts and uncles. For example, the use of explicit euphemistic words referring to sexual and reproductive matters was strictly forbidden. However, this restraint had some level of relaxation between age mates, brothers, sisters, and grandparents and grandchildren. Due to this avoidance behaviour it is very difficult; for example, for Gusii parents to discuss issues of sexuality with their children.

The concept of *chinsoni* plays a big role in influencing individuals' interactions and behaviour. As noted by Masita (2007), the parents were constrained from monitoring the sexual behaviour of their male adolescents due to "*chinsoni*". Given the fact that HIV/AIDS prevention strategies are concerned with the modification of individual's sexuality, this rule is critical in determining how such messages are derived to the target group. Further, the hierarchical order which this rules stipulate is also a factor in determining how individuals negotiate and use various HIV/AIDS prevention methods like ABC. In essence, individuals' protection action against HIV/AIDS cannot be divorced from the principle governing social behaviour.

In conclusion, although the Abagusii community is made up of seven autonomous clans with clear defined territorial boundaries; they are all linked together apart from the common language by marriage, circumcision and principles governing social behaviour "*chinsoni*". These three form key components in determining an individual's daily life within the community.

Illness among Abagusii

Among Abagusii illness is intricately interwoven in the social fabric of the people. This attitude is derived from the fact that within the social milieu of extended family, when an individual contracts illness, he /she cannot perform his/her functions within the social context (Sindiga, 2006). As a consequence, the group comprising the family members, neighbours is affected by the individual illness and may attempt to seek treatment and other forms of remedies for the patient. Thus what was initially an individual problem, transforms into broader social and cultural issue affecting multiplicity of social groups.

In health seeking behaviour, especially in Africa, therapy managers play a critical role. The therapy management deals with authorative diagnosis and control of treatment and supportive care (Feierman and Janzen, 1992). Among the Abagusii, authorative diagnosis and control of treatment is usually in the hand of the family members who have judicial authority over the patient. As a primary social group, the family uses its knowledge of illness and authority to determine the health seeking behaviour of the patient. Knowledge of illness will assist in the recognition of illness symptoms while the family authority will influence healthcare decisions.

In making decisions about the health behaviour to be undertaken for the patient, the head of the homestead is mostly consulted for the final decision. This is because; first, the head of the homestead is the custodian of all resources which are critical in determining the implementation of health behaviour; and second, according to Abagusii social order, the head of the homestead is higher in social status than any family member. Thus any decision reached and endorsed by the head of the homestead will be binding to all members below as social sanctions are imposed on those who become non-compliant to decisions reached (Levine *et al.,* 1994).

In some cases; however, adult patients may be allowed to make their own management decisions. However, the extent of their independence is determined by the nature of illness. If the illness is perceived as serious, therapy management group may take over the management decision. Even then the patient may not be provided with treatment against their will. If the therapy management group is unanimous in their choice of treatment, it may be provided without the knowledge of the patient.

As in many communities in Kenya, the composition of the family among the Abagusii is being redefined. More people, especially those who have migrated to urban areas are moving away from the traditional Gusii family (family with extensive network of relatives) to nuclear family. This has altered the structure of therapy management group although such groups continue to exist with limited involvement. Their involvement might depend on factors such as their closeness to the patient and seriousness of the illness. Close relatives such as siblings will usually be informed at the earliest opportunity. Although they might not get involved in decision

making, they will help in the implementation of health behaviour decisions by availing resources.

Among the Abagusii also, gender power relation, particularly on decision making is changing. Women are taking over decision making (Silberschmidt, 1992) and are diversifying more into a variety of non-agricultural activities[49] that provide them with independent source of income (Orvis, 1997). With independent income, women are now making their own decisions on health seeking behaviour. But still they will involve their husbands even though the latter's input may not matter so much as a way of avoiding conflict in the household given the patriarchal nature of the community (Masese, 2002).

In health behaviour, Abagusii use both indigenous and biomedical medical practices for the same illness albeit at different levels. The choice of either practice depends on the perceived cause of illness, the interpretation of illness symptoms/manifestations and perceived efficacy in alleviating ill health (Sindiga, 2006). For instance, people may refer their illness to medical practitioners and later to traditional healers or indigeneous medical practice. Such a situation normally occurs when the illness which was perceived as normal is regarded as abnormal by individual patients or their social network. Such cases occur when modern medicine fails to accrue the expected result that is when illness fails to respond to modern treatment or new symptoms continue to appear despite treatment.

Similarly, people may seek traditional/indigenous medicine initially but later change to modern medical practice. This occurs when traditional medicine fails to cure the illness, when the patient and social network fail to accept the traditional/indigeneous diagnosis of the illness and when the suspicion the patient and social network had regarding the cause of the illness is not confirmed.

In some cases, people have been observed to use the two medical practices simultaneously (Sindiga, 2006). This normally occurs when people are not certain of the real cause of illness which is mostly reflected by the saying, *Nkio giasirere rogoro, kerigerie maate*" literally

[49] Non- agricultural activities like brewing local beer, selling second clothes are not dependant on land resource which is under the control of the men.

translated as, "If not certain where to find it, try all directions." Such cases occur when symptoms of the illness cannot be classified with certain whether they are normal or abnormal. By using the two systems at ago, people gamble that either medical practice can be effective in alleviating suffering.

People may also use the two medical practices simultaneously because of their distinction between medicine and practice. A patient may use modern medicine because of its perceived efficacy in alleviating particular symptoms faster in relation to traditional medicine. At the same time the patient may also resort to traditional medicine to deal with the perceived cause of illness and prevent it from reoccurring. In this case, the modern medical practice provides the patient with the healing process while the traditional medical practice not only gives the healing process but also the protection against the process of the illness from reoccurring.

The existence of two medical practices; however, has impact on the use of modern biomedical technologies. In a study by Masese (2002), it was found that the problem of adherence to malaria treatment and use of biomedical technologies among Abagusii was due to ethno medical beliefs and remedies available in their indigeneous medical system. In this study, it was found that malaria biomedical technologies were evaluated in relation to knowledge acquired in their ethno medical practices. Given the fact that indigenous medical system are at best different from and at worst in direct conflict with modern biomedical practices, this affected the use of biomedical technologies, adherence to treatment, their relationship with health professional and decision making regarding health behaviour.

As there are two medical systems, there are also two classification of illness namely; normal and abnormal illness. This classification of illness is based on the interpretation of symptoms. Kleinman (1988) has argued that symptoms of illness carry cultural significance which makes each of them be treated differently depending on cultural, historical setting, and local knowledge about the body and its pathologies. This means a symptom can have different meanings in time and space and this can influence how the patients or members of their social network respond to it. Consequently, among Abagusii, symptoms signify whether an illness is either abnormal or normal. Symptoms of an illness like coughs, fever and slight headache are generally regarded as

normal since they occur from time to time and respond quickly to simple medication. However, if these symptoms persist, their intensity prolongs and fails to respond to medication, they will signify abnormal illness. This classification of illness forms the first step in health behaviour process.

The classification of illness into either normal or abnormal gives an indication to its cause. In this case, there are three causes of illness among the Abagusii namely; naturalistic, supernatural and personalistic/interpersonal causation. In naturalistic causation, illness is believed to stem from natural forces or condition within an individual environment. In dealing with these illness, people are only interested in the "how" explanation of the illness which refers to the immediate cause. The "how" of an illness is arrived by empirical observation of the patient's interaction with physical environment prior to appearance of symptoms of an illness. If anomalies in the immediate environment are observed, they are taken to be the cause of illness. Illnesses in this category of causation are easily amenable to treatment.

Also in a naturalistic causation of illness, an individual's health is taken to transcend mere absence of illness or coming into contact with pathogens. The body and mind had to be simultaneously in a state of well being recognized and accepted by both the individual and the society. In consequence, illness was understood to be caused by simultaneous destabilization of an individual's environment making the body and mind incapable of functioning well. This is epitomized by the Gusii phrase "*Orogongo rwasarekire.*" This phrase connotes a variety of conditions which include physical, social, economic and religious problems which make an individual's functioning problematic. Illness in this case is conceptualized as an expression of both physical and physiological malfunctioning of the individual as defined by both the individual and society due to the unconducive environment. Therefore, it is assumed once the environment becomes conducive, the individual will regain his/her health.

By linking illness causation to the environment in which an individual is in, the Abagusii exonerates an individual's personal action to illness causation. Although in some cases an individual's action can be seen as a contributory factor to illness, the immediate social, economic, political and religious environment is attributed as the main cause. For example, an

individual knows very well that eating rotten food can lead to stomach problems. If the individual eats this food despite his knowledge, people will not blame him but will try to understand what made him to eat such food. By analyzing various circumstances within the immediate environment they can conclude that he ate the rotten food because he was starving due to lack of means to buy food. So the cause of his stomach problem will be seen as eating of rotten food but will be qualified by the reason behind the action. In explaining the cause of illness in this circumstance, people will assume (not take account of) the immediate and direct cause which in essence will directly indict the individual but instead attribute it to the reason for the individual's action. In daily experience this explanation on illness causation is expressed by the phrase "*Enda yamoria*" (literally translated it's the stomach which has eaten him/her). The stomach in this context signifies the immediate individual needs which are beyond his/her controls as the cause of the problem or illness.

The attribution of illness not to the immediate direct cause is done in two circumstances. First, when human action is the cause of illness but the illness is not life threatening (that is normal illness). Second, when the illness is life threatening, stigmatizing and caused by the patient's personal action. The latter normally happens when people know the exact illness the patient is suffering, what causes it and the consequences of the illness. The cause or action leading to such an illness is normally stigmatized and the consequence is mostly death. By attributing the cause of illness not to its direct and immediate cause, people are trying to protect the patient from blame and shame associated with such an illness. This explanation of illness causation in terms of structural factors is common with HIV/AIDS illness and death.

Consequently, in dealing with illness causation especially those attributed to the individual's immediate environment/ circumstances among the Abagusii, it is important to understand the context and period such an attribution is made. This is because such illness explanations are based on the cultural values and social relations which shape how people interpret and make meaning of various illnesses (Kleinman, 1988). For example, during my fieldwork, a young widow, with four- school going children was bedridden with HIV/AIDS related complications. The patient and the people who were taking care of her attributed the cause of the illness to her efforts of meeting the needs of the children, although they knew the exact cause of illness. In the

same village, a young unmarried secondary school teacher who was ill with HIV/AIDS related complications was said to be suffering from HIV/AIDS.

In these two cases, although both are suffering from HIV/AIDS complications, the cause of illness for the first case is attributed to structural factors which are beyond the patient's control. By doing so, the patient was able to get compassion and care in her ailing process as it removes responsibility of illness from the patient. The second case bestows responsibility of illness and thus stigmatizes the patient. The consequence of this is that most people were not willing to be associated with or provide him any care during his ailing process. These two responses are based on Gusii social philosophy governing individuals' problems and suffering. Any problem/ suffering an individual brings to himself/herself willingly should not attract any compassion or kindness.

In the realm of supernatural causation, illness is thought to be caused by ancestral spirits "*Chinsokoro*". Illness in this category is believed to be a form of punishment to an individual because of omission to observe certain taboos/ rituals or commission of certain acts which are regarded evil to the society (Sindiga, 2006). Among the Abagusii, it is believed that it's the duty of the living to lubricate relationship between them and the departed ancestors. This takes form of livestock sacrifices like cattle, sheep and goats. Failure to do this may provoke the anger of the ancestors which may be expressed through evil spirits "*ebirecha*" in form of madness, infertility and epilepsy to an individual. *Ebirecha* in this context are taken as mere agents of ancestors in executing punishment. Other causes which can lead to illness in this category are; taking part in perjured oath, improper burial of a deceased family member and spotting some animals the community regards as evil like owls and pythons.

The health behaviour involving supernatural forces entails family members of the patient going to a diviner "*Omoragori*" to find the underlying cause of illness. Family members are then expected to take the required action as prescribed by the diviner, which usually involves use of herbal medicine "*amanyasi*" and sacrifices (Sindiga, 2006). These actions are meant to exorcise the cause of illness rather than eliminating the symptoms.

In personalistic/ interpersonal causation, illness is believed to be due to active and purposeful intervention of an agent usually a human being. The human agent can either be an individual himself/ herself or someone else. An individual can also bring illness to himself/herself or those very close members through a breach of taboo, breaking an oath or through a curse. For example, if married woman commits adultery can bring upon her family members illness called "*Amasangia*" (Sindiga, 2006). *Amasangia* is a supernatural punishment against the infidelity of a wife. The adulterous action normally worsens the illness of either her husband or children which can lead to death. Similarly, if someone is cursed by elderly people he/she will suffer from body wasting illness called "*enyamokirimbi*" which Ogot (2004) also referred to *Okoragererigwa.* This illness is stigmatized and is characterized by severe diarrhoea, body rashes, vomiting, loss of weight and death. When HIV/AIDS came into Gusii land, it was interpreted in relation to this condition due to the similitude of the symptoms.

Abagusii also believe that witchcraft is responsible for certain medico-social problems like mental disturbance "*ebarimo*," infertility "*obogomba*", and chronic illness which leads to death. In the community, witches "*abarogi*" are believed to have some supernatural power with which they can harm their fellow human beings. It is also believed that witches perform certain rites, cast spells and posses some magic which causes death among their victims through wasting illness (Masese, 2006b).

In the community, witchcraft is so intertwined with everyday happenings. For example, misfortunes or failure to achieve a particular goal is attributed to witchcraft unless there is a strong evidence to attribute it to other causes like a break of taboo or failure to observe a moral value. However, this account does not mean that Abagusii only believe in witchcraft to be the sole cause of phenomena. To them, what is explained by witchcraft are particular conditions in a chain of causation, which relate to an individual to natural happenings in such a way that it happened and caused illness, misfortune or death. In reality, the Abagusii believe in natural causation. However, these beliefs do not actually give a full explanation why a particular misfortune had to happen the way it happened. Therefore, witchcraft offers a satisfactory explanation by helping them answer "How and Why questions."

Believe in witchcraft causation of illness and misfortune in no way contradicts empirical knowledge of cause and effect (Masese, 2006b). When Abagusii are expressing witchcraft causation of illness or misfortune, they don't entirely neglect the secondary causes, which are the real causes of illness or misfortune. In most cases, they are foreshortening the chain of events and in particular social situations, selecting the cause, which is socially relevant, and neglecting the rest. For example, if a man dies from long illness like HIV/AIDS, witchcraft is the socially relevant cause, since it is the only one which allows intervention and determines social behaviour. This is because witchcraft will provide answers to why the individual was in the first case infected and why he/she had to die at that a particular time.

Therefore, believe in illness from natural causes and believe in illness from witchcraft are not mutually exclusive. On the contrary, they supplement one another, one accounting for what the other does not account for. More so illness is not only a natural fact but also a social fact. Therefore, among the causes of illness, witchcraft is the only one that has significance for social behaviour. However, it should be noted that the attribution of illness to witchcraft does not exclude the real cause but it superimposes on them by giving them social value/meaning.

Among the Abagusii, the relationship between natural and witchcraft causation of illness is ably expressed by a metaphor "*Eyanya gokwa etaberegeti egotonga*". This metaphor literally means that whenever illness, misfortune or death befalls, it does not happen on its own. It must be influenced by other external forces -witchcraft. Hence if a man contracts HIV/AIDS by having unprotected sex, it is believed that the action of having unprotected sex and specifically with infected person must have been influenced by witchcraft force through "*Ogokonerwa*[50]."

To understand the interplay of natural causes and witchcraft, this example of health seeking behaviour is important. Among the Abagusii, illness was first conceived as a natural occurrence. The standard response to this was to seek treatment. However, if illness continued despite the precautions taken, it was taken as unnatural. This necessitated the relatives to consult traditional

[50] *Ogokonerwa* means that some harmful events are supernaturally influenced by witches to happen on an individual by use of psychic acts or magic.

doctors to know the cause of illness. Once the traditional doctor diagnosed the cause of illness, it determined the subsequent sick role and health behaviour to alleviate the illness.

When the cause of illness was found to be the result of filial impiety or some other things that will demand traditional treatment, the sick person was asked to do it. For example, if one didn't observe certain taboos, thus annoying the ancestors, sacrifice to appease them was demanded. In this case the victim was guilty of his/her illness. In case the illness was due to witchcraft, relatives of the sick person did not only seek treatment but also sought who was responsible. This health behaviour led relatives to the following in efforts of alleviating illness of their kin.

First, they may make a more public declaration in the witch's presence without mentioning his or her name. This meant that it is only the relatives and the witch who know who was being referred to. In this case, the witch will know that he /she has been known and therefore stop bewitching the sick.

Two, if the witch continued bewitching the sick person, relatives would make a public pronouncement mentioning his/her name. This way, clan elders summoned clan members to listen to such allegations. In most cases the clan elders only authorized everybody in the gathering including the accused to spit on the sick person. This was done in the belief that if the person bewitching the sick person spits on the patient, the person will no longer be ill. This was because the witch will show that the sick person is not worth killing or harming.

Third, if all these efforts do not help the sick man to heal, the relatives resorted to *ogokenga.* This normally involved the relatives asking the traditional doctor to kill, using his magical concoctions called *omosira,* anybody who is responsible for the patient's illness.

Lastly, if the sick man dies, the relatives would try to trap whoever caused his/her death. Normally, immediately after burial the relatives would place small sharp sticks (*chimbambo*) strategically around the graveyard. These sticks are rubbed with a lethal poison and covered with soil to make them invisible. All this was done because of the belief that the person who bewitched someone to death will always be the first one to come at night to the graveyard to

cleanse himself/herself. This way, the witch will step on those hidden sticks injuring him/her, thus dying of poisoning.

Witchcraft discourse in Sub Saharan Africa has been cited as a cause of HIV/AIDS in many communities (Rodlach, 2006; Allen, 2006; Ashforth, 2001). Among the Abagusii, this linkage can be traced to the socio-economic changes which took place in 1980s. In 1980s, when HIV/AIDS was being experienced in the community, the community like others in Kenya was undergoing intensive socio-economic changes due to internal and external forces. Internally, the community was experiencing high population growth which was affecting resource utilization especially land (Akama, 2006d; Hakansson and Levine, 1997). As an agricultural community, the acreage of land available for each household had drastically reduced; consequently, affecting their living standards which were evidenced by food insecurity and inability to meet other economic obligations (Omosa, 1998).

Compounding the internal problems, were external factors like international policies which the government was implementing in response to the economic crisis of 1980s (Ogembo, 2006). These policies which were in form of Structural Adjustment Programmes were given to the government to implement by World Bank and IMF as a condition for getting continued fiscal and budgetary support. The implementation of these policies at the local level were characterized by reduction in purchasing power of most households as prices of most essential goods skyrocketed, level of unemployment increased as the government froze most employment opportunities in the public sector and instead it started implementing retrenchment of staff; and liberalization and elimination of government subsidies especially in the agricultural sector which made it expensive and uneconomic in most rural communities.

The consequences of these changes were twofold: first, there was an increase in tension and conflict among members of the same lineage in the utilization of resources especially land. Second, because agricultural activities were not viable anymore, some households had resorted to educating their children in formal education as a way of getting income from non agricultural activities. Opportunities for non- agricultural activities existed only in urban areas and thus most young people were forced to migrate there. However, in urban areas due to the prevailing socio-

economic conditions at that time, opportunities for employment were very limited just like in the rural area.

As the consequences of these socio-economic changes were unfolding in many households, HIV/AIDS started killing many of those young people who had moved to urban areas in search of livelihood. This worsened the socio-economic disruption in most households. At this period also, although HIV/AIDS was being recognized as an emerging health problem, the government response was characterized by denial and blame (Ogot, 2004). This in essence reinforced people's perception that either HIV/AIDS never existed in Kenya or the disease which was killing young people who had gone to urban areas in search of livelihood was caused by supernatural evil forces - witchcraft.

Witchcraft accusations in the community involve members of the same lineage. This is because of the three principles in which witchcraft is believed to operate on. First, believe that a witch couldn't harm someone unless they both share the same blood relationship (lineage). Second, witchcraft results from some personal antipathy or hostile emotions among those people who are closely related. These emotions are believed to be born out of jealousy and competition. Three, witches will normally harm people who have started improving their socio-economic status through causing them many illnesses as a way of curtailing their upward mobility and sometimes killing them (Masese, 2007).

Examining these three principles in relation to the social disruption which was taking place and the nature of HIV/AIDS illness, witchcraft became a more plausible explanation to young people's infections and death. First, those who were becoming vulnerable to HIV/AIDS were mostly young people who had moved out of Gusii land to urban areas in search for livelihood. By getting infected and ailing from HIV/AIDS, it was definitely taken that some members within their lineage were against their efforts to improve their socio-economic status due to jealousy. Two, HIV/AIDS is a slow wasting disease with multiplicity of infections due to compromised immunity. Among the Abagusii, illnesses that exhibited multiplicity of symptoms, wasting in nature and defies any form of treatment were taken to be caused by witchcraft. Lastly, those who

are dying of HIV/AIDS are predominately young people; such deaths are classified as bad deaths (Levine, 1982) and thus presumed to be caused only by witchcraft.

Another way of linking HIV/AIDS causation to witchcraft is by examining the Gusii myths on life and death. Myths normally relate us to events that must have happened long time ago but account for the present order of things at the most comprehensive level. According to Paul R (1996), myths provide an authorative foundation for the continual construction, maintenance and reproduction of an ongoing social order. In mythical narratives there is always a plot which brings together goals, causes and a unification of all actions in a logical sequence that creates meaning-effect and links individual desires to inter-subjectivity. Hence, through Gusii myths we can discover the social construction of various social facts.

Myths among Abagusii trace the origin of death or misfortune to jealous emotions which were first experienced within a family setting. According to this myth, long time ago, people used to die, stay in the grave and resurrect on the third day. In one polygamous household, one of the wives died. The husband instructed the surviving wife to stay at home and nurse the dead wife when she resurrects. However, when the living wife saw the grave bulging to surrender the dead wife to life, she struck the grave with wood saying *motienyi okwa oboka na monto akwa asira,* (Literally translation: Moon dies and resurrects; a human dies and perishes). With this, the deceased wife sunk back into eternal death. Since then human beings have continued to die and perish. This myth traces death to jealousy among very close people/members of the same lineage. Jealousy is the emotion behind practices of witchcraft. Therefore, any death which occurs is as a result of witchcraft.

In dealing with illness caused by witchcraft, the common practice was protecting oneself from being harmed by the powers of witchcraft (Masese, 2007). This was done by either nullifying the power of witchcraft by personal protection or planting or hanging of magical concoctions in the homestead. Personal protection entailed wearing of amulets "*Erinsi*" or by applying magical solutions either internally or externally to an individual's body. The commonest personal protection was the use of black powder "*obosaro*". In this case, the traditional medicine man made incisions on the body using a razor blade or a sharp object. While blood gushes out, the

black powder is rubbed into the wound. The black powder is believed to produce some antidotes or anti-toxins that prevent witches from harming the individual concerned.

In other instances, magical concoctions are put in bottles or any other container and either hanged or planted in strategic positions around the homestead "*oginkereka omochie.*" These medical concoctions are believed to protect the homestead and its members from witches' harm.

In conclusion, this section discusses the Gusii concept of illness, its causes and how illness is either perceived normal or abnormal. Though there are distinctive aetiology about illness causation, health seeking behaviour tend to be pragmatic depending on how the illness has been perceived by individual patients or members of the patients' social network. This pragmatism has major implication on illness response/management which involves biomedical approaches.

Sexuality, Gender and Identity

A review of literature on sexuality and gender identities among the Gusii reveal complex codes that "design" the cultural categories of male and female (LeVine 1966, Nyasani, 1984 Silberschimdt, 1991). The gender ideology in the late nineteen century was based on the separation of male and female identities. The male identity was responsible for the family interests'; that is ownership of resources like land and cattle, solving disputes and protecting family members from enemies (LeVine, 1966, and Silberschmidt, 1991).

Additionally, materials produced by the Historical Society at the Cardinal Otunga (1979), based on a large number of interviews with the very old Gusii men and women, provides an important insights on men's life (gender identity) and men image (sexual identity) before the colonial periods. This data for instance indicates that cattle herding and protection were important tasks for men. Adult men were responsible for training unmarried sons to be efficient warriors through rigorous training and guidance.

On the other hand, women were dependant on men for protection and access to land. They were primarily responsible for cultivation, food preparation, and other domestic services like tending

and training young children, nursing the sick and helping in maintaining good relations with neighbours and kin. Women were expected to obey their husbands, accept their land allocation and always consult their husbands before taking any action. Wife beating was a socially acceptable practice of "correcting" women who did not meet their social obligations. Divorce was never an option. However, should husbands not meet their obligations too, women had certain sanctions available, namely: withdrawal of labour, refusal of conjugal rights and failure to make food, return to parental home and wait for her husband to come with a goat as an apology and recompense her parent.

Further, Gusii oral narratives indicate that men and women belonged into two spheres of influence; the public and domestic spheres for men and women respectively. According to Rosaldo (1980) the opposition between domestic and public provides the necessary framework for an examination of male and female roles in society. Consequently, in the Gusii gender code, manliness is basically based on the father's and husband's dignity, reflected in a body - subduing defence of his juniors, his wives and in addition his own self-restraint (Mayer, 1975). Indeed, in Gusii traditional society there is a natural respect towards the male identity. Maleness therefore, was a quality that all men sought. It was associated with dignity and wealth, having land, having many wives, many children and in particular males.

Similarly, an ideal woman was one who knew her place as a female; childbearing, 'not strong-minded', energetic, home keeper among others (Silberschmidt, 1999). It is important to note; however, that literature on Gusii descriptions of who is an ideal Gusii woman are often linked to what they should not be. These include being 'uncontrollable', unfaithful, disloyal to family interests, jealous, quarrelsome and "should not roam around" (Cardinal Otunga Historical Society, 1979, Siberschmidt, 1999).

Despite this clear delineation between men and women, in real life experience there are situations or cases when not every female is a woman and not all males are men. This mostly happens when an individual fails to adhere or live to the expectations of specific gender culturally assigned roles or identities. As a result, within a particular context gender may be

assigned various categories that may be permanent, temporal or situational. This kind of labelling is demeaning and stigmatizing to an individual's identity and social status. For example, the term "*omosacha omokungu*" denotes a womanly male; that is biologically male but behaves like a woman. Such labelling happens when a man is averse to taking risks, not aggressive, perceived to be easily controlled by women, timid in sexual issues and shows emotions easily.

Gendering among Abagusii starts at birth and continues until death. At birth an infant was differentiated either to be of "*egesaku* (cattle pen) symbolizing male infant *or bwense*" (for the world) for female infant (Mayer, 1975). This differentiation was important as it bestowed to an infant the expected roles and identity. For example, a girl was considered to be outside patrilineage as symbolized by the cattle pen. Consequently, a girl was not regarded as a full member of her natal home (lacked proper identity in natal home) and thus she was expected to move out of her natal home (married) once she becomes an adult in order to get proper identity. This means it is only through marriage that a girl acquires proper identity.

The girl's position as an outsider is also reflected in Gusii ritual and jural norms (Hakansson, 1994). In funeral ceremonies, both unmarried and married daughters/sisters are allowed to play only peripheral role equivalent to that of distant kin and affines. This is because they are considered as the property of their husband and his lineage thus seen as an outsider[51]. Further, a girl's status as an outsider is evidenced in the context of death. A woman must be buried at her husband's home and it was a taboo if she dies, married or unmarried at her parents' home. Due to this, women were prohibited to get too old in their parents homestead. Similarly, should unmarried adult girl die at her parents' home, she must be buried at the farthest periphery of the homestead. In contrast, when a young unmarried man dies, he is buried within the homestead, immediately outside his house symbolizing his lifelong status in his father's patrilineage (LeVine, 1982).

[51] Funeral arrangements among Abagusii are done by nuclear patrilineal group and those considered outsiders are only allowed to attend the burial ceremony.

Consequently, as outsiders, females in a family setting are considered to be of lower status than that of males. As a result, the male child is usually accorded more attention as far as improving his welfare is concerned. Also, due to their status, Gusii females' rights to property are realized only through marriage unlike males who have inalienable right to inherent property from their fathers.

Among Abagusii, the concept of man and woman is based on power relations, control of decision making and access to and ownership of resources. In this case, it is the man who has power, sole decision maker and the custodian of resources. This concept of man and woman is inculcated among children through socialization where both sexes learn various societal expectations as they grow up. Learning of different scripts for both sexes is mostly done at puberty and during circumcision ceremonies. As noted earlier in this chapter, various rituals which accompanied circumcision instilled various values, norms and rules which defined both sexes. Young females; for example, are socialized to believe that their full identity depends on being married and controlled by men who must pay bride price.

On issues of sexuality, Abagusii had well established informal institutions which were effective in disseminating sex education. In the past, it was common for all young women in a homestead "*omochie*" to have a common hut for sleeping. This hut in most cases belonged to grandmothers and thus provided a good avenue for young girls to be given sex education. The subject matter varied from values of virginity to the qualities of a responsible wife and mother. Moral values, marriage regulations and respect for elders were equally important topics of discussion. Equally, young men had a common sleeping hut mostly the grandfathers'. The young boys who were circumcised but not yet married slept together in a hut "*Esaiga*". In such huts the senior boys who were more experienced in the art of seduction could teach the young boys about courtship and the qualities of a good man.

As noted from above, issues of sexuality were kept within the framework of the homestead and surrounded by strict norms and values which were gender specific. This was in recognition that

there is profound biological difference between women and men. These differences; therefore, determined the "dos and don'ts" of each gender. Linked to this, morality among Abagusii was gendered, just as the social value system. What was appropriate sexual behaviour for men was and is not appropriate behaviour for women. For example, men were allowed to have many sexual partners. Having relationships with more than one woman was a sign of virility and away for men to demonstrate their maleness and ability to "manage" (Siberschmidt, 1999). On the other hand women were supposed to be faithful to their husbands till death, only when she can be allowed to be inherited by her deceased husband's brother or cousin or she can also be allowed to choose 'a warmer of the house' (inheritor). Both of whom are allowed to beget children with her.

Further, marital fidelity especially among women was not allowed and was enforced by beliefs in supernatural retributions/sanctions (Silberschmidt, 1999). These supernatural sanctions were; one, the supernatural sanction known as "*amasangia*" (literary translated as sharing). *Amasangia* is caused by adulterous behaviour of married women, but it directly affects her husband and children rather than herself. It is believed that if a woman has sexual intercourse with a man other than her husband and continues to cohabit with her husband, then when the latter becomes ill, her presence in the same room may cause his death or worsen his illness. Also it is believed if the husband cuts himself and the adulterous woman tries to bandage the wound, it will promote bleeding instead of arresting it.

On the same, Monyenye (2006) notes that during circumcision there are instances where bleeding persisted. Customarily, this was attributed to amorous behaviour of the initiate's mother. In such situations the elderly women would urge the mother to show honour and spare her son the agony by admitting that she has been unfaithful to her husband. If the woman confessed her sinfulness, a special magical-religious ritual is conducted to cleanse the couple and ancestors. This act strongly deterred probable sexual misconduct of married women.

The second supernatural sanction enforcing marital fidelity is also related to *amasangia* complex but directed at men rather than women. When two men of the same clan have sexual intercourse with one married woman, regardless of whether or not she is married to either of them, it is believed that a visit by one to the sickbed of the other will result in death of the sick one. However, this is unimportant if the two are distantly related.

The belief in supernatural sanctions to control marital fidelity has more to do with controlling women sexuality by men since woman behaviour is the centre of all repercussions. The preoccupation of Gusii men in controlling women sexuality has to do more with what Siberschmidt (1999: 165) calls "honour of shame". This is because male reputation depends on female sexual conduct. In this case, a man's honour, masculinity and his reputation is severely affected if he cannot succeed in preventing her woman from other men sexually. When a man is not successful in this, his prestige is diminished as he loses honour not to himself, but to the wider society.

Apart from supernatural sanctions on marital fidelity, it was a taboo for unmarried young men to have sexual relations with girls of the same clan for fear of incest. This is because all members of the same clan are regarded to belong to one blood lineage. Nowadays, young boys do have sexual intercourse with girls of the same clan by justifying their actions that they need to have experience and competence on sexual issues before they venture outside their clan as demonstrated by the saying "*You start sweeping the house from inside to outside*". Though it is common knowledge that such affairs exist, they are done clandestinely and thus are of little import to the community. However, should such an affair become public in most cases by the girl becoming pregnant, the boy and girl may suffer some form of disgrace or attract some form of punishment.

According to Silberschmidt (1999), in traditional Gusii, among young people, premarital sex and discrete incomplete sex was permitted, provided that the hymen was not broken and pregnancy did not occur. The traditional permissiveness was in stark contrast to the sexual control of

women in later life. This is still the case today in Gusii. As long as women are not married certain amount of "promiscuity" is expected.

Shadle (2006) also notes that premarital sex was common among young people in Gusii land. Virginity among unmarried women was not emphasized or valued and loss of it did not lower the bride wealth given to a woman. For example, in 1940s, some Gusii women even praised girls' premarital sex because it showed the girl did not have sexual abnormality of preventing intercourse "*ekiona*". Further, unlike girls whom it was considered a taboo to engage in sexual intercourse or get pregnant before circumcision, it was more stigmatizing for boys to continue to be virgins after circumcision. In addition, premarital pregnancy though disdained, it never ruins the girl but limits her appeal as a wife as she mostly ended up being married by only those men who are desperate for a wife due to his poor social and economic status or will only attract half of the bride wealth. The consequences of premarital pregnancy were; however, dismissed by the proverb, "*The boys only opened the gate for the cattle*".

With respect to pre-marital activities, three types of girls are distinguished. This distinction is important in determining whether the girl has good qualities befitting a good wife in future. The first type is the girl who is considered to be loose in sexual issues, that is she engages in sexual intercourse with many boys or men after knowing them briefly or with relatively little persuasion. Although this type of girl is in demand as sexual partner, her reputation is considered highly undesirable as a wife.

The second type is a girl who is considered to be ambivalent about engaging in premarital intercourse. This type of girl may desire sex but is careful not to be taken advantage of. In most cases she is careful not to meet men in private places, reject advances of men whom she knows very little about and her accessibility for sexual liaisons depends on her mood and skill of her-would-be seducer. This type of girl is highly considered as an ideal wife.

The last type is the girl whose sex anxiety and hostility towards men outweigh heterosexual desires. Such a girl quite often rejects sexual advances of boys and; consequently, acquires such

reputation which makes her to be avoided. Though her desirability as a wife is not diminished by such reputation, she is not very much considered as an ideal wife. This is because she is considered over domineering and too independent - an attribute associated with men only. Nevertheless, from the categorization of girls due to premarital activities, it is quite clear that in general, Gusii girls exhibit greater degree of inhibition and anxiety about sexual intercourse.

The behaviour and attitudes towards sexual issues among girls can be traced to their earlier socialization in the family which is guided by intergenerational avoidance (Levine, 1959). In the family, both parents practice sexual avoidance to their children in the sense that they attempt to prevent their children from seeing their nude bodies, in coitus. In this regard, father-daughter avoidance is the strictest, father-son next, then mother-son and lastly mother daughter.

As a consequence of sexual avoidance, daughters aged three years and above are not allowed to sleep in the same room where the father is sleeping with the mother. This is not the case with the boys who are allowed to continue sleeping in the same room with the mother until they are almost ready to be circumcised normally at the age of seven years. Thus, boys cultivate close and dependent relationship with their mother. The daughter never had such relationship from the father who ever remains aloof to her. As a result, the father-daughter relationship in Gusii family provides the girl with training in avoiding and fearing men, while mother-son relationship promotes in male positive attraction toward women.

There are also specific differences in life training among females and males in the Gusii society. Girls are trained from earlier ages (normally three years) not to expose their genitals to people and they are punished if they do so. This is not the case with boys. This earlier modesty training thus must have an impact on their adult sexual attitudes. Another difference is that girls are always in constant supervision from their mother from birth until marriage. The effect of this supervision on the Gusii girl is to isolate her from intensive contact with men. This is not the case with boys who are left free as from the age of three years. Girls' supervision intensifies as they grow older or approach the age of marriage. This strict supervision which solely aims at isolating the girls from interacting with boys and enforced by punishment, helps to foster the

attitude of avoiding and fearing men and; consequently, affecting her orientation towards sexual intercourse.

Sexuality in the community is also greatly influenced by the social principle governing social behaviour "*chinsoni*". This principle forbids any public manifestation of sexuality even the use of explicit euphemistic words referring to sexual intercourse and reproduction among people whom avoidance moral code is applicable like children and parents, aunts and uncles. For example, during family planning campaigns in Gusii land, Matsuzono (1997) observes that family planning educators had difficulties in discussing family planning methods in the open because of the social rules governing behaviour in the community. Family planning methods are centred on reproduction where the principle of *chinsoni* is applicable.

As earlier stated in this chapter, *chinsoni* stipulates social ranking in the family. This ranking is important as it defines the chain of command in the family and influences social interactions and behaviour among family members. Those who are ranked lower are required to have respect to those who are in the higher rank. In the family setting, males are ranked higher than females. Consequently, in issues of sexuality, those ranked lower are forbidden to openly discuss or show knowledge on sexual issues with those in the higher rank. Due to this even in the marriage setting, married women cannot initiate any discussion on or show some knowledge on sexual issues. This is clearly captured by Levine (1959:969), "Wives in monogamous homesteads never initiate sexual intercourse with their husbands, and they customarily make a token objection before yielding to the husbands' advances. The wife does not take an active role in the foreplay or coitus and will not remove her clothes herself if she has not already done so for sleeping."

In some cases; however, women overcome this restriction forbidding them in taking any role in sexual issues by resorting to non-verbal communication. For example, in pre-colonial period, a wife could use non-verbal signals to let her husband know it's time for him to impregnate her again. If the husband was a young married warrior living in cattle camps "*ebisarate*", she would send the recently weaned youngest child, accompanied by an older child to bring calabash of milk to the father. This was understood to mean she was ready to conceive the next child. In

present times, a woman will instead raise some money and visit her migrant husband so that she can be impregnated. She will stay there until she believes that she has conceived before coming home (Levine *et al.,* 1998). The use of non-verbal communication by women in sexual issues is seen not as a sign of disrespect to men but a challenge to the latter to meet their sexual demands as it touches on their masculinity.

Social ranking as stipulated by the *chinsoni* principle goes hand in hand with the distribution of power and authority. In this connection, men are ranked higher and therefore supposed to have power and authority over women. One way of demonstrating this power and authority is by controlling women sexuality. Therefore, in marriage as well as in any sexual relationship, it is the man who decides when, how and why to have sex (Shadle, 2006). Any perceived challenge to this power and authority, real or not, is vehemently resisted by men.

In late 1970s, the Gusii were experiencing the highest population growth. The ardent negative consequences of population growth like high pressure on existing resource growth made the government in conjunction with international donors to intensify family planning programmes. Most of these programmes targeted women with the assumption that once they (women) are educated, they will be able to control their own sexuality and in turn lead to good decision making in planning their family. This approach failed because in the community men sexuality and reproductive power take precedence over those of women. By targeting women alone, men felt that their power over women sexuality was being challenged. Consequently, they were against the use of any family planning methods as they signified loss of their authority to women.

As a result, most men refused their wives from practicing any family planning method. This led to a number of women who wanted to practice family planning to do so discreetly – without their husbands' knowledge. The consequence of this is that communication or negotiation between couples on contraceptive use was negatively affected. Women from there henceforth were not to show that they have any knowledge on contraceptive use. Demonstration of any knowledge was thus taken by men as an indication of practicing family planning which in essence signified

challenging their male authority. This made women to be passive actors on issues of contraceptive use.

The power and authority dichotomy in sexuality is justified by myths and taboos. In sexual issues, it is believed that a man is the one who provides the soul and a woman the body. The soul which is equated to life is superior to the body especially in reproduction. This thus justifies why men should control women in issues of sexuality as they possess the most important thing in reproduction.

Taboos which are in most cases gendered and skewed towards men's advantage further justify men authority and power over women as demonstrated by what I call *"feminization of sex."* In sexual act it is a taboo for a woman to control a man in terms of how and when to have sex. Such control is seen as an affront to the person of man as it demonstrates grave weakness in his part or a sign of being loaded over. Apart from the sexual act, when not having sex a woman is supposed to sleep on the left side of the man. This signifies that a woman is in a weak position thus requiring a man's protection[52].The sleeping position is further given credence by the belief that when a woman sleeps on the right side of a man, she makes his sperms weak which in turn make him sire only girls (begetting girls alone is sign of weakness on the part of a man and thus injurious to his identity and social status in the eyes of other community members).

Sexuality in the community is closely linked to reproduction. According to Levine *et al.* (1998), reproductive goal especially in marital sexual behaviour is of primary importance than a mere by-product of routine sexual encounter. Through reproduction, each woman and man gained social status and identity in the community. Consequently, failure to reproduce is stigmatized and distasted as indicated in the following common song.

Ekegusii	***English translation***
Solo: *Mosaiga Siberia on'ge*	Comrade sip and pass over to me
Chorus: *Toa monto ogosiema nyaro*	Do not give to one who points underneath
Solo: *Nyakoibora o'mo, oraiyaa*	You who gave birth to only one child, Oraiyaa

[52] Among Abagusii the left hand is seen as weak and dependant on the right hand.

Chorus: *Arari/warari Arai*
Solo: *Otare koibora bange oraiyaa* You should have given birth to many, Oraiyaa

In this song, the phrase "*gosiema nyaro*" (point underneath) refers to partial or full male sexual impotence. Among the Abagusii, partial or full male sexual impotence is denoted by failure to sire children totally, getting very few children or getting only girls. The common denominator in all these cases is that they are stigmatizing to an individual man.

Apart from songs, Gusii proverbs and sayings underscore the central role of reproduction in sexuality. Some of these proverbs and sayings are: *Mwanya baiseke bange kerandi getakwoma mbotaka botakoera*(Literal translation: A home with many girls will receive many livestock due to dowry payment and hence have milk in abundance but the family will always be lonely and defenseless). The proverb tells that the house with daughters will not be poor in food and cattle (because of their labour and bride wealth) but loneliness will come to it once the girls marry and move away. Despite the importance of daughters/girls, the family will lack security. Sons are the ones to defend the family once the father is old. Sons were essential for a man's future. Sons preserved the man's memory and ensured his status as a venerated and lineage-founding ancestor. *Sanya aganga ya abanto na banto (*Literal translation: Have blessings of many children and livestock). This proverb shows that every man wished to marry and father many children and own many cattle. This proverb was said by parents to newly circumcised sons. In the community, it was commonly said that "cattle were children and children were cattle." Children were very important and if a wife died childless, the widower could legitimately demand the return of his entire bride wealth. Lastly, the proverb "She or he has died without (meat) in the hand with which to eat *wimbi* (the staple grain)". The proverb shows that a family without children would not often slaughter a goat, for there were not enough mouths to consume all the meat.

The centrality of reproduction in sexuality is further demonstrated by the efforts employed whenever there is disruption of reproduction. These efforts depend on the perceived cause of reproduction disruption which is categorized as either natural or supernatural. In supernatural, reproduction disruption is first seen as disaster visited by the ancestors' spirits, usually for

omission or commission of individual actions like failure to observe certain rituals. In dealing with this cause, compensatory sacrifices and other rituals are performed. The second cause is witchcraft. People believe that witches can use their powers to prevent someone to conceive or sire children. The common ways of dealing with this cause is by getting treatment from traditional medicine man "*omoringori.*" Such treatment involves giving the patient's magical connotations to neutralize the witch power. In supernatural causation, the cause of reproduction disruption is normally taken to be beyond an individual's power[53].

In natural causation, reproduction disruption is perceived to be due to some anomalies in an individual. These anomalies are perceived to be responsible for the failure of the individual to meet his / her reproduction function. In the realm of science, reproduction dysfunction can occur in both men and women. However, among the Abagusii, such dysfunction is solely attributed to women. For example, failure of married couples to get children, the woman is blamed as being responsible or taken to be having problems. Similarly, getting only girls in marriage, the woman is equally blamed.

The gendering of reproduction disruption has two remedial actions all aimed at protecting the dignity of men. First, as a way of avoiding getting stigmatized, the man will chase away the woman and marry another one. By doing so, the stigma remains with the woman. Second, in situations where the man does not want to chase away the wife, he can indulge in extra-marital affairs with other women in the hope of getting a child (where there is no child) or the "desired child' that is a son. In some cases; however, the woman may also indulge in extra-marital affairs when she perceives the problem is with the man. Unlike in the case of a man where such engagement is open and attracts no condemnation, the woman does so discreetly so as not to injure the status and identity of her man or avoid being labelled as immoral.

From the above remedial actions towards reproductive disruption, different motivations among men and women can be discerned. A man's concern about reproductive disruption has to do more with his social status and social identity in the community. On the other hand, a woman's remedial action can be seen from two perspectives. First, they are aimed at protecting man's

[53] Refer also to illness section in this chapter.

social status and identity. By indulging in discreet extra-marital affairs with the sole purpose of getting children, the woman does not want to subject her husband to "honor of shame" as a man's reputation, social status and identity depends on how best he controls his wife sexuality. Also since infertility is more stigmatizing to men than women, by getting children through another man secretly, the woman succeeds in protecting her husband from such stigma.

The second perspective of understanding a woman's remedial action has to do with her security in marriage. The success of marriage and continuous respect of a woman as a wife depends on her ability to get children. This security and status is enhanced more if she bears sons as demonstrated by this Gusii saying; "*Kwaeneire buna morogi ona bamura*" (Literary translation: You are arrogant as a witch with sons[54]). Normally a woman who failed to bear children was chased away and dowry returned to the husband to marry another wife. In some cases; however, the man may opt not to chase the infertile wife but marry another woman. Despite this latter arrangement, in old days the infertile wife would still continue pursuing issues of reproduction by getting a surrogate woman to bear for her children[55]. In the present times also, the infertile woman may opt to adopt a child. The adopted child will be regarded as a true child of the wife and husband. If the child is a boy, he will be entitled to the father's property.

As a community, Gusii has witnessed profound socio-economic and political changes. These changes have ushered in new norms and values. At the same time and paradoxically, the community has managed to stay very enclosed in its own moral system, deeply embedded in rigid norms, values and ancient traditions. So, in modern Gusii land it is not common to see new and old forces coexisting (Silberschimdt, 1999).

In recent decades, scholars in anthropology and related disciplines have produced a considerable corpus of research that details the historical process of changing sexuality and gender relationships in Africa (Maticka-Tyndale, Tiemeko and Makinwa-Adebusoye, 2007). The Gusii just like the other communities in Africa have undergone tremendous social economic and political changes in the last five decades. During this period, the Abagusii have submitted to

[54] Witchcraft among Abagusii is more associated with women and it very much distasted. Normally those accused of being witches are lynched. In this saying, a witch signifies a bad woman who because of having sons, does not care about her behaviour.

[55] See also the section on marriage in this chapter for more details.

numerous changes caused by their colonial experience, education, religion, liberalization, democratization and commercialization of trade in an increasingly globalizing world.

In such periods of rapid transition that begun during the colonial period, Gusii land has witnessed a steady disruption of traditional role patterns for both men and women; the breakdown of traditional notions of sexuality, gender identity and relations as well as norms and values. Indeed, these changes have and continue to define and redefine their cultural notions/identities of men and women and relations between them. The changes have profoundly affected how men and women view themselves and each other.

However, it should be noted that although change has altered the life of both men and women, available literature indicate that the normative centre of their lives remain in place. This means that the norms and obligations of male and female roles are largely intact. The only difference is the transformation of these roles. Men have for instance, acquired new largely western driven roles, as the traditional male "traits" : a 'real man' has lots of land, can handle many wives, many children and many cattle, are being eroded and/or are being redefined to suit the emerging socio-economic realities. The contemporary Gusii man; for example, is expected to take care of family (especially meet financial obligations), educate his children, be generous and provide good advice, have a happy family, a good house, be respectful and more importantly contribute to the development of the society. Women on the other hand should be hard-working, take care of children and husband, a home maker, respect husband and be a peace maker in the family and society at large.

These emerging new gender roles and expectations of men and women, do not actually reflect any change on how a man's and a woman's identity was traditionally viewed but rather a recast of this (traditional) view on new reality – a reality that seem to put Gusii men and women at an identity crisis. The emerging identity crisis in Gusii is a product of conflicting "realities" imposed on men and women due to the rapid changes. On one hand he/she is faced with a long history of complex codes that design the cultural categories of male and female and the current social realities that are driven by money and technology. This new realities must be noted as it is

not consonant with the traditional culturally ascribed "realities". Thus many face great difficulties in finding new identities.

Available literatures (Silberschmidt, 1999 and Amuyunzu-Nyamongo and Francis, 2006) indicate that men are greatly affected by socio-economic transformation in Gusii land than women. For example, due to increasing levels of unemployment, most men are unable to meet their societal expectations or roles. Consequently, most men are increasingly becoming mere "figureheads" as their authority is greatly undermined. This has negatively affected their value, identity and self-esteem.

Men's predicament due to socio-economic transformation is exacerbated by the changing gender roles. In this case, most women are taking over the roles which were the domain of men like providing for the household. This has led to antagonistic relation between the sexes. This relationship has negative implication on sexual behaviour for both men and women (Silberschmidt, 1999).

Section II: Doing Native ethnography as an Insider: Advantages and Challenges

Doing research as an insider is often seen as a solution of minimising challenges faced in the field. Altorki (1982) for example argues that as an insider, one is "spared" from dealing with settling problems in the field. However, as found out in this study doing research as an insider has its own challenge. For example, I found out that the insider researcher has to divide time between work and their family and relatives especially in communities where extended family relations are strong. In this case the researcher had to take time off from the field to attend to family members' problems. For instance, one day in the midst of an interview, I received a call from my brother that he had been arrested by officers from copyright organization because he was playing music in his hair salon and yet he did not have a license to do so. I was forced to stop the interview to attend to this emergency. Apart from this incident, I had to take time to visit my sick relatives and attend funerals. This is because the insider researcher is expected by the community to meet his/ her social obligation first and then attend to research work. I learnt that the community judges the insider researcher against a different standard of social norms compared to a foreign researcher. Consequently, as an insider researcher one has to constantly be on the lookout to seize opportunities that will enhance data collection and on guard against those that might jeopardize the quality of data collection.

When I first thought of studying social construction of HIV/AIDS prevention strategies, the Abagusii came into mind because of their conservatism on issues of sexuality. Studying and writing about your own people is by no means an easy task. But Kenyatta (1953) wrote the famous ethnography of the Kikuyu and Salinas (1978), a native Indian wrote about his people – the Otomi. They each provided powerful accounts of the Kikuyu (Kenyatta) and Otomi (Salinas). So I am not an exception. However, I was aware of the challenges posed by writing about your own people. I had to overcome my own biasness and the tendency to be protective of your "own". It is difficult to completely rid yourself of biasness; whether studying your own culture or another culture. Depending on the role you take, you tend to overlook certain elements, take others for granted and question some. It happened recurrently to Koentjaraningrat (1982) when studying his own Javanese society and when studying Dutch fishermen. In my case, I have tried to follow my scientific roots and removed myself emotionally from the people while keeping close enough to data. Whether I have succeeded in doing so, I leave others to judge.

As a native anthropologist, I interacted with Gusii people as an insider, interested in getting account of how youths make sense of HIV/AIDS prevention strategies in their everyday lives. Having grown up in Gusii, I knew from reading the clues when to stop pushing for more information. Being Omogusii it was an advantage. It took me less time to be accepted as one of them. I speak Ekegusii well; understand the customs and I did not deal with cultural shock. This reduced the amount of time I would have taken if I had to learn the language, master the terrains and customs of the people and overcome culture shock.

The advantage of being conversant with the customs of the Abagusii helped me a lot when I found myself in a tight corner as I did in some days. For example, one day during my fieldwork, community members were hunting down members of vigilante groups "Sungusungu" whom they accused of raping young girls. On this day, I was in the house of one of the vigilante member who was being sought. When the community members stormed in the house we were in, they wanted to lynch both of us. Realizing the danger we were in, I rushed outside the house, uprooted some fresh grass and scooped fresh soil from the ground and held them in my hands as I headed for the advancing crowd. According to the Gusii customs, when a person holds fresh grass and soil in each hand, he or she cannot be harmed but given an opportunity to defend himself/herself. As a result, I was given an opportunity to defend myself by explaining what my mission was in the area. While doing so, I seized the opportunity to remind them of the taboo against shedding blood of their kin. Instead, I asked them to hand the suspected vigilante member to the police. The community members accepted all my pleas. This way, I protected myself from harm and rescued my suspected respondent from being lynched.

Being an insider is not a passport to information as I came to realize during the course of my research. As a young man who is in his 30s, who has spent most of his life in Gusii land, undergone almost all cultural rituals and rites, socialized in all issues regarding sexuality, lived since the first case of HIV/AIDS was detected in Gusii land and acquired all the necessary knowledge and information about its transmission and prevention, my enquiries to my fellow young adults regarding heterosexual prevention of HIV/AIDS was seen as if I was out to tease them. They did not understand why at my age and level of education, I would spend a lot of their time enquiring what they thought I already knew.

In doing researcher as an insider, the common question asked is: Is it possible for one do native anthropology and still be objective? A caution often given to a participant observer is that they should take care not to become too attached to the study community and become too protective to them. This is possible especially when you have lived among the people you are studying all your lifetime, that task becomes more daunting. Furthermore, you must guard yourself against taking "a lot of things for granted" that a person from the outsider would not do (Bernard, 1994).

As Sorbo (182:152) notes, "objectivity in the strict sense of the word is a goal that is not fully attainable because our background biasness, likes and dislikes cannot be entirely suppressed. But the impossibility of attaining it perfectly does not mean that the idea is not worth pursuing...we have come far in developing a body of research procedures, techniques and methodologies that overcome the observed limitations and biasness as they arise." In this case if properly applied, science has the tools to minimize our biasness and limitations. But whether you are an outsider or insider, we are never completely clear of those biasness and limitations.

Therefore, as a native anthropologist I will be an eye opener to the way natives view their own society from the inside of the inside. To study and write about Abagusii; therefore, gives me an opportunity to take a position as a native anthropologist among the Abagusii.

Summary and Conclusion

This chapter has shown how culture and society shape different construction of persons among Abagusii. These different constructions as noted in this chapter have enormous influence on how an individual practices his/her sexuality, understands and responds to health and illness. This therefore means that the way an individual perceives the notion of risk and risk behaviour is shaped by values, norms, rules and taboos in a particular culture. However, as evidenced from this chapter these values, norms, rules and taboos are not statistic. Instead they are undergoing drastic changes due to social, economic and political changes. This has created a crisis in adhering to these values, norms, taboos and rules and the prevailing social, economic and political situation. This crisis has further redefined the perception of risk and risk behaviour.

CHAPTER FOUR

CONTEXTUALIZING HIV/AIDS AND ITS IMPACT AMONG ABAGUSII

Introduction

This chapter discusses the role of contextual factors namely; historical, political, socio-cultural and economic factors in the spread of HIV/AIDS. Using available research literature and ethnographic data from Abagusii, section one this chapter argues that the prevalence of HIV/AIDS in a particular community cannot be divorced from various contextual factors. In doing so, the chapter critiques those studies which have solely attributed HIV/AIDS prevalence especially in Sub Saharan Africa to sexuality. Lastly, section two discusses ethnographically the socio-economic impact of HIV/AIDS among Abagusii.

Section 1: Contextual factors and HIV/AIDS

African Sex as a Problem

As the world marked the 21st occasion of the World AIDS Day on 1st December 2009, the Global reports released on 25th November 2009 indicated that an estimated 33.4 million people are living with HIV worldwide, while 2.7 million people were newly infected and 2 million died from HIV/AIDS related illness in 2008. In this reports, Sub Saharan Africa accounted for the majority cases, making the disease a major social, economic and health problem.

Globally, since HIV/AIDS was first detected, heterosexual has continued to be the most common mode of transmission. However, in Sub Saharan Africa, the cumulative impact of the disease has been devastating as compared to other parts of the world. This created an impetus for medical and social researches to understand why this disease is so severe or unique in Africa. From the onset, most of these researches focused primarily on sexuality and other behaviour determinants. This was actually an influence of earlier researches on Sexually Transmitted Diseases (STD) and TB in Africa. Most of earlier STD and TB researches were full of racial stereotypes as "risk" was equated with the African race. For instance, the spread of syphilis was explained in terms of uniqueness of African sexuality (Packard and Epstein, 1990).

The initial behavioural theories on HIV/AIDS focused also on African sexuality and sexual partners. In these theories, heterosexual transmission of HIV in Africa was attributed to higher

level of sexual promiscuity which is characterized by multiple sexual partners (Aud Talle, 1995). Given this assumption, the nature, manner and practices surrounding African sexuality has continued to be taken as important in understanding the HIV/AIDS pandemic in Africa even where other factors like socio-cultural and economic look plausible explanations (Larson, 1990).

Caldwell and Caldwell (1987) have also explained HIV/AIDS pandemic in Africa using cultural explanations. To them, the pattern of HIV transmission can best be understood by looking at cultural norms and practices associated with African sexuality. These norms and practices are characterized by sexual permissiveness due to lack of moral and institutional constraints. Consequently, sex among Africans is free for all as characterized by permissive attitudes towards sexual relationships with multiple sexual partners and towards extra-marital sex especially among women.

Caldwell and Caldwell (1987) explanations about heterosexual transmission of HIV/AIDS has; however, been critiqued by various research findings. The thesis that sexual promiscuity particularly among women is a norm due to lack of control of women's sexuality is not valid. Oppong *et al.* (2004) argue using the examples of Chewa of Central Malawi in Malawi and Mozambique that even typical traditional society, women in polygamous unions were expected to be faithful to their husband so does the husband. Failure to do so resulted in tragedy like death of the husband or child. A similar finding is evidenced among Abagusii in Kenya where a woman's infidelity can lead to the worsening of an illness among her family members specifically the children and husband through supernatural force *amasangia* (Le vine, 1966). In a study among young people in Zambia also, Mafune *et al.* (1993) found that most of them did not favour extra-marital sex or multiple sexual partners.

Despite the critiques levelled on these researches, most HIV/AIDS actors were more concerned about how to deal with cultural practices, norms and behaviour patterns that spread the disease by either providing solutions or containing them. HIV/AIDS was thus seen both as behaviour and cultural problem. With time; however, the cultural paradigm was found to be inadequate in explaining fully HIV/AIDS in Africa. Consequently, the focus shifted to the context in which HIV transmission occurs. Researches started focusing on poverty, migration, violence, gender,

vulnerability and political factors. Findings from these researches undermined the dominant view that African's sexual culture is responsible for the epidemic. It was argued that the cultural approach did not take into account social, political and historical factors which are unique to Africa.

Ironically, most HIV/AIDS intervention strategies continue to be influenced by the explanations based on Africa sexuality. These strategies believe that unless there is fundamental change in Africans sexual behaviour and culturally sanctioned practices, HIV/AIDS will continue to be a major health problem. This is because as Larson(1990) notes, "it's the social context of various forms of sexual relations that is found in Sub Saharan Africa that has implication for the dynamics, the constraints on behaviour change and the effect of such change." This means that the African culture which is perceived as risky must be changed and also transformed if HIV/AIDS has to be controlled.

The "African risky culture" has been initially used to explain the spread of other sexually transmitted diseases in Africa. In Kenya during the colonial period, the spread of sexually transmitted diseases like syphilis among migrants in Nairobi was blamed on African character. This is in spite of the disruptive nature of colonialism in most communities which triggered rural-urban-rural migration with its attendant consequences.

Africa migrants in Nairobi; for example, had to endure with shortage of houses and low wages which prevented men from bringing their wives to the city. Given the fact that migration was skewed towards men, there were 25,886 males employed and living in Nairobi as compared to 3,356 females. This encouraged prostitution and contraction of STD.[56] Vaugham (1991) has also observed that in 1930 in Uganda physicians, missionaries and colonial officers blamed the spread of syphilis on the breakdown of socio-cultural norms governing female sexuality.

The existence of inadequacies in medical approaches to HIV/AIDS which focus on African sexuality does not deny in any way that HIV/AIDS is heterosexually transmitted and multiplicity

[56] Eric St A. Davies, some problems arising from the conditions of housing and employment of natives in Nairobi, Nairobi, August 1939, PP 3-4, Kenya National Archives (KNA): MD 40/1143

of sexual partners increase the risk of contracting and transmitting HIV. However, the limitation of these approaches is that they fail to consider the contexts in which sexuality takes place (Packard and Epstein, 1990). This is further amplified by Farmer (1992) who argues that studies that focus on Africans' sexual promiscuity and other socio-cultural practices and behavioural norms, negate other co-factors which are important for heterosexual transmission of HIV/AIDS in Africa which in essence makes individuals vulnerable to infection.

In short, to understand the transmission and contraction of HIV/AIDS in Africa, it is important to consider other contextual factors like political economy, poverty, gender, violence and socio-economic changes which not only influence vulnerability of individuals to HIV/AIDS infection but also health seeking behaviour. These factors are equally critical in influencing sexuality which is core in intervention strategies.

Political Economy and HIV/AIDS

Before the advent of colonialism in Africa, the medical systems in most societies were characterized by a number of features. Falola (1994) divides this features into five categories namely: diseases were considered to be a result of natural or supernatural causes beyond human control, cures dealt with sick individuals and supernatural forces, dealing with supernatural forces that involved offering sacrifices by the sick individual or the entire community, each community had health experts and the community involved itself in health matters by accepting expert or qualified diagnosis and prescription.

From the above features, it's clear that most societies had their own medical care systems. These systems enabled them to have control over any illness either natural or supernatural by emphasizing preventive measures. Illness was perceived as a threat to the welfare of the community and thus it was the responsibility of all members to protect each other from illness. In dealing with illness a holistic approach was emphasized.

However, with the introduction of western medicine, new features which were alien to African indigenous medical system were introduced. These new features included an emphasis in curative care system. The new approach emphasized on the construction of hospitals which;

however, was skewed to urban areas. The holistic and collective approach to illness was discarded instead individualism and biomedical or scientific approaches were emphasized. These were further reinforced by missionaries who taught indigenous people to drop their "wicked" ways and adopt teachings in the bible. Wicked ways were synonymous to anything "African." In some cases though, the transition from indigenous to western healthcare system was not smooth. In central Kenya; for example, the Kikuyus resisted the church and government plans to outlaw clitoridectomy by withdrawing their children from missionary schools (Kenyatta, 1953). Nevertheless, there was a decline in indigenous healthcare system.

As noted from above, colonialism ushered in a number of changes in many communities which came under their rule. These changes are argued created conditions which enhanced the spread of HIV/AIDS in Africa later. In the late 18th century, the expansion and subsequent scramble and partition of Africa by European countries were largely driven by economic wealth which was later repatriated to their mother countries.

In Kenya, the first colonial settler came in 1888, when the Imperial British East Africa (IBEA) was established. Shortly afterwards, missionaries arrived in 1890. By 1920, Kenya became a British colony and by then there was a large group of European settlers occupying vast land referred to as "white highlands". Most of these lands were areas having favourable climate and high agricultural potential and were in the North of Nairobi. Therefore, the independence movements which began in early part of 19th Century were reaction to this occupation.

The IBEA was the main body governing the white farmers. Its main role was business, a factor that required a health population. In this regard, IBEA, the colonial government and missionaries worked together in issues of health. However, health care policies were only directed toward the working class. People were tiered on the basis of race with Europeans at the top, followed by Asians with Africans came last. The quantity and quality of care declined as one moved down from Europeans to Africans (Mburu, 1992).

Consequently, Western medical systems were set in areas occupied by the Europeans farms - away from the Africans and Asians. Very little effort was; however, made to have medical care

in areas occupied by the Asians and Africans especially where labourers lived (Mburu, 1992). In this regard, "The East African medical department was instructed; firstly, to preserve the health of the Europeans' community. Secondly, to keep the Africans and Asians labour force in reasonable working conditions and lastly, to prevent the spread of epidemics (Doyal, 1979). Thus, medical care was given to non-European population based on their contribution to settlers' economy.

This trend of providing health in relation to one's contribution to the economy is still evident in Kenya to date. Government and private corporations use the same principle. High ranked employees receive better medical service and more health benefits than those in relatively lower positions. Similarly, access of public services like water, security and education largely follow the same socio-economic ladder (Mwenzwa *et al.*, 2006). This means people in low income categories are greatly disadvantaged in terms of accessing public services like health; an apt explanation why they continue to face the greatest brunt of many diseases including HIV/AIDS.

Generation of wealth for the European farmers was crucial in deciding who could get medical care. Those whose economic distribution was considered less important were accordingly given less medical attention and where medical care was available, it was limited. Since Europeans tended to concentrate in some areas such as "White Highlands" and in towns, it was easy to direct funds to such areas so do health personnel and healthcare facilities (Doyal, 1979). Consequently, this left most rural areas with no healthcare facilities. After colonialism, health facilities and services continued to be skewed to urban areas.

The radicalized structure of Kenyan society during the colonial period had a fundamental influence on the nature and implementation of public health policies especially regarding prevention and treatment of venereal diseases. Research has shown that health conditions of African Kenyans deteriorated during the colonial period even though European rule in Kenya, according to advocates of colonialism, was to improve the conditions of life of the colonized. The high prevalence of sexually transmitted diseases amongst African populations was in many ways a consequence of the disruptive influence of early colonial rule. This fact is; however, disputed by European contemporaries who instead identified this prevalence as a defect of the

African character. Consequently, high priority was given to racial segregation in order to prevent inherently diseased populations of Africans and Indians from infecting Europeans.

Generally, the prevailing health policy ensured that Europeans consistently enjoyed better health care services relating to STD. They received full dose of treatment, rapid response from medical circles whenever there was eminent threat of STD among Europeans and subsequent follow-up medical visits were ensured to realize full recovery. Although colonial administration was primarily preoccupied with the health of the Europeans to the detriment of the health of Africans and Indians, there were some attempts to prevent and treat STD among the Indian and African populations.

The inclusion of Indians and Africans in colonial policy regarding treatment and prevention of STD was largely informed by fear of transmission of diseases from non-Europeans to Europeans. This became a reality during the Second World War when it came to the notice of colonial administration that many soldiers stationed in and around Nairobi had been suffering from STDs. With Africans providing the labour, which powered the colonial interests, and Indians active in commercial sector, interactions between the races, was thus unavoidable. Due to this, health officers advocated for public health initiatives among Africans and poor Indians as a way of protecting Europeans from STD infections[57]. For example, during a campaign against STD in the 1940s, the examination and treatment of child minders/babysitters (*ayahs* as they were commonly called) was recommended for the benefit of the European children. Also, the removal from the streets of African women 'loiters', and the administration of a compulsory Kahn test for syphilis on all African women arrested in Nairobi, was seen as protection for British East African Command Personnel, during the First World War, who exhibited a disturbingly high rate of infection[58].

In spite of the fear that STD from Africans would infect Europeans, there were still some Europeans who showed marked reluctance to spend money on services for Africans, this was the

[57] See for example pamphlet titled 'Venereal Diseases, Nairobi municipality'. Tabled at meeting of public health committee on 11th December 1944, KNA RN/11/3

[58] See for example pamphlet titled 'Venereal Diseases, Nairobi municipality'. Tabled at meeting of public health committee on 11th December 1944, KNA RN/11/3

case with European councils in the Nairobi municipality who argued that Africans, in Nairobi for example, were not ratepayers and so had little entitlement to municipal services. Africans were said to benefit doubly; from services provided for them in the reserves and from those available in town. Councillors suggested that a special urban rate should be imposed on Africans living in towns[59]. This is in spite of the low-income levels that characterized the African population.

The escalation of TB and STD infection in the 1940s and 1950s became a matter of official concern bordering on panic, especially in Nairobi. This generated a dispute between the central government and municipal governments over who should assume responsibility for charges arising from the hospitalization of Africans in Nairobi diagnosed with communicable diseases such STD. The Director of Medical Services in the central government insisted that this was the responsibility of the municipal Public Health Department (PHD), charged as it was with the protection of urban residents from the threat of the disease. The MOH and Nairobi councillors preferred to shift liability to an African's local authority in his or her rural home, in fact there was a suggestion to arrest and repatriate all prostitutes to rural areas. Citing African Migrancy, the MOH argued that Africans' infections should be assumed to have been contracted in rural areas.

The government eventually insisted that it was the responsibility of the municipality to protect the urban population irrespective of the source of infection. This subsequently led the Public Health Department (PHD) to establish a chest clinic and a venereal diseases and special treatment clinic in Nairobi. It was thought that this would facilitate treatment of STD and thereby protect Europeans from the menace. However, Migrancy compounded the situation. Patients repeatedly interrupted treatment to return to the reserves for a spell. There had been little investment in treatment of STD in rural areas despite the threat of infection that migrants from urban areas posed to their rural folk. This led to considerable anxiety over both the spread of urban epidemics to the reserves, and over the potential development of resistant strains of the

[59] Report of public health committee meeting 14th October 1949, refer to minute 5 of the public health committee meeting of September 1949 about government plans of setting up centers for treatment of persons suffering from VD but who are not residents of the municipality, KNA RN/11/13

micro organisms[60]. Annual reports of the MOH continually complained of the impossibility of ensuring that African victims of such diseases as STD and TB received the full course of drug treatment which in most cases lasted up to twelve months.

In the later years; however, more liberal views about Africans began to sprout which held that Africans needed education to wean them out of their primitive habits. In an exhibition lecture given in November 1954, the precarious circumstances of many Indians, along with ingrained cultural habits, were blamed by Dr. McAllen, the deputy MOH, for the lack of receptivity towards Public Health Department initiatives in this community[61].

From the 1940s, health visitors extended education to homes. Visitors assessed domestic conditions, offered advice on the necessary changes to be carried out, and through follow-up visits, monitored improvements. Health officials enjoined all Europeans to take seriously the challenge of making every encounter with an African, an opportunity to impart knowledge about health rules. European housewives in particular were exhorted to make their homes a schoolroom for their African servants[62]. Health education was carried through health exhibitions where lectures were provided on the difference between health and disease. In addition, women were educated on matters of health whenever they visited antenatal and post-natal clinics. From 1956, attempts were made to persuade fathers to attend some of these classes; the perception being that much more could then be achieved within a few hours than with numerous lectures to women when men controlled the family budget[63]. These health education programmes were also initiated to prevent the spread of STD.

In 1940s and 1950s, the Nairobi PHD produced numerous leaflets, public notices, films and press releases. During the highly publicized post-war campaigns against STD and TB, Africans were given information through leaflets and through lectures on the causes and prevention of STDs, the importance of receiving full treatment and follow-up, as well as responsible behaviour towards sexual partners and the value of proper sanitation, housing and feeding.

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[60] See for example pamphlet titled 'Venereal Diseases, Nairobi municipality'. Tabled at meeting of public health committee on 11th December 1944, KNA RN/11/3
[61] See Report of MOH 1955. Introduction
[62] See reports of MOH, 1951, 1952, 1954
[63] Report of MOH 1956

A synthesis of the colonial policy on STD elucidates that the high prevalence rates among African immigrants was blamed on their primitive culture which needed to be changed through public health education. Similarly, when HIV/AIDS emerged in Africa, the same thinking was applied in mitigating the impact of the pandemic. However, this thinking has been found flawed by numerous studies which have shown that information alone does not lead to behaviour changes (Rugalema, 2004).

The colonial policy also individualized the risk of STD infection. This meant that victims of STDs were blamed for their infection. Consequently, the colonial government came up with legislation to deter individuals from spreading infection through Public Health Ordinance of 1921[64]. Part V of this Public Health Ordinance spelt measures for dealing with STD/VD in the colony. After colonialism, the same ordinance is replicated in Kenyan Laws as Chapter 242, The Public Health Act, and PART V- Venereal Diseases.[65] Another aspect of the colonial policy on STD/VD that was continued during independence was the issue of contact tracing whereby patients are required to bring along their sexual partners for treatment.

The individualization of risk of infection led to stigmatization of STD victims which made people not to seek medical attention on time. It further obscured the factors which made most African vulnerable to STDs infection. As indicated from the onset, the changes which were brought forth by colonialism created conducive environment for subsequent vulnerability of STD and later HIV/AIDS as hereafter discussed.

The colonial economy was mainly based on exploiting abundant resources in Africa. To achieve this, it relied on African cheap and unskilled labour. In most instances, Africans were forced to provide the required labour through force. To make it seem less like slavery, poll taxes were introduced. Among Abagusii, the introduction of taxes by the British colonial government forced men to work for wage employment abandoning their farms. Initially, they worked in roads and bridge construction in Gusii land. However, with time the demand for jobs exceeded the

[64] See this in Kenya National archives (KNA) BY/13/91
[65] Republic of Kenya, Chapter 242, Public Health Act, Part V venereal diseases, revised edition 1986, Nairobi: Government printer

available jobs. This forced most men out of Gusii land to major urban centres like Nairobi (Orvis, 1997).

In urban areas, the migrants lived in unconducive environments which encouraged the spread of STD. They lacked good housing facilities and in most cases shared rooms which made it impossible for them to stay with their wives thus encouraging prostitution. In this context, prostitution represented one form of adaptation to the intolerable strains faced by migrants. Migration was characterized by unequal sex ratio, which made it difficult for men to establish stable sexual liaisons with women; thus encouraged prostitution. Infections which were contracted from these extra-marital practices were later spread to rural areas where they had their wives.

The impact of population dynamics on the spread of infections is clearly captured by Dawson (1988) in explaining the spread of smallpox during the colonial period. He points out that in the pre-colonial period, the prevalence of smallpox was very low due to limited travel and inter population contacts among sparsely populated communities. However, in the 20th century during colonial, conscription into armies, labour migration and increased interaction among people due to long distance trade created conducive environment for the spread of the disease.

Silberschmidt (1992) also notes that given migration to urban areas increased male absence in most Gusii households. It disrupted the social organization of most families especially on decision making. In the community, men are the sole decision makers. Their absence; therefore, meant that women were to take up the role of decision making regarding family activities. This disempowered men and as a consequence they resorted to violence and sexual immorality as a way of asserting their status, putting both women and men vulnerable to contracting sexually transmitted diseases.

Migration also entailed separation of the family members and weakened social capital as most households were characterized by male absence. The absence of male (fathers) at home has negative effects on the socialization of young adults especially on their sexual behaviour (Masita, 2007). In her study among young people in Gucha district, Masita found that the presence of

males (fathers) in the household had a positive influence on adolescent sexual behaviour specifically on age at first sexual relation with a person of opposite sex, number of sexual partners, involvement in sexual relationships and use of contraceptives such as condoms. She attributes these findings to cultural and historical factors that shape gender differences in parenting tasks, division of tasks in patriarchal communities.

According to Masita (2007), among Abagusii fathers provide social status and income while mothers provide children with care and nurturance. Being a patriarchal community, fathers are the custodians of resources which are important in adolescents' development. Further, the principle governing social behaviour among Abagusii *chinsoni* equally makes it difficult for mothers to advise their sons on issues of sexuality. Normally boys are advised by their father. The consequence of this is that young boys grow up with no adequate knowledge on sexuality which later exposes them more to STD infections.

In Gusii land, another significant impact of colonial rule was the compulsory abolition of the traditional military encampments, "*ebisarate*" for security reasons. As a result, most Gusii young men found themselves free from the customary obligation requiring all circumcised males to stay in the military encampments in order to protect their community from external aggression and herd cattle. With no duties or obligations, most young men started marrying at a very young age unlike in the pre-colonial period where most young men were allowed to marry after spending two to five years in the *ebisarate* after circumcision.

The reduction of marriageable age as a consequence of abolition of *ebisarate* increased the demand for more young women for marriage. This drastically reduced the age of marriage to as low as 15 years for young women. This had two implications though interrelated. First, young people started indulging in sexual issues at a very young age. Two, engagement in sexual issues at very young ages especially for girls meant a long period of fertility. The latter factor in combination with improved survival rates of children to maturity per woman during colonialism led to a high increase of population growth in Gusii land. High population growth rate became one of the major push factors for many young people to migrate to urban centres for sustenance.

Migration to urban centres did not; however, ease pressure on resources like land. Migrants continued to have a lot of attachment to this resource -land at their point of origin (Ntabo, 2006). To Abagusii, the land you inherit from your parents gives you an identity and status in the community. For example, if a Gusii kin dies in far off places, the community members must ensure they bring the body home for burial in the land allocated to him to symbolize reunion with his ancestors. Also any Gusii young man must ensure he has built a house in his ancestral home in order to gain respect and recognition among community members. This cultural value attached to land ensured that all migrants left behind their spouses to take care of this all important resource. Given the poor living conditions associated with such migration like poor and unstable wages, long separation from spouses, migrants are predisposed to risk sexual behaviour not only to themselves but also to their spouses in rural areas.

The disruption and replacement of traditional agriculture life with cash crop farming by colonial government, led also to social dislocation of both men and women. In Kilimanjaro, single women and children were socially dislocated and moved to urban centres to work in coffee factories (Setel, 1999). However, due to the structure of colonial economy, it was impossible for women to sell their labour. Consequently, most of them were forced to live off low wages of male workers which often entailed involving either formal or informal prostitution (Doyal, 1979).

The colonial cash crop economy required vast areas of land. This necessitated alienation of land from most African communities. In Kenya, these processes caused mass displacement in alienated areas, especially among Kikuyus of Central Kenya. This situation gave rise to a mass of people without land rights (squatters). Other communities like pastoralists were forced to vacate their grazing lands, cutting off their means of livelihood. Among the Chagga in Tanzania, the introduction of coffee plantation led to land crisis through a squeeze in family holding (Setel, 1999). Those who were pushed out of agricultural land in Kilimanjaro and pulled to Moshi towns are reported to have been living in poor, overcrowded and polluted environment. Often, they were involved in public drunkenness and prostitution (Ibid).

In postcolonial era, the trends that originated in the colonial period in terms of political and economic structures have continued. Population movement and urbanization have remained important dynamics in the social and clinical epidemiology of most sexually transmitted diseases and most notably HIV/AIDS in Sub Saharan Africa (Hunt, 1988; Larson, 1990; Schoepf, 1991; Setel, 1999). This is underscored by Dawson's (1988) and Denis *et al.*, (2006) observation that the same historical forces that shaped the sexually transmitted diseases pattern in the twentieth century Africa are very important in understanding the social epidemiology of HIV/AIDS today. For example, among Abagusii, young people continue to migrate to urban areas in search of employment or alternative means of livelihood due to the socio-economic structures laid out by the colonial economy. Conditions in urban areas like poor living conditions, unstable income makes them vulnerable to HIV/AIDS infections.

In a study targeting Gusii migrants in Nakuru town and their survival strategies, Nyatigo (2008), found out that the migration was skewed towards men, who were engaged in short term causal jobs with very little income. Most of the migrants were living alone in town while their immediate families were at their rural home. Due to little wages, most of the migrants visited their families at most once a month depending on how much they have saved in a particular month. As a result, the study observed that most migrants engaged in short term sexual relationships with commercial sex workers because they could not afford to stay with or visit their wives. Although Nyatigo's study did not delve on whether the migrants practised safe sex or not, it important to note such sexual behaviour exposes the migrants to high risk of acquiring HIV/AIDS. Similar findings regarding migrants' sexual behaviour have been evidenced among migrant miners in South Africa (Campbell, 2004).

The predicament facing migrants from Gusii land in urban towns is better understood and appreciated by the song *Ekebe egetangani* Volume 2, 2008 by Rev. Samuel Otiso[66]. *Ekebe egetangani* (Literally translated as First sin) talks about young people who have gone to various urban towns to look for jobs. Because of scarcity of good jobs, these young people start engaging in "*first sin*" (sex) in urban towns. Since God does not like sin, he punishes them with an illness

[66] Samuel Otiso is both a contemporary gospel singer and preacher based in Kisii town. Most of his songs are based on contemporarily issues which are affecting many Christians. He is very popular among evangelical cal church goers and young people because of use musical instruments, and mastery of language.

which does not respect the principle of *Chinsoni* (avoidance or constraint behaviour). This is because those who are being punished reach a stage where they are "*wrapped with napkin/ diapers like newly born babies, dressed and fed by their parents regardless of their gender*". Despite all the efforts to treat and care for them, they die and their bodies are brought home wrapped in black polythene papers for burial.

Although Otiso's song tries to emphasize the moralistic construction of HIV/AIDS, it nevertheless highlights other important issues regarding HIV/AIDS. First, young people are pushed into urban towns to search for jobs which indicate that in their rural areas, they are unable to meet their sustenance. Second, due to scarcity of good jobs, young people are forced to engage in sex. Combining these two issues, we can infer that in urban areas young people are forced to use sex as a survival strategy to meet some of their basic needs. This underscores the importance of structural factors in the spread of HIV/AIDS.

In Kilimanjaro, Tanzania, Setel (1999:73) has also captured vividly how social dislocation and urbanization which intensified in 1980s predisposed young people to HIV/AIDS:

> ..... *Throughout this century, there are many men and women for whom this increased pressure (migration to urban centres) proved irresistible. They are the ones for whom, in the first decade of the epidemic; AIDS was such a deadly paradox. The men were pushed off the mountains by land scarcity and economic stagnation and pulled to the town and market by the desires both modest and magnificent; their journey of dislocation from the kihamba (household land holding) became emblematic of rural demography of Kilimanjaro. Over the years the cultural logic that had long linked sexuality to ordered social reproduction in fixed locations on the mountain had to be stretched to accommodate the shifts in domesticity of those who could not be physically provided for on the mountain. The strain from this process began to show mostly clearly when men began to return home to die from AID, their devastated bodies the portentous signs of dislocated and disordered desires.*
>
> *Suddenly a visit from a long-absent spouse raised the spectre of infection with HIV, and the moral demography of Kilimanjaro quickly became a moral epidemiology of infective manhood against background of vulnerable, pliant woman.*

The destruction of traditional economy by the colonial government and replacement of it by cash economy has continued to predispose many people to HIV/AIDS vulnerability. Before the

introduction of cash economy, most traditional societies like the Gusii were egalitarian. The cash economy not only created new demand for western goods but also class division of those who could and could not afford. The money for purchase of these goods can only be earned either through trade or employment. These two means are; however, not accessible to most people. In rural areas; for example, high unemployment rates, declining viability of small scale farming has increased dependence ratio among few members who have income (salaried). This leads to low investment which in turn leads to a continuous vicious cycle of poverty. This compromises individuals' ability to invest in their health behaviour especially where such actions attract economic cost (Mwenzwa *et al.*, 2006).

Further, given the fact that means of accessing goods and services are so limited in the cash economy, most people may resort to using unconventional means. For example, women who cannot afford bare necessities may resort to earn an extra income through sexual exchange. This is a result of western capitalist system of materialism, which has objectified sexuality and turned it into an exchangeable commodity that can be sold in the market or exchanged for desired material goods. In this exchange, women often work from a fragile financial position which compromises their bargaining power regarding use of contraceptives like condoms.

As from the above discussion, it can be concluded that the HIV/AIDS epidemiology in most communities in Africa cannot be divorced from the African political economy which can be traced to the historical, economic and political environment. This is because the political, social and economic structures which were introduced during the colonial period continue to influence people's vulnerability to HIV/AIDS. Also the response by the colonial government in dealing with STD is still reflected in the handling of HIV/AIDS today. Just as like in the colonial time, the response to HIV/AIDS has been through condemnation of the victims and stereotyping of the African cultures and behaviour rather than focusing on the social and economic conditions which predisposes individuals to HIV/AIDS vulnerability.

HIV/AIDS and Development

In most discourses in Africa, underdevelopment has been cited as a major factor for the myriad problems afflicting the continent. In this school of thought, it is argued that if development was to take place in many parts of Africa, most of her current problems will cease. Development in this case is equated to positive changes which are important in improving human welfare. However, in some cases what is taken to be development may actually have more negative impact to the people who are supposed to be beneficiaries.

In Africa, colonialism was justified on the ground that it was to spur the continent into a development course. However, Hughes and Hunter (1970) have argued that the colonial development often led to the spread of infections; in most cases they altered the ecology, disrupted social relations and lifestyles which led to health problems. To them, what is supposed to be positive improvement in the social condition of living is often maldevelopment. Similarly in Kenya, some of the development programmes initiated by the government may have some attendant negative impact to the beneficiaries.

Since 2003, the Kenyan government has been pursuing aggressively rural electrification projects in an effort to provide cheaper energy to local people as a way of spurring development in rural areas. Most of these electrification projects have targeted mostly rural shopping centres. The consequence of this development is that most of these rural shopping centres have turned into a hub of both social and economic activities. In Bomariba shopping centre in Suneka division (part of the study site); for example, it was noted that prior to the coming of electricity in 2005, the centre was dormant with no much economic activities. Since then the centre has drastically changed to the extent that local people refer to it as "town" because of the migrants who have begun economic activities and emergence of new cultural. For example, new forms of entertainments have emerged like public airing of films and videos in small rented rooms in shopping centres using home entertaining systems.

As observed during the entire fieldwork period, the most popular videos which were broadcasted glorified war and sex. Though the videos were clearly identified as being for adults, an age restriction was never enforced as long as one paid entry fees. Some children were for

instance seen peeping through windows and standing besides the entrance trying to have a glimpse of action-packed movies especially the steamy sex scenes. Young and old men often paid entry fees for women and young girls.

Watching of sex videos was noted to influence most young people to indulge in unprotected sex. Most watched videos which showed actors having sex with no protection giving an impression that good sex means no condom use. Further, most of the sex styles depicted in these movies were perceived as exciting but unconventional to be done with a regular sex partner like a wife. Therefore, a number of young people especially men preferred to experiment these learnt sex styles with commercial sex workers or non-regular sex partners.

The link between development and diseases has been discussed by many authors. Scheper-Hughes (1992), has discussed how the industrial growth in 1960s and 1970s which was symbolized by sugarcane plantations caused a lot of suffering and pain among the inhabitants of Alto in Brazil. The consolidation of landholding into large plantations dominated by single export crops like sugarcane at the expense of diversified and subsistence farming led to growing wage dependency and the loss of gardens which forced many workers to move to Alto do Cruzeiro and to the market of Bom Jesus de Mate. These changes in traditional relations of productions are understood by the locals as the cause of all problems afflicting people. This was compounded further by the introduction of machines to replace human labour. As a result, those who entirely depended on providing labour to sugar plantations for their livelihood were rendered redundant. Actually, most of them were evicted to provide space for sugar - increasing their misery and vulnerability to infection.

In Ghana (Decosas, 1996) has shown how the building of Volta dam in 1960s predisposed people to HIV/AIDS almost a decade later. The Volta dam was built to generate a huge amount of electricity for use in the processing of bauxite into aluminium for export. This necessitated that some 8,500 square kilometres be cleared for the dam reservoir. This displaced many farmers some of whom moved to construction sites to sell their labour. Displaced women ended up as service workers in the hotels and bars built to serve construction workers while others indulged in commercial sex. The changes brought by this construction of the dam created a conducive

environment for the spread of HIV/AIDS. In actual sense, by mid 1990s the HIV prevalence in the area surrounding the dam was found to be five to ten times more than the rest of Ghana.

In a study by Rugelema (1999) in several commercial agro-estates in Kenya, it was found that the physical and living conditions of most workers predisposed them to HIV/AIDS infection. In this study, Rugelema observed that most workers lived in quarters which were overcrowded, shared rooms and lacked entertainment facilities. As a result, most workers resorted to alcohol abuse which encouraged risky behaviour. A similar study done in Dominican Republic among sugarcane plantation workers found that these communities that mostly comprised of female migrants had a higher rate of HIV infection among women than those estimated in the general population (Brewer *et al.*, 1998).

In 1970s and 1980s most Sub Saharan countries were faced with oil and debt crises respectively. In response to these crises, most Sub Saharan countries were forced to implement Structural Adjustment Programmes (SAPs) by Bretton wood institutions namely World Bank and IMF to spur development. These programmes demanded fiscal discipline (limiting budget deficits and cutting down on social spending in areas such as health, education), financial liberalization, privatization of state enterprises, trade liberalization, limitation barriers to foreign direct investment, and elimination of subsidies on consumer items such as food, fuel and medicines(Rau, 1991).

In Kenya, the implementation of SAPS led to the reduction of government's expenditure commitments in mainly -but not exclusively - areas concerned with the provision of basic welfare; that is, health, education and basic sustenance such as food subsidies. These cuts in government's expenditure forced up the cost of primary education and healthcare beyond the reach of many rural families. The removal of price controls and the devaluation of national currency led to the cost of living spiralling. Moreover, rushed privatization resulted in the laying off of ten-of-thousands of workers. All these combined pushed millions of people, especially in rural areas, to the margins of vulnerability to adopt coping mechanisms which exposed them to greater risks of HIV/AIDS infection (Ogot, 2004; Hunt, 1988).

Further, the reduction of healthcare and social service spending has constrained the availability and accessibility of these services. Between 1980 and 1985, there was 26 per cent decline in spending on health, education and other social services for low income people. In low income countries, health spending dropped from 5.5 to 2.8 per cent of national budget over the same period (UNDP, 1990). Despite this, some countries were forced to introduce cost sharing towards medical services which were previously free. This affected negatively the provision of health services. In Kenya for instance, the number of people seeking medical services especially in public, sexually transmitted diseases clinics fell by 35-60 per cent when fees was introduced (Moses, 1992). Cutting of funding for public clinics also encouraged the reuse of disposable syringes which contributed to HIV transmission (Mann, 1986).

Besides the health sector, SAPs emphasized the reduction of agricultural subsidies especially on non-export crops. Over emphasis on cash crops undermined the rural economy leading to nutritional deficiency and exacerbating poverty which led to labour migration and urbanization. In Thailand, Bello, Cunningham and Rau (1994) observed that SAPs exacerbated poverty in rural areas as most resources were focused in urban areas. This encouraged many people to move to urban areas which in turn increased their vulnerability to HIV/AIDS.

The high prevalence of HIV/AIDS in Sub Saharan Africa has also been linked to the development status of these countries. Using data from United Nations Development Programme (UNDP)'s, Human Development Index (HDI)'s, Decosas (1996) found that countries with relatively higher HDI values were the same countries with very low HIV prevalence, while countries with lower HDI had higher rates of HIV prevalence. He went further to argue that the risks of counties or societies for experiencing serious AIDS epidemics are not clearly equal. These differences in the prevalence of HIV/AIDS between; for example, Western and Sub Saharan countries can never be accounted by any difference that might exist in sexual behaviour patterns. Instead, he argues that such differences can be explained by examining other co-factors that facilitate HIV transmission. These factors according to him are rooted in uneven or dysfunctional development. Perhaps the palpable measure of the inequalities in power in most developing countries has been the concentration of resources in the hands of the minority. As a

result of this, majority of the people have limited power to make choices in their lives thus affecting their vulnerability to HIV/AIDS.

In summary, the socio-economic conditions generated by national and international development policies have contributed to the HIV/AIDS epidemic in most parts of Sub Saharan Africa. Most of these development policies to a greater extent only aim at creating a conducive environment for profit maximization with no regard to how they affect the supposed "beneficiaries". This has raised questions as to whether HIV/AIDS can be considered a disease of development gone wrong and whose remedy lies in rectifying these wrongs of development.

HIV/AIDS and Poverty

Most medical anthropologists and other researchers who have discussed HIV/AIDS in the context of the socio-economy have often acknowledged the role of poverty in the spread of HIV/AIDS (Farmer *et al.,* 1996; UNAIDS, 2001). In their discussion, they have argued that poverty cannot be considered as just another co-factor alongside biological, gender inequality and cultural consideration in the causation and transmission of HIV/AIDS. To Farmer *et al.* (1996); for instance, all biological factors that predispose women to increased risk of infection from chronic anaemia to genital mutilation and early sexual debut are aggravated by poverty, thus, *fundamentally social forces and processes come to be embodied as biological events* (Farmer, 1999:14).

Madise *et al.* (2007) in their research among adolescents in Malawi, Uganda, Burkina Faso and Ghana regarding poverty and risky sexual behaviour found that girls from wealth background had late sexual debut compared to those from poor background although this association was weak in Uganda. Among males, wealth status was found to be a weaker factor in sexual risky taking behaviour except in Malawi where those in the middle quartile had earlier sexual debut. Adolescents from wealthier background were noted to use condoms in sexual relationships, but their status was not associated with the number of sexual partners. Despite the inconsistency between wealth status and sexual behaviour; they however, concluded that poor females were more vulnerable to infection because of earlier sexual debut and having unprotected sex – not using a condom.

In Sub Saharan Africa where the common mode of HIV transmission is heterosexual, most often commercial sex workers has been cited as the leading factor fuelling factor of HIV/AIDS (Caldwell *et al.* 1989). Many studies have documented that most commercial sex workers have high prevalence of STD and HIV. However, what has not been stressed is the importance of comprehending the socio-economic context in which such a sexual behaviour occurs.

Commercial sex work can be classified into two categories. The first category is composed of full or part-time sex workers who exchange sex for money or gifts. The second category is composed of women or young girls who occasionally accept gifts or favours from men in return for sex. In all the categories, what is clear is that women or young girls trade sex as a strategy for meeting their basic needs (McGrath, 1993; Weiss *et al.* 1996).

In Kenya, a study done by Centre of Adolescent Studies (2009), found that young girls exchanged sex for basic needs like food or to access certain lifestyles like mobile phones. Nzyuko *et al.* (1997) in a study on adolescent behaviour along the Trans-African Highway in Kenya found that girls who exchanged sex for money, majority reported lack of income for essential items such food and clothing. In Uganda, a study which exclusively focused on young men and women not attending school in Uganda found that poverty as a major factor in the exchange of sex for gifts and material gains (Bohmer and Kirumira, 2000). In this case, it was observed that men especially sugar daddies took advantage of poverty to put pressure on young girls by offering them gifts and money in exchange for sex. Most of these men do so with the belief that young girls are more likely to be uninfected with HIV/AIDS.

Young men are equally at risk of getting infected by HIV from elderly wealthy women. In Kisumu, Kenya as noted by Orwa, P. (in the article *loaded seductresses on the prowl in Kisumu*: East Africa Standard November 23rd 2009), elderly women who are mostly widowed but wealthy entice young men financially and materially to have sex with them. Most of these women target mostly the poor and unemployed men. In this sexual relationship, given their fragile socio-economic status these young men have no power to negotiate about safe sex. These elderly women as per Orwa's article have multiple sex partners despite the fact that most of their spouses died of HIV/AIDS related complications. Although most young men are aware of the

status of these elderly women, doing away with their current status of poverty and unemployment becomes primary to HIV infection. This is graphically illustrated by the following cartoon in the article.

Loaded Seductresses on the Prowl in Kisumu

Source: East Africa Standard November 23rd 2009

In Thailand, a 1993 study on female commercial workers found that majority came from economically neglected rural areas where cultural norms place the burden on women to support parents and siblings. Due to these, most young girls moved to cities and engaged in prostitution in order to fulfil their traditionally prescribed gender roles (Wawer, 1996).

Commercial sex which is due to scarcity and poverty in most cases foster behaviours which are risky. As observed by Wawer (1996) in a study among commercial sex workers in Thailand, due to poverty most of them had no power to negotiate condom use among clients. In cases where they tried to negotiate, the male client would move to other sex workers who were willing to have sex without a condom; making condom negotiation is equivalent to losing business. In another study by Ford and Keetsawang (1991), due to desperation to meet basic needs, some commercial sex workers opposed use of condoms because they feared it would delay their client's ejaculation through prolonged penetrative intercourse and thus reducing the total number of potential clients.

From the above studies, it's quite clear that poverty is one of the factors which predispose people to risk taking behaviour. People may understand the risk involved in certain behaviours but they will not have incentives to avoid them. This is quite true as observed by Ward (1993) among female commercial workers in Messine in the North-Eastern tip of South Africa where due to poverty; HIV/AIDS was taken as another problem which warranted no immediate attention when compared with other real problems like meeting basic needs like food for the family.

Despite the centrality of poverty as a primary risk environment to HIV/AIDS, most HIV/AIDS intervention strategies have focused mostly on sexual behaviour change. This has prompted to question why most actors like donors and NGOs dealing with HIV/AIDS do not take poverty as a factor in HIV/AIDS intervention but treat it as a consequence of HIV/AIDS. Instead, most of these actors have left the issue of poverty with poor government while they concentrate on prevention of HIV through individual behavioural change – education and condom promotion.

The exclusion of poverty as a factor of HIV/AIDS is also evident in most applied social research in Sub Saharan Africa (Cohen, 1998). Most of these researches have instead focused on cultural differences and the nature of African sexuality (Packard and Epstein, 1990). This negation is not unique as Farmer points out, "AIDS follow the general rule that effects of certain social forces on health outcomes are less likely to be studied (Farmer, 1999:51). In this case, a very important co-factor which not only determines the pattern of HIV/AIDS but the nature of outcomes once an individual is infected is missed out.

This approach in dealing with HIV/AIDS has been faulted by Farmer (1999) for obscuring the ways in which poverty drives so much of the epidemic and instead focuses on "risky behaviours". Such thinking ignores socio-economic and political structures; and power relations which through myriad and often-subtle mechanisms constitute the primary risky environment for HIV/AIDS infections. This exaggerates the individual agency and fails to take into account how social and economic factors structure risks for individuals or groups particularly those who are marginalized from power and from access to goods, services and opportunities which power guarantees.

In Kenya, access to public services like water, education and health are determined by the socio-economic status. The rich are always at an advantage than the poor regarding access, quality and quantity of these services. Access to this especially health services among the poor is limited by several factors including cost sharing and distance to health facilities (Kimalu *et al.* 2002). The poor are further disadvantaged because in most cases the rich double as policy makers and thus advantaged to influence the type, quality and quantity of service and opportunity available to them. This makes the poor to access public service like health and information from a disadvantageous position. The disadvantageous position of the poor is attributed to their relatively low socio-economic and political power as the two remain intertwined.

Studies have shown that poverty correlates with education, household size and occupation (Geda *et al.* 2001). Thus, poverty falls with increase of education, decrease in family size and involvement in modern labour rather than agricultural sector. In Kenya, poverty is more prevalent in rural than urban areas, among female than male-dominated households and the less educated; given that education is closely related to the level of income and therefore access to public services including health information. Consequently, the less educated are more unlikely to access information especially where the economic cost is involved. For example, households without food security may not spare their income to seek any information on HIV/AIDS. This may compromise their health seeking behaviour which is dependent on information.

Furthermore, in most cases the poor live in rural areas where most means of mass communication are inaccessible. In addition, the poor are likely to be less literate and as consequently consequence unable to read and understand the language used by most mass media. Moreover, poor people and more so in rural areas are more likely to be conservative and therefore unable to pass health information especially on HIV/AIDS that revolves around sexuality. This is because most Kenyan communities, sexuality and reference to it remain a taboo. As a result of this, most people in rural areas are unlikely to seek and access health information given their cultural inclination and socio-economic status.

It is worth noting that HIV/AIDS affects both the poor and the rich. Nonetheless with the poor accounting, majority of those affected in Africa (GOK and GTZ, 2001), the poor are more likely

to be exposed to the HIV/AIDS predisposing factors. Some of these predisposing factors include poverty itself, physical exploitation and sexual abuse. Cohen (1997) also concedes that the poor are the most affected with HIV/AIDS due to their means of livelihood which in most cases involves strenuous manual labour, low job security and little or no control over working conditions. Such working conditions can lead to frustration and lack of personal satisfaction, which are released in escapist behaviour such as getting drunk, taking drugs or engaging in indiscriminate sexual intercourse (UNAIDS and PANOS, 2001). On the other hand, the non-poor exposure to HIV infection is related to work, leisure pattern and to high levels of labour mobility (Cohen, 1997).

Among Abagusii young people, poverty which they commonly refer to as *Ekiagaso* (itching of the body) is the leading risky environment in the transmission and contraction of HIV/AIDS. In the lives of Abagusii young people poverty *ekiagaso* cannot be done away with in one's life. It is such a natural predetermined destination once you are born into the community. With no land left to be inherited from parents, *ekiagaso* remains the only sure inheritance for almost all young men and which keeps on multiplying with each subsequent generation. Unlike the itching of the body where one soothes the body by rubbing it, in *ekiagaso* or poverty one learns how to cope or exist in it. Among Abagusii young people, the common coping method adopted is indulging in alcoholism.

Alcohol consumption among the Abagusii is an old phenomena which has existed since time immemorial. In old days, it was a preserve for the old and elderly people as a socializing activity and in some cases for cultural rituals like circumcision. Taking of alcohol was done with observation of rules like who to take alcohol, when to take, how to take and with whom to take. These rules regulated alcohol consumption and curbed any anti-social behaviour which might arise from its consumption. For example, young people were not allowed to consume alcohol and there was no gender mix up in alcohol consumption.

In recent past, however, the consumption of the local alcohol "*Pambua*" among the young people has tremendously increased. With no social rules governing its consumption, many young people are turning to alcohol not only for socialization and entertainment but as a way of overcoming

their day to day stress. In the community, the common alcoholic beverages are *Busaa* and *Changaa*. *Busaa* is made from water, flour and millet through the process of fermentation while *Changaa* which is equivalent to whisky is distilled from fermented *Busaa* and its alcoholic content is more than 100 per cent alcoholic content. The sale of local brews is a booming business especially among women due to the ever increasing clientele.

Among the local people, it is popular knowledge that as long as there is uncontrolled consumption of *Pambua*, HIV/AIDS cannot be controlled in the rural areas. In addition, a number of respondents indicated that local brews are the source of all social and health problems affecting young people in Gusii. It was noted that young men and women who go out to drink mostly end up having sex. This is vividly captured by Nyambura's sentiments;

> *Since pambua was given an okay by our local leaders during the public meetings, we are now living like dogs, but at least dogs have a mating season! Young men are having sex with drunkard old women who are the age of their mothers after buying them a glass of beer. In our market place, old men have resorted for you young girls who need to drink...Walk in the evening and you will see what I am telling you, people having sex on the wayside with no shame..... It is Sodom and Gomorra[67]!*

Drinking too much alcohol can lead to uncontrolled behaviour and impaired judgment especially on sexual relations. In a discussion with a 25 year-old lady Kwamboka, she said:

> *One evening I was coming from the market. I remember it was a bit dark. I met my uncle who was drunk and I greeted him. Instead of answering me, he came straight to where I was and started touching my breasts telling me he wanted "me to save him" (euphemism for sexual intercourse). Imagine my uncle whom tradition demands should not even intend to imagine this thing with me...!*

Mabeya a 30 year old young man who is HIV positive further illustrates how his drinking of *Pambua* led him to contract the virus.

> *You see I was having some money from my touting job in town. At least I will make about Ksh. 150 (equivalent to 1.5 Euros) per day which was a lot of money in the village. Every woman both young and old wanted me to be in my company whenever I went for pambua. After drinking the whole night each morning I used to wake up, I would find myself in bed with a woman .....!. I had no control whom to have sex with once drunk!*

[67] Sodom and Gomorra are cities in the bible which were destroyed by God due to immorality among their inhabitants.

Some informants argued that the local brew especially *busaa* make men to be excited sexually thus raising their urge to have sex. This happens when men consume alcohol with the company of women, they start admiring each other under the influence of alcohol and end up having sex, heightening the risk of contracting HIV/AIDS. This notion is a form of social truism among men that any woman suddenly becomes beautiful as a man gets drunk. Similarly, most commercial sex workers make moves towards men when they appear drunk.

These findings of alcohol use and risk taking behaviour has been evidenced in others studies. Bagnall *et al.* (1990) found that young adults who reported more frequent use of alcohol and drugs were seven times less likely to use condoms during sex. Another study among teenage higher secondary school students in India found that alcohol and drug usage was associated with engaging in actual sexual intercourse (Selvan *et al.,* 2002). Fromme *et al.* (1999) reported that having sex when intoxicated is related to risky sexual practices. Those who are drunk can rarely make rational decisions especially concerning condom use.

Besides predisposing young people to risk taking behaviour, alcoholism increases the likelihood of one getting infected with HIV/AIDS. As observed in the site of study, most young people who are involved in alcohol consumption rarely spent their money to purchase food for themselves. Purchasing of food was seen as a waste as alcohol was seen as equivalent to food. This facilitates malnutrition among most young people, thus compromising their body defence mechanism (Loevinsohn and Gillespie, 2003). The lowered immune system that results from this behaviour thus facilitates the transmission or contraction of HIV/AIDS.

In the environment full of poverty, even those who are not poor are at risk of getting infected by HIV/AIDS. Their being non-poor becomes a risk itself. As observed, young people especially young men who were perceived to be well off were induced by desperate women to have sex with them in exchange for financial and material gains. Samson captures this by the following sentiment;

> *Most women here target men with money or those who can meet their needs. Like a bee which is attracted to a flower because of the nectar, it will use every trick to get the nectar so do our women here. Even if a man tries to run away from such determined woman, eventually he will succumb to their demand.....I think and sometime people say women use some love portion to blind men with resources to*

be their lovers! You see teachers, businessmen and mostly drivers both of public service vehicles and motorbikes, are the most sought group because they have money.....what I find funny is that you can get a woman who knows very well that a certain man is sleeping with such and such woman but she still wants to join the queue. The woman does so not because she loves to but the needs she wants to be fulfilled by the man...!

Roinya, a 33 year-old man who is HIV positive further illustrates how being non-poor is a risk to HIV infection:

Man life can be bad I tell you! After getting a job as an accountant in one of the banks in town, I had real money. In our village, I was the most highly paid person. My friends urged me to move to town and rent a house there but I refused. In the rural area my expenses were very minimal.... I was so much focused to invest before I marry. So I started planting tea bushes, embarked on a zero grazing project and poultry. All these projects were going on well. Many of my casuall labourers were mostly unmarried young women mostly with one to two kids making my farm nicknamed as ladies farm. I was proud that my investment initiatives were helping some people meet their livelihood. Initially I was very strict with all my workers. What mattered to me was that a worker meets her day's target and I pay her. ... I do not know what happened one evening as it was raining, one of my workers just appeared from nowhere. I was all alone. She told me she had forgotten something in my farmhouse, which I later learnt was a lie. Since it was raining, we continued chatting but ooooh dear! We were in bed having sex until the following morning. This mere act opened a floodgate for me having sex with almost all girls working for me. None of the girls seemed to care that I had sex with other workers as long as I gave some something to enable them buy soap! Worse still I bought a second hand car and a mobile phone. All these made me more popular beyond my farmhouse. In town, I was dating many girls.... One day some organization came to our bank and asked us to donate blood, which I did willingly. After one week I was called by one of the people who were involved in getting blood from us. He asked me to meet him in their place of work. I went there after two days. After a lengthy talk they started counselling me after which they told me about my HIV positive status. For me, what brought all this is my own money and I regret.

To all and sundry in Gusii, common wisdom has it that the cradle of evil and good is money. In this age old wisdom observes that money can help you build your life to greater heights and at the same time can make you destroy the same life. This has no better analogy than examining the social activities which take place in Gusii land and other tea growing areas like Bomet and Nandi districts in Rift valley province every December following the payment of "Tea Bonuses[68]" to

[68] Tea bonuses are the accumulated payments paid to tea farmers at the end of every year by Kenya Tea Development Agency (KTDA). This payment depends on the farmers' total accumulated kilos delivered to KTDA

farmers. Year in year out, payment of tea bonuses sees most small scale farmers especially men moving from their homes to rural shopping centres or some to big urban centres to seek various forms of entertainment their payments can afford. Most of these entertainment centres on beer drinking and having sexual exploits with many sex partners. This has made most commercial sex workers to move to these rural shopping centres or to the urban centres which are frequented by these farmers to cash on this abundance every year as illustrated by East African Standard November 16th 2009 cartoon " *Living in a fool's paradise*". The consequence of these is that, not only are women are abandoned by their husbands but also infected with sexually transmitted infections including HIV/AIDS.

Living in a Fool's Paradise

Source: East Africa Standard November 16th 2009

The relationship between HIV/AIDS and poverty is twofold: there are poverty related factors that expose people to infection with HIV/AIDS, while at the same time there are HIV/AIDS related factors that impoverish people. For example, infection with HIV/AIDS means more expenditure on healthcare. This limits investment and savings while increasing consumption and thus entrenchment of poverty in society. On the other hand, poverty may compel individuals and especially women to engage in commercial sex work. It is important to note that commercial sex

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at the end of the year. Unlike the monthly payment, bonuses are paid at a higher rate per kilo delivered. In these payments, most small scale farmers earn a fortune.

work is a special type of sexual relationship in which partners are not at par, often the woman having less power in terms of negotiating for sex. In this case, it is the man who decides whether to have protected sex or not, exposing both to risk of contracting HIV/AIDS. Altogether, poverty is a factor in HIV/AIDS transmission because it is largely associated with fragile financial base and therefore less bargaining power with regard to sexual relationships.

In Kenya, dealing with poverty in relation to HIV/AIDS has; however, been in connection with mitigating its consequences. HIV/AIDS is seen as a cause of poverty, adult and child mortality, the overstretching on health services, the collapsing of education system, reduction of economic growth and increasing food insecurity, but not as being caused by poverty in the first place. In this case, HIV/AIDS is seen as just worsening poverty. This thinking is even captured in UNDP where it talks of mitigating the consequences of HIV/AIDS in relation to poverty reduction. This justifies why efforts aimed at HIV/AIDS focuses on public health and biomedical approaches. The UNDP states:

> *The response to HIV/AIDS so far focused highly so, on the challenge of containing the epidemic and preventing new infections through advocacy, information and education campaigns, behaviour change communication, condom distribution, programmes targeting groups that are particularly vulnerable to infection and other key interventions. The other part of the response is focusing on treatment and care of people living with HIV/AIDS- efforts that are expected to intensify, as new treatment become more accessible and affordable. Both prevention and treatment are top priorities in not only saving lives and reducing human suffering, but also limiting the future impact on human development and poverty reduction* (Loewenson and Whiteside, 2001:2).

They continue to point out,

> *However, despite intensifying efforts focused on prevention and care, the epidemic continues to spread unabatedly, and as people infected by HIV become ill and die, its devastating impact is now being felt in the worst affected countries* (Loewenson and Whiteside, 2001:2).

The above statement invalidates the above public health approach.

In summary, it is important for HIV/AIDS prevention efforts to tackle the underlying causes of the epidemic. Political, economic and gender inequality, structured violence and social conditions of living have deeply and geographically structured risk for HIV/AIDS. Poverty not only dictates the exposure to risk, but also the mechanism through which people can limit the dangers and fatal consequences of infection.

HIV/AIDS and Gender

Gender has often been cited as a major determinant in the spread and prevention of HIV/AIDS in Sub Saharan Africa. However, gender alone does not influence one's vulnerability to HIV infection in a vacuum. Economic and social vulnerability as well as stereotypical gender roles influence women's and men's vulnerability to HIV infection, while fuelling the overall course of the epidemic. Poverty, inequality, and gender are inextricably intertwined and compound each other. Gender and poverty do affect men and women differently. Among the Gusii, women are more affected by poverty than men because of the patriarchal nature of the society where all resources are in the custody of men. Women have to access resources for use only through marriage. This may subject women to violence, sexual abuse and lack of power to negotiate for health behaviour, all which increases their vulnerability to HIV/AIDS infections.

However, in most situations not all women are at risk for HIV/AIDS and other forms of infections because they are women for gender alone does not define risk. It is poor women who are more susceptible to HIV infections (Farmer, 1997). Of course, not all women are affected equally. As Schoepf (1993:57) observes,

> *Macroeconomic conditions operating in the context of pervasive gender inequality have different effect upon the lives of women in different regional, class and family circumstances. Different circumstances also produce different negotiating strengths among women as well as different HIV risks.*

The relationship between gender and HIV/AIDS is clearly evident. In Sub Saharan Africa, data shows that women are more susceptible to HIV/AIDS than men (UNAIDS, 2002). In a study in Western Kenya by Gregson *et al.* (2002), it was found out that 25 per cent of girls aged between 15 and 19 years were HIV positive as compared to only 4 per cent of boys in the same age group. Similarly, Joesef *et al.* (2003) study on HIV prevalence in men and women who attended sexually transmitted disease clinics at HIV sentinel surveillance sites in Kenya between 1990 and 2001, found that prevalence in women was higher for all years. All these have helped to raise the question as to why women are more vulnerable to HIV infection than men? Or what it is in gender that makes women more vulnerable.

To answer the above question, I hereafter examine the various gender values and knowledge in various social institutions among Abagusii which influence such vulnerability. This is important because a person's gender defines her or his social relations as it provides an assemblage of rights and obligations that designate possible interactions and claims on the other. Through the process of socializations, both girls and boys learn various norms, rules, taboos and values as found in various social institutions which determine their behaviour. This socialization commences immediately after birth and lasts in one's lifetime.

Gender relationship among Abagusii is characterized by power imbalance. This power imbalance subordinates women in matters of sexuality in two ways though interrelated. First, men's sexuality and reproductive power takes precedence over those of women and secondly, women have no power to question men's sexual behaviour instead they are supposed to be submissive. These two factors are made possible by the socialization process and the social principles governing social behaviour *chinsoni*. In the socialization process, women are socialized to be submissive to their husbands and be passive in matters of sexuality. Therefore, any woman who is assertive in matters of sexuality is scoffed at or labelled as a bad woman. Regarding *chinsoni*, due to their low ranking in the hierarchy of power and authority, women are not supposed to question their husbands' behaviour or action. Such questioning is taken as a sign of disrespect and may attract violence.

Consequently, due to power imbalances which characterize gender relationships; women are more vulnerable to HIV/AIDS as illustrated by Kemunto's testimony, a 28 year-old lady:

> *We women have problems. You can know your husband has other lovers but you cannot question it. If you do, it is taken as a sign of disrespect or trying to control him. All we do is to pray that nothing bad (meaning AIDS) comes by from such relationships.... You see, you cannot ask him to use a condom since he is your husband.*

Kemunto uses "we" instead of "I" to show that it is not her alone with difficulties in dealing with men's sexual behaviour but most women.

Gender power imbalance is further compounded by socio-economic structures which subject women to depend on men for material and economic resources. Among Abagusii, men are the custodian of all resources. Women only access these resources through marriage. Before

marriage, it is almost a standard procedure that a man will seduce and have sex with his prospective wife. In this relationship, due to economic power imbalance, the woman will not have power to negotiate for safe sex. This negotiation is further compounded by the fact that a good woman is supposed to be passive in matters of sex. Therefore, it becomes difficult for a woman to discuss condom use with the prospective husbands or husband for fear of loss of material access or support. This finding is similar to Wyatt (1991) study among African-American women in Los Angeles. The study found that women who depend on their male partners for financial assistance and housing were more likely to have sex without condoms than women who did not depend on men for economic reasons.

Women's vulnerability to HIV/AIDS as a result of their efforts to access resources through marriage has been worsened by changes in marriage institutions. Unlike there before when marriage was consummated by payment of bride wealth, nowadays there is drastic reduction in payment of bride wealth. As a result, new forms of marriage like cohabitation have emerged. These new forms of marriage do not only accord the woman security to a man's resources but also make her more disempowered in matters of sexuality. As observed during the fieldwork of this study, most women who are in cohabitation (where bride wealth had not been paid) feared questioning their husband's infidelity. Such questioning was presumed would make their husband have an excuse of terminating the relationship. Therefore, most of them preferred not to concentrate on issues which may jeopardize their current relationship like demanding faithfulness from their husbands and negotiating for safe sex. The consequence of this is that both women and men are directly or indirectly predisposed to HIV/AIDS infection.

Women's risk for HIV/AIDS can also be linked to their dependence on men for social and personal esteem that comes from being in heterosexual unions, the need for social status and men's protection as captured by Kemunto;

> *A woman's dignity in the eyes of people depends on her success in having a man in her life who is her husband. If not, such a woman is despised by everybody.... not worth to associate with as she is not a danger to those who are married but to the whole community for she is a vector for many diseases like AIDS.*

Kemunto's sentiments are more to do with Abagusii system of socialization. In the community, a woman lacks proper identity until she is married and she has to depend on men for protection and providence. Also, it is believed that woman's sexuality is more safe or secure if controlled by men in a marriage or a sexual relationship. Consequently, any woman of marriageable age and not married is perceived to be a danger to those who are married because of her "uncontrolled" sexuality. Evidently therefore, heterosexual unions among Abagusii are more to do with perpetuation of masculinity. This in essence places women in a low status and powerlessness in sexual issues. For example, a woman who may prefer to abstain from sex may be stigmatized. Thus, she will be forced to indulge in sexual relations to avoid being stigmatized. Given her low status and powerlessness, her power of negotiating for safe sex is greatly compromised thus increasing her vulnerability to HIV/AIDS infection.

Prevailing gender relations have also serious impact on men's sexual health and the sexual health of partners in addition to shaping the broader marginalization of women. Estimates indicate that between 60-80 percent of women currently infected with HIV/AIDS in Sub-Saharan Africa have had only one sexual partner, their spouses (Adler *et al.,* 1996). Research in many parts of the world suggests that men have a greater lifetime number of sexual partners and that there are clear double standards regarding the behaviour of men (de Bruyn *et al.,* 1995, International Centre for Research on Women (1996). Among Abagusii, young men are encouraged to gain sexual experience which is highly valued. Unlike women whose lack of sexual experience is praised and valued; young men are instead devalued and stigmatized as they are derogatorily referred to as *omosacha omokungu*.

Further, in matters of sex, women are socialized not to be assertive. According to Rickert *et al.* (2002), women's ability to communicate her sexual beliefs and desires is a necessary step towards her development of a healthy sexual intimacy. In the cultural context of Abagusii, traditional gender roles establish the expectations that men will initiate sexual activities and women will respond with permission or denial. Although this is the expected standard procedure, in real life women are supposed not show their beliefs and desires in sexual issues lest they are labelled promiscuous. As a result, women's rights over their bodies and their behaviour expression of their sexuality is greatly compromised more so when masculinity beliefs on

sexuality are at play as illustrated by Samson a 21 year-old man from Bomorenda location of Suneka Division;

> ..... *On earth there is no way a girl can tell you that it is fine we can have sex (even if she really wants it). She will tell you no. As a man you have to make quick decisions. You must use some force and once you "enter" her she will pretend not to be happy but in reality she is....*

Lack of assertiveness; therefore, makes forced sex or sexual violence among women normal from the perspective of men. This negates any communication or negotiation about safe sex. In Kenya, one study found that violence against women was expected in relation to positive HIV test results (Rakwar *et al.,* 1999). In the US "before adulthood, young girls' vulnerability to experiences of gender-based violence, such as incestuous sexual and physical abuse lay groundwork for drug and alcohol addiction and dissociated sexuality in which women may not be aware of their right and capability to claim when, how, and with whom they have sex" (Zierler and Krieger, 1997:418). According to both boys and girls interviewed in Brazil; for example, girls and women are often coerced into sex and some young women may obey their boyfriend's wishes because they believe that girls are 'meant' to be compliant and subservient (Vasonceles, Garcia and Mendonca, 1997).

There are also dominant masculine discourses on sex and women among Abagusii especially among young men. In most cases also, women hold similar views as they are under social and peer pressure to have as many boyfriends as possible. For example, a woman to hold on to a man means yielding to sexual demands. Men, on the other hand, may find that by conforming to stereotypical versions of masculinity like they must have sex with multiple sexual partners to prove their maleness, places them and their partners at heightened risk.

As noted earlier on, reproduction among Abagusii is more of a social process which is gendered and accords an individual social status, security and identity. In pursuit of these values both men and women may be forced to engage in sexual risk behaviour. Among males, their social status not only depends on their ability to sire children but getting male offsprings. Similarly, the security of females in marriage depends on getting male offsprings. In situations where these reproduction values are not attained, both males and females may resort to multiple sexual relationships as illustrated by Nyandusi, a male aged 32 years who is HIV positive;

... In my present marriage I have four daughters. I have tried to get a son in vain. When my wife got the fourth daughter, I was so much devastated, I felt useless as I believed every person though not showing it openly were despising me. To prove if indeed I was the problem, I decided to have several sexual relationships with the hopes I would manage to have a son with any of my lovers. My wife complained of my behaviour but I told her off because she had failed to give me a son.... One year ago my wife became sick and missed her periods for three months. Initially we thought she was again pregnant. When she visited antenatal clinic, the pregnancy test was negative. Due to the rashes all over her body and the loss of weight, she was advised to undergo HIV test. The test turned positive. When my wife broke this information to me I was more devastated as I would definitely die without a son who will inherit my wealth and carry on my name and lineage.... After a day, I decided to go to some hospital far away from my home to be tested also. Unfortunately I was positive compounding my misery. After many days of agonizing about my fate, I heard from the radio that HIV positive people can still get children who are HIV negative. I shared this information with my wife and we decided to visit our district hospital where we were enrolled for treatment. I hope once my health improves and my wife's as per the doctor's advice we can again try to get a child with hopes that God will have mercy on us to have a son....

Decades of change in economic activity and gender relations have placed many women and men in difficult situations. According to Silberschmidt (2001) following the socio-economic changes in Gusii due to high levels of unemployment, men are finding it extremely difficult in fulfilling their social roles and expectations thus affecting their male identity, self esteem and authority. Given the fact that male identity is deeply rooted in men's ability to control women, and with male honour intimately bound up with behaviour of his wife, men have to find new ways to manifest themselves as men.

One way of strengthening and demonstrating their self-esteem and masculinity in this situation is by engaging in multi-partnered sexual relationships and being sexually aggressive. Although women would recognize the risk of infection of HIV by their men, they are generally too fearful to confront them. "Better they remain silent, risk death and preserve their marriage (the Kilimanjaro women) openly say, than the stigma and upheaval of trying to refuse sex or demand the use of condoms" (Setel, 1999:83).

Similarly, recent research in Tanzania (Setel, 1999), and Zimbabwe (Dowsett *et al.*, 1998) suggests that young men may attempt to redress inter-generation inequalities through sexual activity with multiple partners, which is seen by them as symbolizing adulthood and enhanced status. In fact, normally marrying many wives is a show of higher status among generations. Those who cannot acquire the property and status that goes with education and wage employment often compensate for that inadequacy through polygamous marriages.

The impact of socio-economic changes on gender relations has been made worse with HIV/AIDS. Although women household responsibilities have increased due to migration of men in search for a livelihood, it has been worsened by HIV/AIDS. More active care giving for sick and dying relatives has been added to the existing workload (Outwater, 1996). In most cases, children especially girls, have been withdrawn from school to add to the labour force within the household. In situations where children are likely to be withdrawn from school due to the shrinkage in funds because of AIDS-related costs, it is the female that is normally the first casualty. HIV/AIDS is thus facilitating a rapid differentiation along gender lines.

HIV/AIDS and (In) security "Sungusungu"

Conflict and ethnic strife are some of the causes of vulnerability, mortality and economic insecurity in Sub Saharan Africa. These wars and conflict pitting ethnic groups or clans against one another due to the scramble for resources, poverty, local and international policies, and ethnic sensibilities. Population dislocations and the creation of both internal and external refugee population have been hallmarks of these perpetual wars (Kalipeni and Oppong, 1998).

Refugees' situations are often characterized by poverty, insecurity, scarcity of basic needs, rape and destitution. These deplorable social living conditions in refugee camps, in conjunction with the effect of social dislocation create conducive environment for the transmission and contraction of infections (Kalipeni and Oppong, 1998). In addition, some refugee camps are characterized by gender-based violence and lack of access to prevention services as well as Sexually Transmitted Infection diagnosis and treatment (McGinn, 2000; Ward, 2002). All these factors predispose refugees to HIV infection.

During conflict and violence, men endeavour to demonstrate their abilities by committing atrocities against the enemy and worse so, on women. In such circumstances, women's and girls' vulnerability to HIV is disproportionately increased (WHO, 2004). This is because during war and civil conflict, women and girls are often targeted for special forms of violence by men as a way of attacking the morale of the enemy. For example, in Rwanda, systematic and planned rape was used as a weapon of war and genocide against women and their families (Ndarubagiye, 1996). Hence in situations of violence and conflict, the resultant normalcy is a fertile ground for sexual assault including rape, with the possibility of HIV infection.

In Kenya during the post election violence of 2007/2008, many Gusii people who had migrated outside Gusii land were affected most. Though the violence was sparked by alleged presidential election malpractices which favoured the incumbent president (Mwai Kibaki), it later turned ethnic where members of the Gusii community were targeted for being seen as sympathizers of the incumbent president. Consequently, many of them were forced to return to their homeland.

Those who returned to Gusii land composed of two categories. The first category was those who had been forced to move out of Gusii land because of the insufficient land resources to sustain their livelihood. This group mostly leased their piece of land for some period to someone else and used the proceedings to go and settle outside the community or to work as causals mostly in tea plantations like in Kericho and Nandi. The second group composed of those who had been attracted by investment opportunities outside the community and were doing very well economically. The former group had difficulties in meeting their livelihood as their resources (land) were under the custody of another person while the latter group had more resources in terms of money compared to the stayers.

In Suneka Division where this study was carried, the two groups of returnees had enormous impact on people's sexual behaviour due to their survival strategies they adopted. Those who had difficulties in meeting their basic needs especially women resorted to commercial sex. This heightened the risk of contracting HIV/AIDS as demonstrated by Jared, 26 years male resident of Bomariba village:

During post election violence last year (2008), "our town" (referring to their local shopping centre) was a beehive of activities as many internally displaced persons (IDPs) came and settled. Old women and young women were selling their bodies to meet basic needs like food. Sex was extremely cheap even those who had never had sex found it extremely easy.... you needed only Ksh. 20 (equivalent 20 cent Euros) or less to have sex for the whole night. It was harvesting period as we men enjoyed sex with variety of women both young and old.

Apart from politically induced insecurity, Gusii like other parts of the country has been experiencing high incidences of insecurity in form of high crime rates. In response to this, the government of Kenya has embraced community policing to supplement the work of official security agents. According to Kenya Police (2009)[69], community policing is an approach of enhancing security that recognizes the interdependence and shared responsibility of the police and the community in crime prevention.

Consequently, community policing approach ensures that the community does not only feel secure, but actively participate in the achievement of this feeling. The reasoning is that, use of the community members who understand the local crime maps can be a very rewarding strategy given that identification of criminals and crime black spots is made easy. In addition, it ensures community ownership of the process and hence it's local legitimacy. Moreover, it can ensure optimal resource allocation based on improved awareness and understanding of the criminal operating environment (Fuentes, 2006).

Among Abagusii, community policing is in form of Sungusungu vigilante group. Sungusungu is a non state, but quasi-official system of justice which originated in Tanzania, especially among the Sukuma and Nyamwezi ethnic groups. These communities, unable to rely on the state for personal and property protection and resolution of other disputes especially in the vast rural areas of the country, resorted to organizing vigilante groups instead (Paciotti, 2004). As such, informal organizations emerged as alternatives to the largely passive and elusive formal systems of crime control. Later, this system infiltrated and was adopted by communities on the other side of the Kenya-Tanzania border especially by the Kuria ethnic group of Kenya. It is from the Kuria that the Sungusungu vigilante found its way among the neighbouring Gusii.

[69] www.kenyapolice.go.ke:Retrieved November 24, 2009

During the early years of the post-single political party era in Kenya, the provincial administration[70] introduced the Sungusungu vigilante group in Gusii to help stamp out escalating local crime wave. Most members of this group comprise of young men who are mostly volunteers, less educated and unemployed. They have no training or induction on how to work amicably with the public. As a consequence, manhandling of suspects, assault, violence and extortion is not uncommon with the group, hence defeats the essence of community policing. The vigilante group also works as a separate entity from the official security apparatus, hence exhibiting behaviour tantamount to being above the law or in most cases being the law themselves.

At its introduction in Gusii land, Sungusungu entirely concentrated in eliminating crime. To its credit, Sungusungu managed to stamp out criminal activities which hitherto were rampant. Many criminals were either killed by the group members or forced to flee from Gusii land for fear for their lives. However, with time as the crime rate went down, the group found itself with no meaningful role to play. Instead of the group disbanding itself, it transformed itself by taking up the role of providing protection to community members from government security agencies like the police especially those involved in illicit activities like brewing of local brews like *changaa* at a fee, solving disputes among community members and used by interested parties especially politicians or business for the purpose of containing opponents or competitors. These new roles of Sungusungu have either direct or indirect role in the spread of HIV/AIDS.

Conventionally in Kenya, most communities rely on either formal or informal judicial system in the dispensation of justice. Despite their differences in their mode of operation, both systems uphold the principle of natural justice in solving disputes. In most rural communities, these two judicial systems work in a complimentary manner. However, among Abagusii these two judicial systems to a large extent have been rendered obsolete, Sungusungu justice system.

Unlike in the formal and informal judicial system where judgment especially on issues involving sexual morality is guided by natural justice, Sungusungu judgment is based on self interest of individual members. This in turn has made Sungusungu members not to be custodians of

[70] System of official hierarchical governance structures from the president cascading downwards to the village level

morality as explained by Jared in the following incident which in essence increases the risk of spreading HIV/AIDS:

> *John used to sell eggs in Kisii town with his friend Peter. One day Peter came earlier in the morning to John's house. He requested him that he was not feeling well so he should assist him in delivering his eggs to town with his. John accepted. John left to town and left Peter in his house. As soon as John left to town, Peter and John's wife went to bed and started having sex. Peter and John's wife were lovers. Unfortunately, John did not go far before he remembered he had forgotten his wallet in the house. So he returned to get it. On reaching his house he heard his wife and Peter voice in his bedroom. He tiptoed to the bedroom and found them in bed. He raised an alarm and started fighting Peter. Peter ran away. John reported the case to the chairman of the vigilante group who summoned Peter. As a punishment, Peter was beaten and warned by Sungusungu members. John's wife was asked to leave the village.*
>
> *After staying in her parents' home for some time, John's wife started having sexual escapades with the chairman of the vigilante group. The chairman in return started pressurizing John to have his wife back. When John refused, he was threatened of dire consequences. With no option, John allowed the wife back. To date the wife still continues to have sexual relations with the chairman of Sungusungu and John can do nothing for fear of dire repercussions.*

In other incidents, young women who feel insecure in their marriage engage in sexual relationships with some members of vigilante group. By doing so, they are able to protect their marriage as observed in Pastor's explanation:

> *Despite her beauty, Mary is not only a very lazy woman but extremely extravagant with family resources. She just likes very soft life. For the two years she has been married, the husband who is a teacher has lived in a hell of life. About three months ago, the husband was fed up with Mary's behaviour and asked her to go back to her parents so that he can marry another woman. Instead of going to her home, Mary befriended one member of Sungusungu who assured her of total protection from her husband. One day, when Mary's husband was forcing her to get out of his house, three members of the vigilante including her lover came to her rescue. Not only did they beat the husband for trying to chase her away but also warned him of unspecified dire consequences should he try again to force Mary out his house. Similar cases like Mary's are very common here. Husbands have lost legitimacy of governing their wives to Sungusungu. Your wife can despise you or misbehave but since you are not sure if she is linked to Sungusungu you avoid doing anything to her.*

Sex with members of vigilante group is also used by women who are engaged in brewing local illicit brews as a means of protecting themselves from being arrested by local provincial administration. In Kenya, the government does not condone the production and consumption of

"illicit" brews. Due to the fact that most vigilante group members are known to provincial administrators, most women believe that by having lovers who are members of the vigilante group, they can easily be protected whenever such operations of arresting illicit brewers take place.

In many African countries where Sungusungu-type vigilante grouping is an important feature of the security apparatus, violence is common. For example, in South Africa especially during the period of democratic transition from apartheid, violence was an integral feature of vigilante methodology (Harris, 2001). The efficacy of vigilante group violence pivots on fear, intimidation and works to forcibly instil reverence among the general populace. These features in combination with masculinity not only put women at risk of HIV/AIDS infections but equally young men who are members of vigilante groups as explained by a 27 year-old Moi who until he discovered his HIV positive status was a member of Sungusungu:

> *To be a member of Sungusungu is an honour in itself. You not only attract power and fear among villagers but it enables you to have many sex partners like a real man. To have sex, all you needed is to identify the woman you want and inform her of your intentions. If she refuses to your suggestions by insisting she has another lover, we used various tactics to coerce her until with or without her consent to have sex....This is what sometimes attracts many young men to be members of Sungusungu.... I recall this young woman who came to stay in our shopping centre. She was very beautiful and every man wanted her. I approached her but she vehemently refused to assent to my request.... for the first time ever as a man I felt frustrated because a woman can refuse to my demands..... I informed other members. The first thing we did was to identify the man he was having a love affair with. However, in this case she was having many men mostly teachers.... This discovery did not deter me from wanting her for she was extremely beautiful. So I urged my fellow members to harass any man who was found with her or suspected to be her lover. This deterred many men from having sexual relations with her. When she realized she was losing her lovers, she gave in to my demands. From then henceforth I used to have sex with her anytime I wanted for she knew what will happen if she refused. ...In some cases we would frame charges to a man who was a lover to any woman we wanted like he is a thief or having sexual relations with school going girls. Once framed, the man was arrested, beaten and humiliated in front of all villagers including the girlfriend. This way, the girl felt ashamed to continue with that relationship. The last tactic we used was to organize and kidnap the girl and force her to have sex with the member who wanted her. If the girl was extremely uncooperative to the member like being rude, disrespectful, the*

member would allow other members to have sex with the girl as a way of shaming and humiliating her. Normally such ordeals were executed in such a way that many members of the village came to know of it as a way of warning other girls of the consequences of refusing to honour the demands of vigilante member.....This made most girls to have sex with us as a way of protection against any harassment.

Some of the characteristics associated with masculinity which are espoused by Sungusungu such as aggressiveness, dominance and strength, translate into attitudes and behaviours that have become counterproductive in the era of HIV/AIDS. Men's traditional roles as economic providers - a major contribution to family welfare and survival - have traditionally meant that women are the ones expected to look after children and care for sick family members. However, due to high levels of unemployment and scarcity of resources especially land, men are finding it extremely difficult to meet the expectations of the wider society on them.

To compensate for their failures, young men are forced to join Sungusungu vigilante group which provides them an opportunity to exercise their masculinity like taking risks, having frequent sexual intercourse - often with multiple partners - and exercising authority over women. Furthermore, these masculinity expectations encourage men to force sex on unwilling partners, reject condom use and look at the search for safety as unmanly, generally disregarding negotiated safer sex. This meets the expectations of the name Sungusungu which itself is masculine and literally means safari ants.[71] Thus, this gives the group some unofficial legitimacy to *sting* the community in order to get recognition, power, respect and identity.

Studies by Amuyunzu-Nyamongo *et al.*, 2007; Chacham *et al.*, 2007; Mwenzwa and Amuyunzu-Nyamongo., 2006 have shown that skewed gender relations in favour of men and especially in the midst of violence negatively influence women susceptibility to HIV. In the case of Sungusungu this is indirectly evidenced by the lynching of witches. According to Ogembo (2001), witchcraft accusations are levelled against both men and women. However, witch hunting mostly target women. Men who are accused of practicing witchcraft are instead warned only for associating themselves with women who practice witchcraft or abusing their practice of sorcery, which, for the Gusii is less stigmatizing than witchcraft. Thus, this violence to women

[71] Stinging insects that move in a hordes and can together kill big games or livestock such as cows

and not men can be explained by cultural position of women in the community which makes them more vulnerable.

In the Gusii community, women are seen as outsiders in both their natal and bridal homes. In their natal homes a woman lacks proper identity until she is married. In her bridal homes, although she acquires her proper identity as she is integrated to the man's patrilineage because of her role of bearing offsprings who will perpetuate her husband lineage, she is still considered as an "outsider" by a man's lineage. Therefore in her bridal home she is considered as an "insider" by her natal clan, yet her bridal clan considers her as an "outsider." This contradictory position that generates ambivalence in a woman's identity is captured by the proverb mostly expressed by married women that, "*tinkweba aase o rorera na aase e getinge,* literally, "I will never forget my natal home and my bridal home. The ambivalence in a woman "insider" and "outsider" position in her natal and bridal clans is a reflection of "antagonistic and rivalry" relationship among intermarrying clans (Le Vine, 1959) which is often captured by the saying among Abagusii that "*we marry only from our enemies.*"

This ambivalent position therefore makes a woman to lack security in both her natal and bridal home. For example, in her natal home she is regarded as belonging to her bridal clan. Therefore she can't be assisted when violence is directed to her. Also in her bridal home, because of her "outsider" position she becomes an easy target for violence. In case of witch hunt, her vulnerability is compounded further by myths embodying evil to women and taboos which condone meting of violence to "outsiders".[72]

Sufficing from above exposition, witch hunting by Sungusungu embodies women continued disadvantaged position in gender relations in the community. This therefore increases women vulnerability to HIV/AIDS infection (Flint, 2011)

[72] Refer to chapter Three: Illness among Abagusii

Section II: Socio-economic impact of HIV/AIDS

In Kenya HIV/AIDS came at a time when many Kenyans and their economies were experiencing economic and social difficulties occasioned by several factors amongst them poor economic governance, the oil debacle, and Structural Adjustment Programs (SAPS). These dramatic economic changes, over the past several decades; for example, left some households more vulnerable to the impact of AIDS than others. Households and communities already suffering from conditions of poverty were also more impacted by loss of adult members to HIV/AIDS.

HIV/AIDS differs significantly from other diseases such as malaria and its impacts are quite severe. The virus attacks the body immune system and compromises its ability to resist other infections giving rise to opportunistic infections. Although an individual's life can only be prolonged by use of relatively expensive regiments of antiretroviral medication, it strips the individual and households their social and economic ability to generate livelihood. This makes the impact of the disease to reverberate far beyond the infected individual (Bollinger *et al.,* 1999; Elizabeth *et al.,* 2000 Msellati *et al.*, 2001; ANRS and ORSTOM, 1997; Denis *et al.*, 2006).

At an individual level, most infected individuals suffer from stigmatization and discrimination. Due to this, most infected individuals are not willing to reveal the nature of the?>ir sickness to their immediate family members. Moses, an 18 year-old orphan from Suneka Division captures this situation. He explained;

> *... My father died two years ago. He was working in Nairobi. I cannot remember when he got sick.... but always used to complain of chest pain and later tuberculosis. He was treated of tuberculosis and he got better for some time. I did not know he would die. My mother was called by one of my uncles that my father was very sick in Nairobi. She went and took him to hospital.... and died after one week. The doctors said he died of pneumonia.... After the burial, rumours reached us that our father died of AIDS and I could not believe it..... People did not want to get close to me. In school, other children looked at me strangely and none wanted to sit next to me... or share books with me....*

Moses's father knew his HIV status; however, it was the fear of stigmatization and discrimination that did not allow him to discuss his HIV status with the rest of the family. This discrimination and stigmatization do work both at individual and community level as noted in Moses's experience and several other testimonies encountered during fieldwork.

From the infected individual, the impact of HIV/AIDS slowly creeps into the household. Available evidence shows that AIDS pandemic is having enormous effects on the household, which comes in various forms like increased medical, and health expenditure, funeral expenses and decreased income (Bollinger *et al.,* 1999). Household impacts begin as soon as a member of the household starts to suffer from HIV related illness. During this period, medical expenses rise and income generating activities disrupted as family members are drawn away from work to provide care and in some instances children have to work to supplement household incomes. After death, funerals can be costly; impoverishing the household further.

In Gusii land, ethnographic interviews illustrated graphically the experience of HIV/AIDS affected households especially where one or two of its members in regular income are infected. Nyaboke, a 28 years-old widow from Suneka lost her husband to HIV/AIDS one year ago. She narrates the tribulations that have faced her since the husband passed on;

> *.... my husband died in 2008 after being ill for three years... he was working as a clerk in a government office in Kisii..... He took loans from their cooperative to treat himself. After the cooperative stopped lending him more money, he started selling some of the properties he had already acquired. With the skyrocketing of his medical bills, our two children were forced to move from a private primary school to a public school. With no money to continue with his medication, we were forced at times to seek advice from the traditional health providers and prayers. By the time of his death, we had sold everything we owned, my two children had stopped attending school and I was greatly indebted as I had borrowed a lot of money from our village merry-go-round .....Now all my preoccupation is how to repay the money I borrowed....*

While such cases are sporadic in Gusii land, they nonetheless demonstrate that the first and most basic impact of HIV/AIDS are on those who contract the disease and their immediate family members. Loss of income of the patient (who is frequently the main breadwinner), compromises the household resources as the functional capacity to work is reduced, medical expenses increase and the income of the patient and those dependent on the patient are reduced.

HIV/AIDS does not only strip the household of assets and income, it further impoverishes other household members by diverting their time away from other income generating activities. Women who are already saddled with the double burden of production and caretaking are forced

by HIV/AIDS in the family to reallocate their labour from producing income outside their home to caretaking and maintaining the family. Nyaboke explains;

> *.....before my husband got sick, I was a second hand clothes vendor....However when he got bedridden, I had to take care of him.... So I left the business to my sister who did not have enough skills. Soon the business collapsed and I am back to zero!*

In addition to income reduction, it needs to be pointed out that taking care of a person suffering from HIV/AIDS is not only traumatic but also puts women and girls at risk of infection as they are mostly involved in taking care of the sick. Studies have highlighted that minor injuries to the hand skin that women incur during substance work increases their vulnerability to HIV infection while taking care of the patients (Obbo *et al.,* 1995). This vulnerability further increases women subordination in case they are infected. Lizy, a 24 year-old female who is living positively with HIV infection observed;

> *..... I had known no man in my life until I met him. At first, I feared having a relationship with him but he told me he had never had any a love relationship with any woman. I was happy to have met a man who was a virgin like me. He told he had a lot of love to me. Since I thought he was a virgin, I saw no need to have protected sex with him from day one... He introduced me to his people. After "pushing" with him for about six months, I came to realize I was not the only one he was seeing...When I confronted him about this he beat me.... I remained faithful to him and moved to his house in town. While staying with him, he started becoming frequently sick. When he was tested, he was found to have AIDS.....His health continued deteriorating and I continued taking care of him... washing him like a baby. When he died I was accused by his relatives that I am a whore who infected their son with AIDS... was chased like a dog....going to my home all my siblings did not want to see me as I had brought them disgrace.... had nowhere to go but move to a far town to eke a living as a hawker....*

The toll of HIV/AIDS on the household can be severe. Although no part of the population is unaffected by HIV/AIDS, it is often the poorest that are most vulnerable to HIV/AIDS and whom the impact is severe. In Gusii land, over 65% of the population lives below poverty line that is subsisting on less than one dollar per person per day. In these households the impact of HIV/AIDS was found to be severe, particularly on surviving household members as the story of 30 year-old Samson shows;

> *.....in this family we have lost two people to AIDS related illness. First my sister who died three years ago .....we never knew what killed her. We initially thought she was bewitched. We spend a lot of money in treating her in the traditional ways. Shortly, after my sister was interred, my elder brother who was working in Nairobi as a night*

watchman started becoming sick exhibiting the same symptoms as my sister. We had no means left to help him. We sold part of our 1 acre land in order to treat him. While he was in hospital, it is when we were informed that he was infected by AIDS and there is no cure. By the time we knew about this, our family had moved to extreme levels of poverty where we cannot meet even basic needs like food....

Apart from impoverishing the already impoverished households, HIV/AIDS disrupts the social organization of many households especially on the division of tasks. Being a patriarchal society, a number of household members in Gusii land are finding it extremely hard to start performing new tasks which were hitherto not meant for them. In this community, fending for the family is the role of males (fathers) as they are the custodians of resources. Females (women) are supposed to care for the family and the children are supposed to benefit from the family resources and care in building their future. However, with HIV/AIDS, this division of tasks is greatly disrupted as there are no clear guidelines on who should carry a particular task. This disruption accompanied with the existing inequalities especially among women and children, further enhances their vulnerability to HIV/AIDS infections. Mary Bonchaberi, a 33 year-old widow explains;

.....My children and I have been surviving by doing manual labour for the well to do households such as weeding, and washing clothes. The task of fending for us was the role of my husband who was a primary school teacher. With my deteriorating health, I am unable to provide for myself and family ....Consequently we all depend on my 12 year daughter who dropped out of school one year ago. My daughter works on peoples' houses where she is paid very little money per day. Sometimes, old men who are old enough to be my daughter's grandfather try to take advantage of our predicament to entice her with money for sex.....(amid sobs)... I am not sure whether she sleeps with them...! Imagine at my state even colleagues of my husband come pretending to help me but their goal is to use their help to demand sex from me and sometimes my daughter.... I am dying of AIDS and at the same time HIV/AIDS induced poverty is killing all of us!

In Gusii land, HIV/AIDS was found to be at the toll on the already aging population. Hitherto, the advent of HIV/AIDS in this community, people who had reached threshold of aging were being taken care of by their children and grandchildren. However, this trend has drastically changed. As observed during this study, most aging parents are the ones who are taking care of their ailing children and grandchildren. This robs them off the traditional care rendered by children to their parents.

One of the most visible and tragic outcome of HIV/AIDS is the growth in number of orphans in many areas of Gusii land, orphans face myriad challenges like lack of medical attention, separation from their siblings, lack of basic needs and lack of resources for building their future careers. As observed in this study, most orphans or children from HIV/AIDS infected household are often compelled to drop out of school. Even those who remain in school are not able to concentrate fully in their education as they constantly worry about their parents or traumatized by the illness of their parents.

Further, children from HIV/AIDS affected households are traumatized by the memories of society's stigma towards them. The children also suffer anxiety and stress due to uncertainty and insecurity concerning their future. Tom Masagiro captures this experience;

> *...after the death of our father, I remember we went back to school. In school other children did not want to associate with us and in some cases they told us we will also die soon.... I felt so lonely and worried about my life as everything seemed failing part .When this became unbearable I left school. After a while my other two brothers passed on.*

As it can be seen, HIV/AIDS affected children feel excluded by their peers. They feel lack of social acceptance by their classmates and in some cases even by their teachers. Thus, in the fight against HIV/AIDS, stigmatization and discrimination stands out as one of the biggest challenges to intervention strategies in Gusii land.

Despite the fact that HIV infection takes some time before it reverses to AIDS and later death, most parents who are infected do not bother to put in place contingency strategies for their children. Due to this, there is a steady increase in number of households in Gusii land headed by children without an adult presence. This is a new phenomenon and is a clear manifestation of the social and economic disruption and social inequalities exacerbated by HIV/AIDS. Children in such households lack proper care and supervision at this critical period of their life. Schooling becomes a luxury, and agricultural production is negatively affected as the children are less capable than adults. Moturi Mangera's predicaments in Suneka demonstrate the experiences of many orphans who opt to stay within their household after the death of their parents;

> *.....my parents died three years ago... during my mother's burial, we were promised by our relatives that they will take care of us... but soon after their burial, no relative even checked how we were doing. We could go without food for some time. My young sister left to stay with my cousin*

in Nairobi ... I remained with three other siblings to take care of. I had to get some means to help myself and other siblings. I went to herd someone's cattle in the neighbouring village who accepted to pay me Ksh 1000 a month. I told him to pay me Ksh 500 and keep the rest. After sometime I accumulated Ksh 2500, which was enough to purchase a bicycle (a bicycle is used as a means of public transport)... I have used this bicycle to feed these children..... Recently, my uncle came and advised me to get married... I also think this will release these children from the hectic duty of waking up every morning to prepare porridge, rushing to make lunch and fetching firewood. At least they may be able to concentrate in their education...

In some instances AIDS orphans face almost complete marginalization and stigmatization from responsible adults whom the society entrusts to take care. Lucy Keumbu underscores this experience by telling us about her maternal cousins' predicament after the demise of both of their parents. She explains;

.... when my maternal aunt died and immediately followed by her husband in 2007, my four cousins have been facing a lot of problems. They have been mistreated by the grandfather who insults them particularly at mealtime. They are denied food on flimsy grounds. They have run to our home several times but their grandfather comes for them always... my mother cannot intervene to have them stay with us because it is the grandfather who is the custodian of the land which they will inherit. So if my mother intervenes so much she will antagonize the old man and may have an excuse to disinherit them. Honestly, I do not know how my cousins can be helped!

In addition to heading households, children living in HIV/AIDS affected households face other burdens; parents' illness rob children of inheritance from their parents as family resources are used in an attempt to sustain the health and prolong life of parents. Sometimes when children are orphaned, their deceased parent's relatives and employers conspire and cheat out the orphans' inheritance. Moreover, children living in AIDS affected households endure poverty, which exposes them to abuse and stigma. Some are forced by circumstances to fend for themselves and their ailing parents amidst communities that are insensitive to their plight[73].

The powerlessness most orphans face after the demise of their parents has seen many young girls taken from the rural to urban areas. In urban areas, they are meant to work as lowly paid

[73]At home, once household members become ill the children's participation in domestic and farm work increases, often interfering with schooling, and is detrimental to their health. Recent ILO studies also confirmed the linkage between HIV/AIDS orphanhood and the likelihood that a child would work frequently outside the household and in conditions that are sexually and economically exploitative and prone to harassment and violence.

unskilled labourers where they are physically, emotionally and economically exploited. In extreme cases, some are forced to turn to the streets where their physical needs and financial desperation make them vulnerable to crime, substance abuse and sexual exploitation. This places a significant number of them at risk of contracting HIV/AIDS.

Conclusion

In summary, this chapter has shown that research and control of infectious diseases has a long history in Africa, involving changing political situations, changing economic and ecological contexts. These historical forces and changes were noted to play a critical role in determining how people react to infectious diseases and their control measures. The chapter in particular underscores the fact that cultural, social and historical factors are critical in understanding people's response to diseases control measures. Lastly, the chapter analyzes the extent to which people have experienced the ravaging impact of HIV/AIDS at the individual, household and community level. Using ethnographic data, HIV/AIDS was found to stand out as the main catalyst driving households and communities to destitution. No wonder, in this area, HIV/AIDS was referred to as "the *finisher*" as it not only wears out one's body but it deprives people of their properties and cripples their ability to generate wealth in future. The way forward to mitigating the impact of this disease is by prevention and provision of support for those infected or affected by the disease in order to curtail them from resorting to strategies that may make them more vulnerable to infection or re-infection.

CHAPTER FIVE
METHODOLOGY AND RESEARCH DESIGN

Introduction

The importance of describing the methodology is to make known the mechanism applied in producing knowledge and locating my position to the reader. Methodology is the theory of methods which informs the researcher on a range of issues to adopt in a study (Kothari, 2005; Skeggs, 1997). These issues range from "who to study, how to study, which institutional practice to adopt, how to write and which knowledge to use" (Skeggs, 1997:17). In this chapter, I therefore explore the methodological processes and practice that I followed in the present study. Throughout the chapter, I make it clear how the social construction framework guided my methodological choices and decisions. Further, I have explained my experiences, values and attitudes which influenced the methodological choices I made to addressing various research questions.

Research Site Description

The data for this study was collected for nine months (January to September 2009) in Suneka division (**see map 2**), Kisii Central district (**see map 3**). The selection of Suneka Division was purposively done because of the following reasons; first, it is one of the places in Gusii which has consistently recorded high prevalence rates of HIV/AIDS since the first case of HIV/AIDS was diagnosed in 1987. Second, Suneka is one of the divisions in Gusii with poor socio-economic development like high poverty and illiteracy levels. Third, there is rampant insecurity due to the presence of Sungusungu vigilante group. Fourth, the division exhibits both urban and rural characteristics, that is, some of the locations like Bomerenda and Bogiakumu are within Kisii municipality thus regarded as urban areas. Iyabe, Riana and Bomariba are located in rural areas. All these factors have a major bearing on HIV/AIDS intervention programmes (Farmer, 1996; UNAIDS, 2001; Kalipeni nd Oppong, 1998; Burharm, 1992; Packard and Epstein, 1990).

Further, the division is inhabited by members of almost all Gusii clans making the data collected reflective of entire Gusii people. The settlement of almost all Gusii clans in the division has both historical and economic explainations. Oral literature has it that the indegeneous clan of Suneka division, Abanchari, was despised by other Gusii clans because the founder of the clan was a

woman[74]. Due to this other Gusii clans used to raid them frequently taking away their livestock and destroying their crops. To protect themselves from these continuous raids, the Abanchari requested men from other Gusii clans to come and settle there. The rationale behind this was that other clans would stop raiding them as they were likely to get support from those settling clans in their locality. Also by bringing members of other feuding clans to settle in their locality, it acted as deterrence for other members of similar settling clans to raid them. This was because it is a taboo to shed blood of a clan member.

Economically, due to high level of poverty in the division, most indegeneous people sell their land to other people as a means of meeting their needs. Selling of land to members of other clans is made possible because there are no other viable sources of income for the local people and there is high demand for land in the locality due to its proximity to Kisii town. This is despite the fact that the average acreage of land one posses has drastically reduced to bare minimum.

Suneka division is located 15 kilometers to the west of Kisii municipality- the headquarters of Kisii Central district. Along with Keumbu, Masaba, Mosocho and Marani divisions together constitute Kisii Central district. The headquarters of Suneka division is Suneka Township which had a population of 6,802 in 2007. Covering an area of 126.1 square kilometers, the population density of Suneka division at present is estimated to be 763 persons per square kilometers (CBS, 2007).

The division has smaller administrative units known as locations which are further sub-divided into sub locations. The five locations that make Suneka division are; Bomerenda, Bogiakumu, Iyabe, Riana and Bomariba. This study was carried out in all five locations.

In 2007, Suneka Division had a population of 96,471 people (46 % of them male) living in 19,294 homesteads with a population density of 763.2 persons per square kilometres (CBS, 2007). This makes the area one of the most densely populated areas in Gusii and in Kenya in general.

[74] The Gusii lineage system followed patrilineal principles.

The Kisii Central District census reports of 1999 do not give a breakdown of distribution of population by age and sex in administrative units other than at the district level. Only summary statistics for the whole district are given and these data indicate that about 46 % of the 1.4 million people residing in the district were male (the same proportion as Suneka). Over one and half (53%) of the people living in Kisii Central district in 1999 were less than 15 years old indicating the presence of youthful population and a high dependency ratio that reflects similar trends as data from national statistics.

The division is characterized by lack of government health care facilities. Most health facilities are concentrated within the Kisii municipality which has five hospitals: one government hospital - the Kisii General Hospital and four private hospitals namely; Getembe, Christina Mariane, Hema and Nyangena. Within the division, there are four government dispensaries namely; Riotanchi, Iyabe, Nyamagundo and Riani and one private health centre (Iterio Health Centre) which is managed by a Christian organization called Evangelical Lutheran Church. There are also eight private clinics. Four of them – Amani, Royal, Nyambunwa and Makori's clinic are in Suneka Township.

Averagely most health facilities are located about 2.6km from the homes of potential users. However, large hospitals such as Kisii Level 5 hospital (15km away) and Tabaka Mission hospital (10km away) are located further off from study site. Although Tabaka Mission Hospital is outside Kisii district (it is in South Mugirango, Gucha districts), patients routinely go there for treatment but only for referral services. Apart from the health facilities, the area has no Voluntary Counselling and Testing services which are essential in the managing of HIV/AIDS. Despite the area recording the highest prevalence rate of HIV/AIDS (6.7%) in Gusii land, most of these services are offered outside this division.

Research Design

This study was concerned with Abagusii youths emic understanding of HIV/AIDS prevention strategies such as Abstinence, Being Faithful, Condom use and Knowing your HIV status (VCT) in their everyday lives; and how their social construction of sex informs their meaning and practice in regard to HIV/AIDS prevention in various contexts. In this regard this study was more concerned with translating HIV/AIDS prevention strategies messages, teasing their meanings from the perspective of Abagusii youths and interpreting these meanings on the basis of intellectual perspective and making inferences. Due to this, this study adopted ethnographic research approach because it provided an ideal opportunity to study Abagusii youths in detail by directly getting involved with them and their culture over an extended period of time. Because of this it was possible to have a detailed description and context dependent interpretation of all data collected on how Abagusii youths made sense of HIV/AIDS prevention strategies from their own cultural context (Geetz, 1973).

Selecting of Research Participants

Selection of participants for any particular study is the most important thing in research as it determines whether the study objectives would be attained. In positivist thinking the selection of participants should be done using objective procedures in order to avoid bias. Similarly, qualitative research requires some logic in the selection of participants. This logic should be guided by certain principles and procedures. In this study the main participants were youths. I focused on youths because from the literature, this group was the most affected by HIV/AIDS and yet there was no evidence of a study especially among Abagusii that had focused on their life experiences in relation to HIV/AIDS prevention. Consequently, I thought listening to youths' experiences would help to illuminate much of what has been taken for granted in the HIV/AIDS prevention strategies targeting this group.

Given the fact that my study was qualitative, I had the difficulty in determining the sample size from the onset. This difficulty has been acknowledged by other qualitative researchers (Smith and Osborn, 2003; Bryman, 2001; Temple, 1998).Sample size in relation to the study population has often been used by quantitative researchers to determine the extent to which research findings can be generalized (Marshal, 1996). This is not the case with qualitative research which

is criticized for using very small samples hence study findings cannot be generalized to the entire population.

However, qualitative research scholars insist that the primary concern of qualitative research is the depth of the study than the extent to which findings can be generalized. Instead, they recommend the consideration of diversities that exist within the study population when deciding the sample size (Smith and Osborn, 2003; Schroder *et al.,* 2003). Consequently, my aim was to generate deeper understanding and a rich description on how youths make sense of cultural meanings offered by HIV/AIDS prevention strategies (ABC and VCT) and also how their construction of sex inform their meaning and practice in relation to HIV/AIDS. The extent to which research findings can be generalized to the entire population was therefore a secondary consideration in favour of discourse analysis whereby listening to the voices of Abagusii youths was important.

Despite this, measures were taken as recommended by qualitative scholars (Schroder *et al.*, 2003) to ensure that major diversities observed among youths were taken into consideration. These diversities included: age, level of formal education, marital status, location, occupation, level of income and gender. These diversities; therefore, formed the basis on which participants for this study were selected. The final sample size of 100 participants (**See Appendix 4**) was; however, based on saturation, that is, when there was repetition of results with no new information forthcoming.

Although the above decisions were very crucial in the selection of participants, I nevertheless maintained an open mind. Robson (2002:165) notes that in flexible designs, "sampling of who, where and what does not have to be decided in advance, you need to start somewhere, but the sampling strategy can and should evolve with other aspects of the design."

Snowball Technique of Selecting Participants

In selecting participants for my study, I used snowball sampling technique. In this case I made some contacts with one young man and woman who had the required characteristics for this study; that is they were aged between 12- 40 years and were residents of Suneka Division. After

gaining their consent and interviewing them, they later helped me identify other participants. The later also led me to other participants.

The rationale of using snowball sampling technique for selecting participants was because of the sensitive nature of my topic. In the study site, HIV/AIDS is very much stigmatized and many people fear being discriminated against if they are suspected to be infected. Also my topic focused on issues of sexuality; a topic many people will not openly discuss with strangers.

In using this method, I grappled with few problems because some of the contact people wanted me to interview their friends as a way of making them know their sexual behaviour and health status. Other participants I was referred to refused to be interviewed because of suspicion to why the contact person identified them. Despite these, I relied on experience of other researchers who have used snowball technique to be prepared for changed circumstances (Miller, 1998; Shahidian, 2001). Miller (1998); for example, mentions problems she encountered from gatekeepers who in some cases would influence the kind of responses the interviewees gave. Miller also realized that she was entering a particular network of women.

Similarly, Shahidian (2001) notes that use of references to enter into the Iranian exiled community validated his presence and vouched for his trustworthiness. However, there were drawbacks related to him being identified with political affiliation his references belonged to. In addition, Shahidian explains an incident where one of the reference persons decided to become his spokesman:

> *One reference took it upon himself to "represent" me in the community. He would talk about what he believed I was doing, which did not always represent my intentions.... I noticed that even when I was present, the reference would offer "clarification" about my research. Since his comments differed from what I had in mind, I had to address them. I eventually decided that, valuable though his contacts in the community might be, it was beneficial that I distance myself from him* (Shahidian, 2001:63)

To minimize such situations, I had to work with a group of contact persons from various categories of youths. For example, after using the chain of references from my initial contact persons for some time, I will break it by getting a new contact person. This was made possible

due to my long stay in the study site where I had made many friends. Despite this, I continued encountering some challenges in using snowball sampling technique. This made me to start directly approaching potential participants as discussed in the next section. Snowball sampling techniques also had ethical dilemmas for me in accessing participants as I will discuss later in this chapter.

Direct approach

In using snowball sampling technique, I managed to interview 65 participants in a span of five months. This is not surprising given the fact that snowball sampling technique is time consuming. For example, there were times when I would not get any references from some of my contact persons due to the sensitive nature of my topic. Some of the interviewees would refuse to direct me to other interviewees for fear of being accused of disclosing to me the sexual behaviour or health status of the would be participants. This made me to start approaching some of my participants directly.

My long stay in the study site, participation in various community activities like attending funerals, fundraising and other activities involving young people, I knew many young people. Using my acquaintance with the young people, I started approaching them directly by explaining to them the purpose of my stay in their area, my research and its objectives before requesting for consent for an interview. In this approach, some consented to my request and others refused mostly due to the sensitive nature of my topic.

Participants who accepted to be interviewed; however, had their conditions before doing so. These conditions ranged from issues of confidentiality, their freedom of expression in the interview process and where and how the interview would be. All these issues underscored to me that research participants are not just powerless people waiting to be bombarded with any kind of questions. They have power to choose the kind of questions to answer, how and when to answer them. Using this approach, I interviewed 35 participants.

Methods Used for Data Collection

In this study, I relied on qualitative methods for data collection. This is because, qualitative research methods allow the researcher to go into the depth of the participant's experience, social processes and discourses (Mason, 2002). Gillham (2000) notes that qualitative methods focus primarily on the stories that people give the researcher, and from these stories issues can be illuminated that can help to develop explanations about certain phenomena. Further, qualitative methods are important as they help the researcher to explore complexities that may be beyond the scope of more controlled approaches.

Campbell (2003) has also noted that most research on HIV/AIDS has continued to rely on quantitative survey methodologies which, despite having provided vital information, often contribute little to a deeper understanding of the programmes. It has also been argued that in the era of HIV/AIDS, data needs to be qualitative if it is to provide useful information about socially constructed experiences that this epidemic presents (Commonwealth Secretariat, 2002). Therefore by relying on qualitative methods I was able to collect data which was in-depth, emic, reflective, inclusive and sensitive from research participants.

In-depth Conversational Interviews

In this study, I used in-depth conversational interviews to collect data from Abagusii youths who were selected using either snowball sampling or direct approach methods. According to Merrill (1999), a conversational interview is a two way process where the interviewer interacts with the interviewee in a conversation. In this interaction, the interviewer not only asks questions but shares his/her life experiences with the interviewee. Subsequently, in this study I wanted to make use of conversational interview in order to have a two way dialogue with my interviewees in the generation of knowledge. In this case, my interviewees would ask me questions on my topic as I was prepared to respond to them. I was also morally obliged to share my life experience with them because they too were talking about theirs. All this was done because I carried my study from an ontological position which suggests that people's knowledge, views, understanding and interpretations are meaningful for the generation of knowledge (Burke, 2002; Campbell, 2003; Mason, 2002).

In using conversational interview, I had an advantage of having a collaborative dialogue with my participants. This was important as it enabled me to respond to their questions and I could get clarification too as noted by other researchers (Burke, 2002; Mason, 2002). However, I was extremely careful not to turn the interview sessions into therapeutic encounters (Mason, 2002), which is not the aim of a research interview.

In carrying out the interviews, all interviews were guided by broad topics or guiding themes (**See Appendix 5**). These themes helped me to create the atmosphere that was conducive for youths to talk about their experiences and kept the interviews on track in order to prevent some interviewees from deviating from the main issue. During the interview, I left the interview to run like a normal conversation without too many conventions that could make it lose the natural aspect of real life research.

Key Informant Interviews

Key informant interviews are normally shorter than in-depth interviews and are normally preferred when dealing with senior people or people with specialized (privileged) information because of their status. They are short and focus on open and straight questions (Yin, 2003). In this study, I used Key informant interviews because of its advantage when interviewing senior people or those with specialized knowledge on certain issues as it gives them a chance to be in control of the interview. The guiding questions I used in these interviews are in **Appendix 6.**

Through Key informant interviews, I was able to get more specialized information on youths' sexuality and HIV/AIDS prevention. This kind of information is not always available to many people thus it accorded me an opportunity to get a different perspective to my data. Furthermore, these interviews helped me with ideas on where and how to collect further data. For example, they provided me with up-to-date information on various HIV/AIDS prevention programmes targeting young people, their objectives, implementations and impact. Also they directed me to relevant contacts of people who assisted me in understanding various issues on my topic. Because of these, I was able to have a good grasp of what was happening to HIV/AIDS prevention among young people.

The selection of participants for key informant interviews was done purposively by taking into account knowledge and involvement in HIV/AIDS prevention programmes targeting youths. During the course of my research, I came to know various personalities involved in HIV/AIDS prevention programmes in the study site. By virtue of their involvement in HIV/AIDS activities, they were privy to some information which was essential in augmenting data from in-depth conversational interviews. Though there were many actors involved in HIV/AIDS, I decided to directly approach two participants from two institutions which in my own opinion were genuinely involved in mitigating the impact of HIV/AIDS[75]. They were;

1. Head of Bonchari Constituency AIDS Control Committee (CACC). CACC is the lowest branch of National AIDS Control Council (NACC). Its role is to implement HIV/AIDS programmes at community level as designed by NACC. The head of Bonchari CACC has been in office for five years at the time of this study.
2. Head of Patient Support Centre (PSC) at Kisii Level 5 - Hospital.[76] This centre deals with HIV/AIDS prevention and treatment. In this centre, there is Youth Friendly Centre which strictly deals with young people who need any form of assistance on HIV/AIDS like counselling, Voluntarily Counselling and Testing (VCT), HIV/AIDS information empowerment, free condom distribution and HIV/AIDS treatment through Antiretroviral Programmes (ARV). The head of PSC has been in office for three years at the time of this study.

Participant observation

During the course of this study I interacted with and often made significant rapport with my research participants as I joined them in their everyday lives. As I did this I recorded and interpreted what I observed in form of field notes. These field notes included both descriptive accounts of settings, individuals, events and dialogue as well as my experience in the research process. Consequently, my field notes included my observations and field activities and thoughts, as I encountered different experiences in the course of my data collection as hereby elucidated.

[75] There are many organizations which are formed by individuals or groups for the sole purpose of benefiting economically from funds from international agencies in the pretext of fighting HIV/AIDS.
[76] Kisii level 5 hospital is the only referral hospital serving all Gusii and South Nyanza districts.

In the course of this study, I attended a number of HIV/AIDS activities targeting youths and observed how the campaigns were being conducted, including the themes presented/ discussed, the attendance level of youths and their response to various themes. I also observed how poster campaigns were being conducted and noted their location and messages being presented by these posters and how youths perceived such messages.

Apart from attending HIV/AIDS campaign activities, I attended various social activities which involved youths. These activities were: attending funerals within my study site. I started attending funerals for a number of reasons; first, as an insider researcher I had to meet my social responsibilities to the community I was researching on. Although funeral arrangements among Abagusii are for immediate families, community members and those residing there have a responsibility to participate (LeVine, 1982). Therefore, to avoid being charged harshly by community members, I had to attend. In some instances when unable to attend, I would send my condolences in form of *erongori*[77]. Second, many people construct HIV/AIDS infection as death. This construction is also emphasized by many HIV/AIDS campaigns as a way of deterring people from risky sexual activities. Thus, by taking part in some funerals where the deceased was either covertly or overtly[78] said to have died of HIV/AIDS enabled me to have first hand information on how youths' construction and supposed actions to HIV/AIDS in an immediate real context. Three, with high mortality rate caused by HIV/AIDS especially among young people, funeral services have been turned into campaign platforms against HIV/AIDS[79].

Other activities I participated in were visiting social places where youths frequented such as music and football screening halls, popular drinking and eating places, Christian crusades, youth tournament games and visiting market places especially on designated market days. All these places enabled me to observe youths' behaviour in various contexts.

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[77] *Erongori* is the Ekegusii name for porridge. In the funeral context it means donating some cash to assist the bereaved family in their mourning period.

[78] HIV/AIDS death is stigmatized in the community. People may directly link death to HIV/AIDS if the victim is blamed for his/her infection. In cases where the victim is not to blame, people tend to cover the cause of his/her death as away of protecting the deceased and immediate family identity and dignity. For details refer to the section: Illness among Abagusii in this thesis.

[79] Funeral services have also been turned into political platforms to articulate various political agendas by politicians.

Participant observation in this study was found to be particularly useful in collecting data because it is rarely time-bound (Weil, 1995). Due to this as a researcher I was able to interact with my research participants for long hours eliciting information at their pace. Also given the sensitive nature of this study, the research participants needed time both to give over information and to overcome the stigma and cultural conservativeness associated with HIV/AIDS and sexuality respectively.

Apart from participant observation, I indulged with research participants in informal discussions especially relating to my study. These informal discussions especially in social places proved important given the fact that most young people felt free to talk out some of their experiences in relation to sex and HIV/AIDS prevention unlike in formal interviews.

Informal discussions were not; however, restricted to social places only but formed part of my daily activities. As I transversed my study site, many young people became curious of my research. Therefore, I had to develop some discussion with them. Also in most evenings after my field work I sat down with a group of young people where we discussed various topics ranging from football, politics and social relationships with people of the opposite sex to HIV/AIDS and its prevention. From such discussions a lot of information was obtained which augmented data from in-depth conversational interviews.

In the process of data analysis, field notes from participant observation proved to be very important as they helped me to clarify some issues and put some interview texts into context. For example, field notes from participant observation documented body language and setting which offered contextual data that would have been lost in the recording process. This was important because I carried this study from the ontological perspective that saw interactions, actions and behaviour as central in helping me understand ways in which youths made sense of cultural meanings of HIV/AIDS prevention strategies namely Abstinence, Being faithful, Condom use and VCT. The field notes from participant observation and informal discussions helped me to understand what was happening to HIV/AIDS prevention strategies from more than one perspective. In some instances, my diary notes from participant observation prompted me into new sites for data collections as I discovered some issues that I had not thought about before

going into the field. Consequently, field notes from participant observation became part of my data collection and making sense of these notes remained part of my data analysis.

Recording of Collected Data from Interviews

One of the major dilemma facing researchers has to do with making decisions on how to keep records of interviews in an accurate and ethical manner. These dilemma ranges from (not) tape-recording interviews to (not) note taking. Reiss (2002); for example, avoided tape recording his interviews and instead took notes because of his own experience of being tape recorded in an interview where he was not able to make any off-the-cuff remarks. Similarly, Preece and Ntseene (2004) decided to avoid tape recording in their focus groups on HIV/AIDS intervention strategies in Botswana to allow more natural discussions.

Contrary to the above arguments, Wengraf (2001) and Gilhamm (2000) note that note taking breaks the contact and rapport with interviewees, and interferes with the flow of information. While acknowledging that note taking can be adequate especially in short interviews, they both agree that it may not work well in longer interviews, as was the case in this study. Due to this, I made the decision of tape recording my interviews where the participant gives consent and was comfortable. Where this was not the case, I resorted to note taking. In general, most of the interviews were tape-recorded safe for three where the participants were uncomfortable.

Tape recording of my interviews formed a major component of recording my interviews although in the course of interview, I took small notes in my research diary notebook on major issues under discussion as they emerged. Tape recording of interviews proved helpful in recapturing the scenes all over again, the tone of voice and the expressions, which would be completely lost if not recorded. When negotiating for access and consent with my potential interviewees, I explained to them that I would tape record the interview but make anonymous any details that could identify them. I did this by changing all the names of interviewees and concealing any information which would have led to their identification by anybody else (**See Appendix 4**)

To make tape recording less intimidating, I used a small digital recorder "Dictaphone" which resembled a normal phone. This device although less intimidating as many young people were

used to some mobile phones which could be used to record conversations, to some interviewees it created suspicion of using the recorded information against them. This fear was borne from their experience of people using recorded information "against others"[80] as I latter came to learn. For example, one young woman who was involved in commercial sex work was not willing to open up during the interview until I switched off my tape recording device. This was even after she had consented to tape recording. Despite this, most young people I interviewed had no problem with tape recording.

Data Analysis

Data analysis includes data management. It is a long process and begins right at the first step of designing research questions and continues to the last fulstop of the research report. From the beginning of this research project, I made several analytical decisions which include: the literature I have reviewed, my choice of theory that has guided this study, my methodology, the questions to ask and whom to ask. All these decisions have become part of my data analysis. While in the field collecting data, I continued making some analysis through summarizing, coding, filing, observing patterns and themes that guided the rest of the data collection.

The data collection exercise took place from January to September 2009. Data collected from in-depth conversational interviews formed my research findings in this thesis. In data analysis, I was interested to know how youths made sense of cultural meanings of HIV/AIDS prevention strategies namely; Abstinence, Being faithful, Condom use and Voluntarily Counselling and Testing (VCT) and how their social construction of sex informed their meaning and action with regard to HIV/AIDS prevention in various contexts from their own cultural perspective. In this case, data from in-depth conversational interviews was taken as discourses which not only transferred information but indicated what individuals or cultures accomplish through language. Therefore these discourses were taken as integral part of the culture in which they are used. Due to this critical discourse analysis formed a major component in data analysis.

[80] Recording of conversation in Kenya using mobile phones came to the limelight in 2005 when the Permanent secretary in the Office of the President in charge for the fight against corruption tape-recorded conversation with some powerful ministers. The recorded conversations were used by opposition parties and civil societies to force the president to make the accused ministers to resign from their ministerial portfolio. Since then recording of conversations using phone like devices was feared by many people especially when talking about sensitive issues. For further details see; Wrong Michela (2009): **It s our turn to eat: The story of a Kenyan whistle Brower.** London, Harper printers

The rationale of adopting critical discourse analysis is due to the fact this study was carried from the premise that there is no universal way of understanding and interpreting HIV/AIDS prevention strategies in different cultural contexts. Therefore by focusing on critical discourse analysis it's possible to show non-obvious ways in which language was involved in pinpointing the multifaceted interpretation and understanding of HIV/AIDS prevention strategies as infused in the dynamics of power, culture and ideology in different social and cultural contexts (Wodak, 1996). Further, discourse draws attention to the context in which text is produced (Wodak and Meyer, 2001). The issue of context was significant to this study in interpreting and understanding HIV/AIDS prevention strategies.

Information used for this analysis was collected from 100 participants in Suneka Division. I personally conducted all the interviews. However, before embarking on transcribing interviews, I listened to each tape recorded interviews at least thrice. This was to ensure that I was hearing what the interviewees actually said, and also listening to my own voice in the interviews. In most cases, I took some breaks between the recordings and second or third listening just to be sure I was hearing the voices clearly. Before making any deeper analysis of data, I wanted to be sure that I got the real meaning behind the words said and my own notes. I ended up with 550 pages of notes and 50 pages of field notes from participant observation.

Having typed out all the interviews, I moved away from listening to reading so that I can start doing some coding. However, I read through the texts before doing coding to be sure that my own attitudes, values and perspectives were not taking precedence over what the interviewee said. This is because I have remained conscious of the fact that it is not enough to give people a voice by interviewing them, but it is equally important that their voices are not "erased" by turning away from their words (Hooks, 1994).

With the large volume of data I had at hand, I decided to analyze my data using the computer software known as Nvino, which is used for qualitative data analysis. But before exporting the files from MS word to Nvino, I did some initial coding of some of the emerging issues. Having formulated the codes, I then performed electronic searches using Nvino. I carried several of these searches and made coding reports which I exported back to MS word. These are the files I

worked with to pull out extracts which I found to be relevant for different themes addressed in each of the chapters in part two of this thesis.

From the themes, I looked for the plausibility of the data. This involved asking questions like: Did the themes, trends and patterns make sense? How valid and reliable were they? I did this by looking for intervening patterns, and issues and concepts in the literature and theories that could explain these patterns, concepts, issues and themes. Most importantly, I kept on asking myself what the data as a whole meant beyond the particular young men and women I had interviewed.

In the data analysis, I continued to think about how my initial questions and data related to the final written report. Further, I was aware and reflexive of the changes I too underwent from the start of this study to the end as this continuously influenced how I interpreted and understood the data. Some questions that would come into mind during the analysis included: What was in my own talk and questioning that contributed to the responses of interviewees? How would I read their reflexivity in their responses? Did the interviews help the respondents to reflect on the issues under study in ways that could contribute to changes at personal level?

In the course of data analysis, I continued to have discussions with professional colleagues, my supervisors and fellow PhD students and further literature review. All these ideas and interpretations assisted me in making more sense of the issues arising from the data. However, the final decision on what has been written was entirely my own.

Ethical Consideration

Ethical consideration formed the central component of this study because of its sensitive nature as it touched on individuals' private lives. Consequently, I had to concern myself with the rights and welfare of all those who participated in this study. As noted by many researchers, it is important to treat research participants humanely and with care, sensitivity and respect (Oliver, 2004). In this case, it is important to obtain the participants' consent before undertaking any study and respecting the participants' choice to withhold any information that they feel not comfortable to discuss.

I considered this study very sensitive because it touched on young people's experience with HIV/AIDS and sexuality. In most communities in Sub Saharan Africa, HIV/AIDS is surrounded by silence, ignorance, secrecy, stigma and discrimination (Nzioka, 2000). Further, the disease is associated with people who are sexually irresponsible (Barnett and Whiteside, 2002) and thus many people will prefer not to be associated with any study which may lead them to be identified with the disease.

The study also involved asking participants to talk about their experiences with a disease that is surrounded by stigma. The revealed information can be problematic to the individual participants, families or close social networks. This is because the interviews I carried touched on young people's private lives in ways that could be stressful if revealed. Nonetheless, I felt that this study was justified in Kenya where HIV/AIDS is a major social and medical problem affecting young people.

Threats that research may pose to individual participants may range from dealing with areas in individual's private, stressful or sacred lives. Thus, research into sensitive topics may be seen as involving some potential risk or cost to those being researched (Lee and Renzetti, 1993). As a result, a sensitive study requires serious ethical considerations throughout the research process.

Consequently, in this study I specifically undertook to ensure my participants' rights and welfare in the course of the study. To do this, I reflected on ethical questions that I thought critical and relevant as a social researcher and some of the ethical dilemmas I encountered as elucidated hereafter.

Confidentiality

The first ethical decision I made from the onset was to ensure my participants' information was kept in confidence. The first step I undertook to achieve this was by changing the names of all respondents. In this case, I decided to use pseudonyms in referring to each respondent but ensuring that such names reminded me of the young people as much as possible. Also all information for each participant was restricted to general background information only (**See appendix 4**). The second step was to carry all in-depth conversational interviews alone.

Although some people helped me to identify potential respondents, the actual interviewing was done by me.

In ensuring confidentiality of my participants' information, I had to grapple with various challenges. One challenge came from my use of snowball sampling in selecting my participants. In this case, some contact people I was relying on in identifying my participants would direct me to their friends for their own personal reasons. For example, Samson directed me to a young woman whom he had tried to date for some time. He wanted to know the young woman's experience in relation to HIV/AIDS and sexuality. So when the young woman gave consent for the interview, Samson wanted to be around and listen to the interview. I had to request Samson to give us room because what we were discussing was private and confidential. He agreed to leave. But immediately after the interview, Samson started asking me what the young woman's experience was even requesting to listen to the recorded interview. This prompted me to tell him that all my discussions with my research participants were confidential.

Despite this, Samson did not stop looking for any opportunity to know what I actually discussed with the young woman. He would ask me some leading questions which I refused to answer or assumed. When these tactics did not work, the following day Samson joined me in identifying another participant. But before doing that, he deliberately disappeared with my recording device for about one hour. He wanted to listen to the interview. Fortunately, I had made a rule before I started my field work that all interviews will be transferred from my recording device to my laptop immediately. After this, I will delete the interview file from the recording device. My laptop had a private security password which was known to me alone and the file folder under which I saved my interviews equally had security passwords. This made accessing my recorded and saved interviews hard to access. After this incident, I had to stop relying on Samson as my contact person.

Another problem I grappled with was to do with upholding the confidentiality principle and my own moral conscience. By virtue of my research, I was able to delve on individuals' private lives. Some of the information I came across was confidential and would cause irreparable damage if released to another person. This dilemma arose in situations where some of my research

participants would confide to me their HIV positive status which they have kept from their close friends, peers or members of their social network. In one case, one participant told me he tested positive to HIV/AIDS three years ago. At first, he thought the test was wrongly done but after two more tests in different hospitals, he confirmed his status. Although he was counseled and asked to live positively, he has been indulging in unprotected sex with different girls. In more than four different occasions in the course of this study, I met this particular participant with different girls all of whom he introduced as his lovers.

The second case involved a woman who was on ARV treatment for the last one year but has kept that information from her husband. Her reason for doing so was to protect her marriage. The third case was a young woman who was about to wed in church. As a requirement in some churches in Kenya, newlyweds have to undergo HIV test before solemnizing their marriage. Doubting her HIV/AIDS status, she discreetly went for HIV test which turned positive. Fearing to be stigmatized as a consequence of her status, she was forced to pay someone to undergo an HIV test on her behalf using her name. She later presented this medical report to the church for permission to go on with the wedding plans.

In all these cases, was I justified to break my confidentiality principle for the sake of helping the other person who was at risk of being infected by my research participant? As a practicing Catholic, was it morally right to keep quiet given my church teachings that one can commit sin by commission or omission? These dilemmas were made worse by the Kenya's HIV and AIDS Prevention and Control Act 14 of 2006 which in section 22 prohibits the disclosure of information concerning the result of HIV test or any related assessment to any person except;

a) with written consent of that person,
b) if that person has died, with written consent of that person's partner, personal representative, administrator or executor,
c) if that person is a child , with written consent of a parent or legal guardian of that child,
d) If that person is unable to give written consent, with the oral consent of that person or with written consent of the person with power of the Attorney for that person.

Further, under section 23, Breach of Confidentiality is an offence punishable under section 42 by imprisonment for a term not exceeding 2 years or to a fine not exceeding Kshs. 100,000/= or both.

These dilemmas put me into a lot of emotional strains. This was not an exception to me as Corden *et al.,* (2005) notes that in social research involving sensitive issues, the emotional strain has potential risk for both the researcher and the participant. Despite the fact that before I embarked on my research, I had keenly read the experiences of other researchers who have studied sensitive topics (Dunn, 1991; Chatzifotiou, 2000); my field experience was all the same another ball game! One option for me as Corden *et al.,* (2005) recommends was to seek professional help or support group. Unfortunately, I did not have such access. Therefore, I had to look for ways of overcoming my emotional strains without compromising the Confidentiality Principle.

One method I used to overcome these dilemmas was to hold either immediately or after sometime informal discussions with participants whose cases were emotionally straining. In these discussions, I delved to understand the reasons behind their actions. However, I was keen not to turn such discussions into therapeutic sessions which I was least professionally qualified.

These informal discussions proved to be very relieving to my participants and myself. On my side, I was able to understand the reasons behind their actions. To my participants, they were able to open up by seeking information on how and where they can seek further help to their situation from me. Consequently, using my knowledge and experience as fieldwork practicum coordinator in Moi University, Department of Sociology and Psychology[81] prior to my doctoral studies, I was able to direct them to various offices where they sought help. Those who sought such help overcame their fears and lived positively with their HIV/AIDS positive status. For example, the young woman who cheated in her HIV test (in case three above) for the sole purpose of getting married decided in her own volition to cancel the wedding ceremony which

[81] As a lecturer at Moi University, Department of Sociology and Psychology, apart from teaching, I was in charge of organizing and coordinating field practicum for all fourth year undergraduate students majoring either in Sociology or Psychology. Field practicum required all students to work in various organizations for a period of three months. Some of the organizations where the students were attached dealt with counselling, advocacy and empowerment.

was due in two months time. By the time I finished my research, the young woman was actively involved in sensitizing youths to know their HIV/AIDS status through Voluntarily Counselling and Testing (VCT).

The dilemma posed by upholding confidentiality as discussed above in away challenges the principle of cultural relativism among anthropologist. Whereas this principle advocates that anthropologists should understand their research subjects from their own culture it does not mean an anthropologist should turn a blind eye when an individual behaviour in a certain cultural context is detrimental to other people. Instead as illustrated in above cases, cultural relativism should mean that the appropriateness of any positive or negative behaviour or custom in certain cultural context must be evaluated with regard on how this behaviour or custom fits with other people's wellbeing. For example, although as an anthropologist I was supposed to understand the young woman behaviour (in case three) from her own standpoint, this did not accord me leeway not to intervene given her behaviour posed risk to another person.

Compensating Participants

Research participants take some time off from their activities to take part in research. In all fairness, they need to be compensated. However, the issue of compensating participants is controversial depending on various traditions guiding research in many parts of the world. In Western countries as I learnt from one French professor whom I discussed my research methodology with, participants must be compensated for participating in research. The Professor, who has done a number of researches in South Africa on HIV/AIDS, indicated that in all his research projects he paid research participants. To him, this is not only ethical but morally right.

In Kenya and more so in Moi University where I am based as a teaching staff, it is ethically wrong to pay research participants in any academic research project. The argument for this is that such payment or compensation will influence the research participants' responses. Instead it is recommended that a researcher should explain to research participants the objectives of the study and make him/her understand the importance of participation. It is assumed that once this is done, the research participant would make a rational choice to participate.

These two scenarios confronted me in the course of my study. In the eyes of my French professor, I will be morally and ethically wrong if I did not compensate my research participants. For my fellow academic colleagues in Kenya, I would be accused of influencing my research participants to take part in my study thus compromising objectivity or quality of data. These situations were not peculiar given the fact that ethical theories are based on differing views, values and principles as demonstrated by a World Council of Churches Study Document on AIDS (WCC,1997) which describes ethics as a theory that:

> *.....clarifies questions about right and wrong, but also demonstrates their complexity: most ethical theories and much moral judgment are contestable.... Nevertheless, meaningful and constructive frameworks developed by ethical reflections over the ages can be used to examine the facts and values in question, leading to a degree of consensus, or at least a mutual understanding of divergent views (WCC, 1997:50)*

Granted from above, I used my own discretion to make what I considered ethical judgments in various situations I encountered. However, most of my decisions were influenced by Kenya academic research tradition which forbids compensating research participants as demonstrated hereafter.

In the course of my study, one research participant who was HIV positive by the name Mr. Jamal decided to introduce me to one young woman who was HIV positive. Mr. Jamal after knowing his HIV status decided to work as a volunteer with one Community Based Organization. His duty was to mobilize community members who were already HIV infected to seek treatment and minimize HIV stigma. By the nature of his work, Jamal was close to many HIV positive patients.

On this day, we decided to visit the young woman for the sole purpose of seeking her consent to be a participant in my research. As we drove to the young woman's home, I learnt from Jamal that the young woman was a case of discordant couples; that is, she was positive while her husband was still HIV negative. As a consequence of her status, the husband decided to divorce her. So the young woman was staying with her aged mother.

Given that Jamal was well known to them, we were warmly welcomed. He did the introduction and then after tried to enquire how she was fairing. The young woman told us she was fine

although she was itching all over the body. She had visited a nearby hospital a week ago for medical attention for the problem where the doctor recommended her to buy some medicine from a private pharmacy. Unfortunately, she won't afford the recommended medicine and thus she resigned herself to fate.

After listening to her tribulations, I asked the cost of the recommended medicine. The cost of the medicine was about 300 Kenyan Shillings (equivalent to 3 Euros). So I further asked how much money she had at that moment for the medicine. She told me she had 100 Kenyan Shillings (equivalent to 1 Euro). Instead of giving her the remaining money to top up, I decided to top up the amount and bought her the medicine at the pharmacy. After this, I explained briefly my mission in the area and the possible role she can play in my research. Although she was willing to be a participant immediately, I requested her first to take her medicine and once she got better, we could organize for the interview. I did this to give her time to look critically at my request and at the same time not to exploit my compassionate gesture to her for an interview. After three weeks she sent word through Jamal that she wanted me to have an interview with her. She felt that her experience with HIV/AIDS would help other young women to take care from being infected.

Suffixing from above, it is clear that I never directly compensated my research participants. What I did was to take part in solving their problems. This was not peculiar because among the Abagusii illness management; for example, is a communal issue where every community member participates in getting its solution (Sindiga, 2006). Consequently, my actions were not seen in light of compensation but as part of my social responsibility in the community.

Negotiating access and consent

In this study, I found access and consent intertwined. Consequently, first I had to make contact with potential participants before explaining to them the study objectives and then seeking their consent to be interviewed. In this case, I had to use different techniques in negotiating access and consent in all my 50 interviews because each case was unique.

Despite this, in most cases I relied on snowball sampling technique which is commonly used in situations where accessing potential participants is seen as challenging (Miller, 1998, Standing, 1998). Given my study topic was sensitive and stigmatized, I decided to make use of this method of accessing and seeking young people's consent. Further, I chose to depend on verbal consent only because as Miller and Bell (2002:54) point out, "written consent has implication for those trying to access hidden groups or those who are difficult to access and where people may not want anything bearing their signature as evidence that they gave such an interview."

My decision to overlie on snowball sampling technique brought with it some ethical difficulties. One of it was to do with participant consent. Given the fact that consent is influenced by the information given about the research to the participants. They need to evaluate the information given and then decide if they would like to participate. In this connection, I noted that some of my link persons to potential participants choose to give information which was not intended by me as a researcher. This made some research participants to consent without clear understanding of what they were getting themselves into.

In one case, a participant who was herself HIV positive had agreed to provide me with another contact decided to inform her on my behalf. The information she gave out was that I was interviewing HIV/AIDS patients in an effort to form a group which can get donor funding from international agencies for HIV/AIDS prevention activities among young people. This information was contrary to what my research was all about. When I met this participant for interview, I was forced to explain what my research objectives were. She was comfortable with my explanation and consented for interview. From this I learnt that consent is something that has to be continuously reassessed and renegotiated.

Another ethical problem I encountered was to determine when a research participant had fully consented to participate. This problem came into the fore in two situations. The first situation was when I was interviewing a young woman who was involved in commercial sex work. The young woman was contacted on my behalf by one of her closest friend. So, she obliged not to fail her friend. Prior to the interview, she consented to my request to tape record the interview. But during the interview process she was uncomfortable until I switched off my recording

device. Later, I came to learn that she feared that, "I was to use her recorded interview against her".

The second situation was when the doctor who was the head of Patient Support Group in Kisii Level 5 - Hospital decided to contact on my behalf one of his patients. The young man agreed to participate in my research because he did not want to go against his doctor's request. However, during the interview the young man was uncooperative. As a consequence, I was forced to shorten my interview and focus on general issues on HIV/AIDS instead of personal experience.

These two situations underscored to me that participants may consent to participate in research because of various reasons. Chief among them is fear to embarrass their friends who have contacted them (in situation one) and the power relation between the potential participant and the contact person (in situation two).

In dealing with these problems of consent, I was guided by Miller and Bell (2002:56) argument regarding consent that, "whichever approach is adopted, the motive around why some people become participants and others resist should concern the researcher and be documented in research diary". This is what I did whenever I sensed some resistance. In some cases I resorted to take some time to ask for consent from potential research participant for interview even after initial contact and explanation of my research objectives. This was mostly when I observed that the research participant was in a dilemma on what to do with my request. I did this with an assumption that consent may take time as participants evaluate the information on the research and then make a decision.

Lastly, in many cases of getting potential participants, I was careful to avoid asking contact people to provide details of my study. In this case, I would ask to be given the details of my potential interviewees so that I could contact them directly. This was made possible by my long period in the study site whereby I came to know many young people and places.

Summary and Conclusion

In this chapter, I have discussed the process I followed in the data collection exercise, including a theoretical basis for each of the choices I made. In my discussion, I have shown some of the decisions I made due to the realities in the field. Further, this being a sensitive study, I was faced with a number of ethical challenges. I have discussed these challenges and how I tried to overcome them.

CHAPTER SIX

HIV/AIDS CAMPAIGNS: PREVENTION STRATEGIES AND THEIR IMPACT ON YOUTHS' PERCEPTION AND SEXUAL BEHAVIOUR.

Introduction

This chapter analyses various HIV/AIDS campaigns strategies that are used in the fight against HIV/AIDS among Abagusii young people. It examines how youths access information about HIV/AIDS prevention and the nature of information they have access to. The chapter in particular focuses on the use of both the media and interpersonal communication channels which are used to encourage sexual behaviour change and the extent to which youths are involved in HIV/AIDS activities. The chapter further discusses the impact of HIV/AIDS prevention campaigns especially on youths' perception about HIV/AIDS and sexual behaviour.

Section 1: HIV/AIDS Prevention Campaigns

Since 1984 when HIV/AIDS was first discovered in Kenya, HIV/AIDS campaigns programmes have focused on information supply, promotion of "safer sex" practices and recent treatment. The first two aspects are premised on the information-giving model which focuses on the cognitive abilities of individuals to process information on the risks of unprotected sex with assumption that the individual will make "rational" decision of choosing safe sex practices. Information is assumed to empower people to arrive at relevant health behaviour decisions which take into account *inter alia* the perceived severity of the condition, the level of risk, the cost and benefits of alternative behaviour (Ingham *et al.,* 1992).

The information- giving model is also based on the theory of reasoned action or planned behaviour. In the theory of planned behaviour, the change agent like the government or Non-Governmental Organizations introduce new ideas by encouraging people to experiment with them in the hope they would later become integral parts of their lives. The assumption is that people fail to adopt new ideas or to respond positively to risky situations because they lack information. Consequently, the government and other agencies like Non-Governmental Organizations have been supplying persuasive information to encourage people to desist from certain sexual practices or to adopt certain sexual behaviour regarded safe.

Most of the information supplied by the government and other actors[82] to the public contain information on the dominant modes of transmission, ways of avoiding the risk of HIV infection and how to live positively if already infected by HIV. Alongside these is the promotion of safer sexual practices. Although the precise meaning of the concept of safer sex remains obscure and the term is still used in generic sense without explication (Wright, 1993), in Kenya, its meaning is often restricted to condom use. Thus, the success of safer sex in HIV/AIDS prevention is often evaluated in terms of the number of condoms distributed or sold.

In most HIV/AIDS campaigns programmes, both information supply and condom are used complementarily. However, critics of both methods point out that results drawn from the evaluation of both could yield to misleading results, and give various actors in HIV/AIDS prevention a false belief that all is well with the programmes. For example, in Kenya condoms are distributed both in public and private clinics or sold at subsidized prices. Further, they are a lot of awareness campaigns especially in the media encouraging condom use. However, impressive statistics on condom distribution and sales are by no means conclusive indicators of change in sexual practices.

Critics of both the information and condom promotion campaigns point out the assumption that people engage in unprotected sex because they are unaware of the risks of HIV infection, or because they lack condoms, are ill-supported by evidence (Silverman, 1990). People do engage in unprotected sex even when they are fully aware of the potential risks of HIV infection. Based on observations of sexual behaviour among gay men in Britain, Wilton and Aggleton (1999:149) argue that:

> *Individuals do not simply absorb information and respond logically by modifying their health – related behaviour. Rather, people actively "make sense" of new ideas they encounter by assessing them in light of pre-existing beliefs, interpreting them accordingly, and fitting them in what they already know.*

Cohen (1991) also argues that even if information alone is well presented or dramatized is not sufficiently powerful to cause people to refrain from unprotected intercourse. People engage in

[82] Apart from the government other actors involved in HIV/AIDS campaigns are non governmental organizations, community based organizations and individuals.

unsafe sex for a range of reasons not just simply lack of information on the risks of HIV. This is because most people tend to misinterpret, selectively perceive or rationalize information in order to conform to their own biases, interests and desires.

Information supply campaigns appeal to a sense of "rationality" or "reason". In this case, it is assumed that people engage in sexual practices on the basis of rational risk calculation based on detailed and complex epidemiological data or sophisticated models of contagion and infection. However, studies by Airhihenbuwa and Obegon (2000); and Hoosen and Collins, (2004) have shown that an individual's capacity to make a rational decision is affected by other intervening factors like poverty, gender, power inequalities and the desire to adopt modern lifestyles. Therefore, safer sex promotion campaigns which tend to appeal to reason tend to decontextualise sex from the cultural, economic and social frames in which it occurs. Additionally, they fail to incorporate the meanings that shape the kind of attitudes and beliefs individuals attach to sex and HIV/AIDS.

It is noteworthy that the Kenya government and other actors involved in HIV/AIDS campaigns rely mostly on global World Health Organization biomedical approach. This approach holds that all prevention strategies are applicable to all communities and groups regardless of their socio-cultural and economic contexts. Consequently, most HIV/AIDS campaigns in Kenya are mere reflections of WHO HIV/AIDS prevention approaches which emphasise sexual behaviour change through promotion of Abstinence, Being Faithful, Condom use and VCT programmes.

To ensure the effectiveness of these programmes, the government and other actors have underscored the importance of effective communication. As a result, the National AIDS and STD Control Programme (NASCOP) came up with Kenya National HIV/AIDS Communication Strategy 2002-2005 (GoK, 2003).

The purpose of the communication strategy is to define the framework, guiding principles and the key elements of communication programmes which emphasise behaviour change for HIV/AIDS prevention (GoK, 2003). In the strategy, it is recognized that although HIV/AIDS awareness is high, many people lack comprehensive knowledge and many issues concerning the

pandemic, particularly on spread and prevention. Consequently, there is need to target the most vulnerable in society like youths, commercial sex workers, immigrants among others (GoK, 2003).

In order to effectively reach these vulnerable groups, the strategy proposes to use several approaches including community and school based communication programmes, the mass media and public-private sector partnership. The primary target of these approaches is largely youths who are recognized as essentially vulnerable to HIV/AIDS. The emphasis on youths is based on the need to shape their moral character in their formative years; while community-based communication approach recognizes the efficacy of oral tradition in communication, particularly among rural folks who are generally limited in their access to modern mass media.

The Mass Media

The role of media in influencing social change especially in HIV/AIDS prevention has generated a lot of debate among many scholars. Most of them agree that mass media is important in creating awareness and disseminating correct information regarding HIV/AIDS. However, they point out that it has limited impact in influencing social change. Oakis (2003) notes that mass media is crucial in informing, shaping and sustaining attitudes concerning HIV/AIDS, but concedes that mass media often ignore the political, economic, social and cultural contexts of the people they address. Further, PANOS (2006) also points out the importance of mass media but perceives locally generated initiatives as more effective in influencing social change.

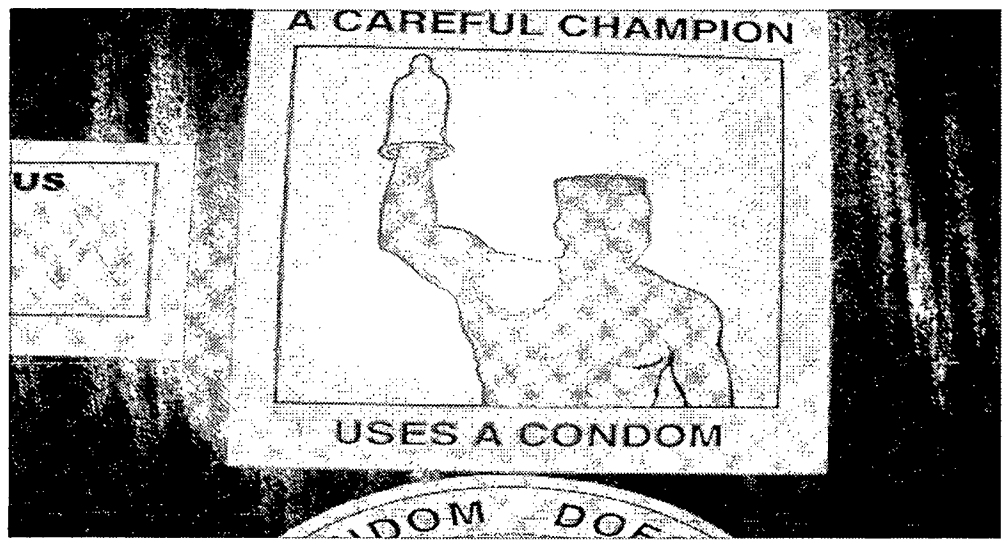
Despite this, mass media in Kenya continue to play a major role in the fight against HIV/AIDS. Consequently, this study tried to understand the various channels which Abagusii youths use to access information about HIV/AIDS. These channels are hereafter discussed.

Posters and leaflets

Posters were noted to be the most popular channel of communication in the fight against HIV/AIDS. As observed, these posters were produced by the Ministry of Health through funding of international Non-Governmental Organizations like USAID and Family Health International.

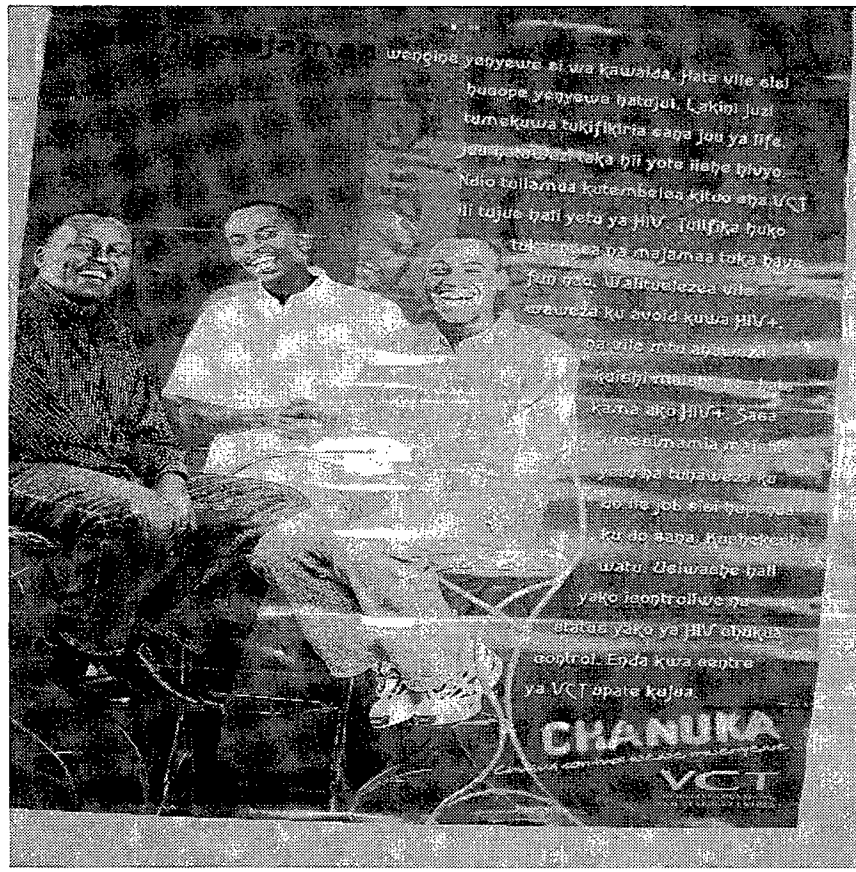
Some of the messages contained in these posters and leaflets did not target any particular group or context of various audiences (**See Figure 6.1**).

Figure 6.1: Ministry of Health Posters for Promotion of Safer Sex or Use of Condom



Interviews with the head of Kisii Level-5 Hospital Patient Support Centre also confirmed that most posters were made for the general population with specific messages on HIV/AIDS prevention. However, in recent past efforts have been made to make posters which target specific groups. For example, posters which target young people normally feature various celebrities like models, renowned artists or sportsmen whom young people identify with (**See Figure 6.2).**

Figure 6.2: Poster Featuring Celebrities Urging Young People to Know their HIV Status



In **figure 6.2** above, the poster features renowned comedians namely Tony Njuguna, John Kiare and Walter Mongare of Reddkylous Comedy Group. The trios are urging young people to know their HIV status by visiting VCT centres so that they can prepare their future life with certainty. By using celebrities, it is rationalized that young people who prefer to identify themselves with celebrities will easily adopt the behaviour change they are advocating since it forms part of their lifestyle.

The poster targeting young people were also observed to use *Sheng* language in the delivery of HIV/AIDS campaign message. *Sheng* is a mix of English and Kiswahili words in a sentence. This kind of communication is common among young people especially those residing in urban areas and thus associated with urbanites. For example in **Figure 6.2** the poster starts with three Kiswahili words "*Sisi ni Majamaa*" which translates to "us people". In this context, the words refer to "special or unique people"- underscoring the celebrity identity. In the text there is also a mix of English and Kiswahili words like "*ku do*" (to do); "*Ku avoid*" (to avoid); "*Chanuka*" (Be

wise). Therefore, by using *Sheng* language in these posters it is rationalized that young people will easily identify themselves with the message which is being passed.

The use of celebrities and *Sheng* language; however, raised the question of whether such strategies were effective in HIV/AIDS campaigns especially in rural areas as demonstrated by the following interview with a 26 year old Mr. Aura:

Researcher: Have you come across any poster in this area dealing with HIV/AIDS?

Aura: Yes, but they are very few nowadays.

Researcher: Do you think the message in these posters concerns you?

Aura: Not at all.

Researcher: Why?

Aura: You see these posters are not meant for us people in rural areas.

Researcher: Implying?

Aura: Look at most posters and you will agree with me. All the young people featured are well to do or come from well to do families and reside in towns. Not like us poor rural people. Those guys are town people and even the language these posters are written in is for town people....I think it is because HIV/AIDS is so rampant in town and that is why these posters are meant for young people in town.

From the above interview, it is clear that most posters use language and pictorials which many youths in rural areas cannot identify with. This is because all posters for HIV/AIDS campaigns in Kenya are made at the Ministry of Health headquarters with common features. The posters are; therefore, supposed to convey the same HIV/AIDS messages to all people regardless of their socio-economic orientation. This is contrary to Parker (1994:146) finding "that the media cannot be divorced from social processes that seek to promote change, and further to this, if media is to be functional to these processes, then the incorporation of community perspectives into the production of media products is of paramount importance."

The use of posters in the campaign against HIV/AIDS was also observed to be skewed towards urban and semi-urban areas. Most of these areas had many posters on HIV/AIDS than in rural areas. For example, in Suneka Township, the researcher observed more posters which were

either pinned on electricity poles along Kisii-Migori road or on the doors of most shops or entertainment places. In rural areas, these posters were observed to be only in rural shopping centres and more specifically in entertainment places like bars.

The skewed concentration of posters in certain areas was; however, justified by the local official of National AIDS Control Council that those areas are easily accessible and have a high number of people. As a consequence, HIV/AIDS messages were thus taken to reach many people. Contrary to this argument; however, such skewed concentration of posters was found to create wrong perception about HIV/AIDS risks as demonstrated by Samson:

Researcher: Are you at risk of getting HIV/AIDS?

Samson: No

Researcher: Why?

Samson: AIDS is not rampant in rural areas. If you go to town you will see many advertisements about HIV/AIDS ...on the building walls, trees and telephone poles. This means many people have AIDS in town.

Researcher: Do you mean HIV/AIDS is only rampant in towns than rural areas?

Samson: Yes, yes. The only places (in rural) which are risky are entertainment places like bars. Actually if you go to any bar in our shopping centre, you must get an AIDS advertisement warning you. Therefore, as long as you are not residing in town or visiting these entertainment places, you are free from getting AIDS.

Posters on HIV/AIDS campaigns were further observed to be focusing on various themes on prevention at different periods. This observation was also confirmed by the head of Patient Support Centre in Kisii Level 5 -Hospital and the head of Bonchari Constituency AIDS Control Committee. According to them, each year or in a particular period, the Ministry of Health comes up with various themes on HIV/AIDS. These themes are mostly influenced by World Health Organization or International Non-Governmental Organizations like USAID and United States President's Emergency Fund for AIDS Relief (PEPFAR). These institutions are major financiers in HIV/AIDS campaigns. Therefore, for the government to access funds from these institutions it must advocate the themes they are professing at a particular period. As a result, the government is mostly forced to abandon the ongoing HIV/AIDS campaign themes even if it has

not accomplished them and instead adopt what the funding agencies want. This was found to have major impact on the effectiveness of HIV/AIDS campaigns as argued by the head of Bonchari Constituency AIDS Control Committee:

> *Our HIV/AIDS programmes depend entirely on external funding. These funding agencies have their own interests which they want to accomplish. Since our government has no enough money to carry out various HIV/AIDS activities we are forced to implement what our donors want.... As much as these programmes are equally good in the fight against HIV/AIDS, they nevertheless don't meet the actual needs of the target population. Look for example, when our government got funds from the President of United States of America (referring to PEPFAR fund), our Ministry asked us to stop promoting condom use themes among young people. Instead it wanted us to promote Abstinence programmes. Honestly, these abstinence programmes are not workable in this area given the fact that most young people take sex as a form of initiation to adulthood. At least condoms look more realistic in the prevention of AIDS here.*

The above argument is further fortified by a 28 year-old Mary observation:

> *Our church was right from the beginning in opposing the promotion of condoms. But our government was against the church stand. Everywhere you will see posters urging people to use condoms, condoms and condoms! Now you know what! The government has realized the condoms are not effective in protecting one from getting AIDS. That is why of late the government is unashamedly printing many posters asking young people not to depend on condoms for protection but abstain from sex.*

Mary's observation is borne by the fact that most HIV/AIDS campaign posters promote a particular theme at a given period. In doing so, they make no reference to earlier themes or carry out an explanation that the earlier promoted themes are still valid/effective in the fight against HIV/AIDS. This is because funds which are got from donor agencies are specifically made to promote a particular theme. Consequently, the programme implementers are forced to abandon the preceding programmes or themes. In cases where the preceding themes are pursued, their intensity is low.

Some of the posters on HIV/AIDS campaigns were also noted by a number of research participants to be ambiguous in their messages. Citing for instance a poster featuring Prezzo (renowned musician in Kenya) in the promotion of condom use (**See Figure 6.3**), Nyandusi argues that the poster does not actually pass the information that young people must use condoms in every sexual encounter. Although the poster features Prezzo holding a packet of

Trust™ Condom packet with Kiswahili words *"Prezzo ana yake, je una yako?"*(Prezzo has his and you?), it does not qualify why he is holding the condom or what does he use it for. To Nyandusi; therefore, this lack of clarity gives room for various interpretations among many young people. For example, young people are more likely to think that sex is the in thing for the outgoing and successful especially when celebrities like musicians are used in the advertisement.

Figure 6.3: Poster Promoting Condom Use Featuring Renowned Musician

Another source of information on HIV/AIDS among youths was leaflets. Leaflets were also noted to promote various themes of HIV/AIDS at each particular period. These themes were mostly in response to the government HIV/AIDS` programmes at a particular period.

Unlike posters which mostly aim at creating awareness of particular themes, leaflets concentrate on providing details of these themes. This is done by giving factual information about a particular aspect of HIV/AIDS. For example, when the government is creating awareness about HIV/AIDS treatment using antiretroviral drugs, it will use leaflets to provide further details on how to use antiretroviral drugs.

As a source of information about HIV/AIDS, leaflets were found to reach a limited number of people. This was because most leaflets on HIV/AIDS were found in health facilities or in offices

of organizations dealing with HIV/AIDS. Consequently, those who had access to this source of information were those who visited these institutions. For example, in this study it was noted that most married young women mentioned leaflets as their source of information about HIV/AIDS. One reason for this is that women have higher likelihood of visiting health facilities more frequently than men.

The concentration of leaflets in health facilities or organizations dealing with HIV/AIDS was; however, found to create negative perception among some people. This was because some people associated leaflets as only targeting people who were already infected with HIV/AIDS or those who doubted their health status. As a consequence, some research participants avoided possessing HIV/AIDS leaflets for fear of being stigmatized as captured by Kwamboka:

> *I went to visit my boyfriend in his house. In my handbag was HIV/AIDS leaflet which I had gotten from our health centre. When my boyfriend saw this leaflet he was very emotional and inquisitive on who gave me and why. Even though I tried to explain on how I came to posses that leaflet, he accused me of hiding that I have AIDS. He told me that only those who go to hospital and are diagnosed with AIDS are the ones given those leaflets to help them know how to live longer. On that day for the first time in our love relationship, he chased me like a dog! From then on, I resolved never to posses any HIV/AIDS leaflets.*

Most leaflets were also noted to be written in English and never addressed any specific audience like youths. The use of English especially in rural areas where illiteracy level is high, excluded many people from getting the intended messages. Although, it was observed that few leaflets were already translated into Kiswahili (Kenya's national language), none was found written in Ekegusii (local language). Given the fact that language plays a major role in identity formation and group identification, the failure to have some leaflets in Ekegusii made some people not to identify themselves with the intended messages. This was clearly explained by the Head of Bonchari Constituency AIDS Control Committee experience on the use of leaflets in HIV/AIDS campaigns:

> *Although leaflets are rich in detail regarding various aspects of HIV/AIDS, they lack connectivity between the message and the target group .From the various campaigns I have been involved in, I have noted some trends in the use of either English or Kiswahili written leaflets among young people in various social contexts. In learning institutions like high schools, English written leaflets are well received. This is not the*

case with Kiswahili written leaflets. One possible reason for this difference is that Kiswahili is often taken in learning institutions as a language for the semi illiterate people. Therefore, leaflets written in Kiswahili are taken by young people in learning institutions as not meant for them. A similar trend is also observed in rural areas. In rural areas English is taken as a language for the elitists, while Kiswahili is seen as a language for people living in urban areas. Consequently, whenever we use English and Kiswahili written leaflets in rural areas, such leaflets are immediately discarded by our participants even before our campaign is over.

Billboards

These are large outdoor advertising structures and mostly found along the busy roads or placed on tops of buildings especially in urban areas. Billboards normally target passing pedestrians. As a consequence, they are typically large with ostensibly witty slogans and distinctive slogans. They are also designed to grab a person's attention and create a memorable impression very quickly, leaving the readers thinking about the advertisement after they have passed. To attain this, billboards are readable in a very short time because they are usually read while passing them. Thus they contain very few words in large fonts and arresting images in brilliant colours.

In the fight against HIV/AIDS, billboards were observed to concentrate in urban areas and in major roads. Unlike commercial billboards, HIV/AIDS billboards were few, old and defaced (**See Figure 6.4**). Further, they were not strategically located. All this was because of the cost element in using billboards as means of awareness creation. This was clearly explained by the head of Patient Support Centre in Kisii Level-5 Hospital, who before his current position was involved in government sponsored HIV/AIDS awareness campaigns for ten years.

In late 1980s the government relied mostly on billboards to create HIV/AIDS awareness. Apart from the cost of making these billboards, no any other cost was involved. Actually it was very cost effective as one billboard will serve many people in a locality. However, in mid 1990s, due to financial crisis in the government, most local authorities were required to generate their own income to meet some of their needs. One area of generating this income was by charging any advertisement carried in their area of jurisdiction. This meant that all billboards were to attract some cost in terms of their locality, size and duration of the advertisement. This in essence has made billboard advertisement to be very expensive as compared to posters.

The cost element of using billboards as a means of awareness creation in HIV/AIDS was also evidenced in ways in which messages were communicated to various audiences. In the 1980s as

observed by the head of Patient Support Centre, billboards were made to target each community where it was erected. In this case, the billboard would use the local language and visuals to communicate the intended message. Due to this, most people identified themselves with the communicated message. However, this is not the case now. All billboards are either in Kiswahili or English with universal visuals for all communities. The effect of this change on HIV/AIDS campaign is clearly captured by Mr. Aura:

> *I remember vividly on how AIDS was being advertised in our place. There was a huge billboard with people who looked like us rural people. On the billboard were well written words in Ekegusii warning about AIDS. Everybody who saw the billboard took the warning very seriously. Both men and women started going to church as AIDS was seen as a reality in our community. Nowadays, I don't see such effect. Most billboards are so much detached from people whom they are made for.*

Figure 6.4: Billboard Creating Awareness of HIV/AIDS Prevention Strategies (ABC)

Through interviews with research participants, it was established that billboards created different perceptions with regards to HIV/AIDS risk. This perception was based on individual evaluation of billboards in terms of their cost and intensity. Those who saw billboards as a costly strategy in the campaign against HIV/AIDS took the intended messages seriously. For them, they argued that the government will not invest in a lot of money to create awareness over something which is not important. Consequently, by erecting huge billboards in various places to warn people of the risk of HIV/AIDS, the government was demonstrating that the risk of HIV/AIDS is real. This

perception of evaluating HIV/AIDS risk in relation to the cost of the campaign strategy was clearly underscored by Jared sentiment:

> *I am told putting up one bill board for AIDS is extremely expensive. This alone show how serious the problem of AIDS is. With this knowledge I have learnt to take seriously any message on billboards as a way of protecting myself from this disease.*

Other research participants were also noted to evaluate the risk of HIV/AIDS in terms of how the billboards are distributed in a particular locality. To them, where there were many billboards on HIV/AIDS, the risk of infection was very high. Due to this, most youths especially in rural areas perceive HIV/AIDS risk being high in urban areas or in areas which are adjacent to major roads where HIV/AIDS bill boards were many.

In addition, youths also evaluated HIV/AIDS risk by observing the quality of the billboard. Quality was seen in terms on how well they were maintained. As observed, most billboards especially in rural areas were defaced and abandoned. This gave the impression among young people that the messages on the billboards were purporting to communicate were already obsolete, archaic and outdated. This observation was clearly illustrated by the following interview:

Researcher: Is HIV/AIDS a major health problem in this area?

Samson: Not now. It is used to be sometime back.

Researcher: Samson, why do you say it used to be a health problem?

Samson: There was a time when people used to die of AIDS in large numbers. With these deaths, there were many billboards everywhere warning people about AIDS. Each day there was a new billboard coming up in one place or the other. These bill boards really made people to know how to avoid getting AIDS....AIDS at this time was a real threat! With no many deaths from AIDS nowadays especially in our place here (meaning rural), most billboards have been abandoned as the messages are not relevant.

Researcher: Why do you say that messages on billboards are not relevant now?

Samson: Look everywhere in this place! You will never see any new billboard coming up on HIV/AIDS. All you see are old defaced billboards which are hardly readable....some already covered by the bush. This shows AIDS is no longer a threat as it used to be.... My friend, let me just ask you this. Do you think the government is stupid to abandon all these billboards everywhere if AIDS is still a threat? For me it is absolutely no.

Regardless of the above misgivings on billboards, other research participants observed that it was the most effective strategy in the fight against HIV/AIDS. This effectiveness was seen in terms of the time taken to access information and its impact on an individual's identity. Regarding time, research participants argued that billboards were written in very few words which are catchy, factual and thought-provoking. Due to this, it took very little time to comprehend the intended message. This was unlike other sources of information like leaflets and posters which were mostly wordy and unappealing.

In addition, billboards were noted to protect an individual's identity while accessing information due to high levels of stigma associated with HIV/AIDS. This is because billboards were placed in public places where everyone can easily see them. Also billboards communicated their messages using few words but which were factual. Due to these features, it was easy to access HIV/AIDS information without creating any suspicion as explained by a 29 year-old Sarah who was HIV positive:

> *Since I discovered that I have this disease, my fear has been to let anyone know about my status. Initially, I would get some reading materials on how to live healthy from our health centre, listen to the radio whenever there was a programme on AIDS. With time, my husband became suspicious on why I was so keen with AIDS information. To protect myself from further suspicion I stopped reading or listening to anything on AIDS. At the moment I only depend on those billboards for any new information on AIDS.*

Newspapers

Since the advent of HIV/AIDS in Kenya, newspapers have been in the forefront in disseminating information on the disease to the general public. Most of this information is public pronouncements from official and unofficial sources. This information include: HIV/AIDS prevalence, HIV/AIDS prevention, HIV/AIDS awareness, the impact of HIV/AIDS in terms of economic, medical and social cost, and HIV/AIDS treatment and cure.

This information on HIV/AIDS was; however, not taken as gospel truth by research participants. Instead, such information was evaluated using various criteria which determined how such information was perceived, informed individual perception and action towards HIV/AIDS.

As a fact, all newspapers aim to cover as many stories which are deemed of interest to the readers. However, the decision on where each story is placed within the newspaper lies not with the editor who assigns the story, but with the chief sub-editor. Consequently, a story can be placed on the front, inside or back page. In this study, it was found that research participants used the placement of HIV/AIDS articles to determine how important the information was. Thus, articles which were placed in front or back page were perceived by research participants as crucial and important, while those in the inside pages were not regarded as so. This was explained by a 25 year-old commercial sex worker by the name Mary:

Mary: You know our trade is full of risk especially at this era of AIDS....Some men after paying you for the service will insist to have unprotected sex. You can explain to them but you know how men in that state behave! So in order to protect myself from AIDS, I preferred to deal with men who are only married because I took them to be safe from AIDS. This thinking has, however, changed when I saw in the front page of Daily Nation newspaper that AIDS is now rampant among married people....

Researcher: What has the front page to do with your decision?
Mary: You know any news in the front page of any newspaper is very important....it is factual and must be taken very serious. This is not the case with information in the inside pages.

Although Mary's action towards HIV/AIDS was influenced by information in the front page of the newspaper, further investigation revealed that such information was also more prone to various interpretations which either positively or negatively affected action towards HIV/AIDS. As found out in this study due to the cost involved in accessing information from newspapers, most research participants relied on front page titles to make decisions. These decisions were not based on facts as contained in the story but on individual biased interpretation of the title. This is made possible by the fact that most titles in the front page of newspapers are supposed to be catchy but not detailed enough to influence readers to buy them. All this was clearly captured by Mr. Jamal who lost his wife due to the information he saw on newspapers on people infected with HIV/AIDS getting uninfected children.

> *When I discovered I had AIDS, I had only two girls. This meant no son to take over my lineage. This not only disturbed me but also my wife. At this time infected people were discouraged from getting children. So we did all we can so that no conception took place. However, this changed when I went to town and saw in one of the newspapers which were displayed by newspaper vendors that AIDS people can get children who are not infected. I read and reread this title many times. I wanted to get more information on this issue but I did not have the money to buy it. So I took it that the information in the newspaper title was more than enough. I was so pleased with this information and*

shared it with my wife. From then henceforth we abandoned all family planning methods we were using. In two months time my wife conceived and we were all happy. Our happiness; however, did not last as her health turned from bad to worse. When I took her to hospital, the doctor told me her power to withstand any illness was extremely low due the pregnancy..... The doctor told me my wife should have been guided by the doctor on how and when to conceive. .....The doctor advice on how infected people should get children was not contained in the title I had read... I wish I had read the whole story for I believe I would have made a better decision...

Closely related to placement of articles is the issue of their prominence. In this study, research participants evaluated prominence by looking whether HIV/AIDS article was an edition lead, page lead or it was the subject of the main editorial or special commentary in the paper edition. In this case, HIV/AIDS stories which were edition leads or page leads were perceived as factual and important. However, special commentaries mostly by regular correspondents were not taken seriously.

As observed during the period of this study, most HIV/AIDS articles in the four prominent newspapers namely: Daily Nation, East Africa Standard, The People Daily and Kenya Times, were special commentaries by regular correspondents. This created an impression among research participants that HIV/AIDS information was no longer important when compared with political issues which formed most of edition lead or page lead in all papers. The implication of this was clearly underscored by Mr. Onsarigo; a teacher by profession who observed that many youths no longer view HIV/AIDS has a threat to their future careers but bad politics in the country.

We young people depend mostly on newspapers on current information which cannot be found in school textbooks. Unlike in textbooks, newspapers news is meant to inform and in one way or the other generate further debate. I think this is the reason why most young people in this area like talking and discussing politics. Actually most of this talking and discussion centre on what the newspapers gives prominence to in each day.... Since issues of AIDS are not given much prominence, there is a strong feeling that AIDS is no longer a threat... This in a way has made most of us not to bother with AIDS but on issues dealing with politics.

The level of coverage HIV/AIDS received at this period of this study can; however, be explained by three scenarios. The first scenario had to do with the fact that at the time of this study, Kenya was on the path of recovery from the 2007 post election violence. Therefore, electoral politics

received more attention than any other event/issue in the media. This pushed HIV/AIDS issues to the background of editorial attention.

Secondly, the Kenya government policy response to HIV/AIDS pandemic has remained ambivalent about the seriousness of the problem since 1984 as discussed in Chapter Two. This is because the government has not found a fitting response to the opposition of certain powerful groups such as the church and traditional value constituencies. Also the government failure to provide adequate reproductive health service to her people has made it politically unattractive to tackle the HIV/AIDS. This has led HIV/AIDS issues into the periphery given the fact that the government is one of the major sources of information to the newspapers.

The third explanation for the level of HIV/AIDS coverage may have to do with the inability of editors and reporters to properly appreciate HIV/AIDS and its impact on society as newsworthy or of human interest. In this case, most editors and reporters see HIV/AIDS as just a medical problem which does not span beyond the social, economic and political structures of the society.

Youths were also found to evaluate HIV/AIDS information in newspapers by looking at the source of information. These sources include Ministry of Health, politicians, religious bodies, scientific reports, workshops/seminars reports, journalists' initiatives and readers/letters to editors were either perceived to be authentic or not depending on individuals' knowledge about them.

Information on HIV/AIDS which had Ministry of Health or scientific report as its source was taken to be more authentic as compared to politicians', journalists' initiatives and workshop reports. This was because of the knowledge among many youths that HIV/AIDS is a medical problem which requires certain expertise knowledge which is only found in the Ministry of Health and those carrying out various HIV/AIDS scientific researches. This is not the case with sources like politicians and workshops/seminar reports which were perceived to be biased and self-centred. For example, one research participant argued that most statistics on HIV/AIDS prevalence released by workshop/seminar organizers are not authentic but aimed at influencing international funding bodies to continue funding HIV/AIDS activities.

As a consequence, youths were found to selectively use information from various sources to inform their action towards HIV/AIDS. This selection of information was based on their own perception and experience towards the source of information. This was clearly demonstrated by a 26 year-old university graduate Mr. Chuma who was yet to get any formal employment when asked on HIV/AIDS information sources:

> *I do not believe any information on AIDS from our politicians. Most of them tell us to be careful because many young people are dying from AIDS. But what I know is that most politicians have mistresses everywhere, some younger than me. They keep on telling us this because they want to create an impression that we young men are all dying or carriers of AIDS. This gives them a leeway of having sex with many young girls. Also I know some politicians who are using the presumed high AIDS prevalence rates among young people to deny us jobs.*

It is crystal clear from Mr. Chuma's sentiment that negative perception about the source greatly impacts the consumption of HIV/AIDS information. In this case Mr. Chuma has a lot of antipathy towards politicians because of his own experience with them. As a result, any interpretation of information from this source was influenced by already preconceived perception which in this case was not conducive for enhancing positive action towards HIV/AIDS.

Apart from the above three criteria of evaluating information in newspapers, the interpretation of HIV/AIDS information was also found to play a critical role in influencing research participants' action. In this study, it was noted that many research participants' actions were greatly influenced by *oppositional reading* of HIV/AIDS information.

According to Stuart Hall, *oppositional reading* occurs when the media user interprets the media message "within some alternative framework of reference" (1996: 48). Corner (1980) also notes that *oppositional reading* occurs when the audience is aware of the difference between the intended meaning and that they choose to read. This observation is supported by Schrøder *et al.* (2005) who argue that audience construct meaning in relation to their social environment. In this case, different social groups are actively involved in constructing everyday truths that work for them in their daily lives.

In this study, it was noted that the interpretation of prevention messages which promoted Abstinence, Being Faithful and Condom use among research participants resonated with Michel

de Certeau's notion of *détournement*. According to De Certeau (1990), audience are not shaped by cultural products imposed on them instead they conduct "raids" on the sites and structures of coercive institutions and generate their own meaning, which then overthrows the power of hegemony. Thus, through use of "tactics" audiences will seek to curtail the "strategies" of structures of coercive institutions by reinventing new ones that disqualify the disruptive power of those strategies. This is clearly captured by a 29 year-old Mr. Onchiri who sees Abstinence and Condom use messages in newspapers as a form of imposition from powerful forces other than God to curtail young people to have sexual pleasure.

> *God was not stupid to have created Adam (man) and Eve (woman). He particularly created Eve to sexually make Adam happy. Actually if this was not the case God will have created another man! More important He never asked Adam to use condoms whenever he had sex with Eve.....even the bible does not mention condoms in man and woman union. Thus messages promoting abstinence and condom use in newspapers are merely playing God's purpose of creating man and woman. This is common among newspapers whose aim is to promote modernity which is ever anti-God!*

As noted from Onchiri's argument, it is clear that the notion of abstinence and condom use is perceived by young people as entailing "structures" that restrict individuals' engagement in sexual pleasure. This does not articulate well with the meaning young people attach to their sexual practices. Therefore, young people have to look for ways of overcoming these structures. One way of doing so is by deploying interpretative strategies that generate meaning which is favourable to their sexual lifestyle. In this case, young people decode the notion of abstinence and condom use in a way that "detotalized" the messages in the preferred code in order to "retotalize" the message within some alternative framework of reference (Hall, 1996).

Consequently, the use of religious codes in the interpretation of abstinence and condom use messages in newspapers can be understood as a "tactic" of generating new meaning. This new meaning is then used by research participants to rationalize their opposition to abstinence and condom use messages.

Oppositional reading of HIV/AIDS information in newspapers was; however, noted to be common among male research participants. One plausible explanation for this as found out was to do with the socio-cultural factors governing gender and sexuality. These factors gave the male

folk power to control female sexuality. However, messages in newspapers promoting Abstinence, Being Faithful and Condom use were perceived by male folks as a challenge to their power over female sexuality. As a consequence, males were forced to reinterpret such messages in ways that justify their dominance over female sexuality.

As a source of HIV/AIDS information, newspapers were found to reach a limited number of people due to two structural factors namely cost and gender. On the latter, it was noted that most research participants particularly females associated newspapers with politics, which was perceived as a domain for male folks. As a result, they rarely read newspapers thus limiting their chances of getting HIV/AIDS information. However, those who read them were observed to prefer magazine pullouts in newspapers which dealt with social issues like relationships and entertainment. These sections rarely carry information about HIV/AIDS.

Accessing HIV/AIDS information from newspapers was also found to be negatively affected by the economic cost involved such as the purchasing cost. For example, due to poverty and desire to meet basic needs, most youths preferred not to spend their resources to purchase newspapers. However, in cases when youths purchased newspapers, they did so to access information which can improve their living standards like accessing information on available job opportunities in various economic sectors and not HIV/AIDS information. This meant accessing HIV/AIDS information in newspapers was secondary to youths' socio-economic needs.

The Television and Radio

In this study, the radio was one of the most cited sources of HIV/AIDS information compared to the television. This was because of the rural nature of the study site which was characterized by poor road network, poor power (electricity) distribution, high levels of poverty and illiteracy levels. For example due to liberalization of Kenyan market, there were many cheap radio transmitters from China whose operation cost was low compared to that of television. Further, there were many local radio stations which broadcasted in many local languages including Ekegusii thus reaching many rural people who were not conversant with either Kiswahili or English.

Despite its wide reach in rural areas, the radio was noted by many research participants to broadcast very few HIV/AIDS information. Instead most concentration was on commercial advertisement and politics. In cases where HIV/AIDS information was broadcasted, its nature in terms of details, informative and analytical depended on the sponsoring agency. For example, HIV/AIDS information which was sponsored by private companies, individuals and Non-Governmental Organizations was observed to be more detailed than government's.

This difference in dissemination of HIV/AIDS information can; however, be traced back to early 1990s when the government was forced by Bretton Wood Institutions to start implementing Structural Adjustment Programmes (SAPs). According to these programmes, the government was required to delink itself from providing non-economic services like health promotion as a way of cutting down its expenditure. Further, with the privatization of public corporations like the state owned Kenya Broadcasting Corporation, all government's HIV/AIDS advertisements which hitherto were done free, started being paid for to enable the corporation to generate its own revenue for self sustenance (Nzioka, 1994).

All these changes have forced the government to take a peripheral role in HIV/AIDS information dissemination. This has given room to other actors like private companies, individuals and Non-Government Organizations to take a leading role in information dissemination. As a result, most of the information being disseminated is mere reflection of various actors' vested interests. This has been made worse by the liberalization of the broadcasting industry[83] which has led to plethora of information about HIV/AIDS especially on the cause, prevention and treatment from many sources regardless of its quality.

For example, at the time of this study, there was a programme running live every Sunday at 10.30am to 11.00 am on Citizen Radio known as *Tiba na Neema Foundation.* This programme featured some traditional medicine man who claimed that he had some medicine which clears HIV virus from one's body. To him AIDS was not caused by HIV virus nor was it transmitted

[83] Prior to 2003, the broadcasting industry in Kenya was restricted to State owned Kenya Broadcasting Corporation where the government controlled what was to be broadcasted and in which manner. However, as from 2003, the government allowed many private broadcasting stations to operate. Most of these stations depended on advertisements to generate their revenue.

sexually. Instead it was caused by eating foods like meat which contain some minute worms. When these worms enter the body, they create some toxicity in the blood leading to illness or AIDS. Therefore to treat this condition one was supposed to take some medicine to detoxify the body. To justify the efficacy of his medicine, the traditional medicine man in the course of the programme allowed various people to testify how his medicine had helped them to reverse from HIV positive to negative.

Similar programmes like *Tiba na Neema Foundation* were observed to be common in many community/local radio broadcasting stations. The quality of information in terms of scientific truism was not a factor in considering what was to be broadcasted but the ability to pay for broadcasting time. Although most broadcasting stations were noted to run a caveat before such programmes were aired informing the audience that the views, suggestions or opinions expressed in the programmes were not true position of the broadcasting station, it nevertheless made no reference to the truism of information. This in itself created an impression that the information disseminated was true as demonstrated by Mr. Rainyo:

> *....I think contrary to the government position that AIDS has no cure, there is a cure. I have seen and heard many people on radio and television programmes testifying they have fully healed from AIDS. I think the government position is either influenced by fear that more people will start indulging in casual sex which can lead to population explosion or fear of giving credit to traditional medicine men for their discovery...*

Failure by the broadcasting stations to censure information based on its quality especially on biomedical truism was found to negatively impact on the management of HIV/AIDS among youths. With plethora of information on HIV/AIDS from various sources, youths were noted to be very selective on the choice of information which guided their action towards HIV/AIDS. This self selection; however, was not based on the biomedical reality of HIV/AIDS but how it fitted their daily lives' experiences in various contexts. For example, some young people especially males were noted to use information from programmes like *Tiba na Neema Foundation* as a strategy of indulging in unprotected sex especially when their sexual partner was keen on safe sex.

> *My girlfriend wanted me to use condoms but I was not ready. Each time I gave her a date it failed because of my desire to have sex without condom. .... So after several unfruitful attempts, I asked her to listen to Tiba na*

> *Neema Foundation in the radio. I knew in this programme the "doctor[84]" who was presenting it was against condom use. The doctor used to argue condoms can lead to other serious infections and AIDS was not transmitted sexually or caused by virus but eating contaminated food like meat. For sure after listening to this programme, my girlfriend agreed to have unprotected sex with the only worry of getting pregnant* (Hare Moturi, a 26 year-old male).

Similar impact of radio HIV/AIDS information on HIV/AIDS management was also observed by head of Patient Support Centre (PSC) at Kisii Level 5 Hospital. According to him, most patients who are under ARV treatment programmes abandon treatment due to information they receive from radio programmes. Most of these radio programmes indicate they can cure HIV/AIDS unlike the ARV programme which is meant to prolong life and lessen the pain of HIV/AIDS among patients. Citing some religious radio programmes which preach miraculous healing and cure of HIV/AIDS, most HIV/AIDS patients do abandon treatment. To the head of Patient Support Centre, this does not only lead to high resistance level of drugs among patients, but also affects negatively other prevention methods like Condom use, Being Faithful and Knowing your status (VCT).

The effectiveness of radio information on youth's action towards HIV/AIDS was found to be influenced by gender and level of formal education. As noted in this study, there was a marked difference between males and females on the preference of HIV/AIDS information which informed action. For example, most females were keen on information which promised them protection from HIV/AIDS without necessarily emphasizing on condom use, abstinence and faithfulness from their sexual partner. As a consequence, they preferred listening to evangelical programmes which promised supernatural or miraculous protection. On the other hand, males were keen on messages which offered them skills of protecting themselves without compromising their prowess in sexual activity. In this case, they preferred messages which dealt with physical attributes of selecting good or "healthy" sexual partner.

The differences in the preference of information regarding HIV/AIDS can be linked to the role of gender and sexuality among Abagusii. As noted in chapter three, gender and sexuality

[84] In Kenya most traditional medicine men refer themselves as doctors. Traditional medicine men are registered and licensed to operate by the ministry of social and culture services.

determines power relationship, roles, identity and access to property. Therefore, due to their disadvantaged position, females preferred information which would not put them in conflict with values, norms and ideologies governing gender and sexuality. This was clearly captured by a 27 year-old married Janet:

> *You see it is extremely difficult to start asking your husband to be faithful or to use condoms. That will be an abuse to him. He is the head of the home and you must show some respect. So messages on the radio which insist on faithfulness and condoms are irrelevant to us women. At least salvation messages by ministers of God in the radio are realistic for they provide you with an opportunity of getting God's favour and protection at this time of many illnesses.*

Janet's views were supported by a 20 year-old Kerubo who pointed that radio HIV/AIDS information which emphasize on only abstinence and condom use are of little importance to females who are yet to be married.

> *It is a fact that we ladies must be married so as to get respect and a place to call home. With very few men wanting to get married, it is difficult to get a potential partner who is willing without having sex as it is a first step towards a long time relationship. Worse still you cannot ask him to use a condom. All that remains is to believe in God to protect you as you gamble on whom to be married to. In these circumstances, evangelical teaching on the radio becomes worth listening to in comparison to those messages on condoms and abstinence.*

Janet and Kerubo's sentiment confirm the reported powerlessness of the female gender in reproductive decision making (Vagra, 1997). For example, Janet and Kerubo have no influence over condom use or abstinence for fear of rejection and stigmatization by partners. As a consequence, information which deemphasizes sexual risk taking becomes rational means of maintaining social and economic survival.

On the other hand, male preferred information which did not compromise their socio-cultural socialization of sexuality and gender. For example, most young male associated sex with initiation to adulthood, a sign of power over female folk and as an indication of manliness. Therefore, information which emphasized abstinence, faithfulness and condom use were distasted as they were seen as a form of control to their sexuality. Instead information which deemphasized sexual transmission was greatly preferred.

Further, gender was also found to determine individual access to radio information. As noted many males were more exposed to radio information as compared to females. This can be explained by two but interrelated factors. The first factor was to do with the nature of information associated with radios. For example, many research participants associated the radio with dissemination of political news. This was because many radio stations devoted most the broadcasting time discussing and reporting various political happenings. Due to this, more males preferred to listen to radio more often as politics was associated with leadership which was regarded as the domain of men.

The second factor was the gendering of information. Due to patriarchal nature of the community, women were not supposed to be more informed than men. Those who were more informed were seen as deviants "aba*chuachi*"[85] (singular: *Omochuachi*). By being labelled as *abachuachi*, women especially those in the marriageable ages were avoided by potential male partners. Given the central role of marriage, according a female proper identity and access rights to resources, most of them avoided spending too much time listening to the radio as it signified too much exposure to information.

The level of formal of formal education was also found to play a critical role in youths' response and action towards radio HIV/AIDS information. For example, those with high levels of formal education like secondary and post secondary were noted to interpret radio information in relation to scientific knowledge they had acquired from formal education. As a consequence, radio information which was in antagonism with scientific explanation/knowledge was questioned and in most cases discarded as not important or not worth listening to.

Similarly, youths with low levels of formal education (no or primary level of formal education) were noted to interpret radio HIV/AIDS information in relation to folk explanation which were propounded by traditional medicine men. These interpretations to youths with low levels of formal of education were easy to understand and comprehend because they drew from common knowledge as contained in their social system of illness aetiology. However, such interpretations were in most cases in conflict with scientific/biomedical explanation.

[85] *Omochuachi* (singular) literally means knowing too much. Knowing too much is a bad attribute especially among female folk.

Consequently, many females were found to rely on folk explanations as disseminated by the radio in the management of HIV/AIDS unlike men. This was because most women were disadvantaged in terms of accessing formal education. As noted in this study, due to socio-cultural factors governing gender, men were assumed to be in higher status than women. Therefore males were given more preference to formal education.

The television, although cited as another important source of HIV/AIDS information, it was limited to a number of people. As noted in this study, it was a preserve of people residing in urban areas and those with higher incomes. As a result, it was not only seen as a source of information but a symbol of social status.

As sources of HIV/AIDS information, both the radio and television were observed to use various strategies in passing on their messages. These strategies were advertisements and edutainment. According to Vaughan P *et al* (2000) edutainment is a way of informing the public about social issues of concern by incorporating educational messages into popular entertainment content in order to raise awareness, increase knowledge, create favourable attitudes and make people to take socially responsible actions in their lives.

Edutainment strategy was noted to use two methods in passing information about HIV/AIDS. The first method was the use of movies, drama, comedies and skits. This method relied on Bandura's Social Cognitive Theory which posits that individuals learn new behaviour by observing, listening and imitating the behaviour of others who serve as role models. In this case it is assumed that individuals may increase their ability to carry out certain tasks by seeing and listening to individuals similar to themselves performing the same tasks successfully. For example, during the course of this study, Citizen Television was screening soap opera every Thursday from 7.30pm–8.00 pm titled *Siri*. *Siri* which is a Kiswahili word for "secrets" was produced and broadcasted to promote family planning, prevention of HIV/AIDS and other sexually transmitted diseases, gender equity and other social development goals which affect people's daily lives.

At the time of this study, soap operas like *Siri* and others dealing with reproductive health and illness were noted to be heavily advertised both in electronic and print media to increase viewer ship. However, as found out, such soap operas dealing with reproductive health were not popular among men. This was because many men regarded such soap operas as meant for women only. This thinking emanated from the community's division of labour which was based on gender where women were supposed to perform tasks related to child bearing and taking care of family members whether sick or healthy. Therefore, soap operas like *Siri* were thus associated with women folk by men because they focused more on reproductive health. However, where men preferred watching them, they did so purely for entertainment purposes.

The second method of edutainment used to convey HIV/AIDS information was the use of music. In Kenya, music has been claimed to have a strong influence in the lives of Kenyans of various ages (Nyairo *et al.*, 2005). Nyairo *et al.* for instance studied the strong influence of *unbwogable*[86] song in the 2002 political campaign that led to the 40 years of reign of KANU[87], a political party. In recent years also, popular music has continued to have a strong influence on the lives of youths especially on HIV/AIDS prevention and sexuality. As observed during this study, most of the music played in both the radio and television focused not only on love; rather on sex organs and sex itself vide unique lexemes and expressions. Further observations revealed that when such music was played, young people not only sung along with the musician but also made sex gyration in their dancing.

Most music targeting youths were observed to use unique lexemes and expressions in conveying HIV/AIDS messages. For example, the 2004 song which was very popular among young people at the time of this study, *Manyake* by artists Circuite and Joe (**See Appendix 3**) uses lexemes *Manyake* and *Juliana* to talk about young people's sexuality and condom use. In talking about sexuality, the two artists use lexeme *Manyake* to refer to female genitals; *"Eeh naongea kuhusu manyake, na wala si zile za butcher"* ('Eeh, I am talking about girls' genitals and not those

[86] Song by two young musicians namely; Gidigidi and Maji maji. The song was used by opposition coalition in 2002 to mobilize masses against the then ruling party. Un*bwog*able is code switching between the English prefix un-, the Dholuo stem ***-bwog-*** (shake) and the English suffix -able. It means unshakable and refers to the opposition's motto of being unshakable in their quest for change and winning the election.

[87] KANU is Kenya African National Union political party that ruled Kenya from independence in 1963 to 2002.

pieces of meat found at the butchery). The picture is enhanced further when the singers use *manyake* as a metonym for the girls and their genitals that drive men crazy - *"manyake zikipita mtu anakula kucha"* ('when the girls (with their genitals) pass by, men are left looking at them biting their nails'). Therefore, when a person encounters these girls' genitals, he needs condoms to protect himself from diseases; *"manyake kama 'loons na maji. Juala ndio wahitaji"* (Girls' genitals are like balloons with water. A condom is what you require').

Music on HIV/AIDS and sexuality which; however, targeted general population was observed to use euphemisms to pass their message. The use of euphemisms is common among many cultures in African communities especially in the discourse of sex which is deemed a taboo subject (Horne, 2004). As a result, songs sung by Gusii artists used various euphemisms drawn from their immediate social environment to talk about HIV/AIDS and its management. For instance, one of the popular local musicians, Ontiri Bikundo in the song *Ekayaba*[88] uses the euphemism of a public booth to warn people about the dangers of sex with multiple partners; "*you became a public booth where everyone dialled and now you cannot be accessed or reached* (bedridden with AIDS). Other euphemisms used in the song to refer to irresponsible or reckless sex intercourse include; *you drove your car with no regard to pumps and potholes. Now your car is totally damaged and can't be used by anyone.*

The use of lexemes, expressions and euphemism though important in communicating information on sensitive issues like those touching on sexuality in a conservative society, they were more prone to misinterpretation. As a fact, the meaning of lexemes and euphemisms are context and time specific. For example, in the song *Manyake,* artists Circuite and Joe use the lexemes *manyake* and *Juliana* to encourage youths to use condoms in every sexual encounter in order to avoid being infected with sexually transmitted infections. However, as noted among research participants especially males the lexemes not only provided them with vocabulary of talking about sexuality but also acted as a yardstick of measuring their manliness. In this case, by using the lexeme *Manyake* which in its ordinary meaning meant meat in the study site to refer to

[88] *Ekayaba* is Ekegusii word for kei apple. In this song it is used to refer to HIV/AIDS. This reference comes from the impact of kei apple thorns on the tyre of a vehicle where they cause slow punctures eventually deflating it. Similarly when one is infected with HIV/AIDS, he or she suffers from wasting illness and eventually dies. The use of euphemism to refer to HIV/AIDS is because HIV/AIDS is seen as synonymous with sexual intercourse which is a taboo subject to be talked directly in public.

female genitals, young men felt it was fashionable to have many sexual encounters with many sexual partners. This is so as one research participant quipped, *"that meat from different animals tastes differently likewise sex with different sexual partners gave one different "tastes" or experience."* Thus, such interpretations negatively affected those messages which promoted faithfulness among sexual partners.

Radio and television also conveyed HIV/AIDS information through advertisements. These advertisements were mostly on condom use promotions. However, other advertisements particularly commercial promotions were found to provide youths with indirect language in the discourse of sex and HIV/AIDS. For example, *Kumbambua manzi (*Literary translated to peel a girl). *Kumbambua* (peel) is the removal of something that is stuck to another. It could also be the removal of some item that is fastened by glue or cello tape. *Kumbambua* can also be associated with skinning some carcass.

Kumbambua manzi came from the largest beer company in Kenya business promotion dubbed *Bambua Tafrija* which was running prior to this study. In this promotion, a beer buyer was expected to peel rubber on the inner part of the bottle top and win whatever was drawn on the rubber. The peeling of a bottle top rubber and winning a present was extended by youths to seduction and love making. So, one could *bambua* ('peel') if he succeeded in seducing and making love to a woman. Perhaps the penetration of a woman was likened to a firmly fastened rubber on the inner side of the bottle top.

The use of indirect language from advertisement in the discourse of sex and HIV/AIDS was not universal among young people. Instead the choice of language depended on their socio-economic activities they were engaged in everyday life. For example, youths who were involved in public transport industry as either drivers or touts, preferred using language which was contained in advertisement of vehicle products like *kupima oili* (ascertaining the oil level) to mean making love. Ascertaining the level of oil in a vehicle's engine is important to ensure its smooth and efficient running. This is done by removing the deep stick from the oil aperture in the engine casing, wiping it, dipping it into the aperture and removing it to read the oil level. These actions are reminiscent of actions involved in the process of making love.

The use of indirect language from commercial promotions in the discourse of sex and HIV/AIDS was found to ease communication among research participants on sex and HIV/AIDS. As noted, many research participants felt that indirect language from commercial promotions was culturally and socially tolerant in talking about sensitive issues like sexuality. This was also observed during the course of this study where many research participants preferred using indirect language in referring to sexual acts or HIV/AIDS.

On the hand, indirect language from commercial promotions was; however, noted to negatively impact on HIV/AIDS messages promoting positive sexual behaviour. For example, the likening of sex acts with *kupima oili* (ascertaining oil level of a car) made such acts look normal and worth indulging in given the fact they were depicted as functional regardless of their consequences. Also given that the use of indirect language was context and group specific, this study found that research participants who identified with certain indirect language used such language as a yardstick of measuring their sexual behaviour as either normal or deviant. For instance, those who likened sexual acts to ascertaining oil levels of a vehicle saw abstinence as an abnormal behaviour.

Interpersonal Communication Media

Interpersonal communication programmes involve closer interaction where issues are debated between communicators, rather than the top down mass media approach, where information often flows in one direction. Because of this, Green *et al.* (*2006*) and Wawer *et al.* (2005), consider interpersonal communication to be more effective in bringing social and behavioural change as compared to mass media campaigns. This; therefore, suggests that to achieve social change, mass media campaigns must be complimented with contextualized interpersonal campaigns. This will create a social communication network which will contribute to tackling the underlying socio-cultural challenges that make it difficult for individuals to undertake steps to prevent HIV infection.

In this study, interpersonal communication media were found to be either formal or informal. Formal interpersonal campaigns were characterized by well structured organization with clear

objectives and methodology. They were mostly conducted by people who had undergone some form of training or had some know how on HIV/AIDS and they included peer counselling, public meetings, conferences, workshops and seminars.

Informal interpersonal communication media on the other hand was a form of endogenous communication system where people used informal media for personal and group information sharing and discussions. In this case they utilized values, symbols, institutions as contained in their social system to communicate. Examples of informal media in this study were funerals and songs.

Peer counselling

Peer counselling is theoretically underpinned on both individual cognitive theories such as Theory of Reasoned Action as well as collective action and group empowerment theories such as Social Network Theory, Social Learning Theory, Social Inoculation Theory, Role Theory and Communication and Innovation Theory (Deutsch, 2003). During this study, peer counselling was found to be an important source of HIV/AIDS among youths in learning institutions. Its importance; however, was noted to decline among those not in learning institutions. According to the head of Bonchari Constituency AIDS Control Committee each year they train at least 50 peer counsellors in each learning institution in the locality. However, majority of those trained as peer counsellors quit immediately after leaving learning institutions to engage in income generating activities. This partly explains why many youths out of learning institutions did not cite peer counselling as a source of HIV/AIDS information. When asked whether, he has ever got any information on HIV/AIDS from peer counsellors, Ndanu, a 26 year-old man at Bomariba village, responded that he has never even heard about peer counsellors in his area.

Researcher: Have you ever come across peer counsellors in this area?

Ndanu: Who are those?

Researcher: These are young people who have been trained to conduct peer education or discussion about HIV/AIDS with other young people around this area.

Ndanu: I have never had contact with such people in this area. I only hear about doctors who teach people about HIV/AIDS in hospitals and in some schools around here.

In this study it was also observed that the dissemination of HIV/AIDS information was conducted by HIV/AIDS patients who had gone public about their status by assuming the role of "moral career patient" (Goffman, 1990). The use of moral career patients was found to have a very strong impact on the dissemination of HIV/AIDS information. Some youths interviewed indicated that they took information disseminated by such people seriously as they perceived it real and practical. However, this was found to be negatively affected by high attrition rates among moral career patients.

This high dropout was found to be due to non-payment. In this case, dissemination of HIV/AIDS information was seen as a form of employment which required compensation. However, as observed some organizations which were involved in HIV/AIDS campaigns were against monetary compensation to participants. According to Mr. Jamal, lack of monetary compensation made it difficult especially among men who were HIV/AIDS positive to continue disseminating HIV/AIDS information due to cultural standards of men being regarded as providers. Jamal explains:

> *Men are breadwinners for the family and therefore they need money to meet this obligation. So it is very difficult to continue offering free service of disseminating HIV/AIDS information to the public.*

This cultural norm was also found to account for the dropout among females. As found out, women were conditioned by their husbands to stop disseminating HIV/AIDS information because they perceived it as a "waste of time," a euphemism for lack of monetary compensation. In a society, such as the Gusii, gender–power differences favour men. Therefore, lack of spousal support would negatively affect women's participation in disseminating HIV/AIDS information.

The dropout by moral career patients was also in part prompted by high expectations among them. This expectation arose from the perception that most organizations campaigning against HIV/AIDS had a lot of monetary resources from donor organizations. Therefore, moral career patients who participated in these campaigns expected to be compensated kindly. As a consequence, some of the moral career patients migrated from one organization to another due to perceived benefits the new organization offered such as allowances during training and campaigns. As observed during this study, venues for training and campaigns were usually in

hotels located in the district headquarters, in which participants were accommodated or sometime returned home after each day session. Transport, participation and lunch reimbursement varied from one organization to another. These allowances accumulated to a reasonable sum, which on average was better than manual work most people engaged in the community.

Public Meetings

Youths accessed HIV/AIDS information through public meetings which were organized by various organizations campaigning against HIV/AIDS. These meetings as noted from research participants dealt on many aspects of HIV/AIDS management at one go through songs, public discussion and teaching using experts on HIV/AIDS or those who have gone public on their HIV positive status, drama and screening of movies featuring some aspects of HIV/AIDS. These meetings were mostly held in public places where most people could easily access.

According to research participants, public meetings were rarely used by organizations campaigning against HIV/AIDS in the study area. This was also confirmed by my own observation during the nine month period of collecting data for this study where only three public meetings on HIV/AIDS were organized. Further observation revealed that public meetings were entirely used by constituency AIDS Control Committee whereas Non-Governmental Organization preferred seminars, workshops and conferences which were held in hotels located in the town headquarters.

Interviews with research participants and observation revealed that many youths rarely attended such public meetings. However, those who attended left such meetings immediately after the end of entertainment activities. This was unlike public meetings organized by politicians in the area where many youths attended and stayed until the end of the meeting. The reasons for youths' participation in public meetings on HIV/AIDS campaigns was found to be due to the way the meetings were organized, the themes which were discussed and how they were executed as discussed later in this chapter in the section dealing with youths' involvement in HIV/AIDS campaigns.

Seminars, Workshops and Conferences

Seminars, workshops and conferences were the least cited sources of HIV/AIDS information among youths in the study site. As observed these seminars, workshops and conferences were organized by Non-Governmental Organizations and held in hotels located in district headquarters or urban areas. Unlike public meetings where attendance was open to all people, attendance to seminars, workshops and conferences was strictly by invitation. This in essence curtailed many youths from accessing information from these sources.

Among research participants, seminars, workshops and conferences were mostly not seen as a source of getting HIV/AIDS information but as a source of making money. As a consequence, there was stiff competition which was characterized by a lot of lobbying among youths in trying to get a chance to be a participant. As noted, those who attended these seminars, workshops and conferences were paid some allowances to cater for their transport, accommodation and meals. These allowances would accumulate to reasonable amounts; for example if the seminar, workshop or conference took five working days on average the participant would receive about 30 Euros which was considered a lot of money by local standards. Some participants stayed with relatives or friends around the venue of seminars, workshops or conferences and went home happy with money saved when sessions ended.

However, not all organizers of HIV/AIDS seminars, workshops and conferences paid allowances in the form of cash; instead they provided food. This did not augur well with participants since they preferred the cash approach because: "*When you are given food, you eat it only once and you have nothing to show later. With money you can save and invest thus assured of steady income even when you are not invited to any seminar.*" (Comment by a regular participant in HIV/AIDS seminars). The preference for monetary compensation arose because most youths were unemployed or did not have any meaningful and steady source of income.

Funerals

Among Abagusii, funerals are big social events for the deceased and the lineage. They provide the context for the family or lineage to give respect and affirm status to the deceased and lineage. The status of the deceased and lineage is affirmed by how well the funeral rite is organized

which gives an indication to the deceased and lineage social standing in society and the type of death[89].

When funeral rites are held, lineage members and other close community members do not engage in any socio-economic activities on this day. Instead, the day is reserved for attending the rite. Those working outside the community come back to attend the funeral demonstrating kinship and other ties.

As observed in this study, funeral rites among Abagusii have become avenues for disseminating information on political, social and economic issues affecting the local people. This is because of their wider reach. As a fact, among Abagusii attending funeral rites of close deceased community members, kinship members or anyone with close social ties like relatives is obligatory and almost compulsory. A person who fails to attend such rites without a sound reason is regarded as a social deviant in the eyes of community members.

Funeral rites ceremonies are characterized by making of speeches from community and kinship members on the life history and achievements of the deceased. In the recent past also, opinion leaders and other professionals are given opportunity to make speeches of not only consoling the family members but to disseminate any important information to mourners and to the community at large. As observed in this study, the latter group is allowed to make their speeches after all community and kinship members have spoken. The funeral ceremony on average takes about five hours.

Unlike in other public meetings where people can walk away as the meeting progresses on their own volition, in funeral rites this is not allowed. Community social rules, norms and values make it mandatory that anyone who attends and participates in any funeral rites must do so until the last ceremony when interring the body is done. Failure to observe this may bring forth misfortune like death to oneself or close kinship member. Also in funeral rites, all participants are required to observe a lot of decorum as a sign of respect to the deceased. It is believed that if

[89] Among Abagusii death is classified as either good or bad. Bad death is stigmatizing to both the deceased and lineage. This type of death results from stigmatizing illness or suicide. Funerals for victims of bad death is poorly organized and attended by very few people.

one does not accord respect to the deceased especially during the funeral rite, the deceased may in turn hurt or cause suffering to the individual as revenge for disrespect.

In this study, many young men indicated to have gotten information on HIV/AIDS in funerals compared to young women. For example, out of 29 youths who said they got information about HIV/AIDS in funerals, only 8 were females. This was also confirmed by participant observation where it was noted that the number of young men attending funeral rites was higher as compared to young women. These differences can be attributed to females' gender status among Abagusii. In the community females are regarded as outsiders in the patrilineage (Hakansson, 1994; Mayer, 1975). Therefore as outsiders, they are only allowed to play peripheral roles equivalent to distant kin or affine in funeral rites. Due to this, their attendance and participation in funeral rites is not obligatory or compulsory. In cases where they attend or participate, their role is mostly restricted to ensuring other mourners are comfortable during the funeral process. All this excludes females from benefiting from information disseminated during funerals.

As avenues of disseminating information about HIV/AIDS, funeral rites were; however, observed to be characterized by public silence on HIV/AIDS. This public silence can be explained by three factors. First, HIV/AIDS is a stigmatized illness which is associated with sexually deviant behaviour. Therefore, as a matter of respect to the deceased, immediate kinship members and to the mourners in generally, people preferred not to talk about it or in case where they did, they preferred indirect communication. Also due to social principals governing social behaviour *chinsoni,* people were not supposed to talk or make reference in public issues touching on sexuality. Given the fact that HIV/AIDS transmission is associated with sexual intercourse; it provided the scope for moralization. Due to this, it was deemed unpalatable to talk about HIV/AIDS in a public forum like a funeral where there was a mixed audience of varying social moral code. As a consequence, those who used direct communication on HIV/AIDS in funerals were accused of disregarding the social moral code that govern social behaviour "*ogotokania*" which was taken as disrespectful to the deceased, kinship members and all mourners.

Secondly, HIV/AIDS is feared as a dreaded illness because it is a symbol of pollution and social contamination. Although scientifically HIV/AIDS is known to be contagious in specific ways

such as having unprotected sex with infected people, in the community HIV/AIDS is still feared and public attitudes seem to be that any exposure to HIV positive people may bring contagion. Therefore, families or kinship members with people who have died of HIV/AIDS are shunned and isolated by friends and relatives for fear of contagion. To prevent this, people avoided talking about HIV/AIDS or making reference to it especially where it was believed the person died from HIV/AIDS related complications.

Thirdly, among Abagusii death is believed to be caused by both natural and manmade forces like witchcraft as expressed by "*Eyanya gokwa etaberegeti egotonga*" metaphor. This implies that even if a person dies of HIV/AIDS, his/her death must be in the first place been influenced or hastened by malevolent forces - witchcraft. Therefore in funeral rites, talking or discussing about the cause of an individual's death, implies that the discussant must have been privy of his/her imminent death. In this case to be privy of someone's death means you are part of the cause of his/her death which may bring upon yourself severe consequences like being lynched by other community members. Due to this, people avoided discussing issues related to HIV/AIDS in cases where the deceased was believed to have died of HIV/AIDS complications.

Although the above three factors seem to militate against open/public dissemination of information about HIV/AIDS in funerals, this study found out that people still shared such information through informal silent coded whispers "*okomonyamonya*" by making use of metaphors. The use of metaphors enabled the communicator to pass the information without attracting any social sanctions or repercussions associated with the deceased death.

The choice of metaphors to pass information about HIV/AIDS in funerals was noted to be context dependant and with the sole aim of depicting a certain identity of the deceased. Among Abagusii, ascribed identity even at death is important as it determines one's status to the living and future generations. This identity depends entirely on the cause and type of death.

The cause and type of death in the community are; however, intrinsically intertwined in identity formation. For example, if one dies of stigmatizing illness like HIV/AIDS or he/she is responsible for his/her death like through suicide, such death is classified as bad death. Bad death

bestows to an individual a spoilt identity which other living community members or kinship members would not like to be identified with.

The use of metaphors to pass information about HIV/AIDS was; therefore, found to depend on the type of identity kinship and community members wanted to give to the deceased. Therefore, where members of the community and kinship wanted to give the deceased a positive identity, they used metaphors which depicted HIV/AIDS as an accident, fate or an eventuality beyond the powers of the deceased. These metaphors managed to create a positive identity to the deceased by exonerating him/her from being responsible for his/her infection with HIV/AIDS. In this case, risky behaviour like having sex with multiple sexual partners did not form part of the discourse in the aetiology of the cause of death.

Metaphors were also noted to confer a positive identity to the deceased by creating a sense of collective risk among all people. A metaphor like "*nigo abetwa ne' kayaba*" (He/she was pierced by kai apple thorn) was used to show that everyone in the community had equal probability of being infected with HIV/AIDS. The only difference being one's fate. The use of this metaphor to show collective risk came from the fact that most homesteads in Gusii were fenced by kai apple. Due to their abundance, everyone in the community had equal chance of being pierced by its thorns. Similarly, due to high prevalence rates of HIV/AIDS in the community, everyone had equal likelihood of being infected. By appealing to collective risk, kinship and community members were able to exonerate the deceased from blame of being infected by attributing it to fate.

On the other hand, when kinship and community members wanted to depict a negative identity to the deceased, they used metaphors like "*nigo aria bobe*" (he/she ate badly), "*nigo eita*" (he/she killed him/herself) to underscore that the deceased was solely responsible for his/her death[90]. These metaphors were further noted to create a negative identity to the deceased by individualizing risk of infection. In this case, the individual was blamed for his/her infection.

[90] To kill oneself among Abagusii is seen as a taboo which attracts severe punishment.

Individualizing risk in this study was; however, noted not to focus on the risky behaviour the deceased indulged in but the "risky people" he/ she associated with. By focusing on risky people and not risky behaviour, it was observed that research participants were keen on getting information on the people the deceased must have associated with so that they could avoid them as a way of protecting themselves against HIV/AIDS.

In funerals ceremonies, kinship and community members also used the notion of witchcraft to ascribe positive identity to the deceased especially where death is believed to have been caused by HIV/AIDS. In attributing witchcraft as the cause of death, it was observed that kinship members devoted most of their eulogies in explaining how the deceased illness defied all treatment. By doing so they directly or indirectly indicated that the illness which caused death was not natural.

Arising from the above discussion, it is clear that funerals as avenues of disseminating information about HIV/AIDS were greatly influenced by the identity both kinship and community members want to ascribe to the deceased. As a consequence, there was myriad information about HIV/AIDS passed on to audiences in funerals which would either positively or negatively affect HIV/AIDS preventions efforts among young people.

Section II: Youths' Participation in HIV/AIDS Campaign Strategies

HIV/AIDS is one of the greatest challenge facing humanity today (UNDP, 2003; UNAIDS, 2001). Due to its unprecedented nature, many governments have been forced to seek combined efforts in combating the virus. Leaders all over the world have come to realize that turning the scourge: "*is a task beyond individual's efforts, no matter how outstanding or heroic*" (Annan, 2000). With no effective drug to combat the pandemic (Alcomo, 2003), countries have shifted their focus on educating the society on the necessary behavioural changes to avoid contracting the virus (UNAIDS, 1997).

The HIV/AIDS education programmes/campaigns aims at achieving an "AIDS competent" society. That is, a society whose members are aware - in a detailed and realistic way - of their collective vulnerability to HIV/AIDS are mobilized to do something about this vulnerability and have practical knowledge of the different options they can take to reduce their vulnerability (UNAIDS, 1997). To achieve this, intensive HIV/AIDS campaigns have been launched at the village level involving educators from various sectors of the government, Non-Governmental Organizations (NGOs), political leaders and even religious groups (UNAIDS, 1999).

Despite huge amounts of money spent on the HIV/AIDS campaign programmes, little has been achieved in terms of attendance, participation and the behaviour change of the target audience (UNESCO, 2000). A significantly small percentage of the target audience turns up to listen and participate during the campaigns especially in the rural areas. Yet, recent debate on HIV/AIDS prevention campaign have underscored the need for horizontal communication programmes that seek to engage the audience in identifying, understanding and developing local response to mitigate the spread of the epidemic (Ford Foundation, 2005). Also, research in some Sub Saharan African countries, in which significant decline of HIV/AIDS prevalence have been recorded indicate that in addition to political support, social communication strategies involving local communities are equally paramount in attaining success (Diop,2000; Wawer *et al.*, 2005).

Further, social movements have also been identified as the main catalysts in the processes that lead to social and behaviour change, especially with regards to changing attitudes towards those affected by AIDS. Pilot case studies conducted in South Africa and Namibia have showed that

social movements effectively draw people together and create spaces for dialogue on problematic issues(PANOS, 2006). They are also instrumental in giving voice to and enhancing the active participation of those infected with or affected by HIV/AIDS.

It is with this background that this study sought to investigate youths' participation in HIV/IDS prevention activities. In doing so, this study sought to understand various factors which militate against youths' participation in HIV/AIDS activities.

In the fight against HIV/AIDS, the role of communication cannot be overemphasized. Communication is the key to understanding issues related to HIV/AIDS and is instrumental in inducing behaviour change both in people living with HIV/AIDS (PLHIV) and other members of society to check both infection and spread of the disease. This is particularly important in light of the fact that "since there is no vaccine and cure for HIV/AIDS, education about prevention and care is very important. The only way to stop the spread of the disease is for everyone to understand how its spread and then to avoid being exposed" (World Council of Churches 2002:23). Effective education is; therefore, a key to fighting the epidemic and this can only be achieved through effective communication.

According to Vickery and Vickery (1991), communication can take place if the source has information and emits it, if the target receipt wants the information and accepts, and if appropriate channel is available to both. This implies that, the source/originator of the message does not simply pass information to the recipients but must also seek their active involvement and participation (Akonga, 1988). This active involvement will be possible only when the targeted recipient of the message develops a positive attitude towards the communication process as a whole and identifies with the message.

In communication, language can either facilitate or hinder it. For instance, lack of a common language between the communicator and the communicated can be a major impediment to any form of progress and failure to communicate could also have major consequences. This is because in any a communication setting different languages can be used for different functions and intentions. Similarly, different strategies such as code switching and code-mixing are used to

signal different identities and either to include or exclude some people from conversation or communication in general.

In light of this, this study found that the choice of English or Kiswahili, which are inaccessible to majority of youths living in rural areas, to communicate on issues relating to HIV/AIDS, discriminated against them. It put them in a disadvantaged position due to their inability to read and understand the information on which their survival against HIV/AIDS depends. Due to this many youths felt helpless and isolated by materials which cut them off. This was a barrier to participation in HIV/AIDS activities considering that majority of the rural youths in Kenya have not gone through formal education and; therefore, do not understand English. This means that accessibility of the information contained in such materials like leaflets is limited.

In communication also, language goes hand in hand with personal identity. Therefore, failure to identify with language could lead to failure to identify with the information relayed in that language. The argument might be; "*if it is meant for me, it should be communicated to me in a language I understand.*" Thus in this study it was found that the use of English, Kiswahili or *Sheng* and celebrities to pass certain information about HIV/AIDS made many youths not to identify themselves with the information.

> *All the young people featured in HIV/AIDS posters are well to do or come from well to do families and reside in towns. Not like us poor rural people. Those guys are town people and even the language these posters are written in is for town people.... I think it is because HIV/AIDS is so rampant in town and that is why these posters are meant for young people in town* (a 26 year-old Mr. Aura).

The way HIV/AIDS campaigners/educators used language was also found to influence youths' participation in HIV/AIDS activities. As a fact, the way we use language is very important in determining whether or not that which was intended to be communicated is indeed understood by receipt. Consequently, the use of euphemisms and lexemes to communicate certain information about HIV/AIDS was found to create different meanings/interpretations to youths. These interpretations/meanings were in most cases contrary to campaigners'/educators' objectives. Thus, there was lack of congruence between the objective of communication and what was communicated. For example, the preference of songs with lexemes like *Vuta Pumzi* (hold your breath – delay sexual intercourse) at the start of HIV/AIDS public meetings were mostly taken as

theatrical entertainment than educative by youths. And indeed as observed in this study, many youths left HIV/AIDS public meetings immediately after campaigners stopped playing music (entertainment) and started lecturing on various aspects of HIV/AIDS.

Apart from language, youths' participation in HIV/AIDS activities was found to be influenced by their attitudes towards HIV/AIDS campaigns in general and those involved in these campaigns. According to Ellis and McClintock (1990), attitude colours the way we perceive other people, the assumptions we make of their personalities, what they say, and even whether we are going to listen to them or not. Thus, success in HIV/AIDS campaigns is determined by the attitude of the targeted audience towards the campaign exercise, which influences their willingness to actively participate in the communication process.

In this study, three factors were found to determine youths' attitudes towards HIV/AIDS activities. First was their social construction of HIV/AIDS campaigns. In this study, research participants were found to perceive HIV/AIDS campaigns as either economic ventures or genuine health education programmes in mitigating the impact of HIV/AIDS among all people. Research participants in the latter category were noted to participate in HIV/AIDS activities fully. However, in the former category they rarely took part in them.

Research participants who perceived HIV/AIDS campaigns as an economic venture did so because of two factors. First, mass media reports which indicate that HIV/AIDS campaigns attract a lot of funding from International Community and Non-Governmental Organizations for those involved in the campaigns against HIV/AIDS. Two, observations by research participants on improved socio-economic status of those involved in HIV/AIDS campaigns. In relation to these two factors, some research participants saw their participation in HIV/AIDS activities as a form of exploitation by HIV/AIDS campaigners for their own selfish socio-economic interests.

The second factor was how HIV/AIDS campaigns were organized. Data from research participants and participant observation indicated that most HIV/AIDS campaigns adopted audience composition of audience mix that is adult and young males and females. This audience mix was found to make most research participant uncomfortable in participating in HIV/AIDS

activities. This was because most research participants feared and felt shy to participate and ask questions in a mixed audience. These feelings of fear and shyness emanated from young people's socio-cultural socialization on issues related to sexuality. As a consequence, many were constrained from contributing freely or ask for clarification on issues that they had not understood because of the presence of those they thought were too young or old to listen to them asking such questions. In some cases, other research participants opted not to attend HIV/AIDS activities rather than feel embarrassed listening to certain things with members of certain age groups.

Related to organization of HIV/AIDS campaigns was the issue of timing. Timing of HIV/AIDS campaigns was found to be taken seriously by HIV/AIDS campaigners/educators. This was because timing of HIV/AIDS activities determined how wide they reached the target audience. Thus, most HIV/AIDS activities were carried out mostly at the time when they were perceived to have a wider outreach. Consequently, most public meetings on HIV/AIDS were carried out on market days. On these days, it was assumed that such meetings would have a wider reach given the fact that many people both young and old came to market places for various socio-economic activities. Similarly, it was observed that most HIV/AIDS advertisements and programmes especially on radio and television were done in the evenings and more particularly slightly before broadcasting of the day's news. This time was perceived appropriate for reaching all family members who were preparing to listen or to view the day's news.

Although timing was important to the success of HIV/AIDS activities in terms of outreach, this study; however, found that it made research participants to develop negative attitudes towards such activities. For example, broadcasting of HIV/AIDS advertisements like condoms use slightly before the day's news when all family members were gathered made most research participants not only uncomfortable but also distaste such messages. This was because of the social principals governing social behaviour "*chinsoni*" which forbids discussion or talking of issues related to sexuality among family members who exercised different moral constraints. As a consequence, most family members deliberately delayed or avoided watching or listening to the day's news until such a time when they were sure that all advertisements which preceded broadcasting of news was over.

The last factor was how research participants perceived HIV/AIDS educators/ campaigners. This perception was found to be hinged on two factors. First was how research participants evaluated educators whether they qualified to address them on issues concerning HIV/AIDS. This qualification was; however, not based on educators' expert knowledge on HIV/AIDS but on their physical attributes like age and style of dressing.

On age, most research participants were noted to prefer to participate in HIV/AIDS activities when they perceived the age of educators as appropriate in addressing them. This appropriateness was seen in terms of how young or old educators were in relation to them. For example, when research participants perceived educators' age to be young to them, they withdrew their participation or never identified themselves with intended messages. This behaviour can be explained by the "*chinsoni*" concept which defined the chain of command in any social setting. That is, it was socially and morally wrong for people who considered themselves older to take instructions or commands from those they perceived young[91]. However, this was not always the rule of the thumb. As found out also in this study, research participants who considered themselves young were also not willing to take commands or instructions from those they considered old albeit covertly[92]. This was because the young considered taking of such instructions or commands as legitimizing the imposition of older people's conservative whims on them especially on issues of sexuality. Consequently, HIV/AIDS activities which comprised educators of diverse (mixed) age groups were observed to elicit high level of participation among research participants.

In a rural setting like Gusii, dressing is used as a yardstick in defining one's identity in the eyes of community members and their attitudes towards the person. As a conservative community, there are clearly defined rules governing the dressing code of both females and males. For example, females are not allowed to wear males' clothes like trousers or wearing clothes which exposes their bodies like miniskirts. Similarly, males are not supposed to put females' clothes, plait their hair, and adorn necklaces or earrings. Failure to observe these dressing codes was

[91] Apart from age, the chain of command as stipulated by *chinsoni* concept forbids males from taking instructions or commands from females regardless of their age.

[92] Fear of being reproached by older people for disrespect, young people resorted to avoiding participating in activities led by those they considered older to them.

generally classified as indecent dressing and bestowed to an individual a spoilt identity which consequently made community members to have negative attitudes to the person.

Consequently, in this study HIV/AIDS activities which featured educators/ campaigners who never measured to the community ascribed code of dressing were noted to attract least participation from research participants. For example, HIV/AIDS advertisements which featured celebrities whose males adorned necklaces and earrings, plaited their hair and females wearing trousers or putting on clothes which exposed their bodies were seen more as encouraging immorality than campaigning against HIV/AIDS. This was because by their dressing, which by local community standards was defined as indecent, made them to acquire a spoilt identity which was normally associated with people of questionable morals like prostitutes. Given the fact that HIV/AIDS for a long time has been associated with specific risk groups with spoilt identity (Ogot, 2004; Sontag, 1989), their dressing thus made them to be seen more as vectors of HIV/AIDS than campaigners/ educators against it. This was clearly captured by a 27 years-old Mr. Oira:

> *How do you educate people to be sexually responsible because of AIDS and at the same time arousing their sexual feelings with indecent dressing? ... I strongly feel these people who claim to campaign against AIDS are not after stopping it but getting more disciples (Having more people getting infected as them)*

The above sentiment by Mr. Oira was not peculiar to him alone but to the whole community as found out in this study. As noted, there was a strong belief among research participants that people who were already infected by HIV/AIDS wanted to avenge their infection by infecting other people. By doing so, they hoped to lessen their stigma as more people are infected thus making HIV/AIDS infection more of a general and not an individual problem. In line with this thinking, HIV/AIDS educators who were "indecently dressed" were seen more in terms of encouraging more people to get infected than preventing them. This thus discouraged people from taking part in these HIV/AIDS activities.

The second factor which influenced people's perception about HIV/AIDS campaigners but linked to participation to HIV/AIDS activities was the social construction of HIV/AIDS. In the community, HIV/AIDS is highly stigmatized as it is associated with specific risk groups. As a

result, most people do not want to be identified with HIV/AIDS either by professing too much knowledge or actively involved in its prevention because "*if it does not concern or directly touch you, why involve with it*" (Comment by one research participant on why she does not take part in HIV/AIDS activities). With this thinking therefore, those involved in HIV/AIDS campaigns were seen as already infected and thus they had more knowledge about the disease. This thinking in addition to the stigma associated with HIV/AIDS made most research participants not to actively participate in its activities.

> *By my own volition I decided to get actively involved in educating my fellow young people about the dangers of AIDS. In my free time I would visit various homesteads with young people where we would discuss various ways on how to protect ourselves from AIDS. With time, most young people started shunning me. Some even went to the extent of telling me to my face that I should never set foot in their homes because people were thinking they were infected with AIDS. My own boyfriend even thought I was already infected with AIDS and that is why I was involved in its prevention activities. .... I had to quit in order to protect my identity and my love relationship* (Sabina 25 year-old lady)

Sufficing from the above discussion, it is crystal clear that there is need for HIV/AIDS educators/campaigners to conduct preliminary researches to understand the nature of clients they are dealing with in terms of socio-cultural, economic and political status. This is important because these factors not only determine young people's participation but also where, when and how HIV/AIDS information is passed to the audience. Also educators/campaigners should develop a feedback system through which they can understand the reaction of the audience towards the programmes. This will enable them make necessary adjustments to suit the needs of the target audience without necessarily changing the content of their message.

Section III: Impact of HIV/AIDS Campaigns on Youths' Perception on HIV/AIDS and Sexual Behaviour

HIV/AIDS campaigns targeting young people most often revolve around interrelated themes such as creation awareness of HIV/AIDS, prevention of HIV/AIDS, Voluntary Counselling and Testing, stigma and discrimination, HIV/AIDS treatment, and renegotiating socio-cultural factors that encourage the spread of HIV/AIDS. All these themes most often aim at creating positive perceptions towards HIV/AIDS and sexual behaviour which are key in reversing the spread of HIV/AIDS epidemic among young people (Ncayiyana, 2005).

To attain this positive perception which is crucial in HIV/AIDS prevention, communication of HIV/AIDS objectives to the targeted audience is critical. In this case, there must be congruence between what HIV/AIDS programmes communicate and what the target audiences make of what is being communicated. Therefore, the way these programmes communicate their objectives will determine whether or not that which is intended to be communicated is indeed what is understood by the audience.

However, as noted in **section I** of this chapter, the effectiveness of HIV/AIDS campaigns are affected by socio-cultural, economic and political factors. These factors also play a big role on how individuals interpret and make sense of that which is being communicated. According to Speech Theory Act (Crystal D, 1987); for instance, an utterance in interpersonal communication can have different effects to the behaviour of both the communicator and the communicated. This effect is evidenced when a speech act is analyzed using a three-fold distinction, that is the locutionary act, which is the bare fact that a communicative act takes place, the illocutionary act, which is the act performed as a result of the speaker making an utterance like promising, warning, and the perlocutionary act which is the particular effect the speaker's utterances has on the listener.

In this analysis; however, it is important to note that the illocutionary force of an utterance and its perlocutionary effect may not coincide. In speech act; for example, that which is said to either warn or inform young people about HIV/AIDS will not necessarily perform those

perlocutionary acts but instead gets a different interpretation by the reader or listener depending on their socio-cultural, economic, political and geographical context. When this happens, the intended message fails the effect it would have if illocutionary act coincided with perlocutionary act. In essence, rather than educating or informing, a message may reinforce existing social practices, perceptions or attitudes which will not be conducive for HIV/AIDS prevention.

In addition to Speech Act Theory, theories of semantics and pragmatics have also isolated three aspects which are important in understanding and interpretation of sentences in communication. These are truth conditions, presuppositions, and implicatures (Crystal D, 1987). The truth-conditions capture what can be referred as the "literal meaning" of a sentence. Presuppositions are inherently tied to the words and constructions used in an utterance. Implicatures, on the other hand, are not inherently tied to particular words or constructions. They are things which people are allowed to assume because of the way a sentence is used, that is inferring to what has not been said from what has been said. This "freedom of interpretation" given to the communicator or communicated especially in sensitive subjects like HIV/AIDS can lead to divergent interpretation of a message which according to UNAIDS (2006) may not contribute positively to the efforts being made in dealing with the pandemic.

Sufficing from the above discussion, this study sought to understand how various HIV/AIDS campaign programmes influenced youths' perception towards HIV/AIDS and sexual behaviour. However, given the fact that there were multiple HIV/AIDS campaigns programmes with both divergent and overlapping objectives, it became more difficult to relate how a particular programme influenced youths' perception towards HIV/AIDS and sexual behaviour. Consequently in this study research, participants were asked to state how various HIV/AIDS campaigns influenced their perception towards HIV/AIDS and sexual behaviour in their day to day life's experience as hereafter discussed.

Othering of HIV/AIDS

In this study it was found that the way HIV/AIDS campaigns were organized made some research participants not to perceive themselves at risk of HIV/AIDS infections. This feeling of invulnerability was commonly supported by the view that HIV/AIDS was a disease of other

people especially those living in urban areas, as Ombui 29 year-old male in Bomariba village explains;

> *This disease is for those young people and others living in towns... Us people of the village are mere victims especially when people from towns come to rural areas to infect innocent rural people. This is why there are many campaigns to stop this disease in urban areas. Since I do not stay in the urban area nor do I interact with those living in urban areas, I am safe.*

It is clear from Ombui's sentiment that the concentration of HIV/AIDS campaigns in urban areas made some young people to have the notion that HIV/AIDS is not a problem for people living in rural areas.

The perception of HIV/AIDS as a disease of the urban people was also found to be influenced by the way HIV/AIDS campaigns used language. As noted in this study, most HIV/AIDS campaigns materials like posters were written in English, Kiswahili and Sheng (mixture of English and Kiswahili words). The use of these languages to communicate HIV/AIDS issues other than the local language "Ekegusii" made some youths not to identify with the message and in essence with the problem of HIV/AIDS.

Apart from language, most HIV/AIDS campaigns used renowned celebrities to pass various messages on prevention. The use of these celebrities and not the local people whom rural young people can identify with created a notion that HIV/AIDS was a problem of the people of different lifestyles and values. These lifestyles and values which were perceived as alien to the rural youths were mostly depicted by the way these celebrities dressed and talked:

> *In urban areas young people dress so badly! Like girls they expose most of their bodies to attract men or to arouse men sexually. Similarly, young men dress like women, they put make ups in their faces, wear jewellery.... No rule governing dressing and therefore immorality is the order of the day. This is why most HIV/AIDS is a major problem to these people and not us.*

The concentration of HIV/AIDS campaigns to specific groups like youths made others who do not fall in these groups to have a feeling of invulnerability to HIV/AIDS. As observed in this study, most HIV/AIDS campaigns targeted youths who were mostly unmarried. This made youths who were already married to feel secure from HIV/AIDS infection as Samson observes:

Since I am married now there is no way I can get infected with AIDS. This disease is for the unmarried.

As noted from Samson's observation, it can be argued that the targeting of specific groups by HIV/AIDS campaigns created a perception that those targeted are risk groups. This perception made those who did not fall in this category to concentrate more in identifying the presumed "risk group" as a way of protecting themselves from HIV/AIDS infection than avoiding risky behaviour as Moi explains:

> *I used to attend HIV/AIDS campaigns before I was married for I felt more at risk. Since I got married, it is not important to do so. More so, as a man you know you must once in a while have some extra marital affair to maintain your manhood. In this case, I prefer married women for they are less risky compared to unmarried women.*

Moi's perception towards HIV/AIDS was further supported by Mr. Ombui. According to Ombui, the way HIV/AIDS prevention activities were carried out justified that HIV/AIDS is a problem for some group of risk people. Citing for instance "Moonlight VCT Programme[93]", he argued that HIV/AIDS was a problem for people who preferred to operate or carry out their activities at night like drunkards and commercial sex workers. Therefore to him, people who are not in this classified risk group have nothing to do with HIV/AIDS and its prevention.

HIV/AIDS as not a Serious Health Problem

Interviews with research participants showed that HIV/AIDS was no longer a serious health problem among youths. This was evidenced by the high number of teenage pregnancies which was an indication of low condom use. Faith; for example, reported that some of her friends judge their sexual partners' HIV/AIDS status by their physical appearance and are thus more worried with getting pregnant than being infected with HIV.

> *For my friends very few take HIV/AIDS seriously. All they care most is to get pregnant because it's very shameful especially when you are not married as it curtails ones future socio-economic prospects. With HIV/AIDS, it is just a big joke! They just judge their sexual partners by looking at them and say this one is negative so I can sleep with them without a condom provided it does not lead to pregnancy.*

[93] Moonlight VCT programme is a programme where counsellors bring a tent and create a temporary worksite mostly in places where many people frequent most at night like entertainment places providing counselling, education and HIV testing .It is assumed that this arrangement creates a convenient and discreet environment for people to undergo HIV testing unlike in the case of visiting of VCT centre at day time.

The fear of getting pregnant other than HIV infection was thus the driving force behind the high usage of morning after pills and other pregnancy prevention pills instead of condoms as Bisieri explains:

> *Whenever I have unprotected sex the only thing that worries me the next day is whether I conceived or not. So, as a precautionary measure, I am forced to take e pill® to protect me from conceiving. The idea of whether I am HIV positive after sex does not even close my mind. It is actually the last thing I ever think about.*

From the interview it was evident that young people did not take HIV/ AIDS seriously. This perception was found to be a result of various factors which were all linked to HIV/AIDS campaigns. First, as observed in this study, most HIV/AIDS campaigners/ educators especially those involving interpersonal communication lacked appropriate language to use in linking unprotected sex with HIV infection. This is because of high stigma associated with HIV/AIDS and cultural inhibition of discussing issues touching on sexuality in public. As a result, most educators found it easy to link the consequences of unprotected sex to pregnancy as it was perceived to be more culturally tolerant. Due to this, there was overemphasis on pregnancy as a consequence of unprotected sex to the detriment of HIV/AIDS infection.

Similarly, some social marketing programmes which tended to promote condom use as a strategy for HIV/AIDS prevention were observed to promote condoms basically as contraceptives. This was meant to counter the negative association of condoms with immorality which was seen as a major factor for low condom use (Agha, 2003). However, this linkage of condoms first as contraceptives and later with HIV/AIDS prevention was noted to create a perception among young people that pregnancy was a more serious problem than HIV/AIDS. This was clearly captured by a 25 year-old university student, Mr Osindi:

> *Among us youths, youth pregnancy is a serious problem. This is why the government has invested a lot of resources in encouraging youths to use condoms whenever they have sex. Look at advertisements like "Nakufeel Mpenzi Wangu" all it emphasizes is we should use condoms to prevent unwanted pregnancies. In any case, if such advertisements wanted us to use condoms to protect ourselves from HIV/AIDS it would have stated so in the first instance.*

Furthermore, the perception that HIV/AIDS was not a serious problem was also found to arise from how HIV/AIDS campaigns were carried out. As observed in this study, most HIV/AIDS

campaigns tended to promote various themes at particular periods in relation to the development of HIV/AIDS intervention strategies. This promotion of particular themes; however, did not make any references to preceding themes which were equally relevant in HIV/AIDS intervention. As a result, some research participants were noted to perceive the preceding themes as irrelevant or obsolete in the fight against HIV/AIDS. For example, at the time of this study, most HIV/AIDS campaigns in the study site focused more on HIV/AIDS treatment than prevention. This is because at this time HIV/AIDS treatment was a major theme in mitigating the impact of the pandemic. This overemphasizing of treatment at the expense of prevention was therefore noted to create the perception that the disease was no longer a threat as it can be treated as explained by Mr. Otiso:

> *AIDS is no longer a threat. It can be treated by using some modern medicine. This is why most campaigns nowadays on the disease have stopped telling people on how to protect themselves. Instead they are focusing more on telling people to seek treatment once they are infected.*

Otiso's perception towards HIV/AIDS as not a serious problem can also be attributed to Abagusii cultural definition of illness treatment and healing. Illness treatment in this case is seen as efforts taken by the patient or members of his/her social network to alleviate symptoms of the illness. These efforts can take the form of taking medicine or carrying out some activities like sacrifices and rituals. Once these symptoms are alleviated and the patient resumes his or her day to day duties, the patient is assumed to have healed. However, it is worth noting that treatment and healing are mutually intertwined in this community.

Although Abagusii definition of illness treatment may have some similar aspects with biomedical treatment of HIV/AIDS, they differ on the definition of healing. Despite both agreeing that treatment involves some efforts to alleviate symptoms or suffering of the patient, they differ on the end result. For example, in biomedical treatment of HIV/AIDS the alleviation of symptoms and resuming of normal duties by the patient is important; it does not; however, indicate that the patient is free from HIV/AIDS or its virus. This is contrary to Abagusii understanding of treatment and healing.

Consequently, lack of appreciation by biomedical HIV/AIDS treatment on local people understands of illness treatment and healing in HIV/AIDS campaigns was thus a factor on young people's perception towards the epidemic. Otiso; for example, further reported that HIV/AIDS was no longer a killer disease because those who were bedridden by HIV/AIDS "healed" once they started taking ARVs as it was demonstrated by various posters distributed by HIV/AIDS campaigners. These posters as explained by Otiso featured pictures of people who were extremely ill from HIV/AIDS (like being emaciated) on one part and the other part showing the same people looking physically vibrant and engaging in some economic activities. These physical changes to him meant that ARVs were capable of healing/curing HIV/AIDS thus making it not a threat.

HIV/AIDS as a disease for anyone

Despite the common "Othering" of HIV/AIDS, some young people refuted the claim that the disease was endemic to particular groups as explained by Bosibori:

> *...because you live in town or frequent social entertainment places like bars doesn't mean you are more likely to get AIDS. I have seen many people die of AIDS and yet they lived in rural areas and never frequented those places. Likewise the young, old, rich and poor are all venerable to AIDS. So AIDS attacks everyone.*

Although Bosibori used her life experience to argue that HIV/AIDS is not endemic to a particular group, other research participants used the information from HIV/AIDS campaigns to refute the claim of "Othering". For example, Mr. Nyangau a 28 year-old form four school leaver argued that the way some HIV/AIDS campaigns communicated their messages made people to feel that they are all vulnerable to HIV/AIDS infection:

> *It is extremely hard to say who is more likely to be infected by or has AIDS. This disease is like a lottery. Take for instance this advertisement on both radio and TV where different people from different socio-economic backgrounds introduce themselves. After this you are asked to pick one who has AIDS. By merely looking at them it is very difficult to say who has the disease. This means anyone can have AIDS or can be infected.*

Nyangau's perception about HIV/AIDS was borne from HIV/AIDS campaigns which aimed at creating collective uncertainty in identifying who was infected by HIV/AIDS. By creating this uncertainty, these campaigns aimed at encouraging people to use condoms every time they had

sex with any sexual partner. These types of campaigns were observed to be common with generic mass campaigns promoting condom use.

Similarly, the way HIV/AIDS campaigns used language to communicate their message made some research participants to perceive HIV/AIDS as a disease which affects all people. For example, in interpersonal HIV/AIDS campaigns, the use of metaphors especially those aimed at bestowing positive identity to a person infected by HIV/AIDS tended to create the perception that everyone can be infected by appealing to collective vulnerability.

Although appealing to collective vulnerability by some HIV/AIDS campaigns was important in creating the perception that everyone was vulnerable. This study however, found that such approach was also counterproductive in some cases. As noted, such appeals made some research participants to feel disempowered in taking any action towards HIV/AIDS. This is because at individual level, action towards HIV/AIDS was perceived as inconsequential given the magnitude of the problem. As a consequence, some research participants resigned to fate as explained by a 27 year-old lady, Nyanchama:

> *You see AIDS is everywhere. You cannot tell who has it or not. The radio, TVs and doctors have said so. This is just a calamity which you have little chances of surviving. You can take steps to protect yourself but they are inconsequential if you look at the big picture. It's a matter of fate.*

HIV/AIDS as economic venture

Since the advent of HIV/AIDS, donors and international NGOs have given a lot of resources to various actors involved in mitigating the impact of this epidemic. As noted in chapter two, the government of Kenya from the onset displayed lukewarm approach to the disease. This gave room for many actors to come forth in the fight against the disease. Some of these actors; however, were only attracted by financial gains accrued from HIV/AIDS activities.

Consequently, due to high levels of poverty and unemployment especially among young people, HIV/AIDS campaigns were taken more as income generating ventures than mitigating the pandemic's negative impact. Mr. Oncharo who was a university graduate reported that after failing to secure any formal employment, he was forced to start his own community based organization dealing with HIV/AIDS so as to get some income. He explains:

> *After my university education I moved to the city in search for job in any formal sector. Five years down the lane I did not get any job nor was there any prospect of getting any. I had to make a quick decision because age was also catching with me..... was getting old and not having a family eh! From newspapers and my own observation I noted that people who were already working in mitigating HIV/AIDS were making a lot of money. So I quickly returned here in my village and formed my own organization. With time I started getting money from donors. Since then, as you can see my life changed.*

The perception of HIV/AIDS and its campaigns as income generating ventures were also observed by a 28 years-old Mary:

> *If you want to be rich by getting easy money, start anything in the name of fighting AIDS. Once you have this, you are on your way to big money! In this village, I have seen some people fortunes change by involving themselves in AIDS war.*

Similarly, it was also observed that individuals or groups especially those engaged in income generating activities engaged in HIV/AIDS campaigns as a way of supplementing their income or attracting extra resources for their activities. For example, in Suneka Township it was observed that most individuals or groups who engaged in soapstone curio shops had programmes dealing with HIV/AIDS too. Most of these programmes were; however, meant to attract funding from donors dealing with the epidemic. As a consequence, most soapstone curio shop owners despite indicating that they were involved in HIV/AIDS campaigns, in reality they never carried them or where they did, it was minimally executed.

HIV/AIDS as Venue of Discrimination

As noted earlier, media is a very powerful tool for educating people about HIV/AIDS. It is instrumental in shaping people's attitudes towards the disease, those infected, and affected and various aspects of life in general. However, it is also a tool that could fuel existing stereotypes and therefore lead to stigmatization and discrimination of various groups in society. In the Kenyan media, a number of advertisements are geared towards educating the public on ways of preventing the infection or spread of HIV/AIDS. These advertisements; however, as noted by research participants contained implicatures which were both discriminating and stigmatizing.

Citing the advertisement by a prominent musician, Prezzo, on promotion of condom use, a 29 year-old Mr. Omosa argued that such advertisements discriminated against those people who were already infected and also women. In this advertisement, it was noted that Prezzo sung about women and at the end of the music, a question is posed: *Prezzo ana yake, je una yako?* Meaning, Prezzo, the musician has his condom, do you have yours?

According to Mr. Omosa, the implication of the question "*Je, una yako?*" is that if you have a condom, you cannot get infected with HIV/AIDS. However, this question is silent on what people who are already infected should do. To Omosa, the message is that those already infected were infected because of their failure to use a condom. While this may be true, it seems to imply that People Living with HIV (PLHIV) are to blame for their status as a result of their irresponsible sexual behaviour and therefore deserve punishment. The fact that the singer is assumed not to be infected by HIV/AIDS also appears to lay emphasis on prevention thereby, basically excluding those infected.

Mr. Omosa observation is further fortified by Mr. Jamal who is living positively with HIV/AIDS by arguing that most HIV/AIDS prevention programmes are more concern with those who are not yet infected. To Jamal this is a form of discrimination given the fact that those already infected can also be re-infected.

> *Apart from being blamed for having AIDS by the general public, the people who are also responsible in educating the public about the disease either by omission or commission ignore our plight. All they care is about those who are not infected. They do forget that that we are equally important in the success of their efforts. What I think they are communicating to us is that you are totally responsible for your infection and therefore you must live with the consequences*

From above cited advertisement "*Je, una yako?*" Mr. Omosa further observed that the question was basically addressed to men. In this case it was the male condom that was referred to and not the women condom which is still rare in Kenya. In this way, women were excluded from the advertisement. The implication of this advertisement according to Omosa was that it was the choice of a man to use or not use the condom. The woman was given no choice whatsoever, hence being left at the mercy of the man. By implication, if the man chooses not to use a

condom, then the woman has to go by his choice. This reflects the largely patriarchal system in Kenya where the man is in control and the woman remains silent.

The fact that women cannot negotiate with the man on whether or not to use a condom leaves the woman as a victim of the man. This is echoed by Phiri (2003:12) who says that most married women know that their husbands have multiple partners but they are powerless to come out of the relationship or negotiate for safe sex. Unfortunately as Omosa observed, the advertisement like "*Je una yako*" in both electronic and print media continues to give this practice validity.

HIV/AIDS as Venue for Gender Inequality

In Sub Saharan Africa, women continue to bear the greatest brunt of HIV/AIDS due to gender power imbalance which characterizes most societies (Gupta, 2002; Silberschmidt, 2001; Vagra, 2003; Wilton, 1997; Blanc, 2001; Campbell *et al.,* 2001). As a consequence, most HIV/AIDS interventions have sought to minimize this power imbalance through information empowerment. However, as found in this study, those efforts especially those relying on advertisements continue to enhance this gender imbalance because of the kind of language they use and lack of appreciation of socio-cultural factors of the target group as evidenced in an advertisement which featured a bride and bridegroom exchanging vows. In this advertisement, the public is warned against accepting that which is considered "normal behaviour" despite the fact that it helps in the spreading of HIV/AIDS. But this advertisement leaves the woman "exposed" and the man "excused" or more literally hidden. For example, the woman in her bridal outfit says (and this appears in very large font); "*I promise to accept your infidelity and never mention condoms.*" Below this are writings that appears in small font; "*ZI, Tusikubali tabia zinazoweza kueneza Ukimwi*" meaning, NO, we should not accept behaviour that can spread AIDS. In the advertisement also, there is a part which appears directly below the bride which reads;

> *"It's shocking the kind of behaviour Kenyans accept these days, just to fit in.*
> *What's even more shocking is that the same behaviour often leads to HIV."*

Looking critically at this advertisement, it is evident that it is loaded in terms of reinforcing the image of women in most African societies. Unlike in the previous advertisement cited earlier; "*Je una yako?*" where the woman is expected to be silent and wait for the man to decide on

whether to use a condom or not, it is important to observe that the first part of this advertisement gives the woman a chance to say something. However, what she says endorses the man's decision, *"I promise to accept your infidelity and never mention condoms"*. So, the man has made a choice to be unfaithful and not to use condom and the woman rubberstamps that choice. And as if to make sure everybody reads that what the woman says, it appears in large font size! The face of the man appears at the corner, obviously "protected" from the public, but smiling gladly at what the woman is saying. This is line; for instance, squarely blends with Abagusii socialization of gender and sexuality whereby a woman has no power over a man's sexual behaviour as discussed in chapter three.

The warning given to the public, *"ZI, Tusikubali tabia zinazoweza kueneza Ukimwi"* further enhances the position of women in issues of sexuality and HIV/AIDS. In this case, other people are warned not to accept that which the woman has accepted! This is further evidenced by the statement below the bride which reads, *"It's shocking the kind of behaviour Kenyans accept these days, just to fit in"*. This message is definitely a follow up to what the bride says - her acceptance of her husband's infidelity and promise never to mention condoms to him. The last part of the sentence gives the reason why women would accept this kind of behaviour - just to fit in. This means that women have to accept men's behaviour, whatever it is, and regardless of the danger such behaviour may pose for them "just to fit" in society. Though the statement is meant to induce behaviour change among the audience, the language used contains implicatures which enhance women inequality in sexual matters. It reinforces the position of a woman in society - she is insignificant, unimportant and has to do anything to be accepted, including putting her life on the line to excuse the man and be accepted to him and society.

Like in the song *Nyaboke* at the introduction of this thesis, this advertisement also puts a woman in a very vulnerable position. A woman has no control over her own sexual behaviour since she must behave in a certain way so as to be accepted to men and society. Therefore, the continued use of such language in an attempt to induce behaviour change is counterproductive in the long run as it gives room for the perception that women should continue to be powerless in issues of sexuality especially in HIV/AIDS prevention.

In a similar advertisement, as the above one but geared more to young people, the same perception of gender power imbalance in issues of sexuality is still evidenced. This advertisement featured a young woman graduating from college addressing fellow graduands during graduation ceremony. In her address, the young graduand says, "I've *learned that I must sleep with my boyfriend to prove my love"*. Once again comes the warning to the public *"ZI, Tusikubali tabia zinazoweza kueneza Ukimwi"*. Below the graduand are also similar messages as were in the wedding ceremony discussed earlier.

In this advertisement, what is of major concern is the address by the young lady graduating from college on that which she has learnt. That is, she "must" have sex with her boyfriend "just to prove" her love. To begin with, such message is misleading as the advertisement is meant to encourage behaviour change among young people. Regardless of what follows to show that this is supposed to be unacceptable behaviour, the fact that it appears in very large print means it captures the readers' interest while that in smaller font is likely to go unnoticed and therefore unread. Therefore, the only message that the reader would get is that which the lady confesses as having learned!

This advertisement thus brings forth the perception the society has about women. Her boyfriend can only believe that she loves him if she sleeps with him. In this case, the woman's behaviour is geared over and over again towards pleasing the man and in this particular case to prove that she loves him. The implication of the language used here is that the lady is ready to sleep with the man, not because she really wants to, or not for her own personal gratification, but just to "prove her love" to the man.

Apart from understanding how HIV/AIDS campaigns influenced young people's perception towards HIV/AIDS, this study also sought to find out how they impacted on their sexual behaviour. Sexual behaviour change among young people has been identified as a major theme in the fight against the epidemic given the fact that the most common mode of transmission of HIV/AIDS in this group is heterosexual (KIAS, 2007; Kamaara, 2005 and NACC, 2001).

"Back to Basic": Towards "Zero Grazing"

Most HIV/AIDS campaigns especially those carried by conservative moralists have constructed HIV/AIDS as a disease of lifestyle. To them HIV/AIDS is a result of permissiveness, moral decadence, and degeneration of family values. Therefore, to win the war against HIV/AIDS people should return to long established values of monogamy and celibacy.

In Kenya, HIV/AIDS is transmitted mainly through heterosexual practices and therefore the most vocal conservative moralists have been the church organization and the clergy. As a consequence, research participants who followed the teachings of the church on morality were found to modify their sexual behaviour to suit the church teachings. These teachings emphasized abstinence for those not yet married and faithfulness among married couples all which were constructed as returning back to basic values governing Christian sexuality.

Apart from the church, other forces which were found to be instrumental in shaping young people's sexual behaviour were traditional healers and herbalists who were involved in HIV/AIDS intervention. Like the church, these groups also emphasized on the " return back to basic" in issues of sexuality but theirs was idealized on the conception of "traditional African ways" which reasserted on " traditional values" of sexuality while challenging "modern values" of sexuality like gender power balance and sexual freedom.

These cultural conservationists (like traditional healers and herbalists) have constructed HIV/AIDS as a disease of West and Western lifestyle and whose cure is embedded in return to "African traditions and African traditional sexual lifestyles". This "back to basics" was noted among research participants to emphasize safe sex practices which were; however, embedded in traditional values. Cosmas, a 30 year-old male who works in the city and his wife stay in a rural area decided to get married to a second wife in the city as a way of being sexually faithful to his rural wife. He explains:

> *It is extremely hard to control sexual feelings. These same sexual feelings can make you have sex with any woman who can easily infect you with AIDS. To avoid having many sexual partners here in the city since my wife is in my rural home, I decided to marry another woman who does not bear children. This woman stays with me in the city and my wife approved this arrangement. With*

her around, I can't mess up. So in the city I am faithful to this wife and in extension to my wife who stays in the rural area.

Cosmos's "return to basics" was premised on a myth of male "insatiable" sexual drive which emphasized return to "polygyny". In this relationship, a man is allowed to have sex and exercise faithfulness to different wives who are legally recognized as his wives. The wives are also required to be faithful to their legally recognized husband because of the belief in supernatural retribution, *amasangia*[94] (Sindiga, 2006). This is unlike the Christian and bio-medical HIV/AIDS campaigns which emphasizes monogamy in sexual relationships.

In response to HIV/AIDS campaigns which highlight the growing prevalence of HIV/AIDS and individuals experience on the disease also, a new concept "*Zero grazing*" was found to have gained popularity among young people. Zero grazing which was conservative model for safe sex emphasized faithfulness to one sexual partner. The assumption in this concept is that each sexual partner will remain faithful. Samson explains:

> *In this place many people have died of AIDS. Those who have this disease are also out to spread it. No one is safe. So for me I have decided to Zero graze that is stick with my wife.*

Although the concept *Zero grazing* emphasized faithfulness among all sexual partners; it was however, found out that it tended to favour men. This is because it was only males who had power to implement *Zero grazing* to themselves and to their sexual partners. In this case, a female had no power to determine whether her sexual partner adhered to the Zero grazing concept. Also in some cases it was noted that men used this concept as a way of controlling women sexuality. By demanding faithfulness from the woman, the man was able to protect himself from the shame associated with one's woman having many sexual partners.

Control of HIV/AIDS through Sexual Restraint

Most HIV/AIDS campaigns emphasized sexual behaviour change as the most realistic way of fighting HIV/AIDS. These campaigns were; therefore, opposed to free-wheeling sex, and saw the solution to HIV/AIDS problem lying on sexual restraint. Sexual restraint among research

[94] For details on Amasangia refer to chapter three on the section on Illness among Abagusii.

participants was; however, found to be influenced by Christian and traditional version of "return back to basics".

The Christian version of "return back to basics" emphasized abstinence for those who are not married and faithfulness among married couples. In this case, HIV/AIDS was seen as a by-product of sexual permissiveness. Therefore, to avoid this disease, one must avoid sexual promiscuity as a 25 year-old teacher Rosemary explains:

> *The bible has many examples where God punishes people through incurable diseases due to their immorality. AIDS is the disease which is already prophesized in the bible. To avoid this, I have made it a resolution that I will never engage in sexual relationship before marriage. Even in marriage, I will be faithful to my husband only.*

Young people who ascribed to traditional version to return to basic constructed HIV/AIDS as a disease which results from "blood mixture" which is a consequence of promiscuity as Jomo a 29 year old male explains:

> *People think AIDS is a new disease. In reality it is not. It is a consequence of modernity and westernization whereby everybody is having sex with everybody else. In this situation, you get all sorts of blood mix up, young, old and relatives. This leads to development of new diseases as punishment from our ancestors.*

According to Jomo, to avoid this disease, people must strive to have sex with good people only;

> *There is nothing wrong having a lot of sex as long as you have it with good people. If you need variety, you must choose carefully not to have sex with blood relatives like cousins, nieces and aunts.*

Jomo's version of sexual restraint is fashioned to suit gender socialization on sexuality. In this case, males are socialized to believe that they have insatiable sexual drives which can only be satisfied by having sex with multiple partners. In this case, young men like Jomo were found to define sexual restraint to include only sex with close blood relatives.

Sexual restraint among males was also found to be influenced by physical attributes of sexual partners like their dressing style and physical appearance. Those who were perceived to be indecently dressed as per certain yardsticks and looked unhealthy or not beautiful were avoided

sexually. As explained by Jared, the way a girl dresses and looks gives an indication on whether she is immoral and infected with HIV/AIDS:

> *You can avoid AIDS by exercising some sexual restraint. In this case, you must have sex only with partners who are beautiful, look healthy and decently dressed. As you know those girls who have AIDS look thin and unkempt. Similarly, those who are immoral normally dress indecently by wearing tight clothes which expose their bodies as a way of attracting men.*

Safe Sex as "Unafrican"

Data from this study showed resistance to condom use among young males on the ground that condoms are "unafrican". Onchiri observed:

> *I think why most of us will die of AIDS is not of ignorance. You see, you need to grow up with a practice, and not just pick it up in your adult life. You have to learn how to use a condom gradually as you grow up, then in adult life, you will not have problems. I think condoms are part of the Whiteman's sexual culture, and not African.*

In the study site, there were also many phrases that amplified the view that condoms were not part of African sexual culture. This discourse of condoms resistance may; however, not be particularly peculiar to youths in Kenya, as other studies in East Africa seem to yield similar findings (Seidel, 1990; Schoepf *et al.,* 1988). In Zaire, for example, Schoepf *et al.* (1988) found *inter alia* that men were reluctant to use condoms because of popular construction of condoms as "unnatural" and "Unafrican". Condoms were introduced in Africa by Western agencies as birth control devices, and the sudden shift of emphasis to promote condoms as HIV/AIDS prophylactic has intensified fears that this could be yet another imperialistic manoeuvre to keep the African population in check (Schoepf *et al.,* 1988). In Uganda, Seidel (1990: 64) observes that condoms are viewed as " foreign" so much that , even President Museveni a firm supporter of the anti-AIDS campaign is reported to have spoken against condoms on cultural grounds claiming that they were not Ugandan, and arguing that what was Ugandan was moral restraint. This politicization of HIV/AIDS was found to serve the legitimization of unprotected sex.

The discourse of resistance on condoms was also strengthened by the construction that they were being used to spread HIV/AIDS among African people. Mr Nyakundi, a 26 years-old said:

Are you sure these condoms are not the ones being used to spread this disease? I have heard superpowers want to control our population by all means, and they are smearing these condoms with the germs of AIDS. Why should condoms be the only free thing in hospitals and everywhere else, and not anything else if this is not the case?

Nyakundi's account contains two more dimensions which males have used to strengthen their discourse of resistance. First, in a bid to promote safer sex practices, condoms have been distributed free of charge in health institutions and other social places. This campaign is partly funded by non-governmental agencies and partly by the government, through the Ministry of Health. However, because condoms are free in a country where almost everything has a price tag, this has fuelled suspicions over the motive behind this kind overture. Secondly, the view that condoms are "smeared with HIV" virus is also part of controversy which lingers as to the origin of HIV/AIDS. Failure on the part of scientists to provide a satisfactory answer to this question, has reinforced suspicions, and led to the proliferation of rumours which reinforce discourses of resistance and undermine safer sex campaigns.

Sex as an Indicator of Social Achievement

For most young males, having more sexual partners was considered as a sign of success. This notion was noted to arise from the way advertisements which promoted condom use were carried out. In these advertisements, celebrities mostly musicians were featured having condoms surrounded by young women. To young men, this meant that to achieve the social status of a celebrity you must have sex with many women and that is why you need condoms.

According to a 25 year-old Mr. Atika, most males pride in the number of sexual partners they have. They conceptualized their concurrent sexual relationship as competition or fun. Sex, to them was seen a game in which individuals compete on the basis of the number of women they had sex with. To young men, this competition has been made possible with availability of condoms.

Summary and Conclusion

This chapter has discussed how young people access HIV/AIDS prevention information. In particular the chapter has focused on both the media and interpersonal HIV/AIDS prevention communication strategies. Findings of the study show that most of these strategies lacked affirmative action for youths from diverse socio-cultural, economic, political and geographical background. As a consequence, youths were unable to access such information effectively and when they did, there were myriad interpretations of the information disseminated which in turn affected or influenced their action towards such HIV/AIDS prevention information.

Empirical evidence emerging from the study further indicated that youths seldom participated in HIV/AIDS activities. This was found to be due to over reliance in World Health Organization biomedical approach which emphasized top down approach in prevention of HIV/AIDS. In this approach, HIV/AIDS prevention activities are designed by World Health Organization and universally applied and implemented to all societies with no regard to their diverse socio-cultural, economic and political contexts. Consequently, the study found that youths participation in HIV/AIDS activities was greatly influenced by socio-cultural and economic factors. As noted, participation in HIV/AIDS campaigns such as public meetings and advertisements was affected by socio-cultural factors governing social behaviour. For example, due to principles governing social behaviour "*chinsoni*" most research participants seldom participated in HIV/AIDS public meetings which mostly adopted audience mix or HIV/AIDS prevention advertisements which mostly preceded daily news bulletins in both radio and Television. This was because social principles governing social behaviour prohibited public discussion of issues touching on sexuality among people of different social moral constraints.

Participation in HIV/AIDS activities was further found to be influenced by the social construction of HIV/AIDS among research participants. For example, research participants who perceived HIV/AIDS campaigns as economic ventures avoided participating in prevention activities as a way of avoiding being exploited. Also due to high level of stigma associated with HIV/AIDS, some research participants avoided being identified with the disease by either professing too much knowledge about it or by actively involving themselves in its prevention activities. Another factor which militated against young people's participation in HIV/AIDS

activities was the choice of language to communicate HIV/AIDS information. In this case, the choice of English, Kiswahili and *Sheng* was found to alienate research participants because they did not identify with such languages and therefore never identified with the information which was being communicated.

An analysis of HIV/AIDS campaign themes on youths' perception of HIV/AIDS and sexual behaviour showed some dissonance. Results from the study showed that research participants had varied interpretations on the themes which were professed by HIV/AIDS campaigns. These interpretations were borne from the failure of these campaigns to take into account the socio-cultural, economic, political and geographical contexts of the research participants. For example, the concentration of HIV/AIDS activities in urban areas and the type of language used made some research participants to perceive HIV/AIDS as a problem of other people. Also lack of proper language in communicating sensitive issues like sexuality and HIV/AIDS by HIV/AIDS educators/campaigners due to cultural inhibitions created the perception among some research participants that HIV/AIDS was no longer a serious problem. This perception was also found to emanate from the failure of biomedical HIV/AIDS prevention approaches to appreciate local people's understanding of illness, treatment and healing. In addition, HIV/AIDS campaigns were found to enhance discrimination notably among those infected and women, and gender inequality.

Further investigation also revealed that youths' sexual behaviour as advocated by HIV/AIDS campaigns was greatly influenced by social construction of sexuality. In this case, the religious and socio-cultural interpretation of sexuality formed a major component which guided an individual's sexual behaviour in relation to HIV/AIDS campaigns. For example, in religious discourse, sexual restraint in HIV/AIDS prevention was seen in terms of abstinence for those who are not married and faithfulness among married couples. However, in socio-cultural discourse, it was fashioned to suit gender socialization on sexuality which emphasized male insatiable sexual drives which can only be satisfied by having sex with multiple partners. In this regard therefore, sexual restraint was taken to mean having sex with only "clean" partners.

In summary, it can be argued that although HIV/AIDS campaigns are crucial in mitigating the impact of HIV/AIDS among youths, it is important that they take into account the socio-cultural, economic, political and geographical contexts of the target group. These factors are important because they determine how youths access HIV/AIDS information, their participation and interpretation of various themes advocated by such campaigns.

CHAPTER SEVEN

THE SOCIAL CONSTRUCTION OF ABSTINENCE, BE FAITHFUL, CONDOMISE, VCT MESSAGES AND SEX AMONG YOUTHS

Introduction

Most HIV/AIDS campaigns themes aim at modifying individuals' sexual behaviour as away of reversing the impact of HIV/AIDS in society. However, as indicated from results discussed in chapter six, these campaigns generate myriad interpretations among target groups due to diverse socio-cultural, economic, political and geographical contexts. This chapter, therefore, builds on these findings in seeking to understand how Abagusii youths made sense of Abstinence, Be Faithful, and Condomise and VCT messages. In doing this, section one of this chapter analyses the representation of these notions within youths social network and how the socially produced meanings influences their understanding of ABC and VCT prevention approach in their day to day sexual lives. The chapter further discusses the meaning of sex among youths in section two.

Section 1: Making sense of ABC and VCT

Most HIV/AIDS prevention campaigns assume that individuals decode messages as transmitted from the source. In this case individuals are assumed to understand, interpret and act as intended by the source. However, according to social constructionists, individuals make sense of information by synthesizing it into common shared knowledge as contained in their institutions and every day language. Common shared knowledge in this case is constructed through socialisation as a result of social interaction, negotiation and power (Huber *et al.*, 1998; Maticka-Tyandale, 1992).

Accordingly in making sense of HIV/AIDS preventions strategies specifically ABC and VCT, individuals construct their own realities which guide their actions. Although these realities are individualized, they are culturally patterned and mediated by historical and cultural factors (Burr, 2003). This in essence means that that how an individual makes sense of ABC and VCT prevention approach is not only dictated by culture alone but also the prevailing socio-cultural, economic and political context.

Interpretation of Abstinence

In the ABC and VCT strategy, abstinence means not engaging in sexual activity. This concept is often promoted together with "delaying sexual debut", which means delaying the onset of sexual activity until marriage or in some communication programmes until one is mature enough to make good choices regarding sex. Findings from this study; however, revealed that majority of the youths had engaged in sex with a person of opposite sex and had varied interpretation of "Abstinence" as discussed hereafter:

Abstinence as "not engaging in sex"

Research findings indicated some research participants understood abstinence the way it was intended by the ABC and VCT prevention approach. This was evidenced when research participants were asked to state what they understood with abstinence in relation to HIV/AIDS prevention.

> *To abstain to me as a Christian means not having sex until I am married* (20 year old Linet)

> *I think abstaining especially at this era of AIDS is important especially for us young people. You know we are still young and old people can take advantage of you sexually for they have a lot of experience. That is why its important to avoid having sex until you have fully matured or you are at the right age like 20 years old* (19 years old Evelyn)

These two accounts demonstrate the exact meaning of abstinence as advocated by various HIV/AIDS campaigns. For example, Linet interpretation of abstinence was similar to that advocated by religious institutions like the church and moralist inclined organisations/ programmes like PEPFAR. Likewise, Evelyn interpretation was more influenced by HIV/AIDS campaigns which were mostly spearheaded by secular organisations where the age of onset of sexual debut is more emphasized.

In addition to these interpretations, some research participants understood abstinence in terms of not having sex in some occasions due to prevailing circumstances. John Nyabs; for example, indicated that he sometimes abstained from sex whenever he doubted the health status of his partner. Similarly, to Ombui abstinence meant sacrificing having sex either when he did not have

a condom or the partner was likely to conceive. In these two cases, it was clear that abstinence was constructed to be equivalent to postponing having sex at particular situations.

Further analysis of data revealed that the connotative interpretation of abstinence was more influenced by gender socialisation of sexuality. As found out more females tended to interpret abstinence exactly as it was intended in HIV/AIDS campaigns. This was because such interpretation tended to be in line with culturally defined way of sexual practice among female. That is, female's social reputation and status as potential future wives depended on their ability in avoiding engaging in sexual activities from an early age or with multiple partners. This, therefore, meant that HIV/AIDS messages which advocated abstinence (not having sex) either until marriage or at prescribed age resonated well with female culturally prescribed sexual behaviour.

However, among males connotative interpretation of abstinence was done in such away to meet the cultural definition of male sexuality and at the same time to "to be in line with HIV/AIDS campaigns intended meaning of abstinence." Culturally, Abagusii males are socialized to be sexually active as an indicator of manliness. However, due to high stigma associated with HIV/AIDS and the fact that it is heterosexually transmitted, males tried to define their sexual behaviour in two ways. One, to be seen to be sexually active as culturally demanded and two not to be seen as sexually immoral. Consequently, males interpreted abstinence in terms of postponing having sex due to prevailing circumstance. This definition was thus perceived to meet cultural definition of manliness as it denoted sexual activeness and at the same time indicated that an individual was taking precaution sexually.

Abstinence as a religious moral practice

Abstinence among research participants was understood as religious moral practice. This was found to be common among research participants who subscribed to religious moral teachings especially Christianity. In this case, abstinence was seen in terms of preserving sexual purity as contained in religious notions of pre-marital chastity. The 20 year old Linet; for example, believed in biblical view that sex should only be practiced within marital union only. To her, abstinence was a moral religious practice of not having sex until marriage:

> *Honestly we young people are not living according to the bible teachings. The bible clearly states that sex is should take place in marriage and for procreation*

only. But nowadays sex is seen as a form of entertainment for those who are not married.....As a Christian I follow God's teachings and thus I am abstaining from sex until I get married.

From Linet's sentiments it is clear that premarital sex is immoral as sex is meant only for procreation purposes in matrimonial relationship. This interpretation draws from biblical teachings which saw abstinence in terms of moral rather than health discourse.

Other research participants saw abstinence as a necessary step of establishing a health relationship with God. In this case premarital sex was construed as sinful and whose consequences were severe. Irene Moraa, a university student, explained:

The only way you can be in peace with God is to avoid engaging in pre-marital sex. I have seen a number of young people suffering because of engaging in pre-marital sex. Honestly there is no way you can have sex before marriage and God leaves you scot free.

The interpretation of abstinence as a moral religious practice was; however, found to exclude those who have already engaged in pre-marital sex. In this case abstinence was seen as a form of sexual purity which is only applicable for those who have not engaged in sex. This was clearly captured by Kwamboka when asked what she thought of abstinence as HIV/AIDS strategy:

The only sure way of avoiding AIDS is to avoid having sex among those who are not married. However, this is only practical for those who have never had sex. Take my case for instance, I am no longer a virgin, how can I tell my boy friend I am abstaining! It is dishonest and unrealistic.

Kwamboka's sentiment on abstinence reflects the belief among many females that there is no secondary abstinence. In this case, secondary abstinence was seen as being dishonest to the other sexual partner and could lead to mistrust in the relationship. In this context it is clear that the power to decide when to engage in sex among females is not individual decision but involves the two partners involved in sexual relationship. This means that the decision on when to engage in sex is mutually negotiated decision rather than individual choice as advocated by ABC and VCT strategy.

Among research participants who constructed Abstinence as religious moral practice believed that abstinence was only possible if one was a practicing Christian. Linet, for example, argued that in the absence of religion it was impractical to practice abstinence.

> *It's not possible to abstain from sex if you are not saved (that is believe in Jesus Christ teachings). ... You see most young people in this area are not saved and therefore they engage in sex as if sex is food to them. My friend even if you launch the biggest campaign to educate those who are not saved to abstain from sex you will only be campaigning to yourself.*

From the foregoing discussion it is clear that research participants who interpreted abstinence as a religious moral practice saw abstinence as only motivated by their understanding that pre-marital sex as sinful rather than the risk of HIV/AIDS infection. This means that the main purpose of abstinence in this account is not prevention of HIV/AIDS but preservation of religious values.

Abstinence as virginity preservation

In this study religious and cultural beliefs were found to play a significant role in influencing the way abstinence was understood by research participants especially among females. As noted in this study female research participants tried to interpret abstinence in relation to religious and cultural construction of virginity. Sarah Mochenu, for example, saw abstinence as a sure way of aiding her to preserve her virginity. To her, virginity was constructed as a special gift given only to one special person that is bridegroom as contained in religious teaching. As a special gift, virginity loss was; therefore, supposed to take place only in marriage.

> ..... *when I will get married I want my husband to know he is the first man to have sex with me. By this he will respect and love me most. I don't want a situation where after engaging with him for many years he finds that there is nothing special with me (not a virgin). Even the bible clearly demonstrates that a woman who is a virgin until marriage is respected and blessed. Take the case of Mary the mother of Jesus. For me to preserve my virginity I must abstain from sex.*

Nyanchera, 20 year-old school leaver also saw abstinence as important in preserving her virginity. Unlike Sarah Mochenu, she construed virginity from the cultural perspective. In this case, she wanted to preserve her virginity so that she would easily find a man to marry her when the time comes. To her, many men are not willing to marry a woman who is perceived promiscuous. Further, Nyanchera saw her preservation of virginity as away of preserving her future husband identity and thus subsequently securing her marriage.

Nyanchera construction of virginity was borne from cultural construction of gender and sexuality. That is a woman potential as a marriage partner depended on how she practiced her

sex life. A woman who was perceived as promiscuous was not regarded as a potential marriage partner. This potentiality was determined by whether she was a virgin or not.

Similarly, females were socialized to understand that the dignity and identity of their partners depended on how they practiced their sexuality before marriage. Those who were perceived as promiscuous were more likely to injure the dignity and identity of their potential partners through what Silberschmidt (1999) calls honour of shame. That is, a man's reputation is severely injured when he marries a woman who is considered to be sexually promiscuous.

As noted from above it is clear that the interpretation of abstinence as preservation of virginity was greatly influenced by cultural and religious construction of virginity rather than HIV/AIDS prevention. Further, this construction was made to suit the patriarchal understanding of sexuality; that is, female sexuality was only constructed to meet male folks' sexual preferences or needs. This underscores females' powerlessness in issues of sexuality especially on ABC approach to HIV/AIDS prevention.

Among female research participants, abstinence as preservation of virginity was also constructed as a precondition for future social and economic success. In this case, engagement in premarital sex was an indication of failure as explained by Rosemary:

> *My mother always reminds me that I should avoid sleeping with men if I want to finish school and get a good job. Every time I go out maybe to a market place she reminds me of this. So, I have come to internalize that if I have sex before marriage I won't make it in life.*

Interpretation of abstinence as preservation of virginity was; however, regarded as difficult and unrealistic among male research participants. This perception was influenced by cultural construction of sexuality that limits pre-marital chastity to females. Among male research participants, for example, there was common belief that as men, they must engage in sex as a way of demonstrating their manliness. Also most males believed that accumulation of too much semen was unhealthy especially after one has been circumcised. Consequently, some male research participants understood abstinence as strategy only applicable to females.

The religious and traditional framework of understanding abstinence in this study was found to generate some *oppositional reading* (Hall, 1996) among research participants who did not subscribe to religious or cultural notions of morality. As found out research participants

interpreted the promotion of abstinence as an attempt to control their sexual behaviour and deny them their sexual pleasure. This oppositional reading was established to emanate from the common perception among research participants that abstinence strategy was externally motivated. As Onchiri explains, many young people reject abstinence simply because they perceive it as something imposed on them.

> *You see my friends some people who think they have monopoly over young people have gone ahead to decide on how to manage our life. From telling us not to seek political leadership for we are future leaders, now they have unashamedly gone ahead to decide for us on how to practice our sexuality. Everywhere and every time they keep on telling us, "young man, young woman and young what! Do not engage in sex; abstain as sex is for the future and old people." Yet they forget sex is a private issue and we have freedom to decide what to do with our life!*

From Onchiri's explanation, it is clear that young people perceive abstinence messages as not serving their own interests but for those whom it advocates. This perception can be attributed to the top-bottom approach adopted by most social communication on HIV/AIDS issues as argued in chapter six. Therefore, oppositional interpretation of abstinence can; therefore, be seen as a form of resistance to the manner abstinence messages were communicated (top-bottom approach) which created the perception that they were being "enforced" by external force on young people. This resistance can also been seen as a struggle over the control of sexuality with young people perceiving those who advocate abstinence as attempting to usurp individuals' responsibilities over their own sexuality.

Abstinence as sexual abnormality

Many research participants who were sexually active were found to interpret abstinence in relation to socio-cultural functions of sex. These socio-cultural functions included but not limited to social status, security and identity. Among male research participants, for example, indulging in sex was perceived as an indicator of adulthood and manliness. Therefore, those who were abstaining from sex were regarded as children "*abana*" and "*womanize*" (that is not manly). These labelling were seen as demeaning and injurious to any male social status and identity in society especially after one has undergone circumcision rites. Consequently, as 25 year Ondigi explains that after undergoing circumcision rites, he was despised and seen as "sexually abnormal" among his peers for not engaging in sex.

> *Few months after seclusion period many of my peers started despising me whenever I told them I had not "slept" with any girl. Whenever we were*

discussing anything my opinion was not taken serious simply because to them I was still a child. Some of my peers even went further to question if indeed I was functional sexually after circumcision. Worse still even girls started telling me into my face I was infertile "riteba" and other men would help sire me children. I had to do something to save my status and identity by having sex with a girl who was my classmate.

The interpretation of abstinence as sexual abnormality was found to arise from the premium accorded to sexual act in marital relationship. In this case, many male research participants believed that their identity and dignity as men depended primarily on how well they sexually satisfied their partners. Therefore, premarital sex was seen as a necessary step for acquiring needed sexual skills and experience in marital union. In this regard, abstinence was seen as antithesis to male identity as Samson explains:

You know very well that practice makes perfect. So how will you manage your wife sexually if you do not have adequate experience! You cannot get this experience from books or school, you must do it (sex) yourself with many girls before you get married. It is hand on experience full stop. This thing you said called abstinence will just bring you more problems with your future wife. You will not have experience on how to satisfy your wife.....and your wife will start looking for other men to satisfy her sexually.

Samson sentiments are similar to Silberschmidt (1999) findings that the dignity of men among Abagusii depends on women's sexual conduct. In this case, male reputation and identity is greatly injured when he fails to prevent his wife from seeking sexual satisfaction from other men. This thinking can also be argued to come from male socialisation during circumcision rites. At this rite, more so during the seclusion period, young male initiates were socialized to internalize that their success as really men and marital relationship depended on their sexual prowess as discussed in chapter three.

Some male research participants believed that abstinence was only applicable to females. This is because females were believed to be endowed with self-control as compared to males. Therefore, males who abstained from sex were seen to posses more of feminine than masculine features which was regarded as abnormal as Ondigi explains:

It is difficult for a normal man to stay without having sex. I know women can because of the way God created their body but not us men. So how can you abstain if indeed you are normal!

Ondigi's perspective feed into the socially constructed notion of male and female sexuality that perceives males as having an uncontrollable urge to engage in sex, while women are asexual beings. Studies have found this perspective to be common among young people across the globe (cf. Dowsett and Aggleton, 1999; Hirdi and Jackson, 2001; Sorrell and Raffaelli, 2005).

Among some female research participants also abstinence was interpreted as sexual abnormality because it was believed that it impacted on them negatively especially in future reproduction functions. According to them, premarital sex was important as it ensured that they never developed some abnormality "*ekiona*" which prevents sexual intercourse. Also some believed that abstinence would lead to blocking of birth canal which would eventually lead to complications when one wants to have children. This was illustrated in the following interview.

Researcher: What do you understand by abstinence?

Boke: I know it means not having sex; however, this is abnormal for us young girls.

Researcher: Why say it is abnormal?

Boke: You know women are created differently from men. Our reproduction organs are within our bodies. So as you grow up you must have sex to open them so that they can work properly.

Researcher: What do you mean working properly?

Boke: I hear stories from my friends that women who have never had sex have many problems when giving birth because their organs are blocked. Therefore, when these women give birth for the first time midwives are forced to use animal horns to open up their birth canal which is very painful than when virginity is broken. I also hear that some women have been chased by their husbands because they find it hard to penetrate them sexually.

Interpretation of "Be Faithful"

According to PEPFAR (2005) "Be Faithful" campaign is aimed at encouraging individuals to practice fidelity in marriage and other sexual relationship as a critical way of reducing risk of HIV/AIDS infections. In PEPFAR campaigns, abstinence is encouraged until marriage for unmarried young people. However, HIV/AIDS campaigns spearheaded by other organisations promote "Be Faithful" to all sexually active age categories. These latter campaigns are premised on the fact young people are involved in concurrent sexual practice which is a risk factor to HIV/AIDS infection.

"Be Faithful" messages tend to promote "sticking to one sexual partner" as a way of reducing the risk of HIV/AIDS infection. However, when research participants were asked to state what they understood "Be Faithful" means to their sexual life and in relation to HIV/AIDS, there were myriad interpretations.

"Be Faithful" as sticking to one sexual partner

Interviews with research participants indicated that a number of them interpreted "Be Faithful" to mean practising sexual fidelity. This interpretation corresponded with the connotative meaning of "Be Faithful" as promoted in HIV/AIDS campaigns as indicated by Jared's explanation.

> *With AIDS so rampant nowadays, "Be Faithful" means having sexual intercourse with only one partner. This is the only way to avoid AIDS. It will look hard due to human nature but it is the surest way to deal with AIDS.*

Jared's interpretation of "Be Faithful" was also echoed by Mr. Mabeya who was HIV positive. Although in his case, he argued that "Be Faithful" would make more sense among sexual partners only after HIV/AIDS test.

> *It is important to stick to one sexual partner if you have to avoid getting this disease (AIDS). Like me now if I had followed this simple rule I won't be sick. However, this business of faithfulness must start first with testing whether either sexual partner has AIDS or not. Therefore before you start sticking with one sexual partner know your status. This makes sense or what do you think?*

Jared's and Mabeya's views illustrate the dominant interpretation of "Be Faithful", that is, an interpretation in which meaning has not been altered. For others, however, this dominant interpretation was done in a way that fitted the values and norms governing gender and sexuality. For example, the belief that male have insatiable sexual urge made some male research

participants to interpret "Be Faithful" to mean engaging in sexual relationship with specific women who know each other and accept that they are involved in sexual relationship with a particular man only. In this case, all women in this sexual arrangement are expected to "Be Faithful" to that man only.

> *My wife lives in here (rural area) and I work in the city. My wages cannot allow me to stay with my family there. Also my wife has to take care of my land. I normally come here twice or thrice in a year. As a man I have feelings (meaning sexual feelings) and my wife knows every man has them. To avoid sleeping with prostitutes I decided to stay with one woman who will ensure I don't mess up. My wife and her know each other and they feel secure that this arrangement won't bring AIDS to any of them.....In the city there is a woman who meets my sexual needs and when I come here my wife is there* (30 year-old, Mr. Cosmas)

Cosmos's interpretation of "Be Faithful" shows that it was only women who were expected to "Be Faithful" to their sexual partners. It was also the sole responsibility of women to ensure that their sexual partners were faithful to them by satisfying them sexually. This latter factor was noted to be used by some male research participants to justify their infidelity by arguing that their sexual partners were not meeting their sexual needs.

The centrality of women in determining faithfulness among men can be traced to girls' socialisation during circumcision rites. At seclusion period, for instance, female initiates were trained on how they can be successful women. This success was measured by how well they satisfied their husbands sexually or prevented them from engaging in sexual escapades with other women (Monyenye, 2006).

Among unmarried male participants, "Be Faithful" also meant engaging in sexual relationship with one partner at a time (serial monogamy). Moturi Mangera, for example, explained that due to high prevalence of HIV/AIDS, he preferred to have a sexual relationship with one sexual partner until that time he quits the relationship. To him this arrangement enabled him to monitor his sexual partner to ensure that she did not have any other sexual partner. However, Moturi Mangera conceded that he was free to indulge in new relationships once the present one ceases.

"Be Faithful" as protecting sexual partner

According to some research participant, "Be Faithful" especially among those who were engaged in multiple sexual relationships meant protecting the main sexual partner from HIV/AIDS or

being considerate. Tom Masagiro, for example, had the following to say when he was asked to explain what the slogan "Be Faithful" means:

> *You can be faithful to yourself and to your main sexual partner by taking care whenever you have sex with someone else. What I mean is if you have sex with someone you don't trust ensure you use a condom. This way you are protecting your main partner and I think this is being faithful.*

Using Tom Masagiro account it is clear that the slogan "Be Faithful" was conceptualized in terms of caring for the main sexual partner by practicing safe sex. In this understanding, concurrent sexual partnership was permissible as long as one undertook steps to ensure that one's main sexual partners were protected from infection by using condoms with other sexual partners. In this case, cheating on the sexual partner was considered in terms of putting life of sexual partner at risk by engaging in unprotected sex, hence one could still "Be Faithful" while having more than one sexual partner.

Tom Masagiro interpretation reflects the negotiated meaning of "Be Faithful" which was found to be common among young people who were involved in concurrent multiple relationships. This interpretation was noted to rationalize their sexual behaviour for they saw themselves as being outside the category of those who were expected to practice fidelity.

The interpretation of "Be Faithful" as protecting of sexual partners was found to be influenced by gender and marital status of research participants. Among married female participants: for example, protecting of sexual partner was more influenced by supernatural retribution associated with marital infidelity than HIV/AIDS infections. According to Monyenye (2006) and Siberschmidt (1999), Abagusii believed that adulterous behaviour of married woman can cause death or harm to her husband or any family member through supernatural retribution called *amasangia*. Consequently, some female research participants avoided marital infidelity as a way of protecting their immediate family from harm. Mary Bonchaberi explains:

> *It is not worth to have sex outside marriage. You see the repercussions of such action are grave. Take for example you sleep with this man and your child or husband falls sick what will happen if you go near them? Definitely they can die or their illness becomes worse because of amasangia. As married woman it is important to protect your family by avoiding sleeping with other men other than your husband.*

However, among male and unmarried female research participants, protecting a sexual partner was more do with image maintaining like being seen as caring and not immoral in the eyes of the sexual partner. This maintaining of the image was solely meant to protect the main sexual partner from being hurt emotionally. John Nyabs and Beatrice Law, for example, argued that they perceived themselves to "Be Faithful" as long as their main sexual partners did not know of their sexual relations with other partners.

> *As a man you should show good example to your wife. You see if your wife comes to know you are sleeping with other women she may decide to do the same. It is a fact I have other extra curricula activities (meaning sexual relations with other women) but I have done everything possible to keep it away from my wife. This way I am faithful to her as long as she does not know of my affairs* (28 year, John Nyabs).

> *I think you may have a different perception about me but let me be frank. At the moment I am involved with two married men sexually. However, I consider myself faithful to my boyfriend because he is not aware of these other relationships* (Beatrice Law, 23 year old university student).

"Be Faithful" as commitment

According to many research participants, "Be Faithful" was interpreted to mean commitment to either a marital relationship, or one that leads to marriage. Lucy Keumbu gave the following answer when she was asked what "Be Faithful" means to her:

> *"Be Faithful" to me means having sex with one sexual partner for a life time. This means that once you are married you will dedicate all your sex life to your husband only.*

Lucy Keumbu's interpretation was echoed by Kwamboka who said that she intended to be faithful once she got married.

> *Once I get married I will be faithful to my husband. This is because this is the only way marriage can be successful.*

Lucy Keumbu's and Kwamboka's interpretation of "Be Faithful" was noted to be influenced by religious and cultural beliefs governing sexual relationship. In Christian religious beliefs, for instance, "Be Faithful" to a marriage partner was taken as a precondition for a successful relationship and marital infidelity was greatly sanctioned. Culturally, marital fidelity was also emphasized among married couples only. Among the Abagusii, Shadle (2006) and Siberschmidt (1999) note that premarital promiscuity was not sanctioned as long as it did not lead to premarital

pregnancy. However, after marriage, marital infidelity was sanctioned especially among females through supernatural retribution "*amasangia*".

The significance of Lucy Keumbu's and Kwamboka's views is that "Be Faithful" message was mainly seen to appeal only to those who were married or in a serious sexual relationship which would culminate to marriage. Consequently, research participants who were not married or in serious sexual relationships considered "Be Faithful" message not applicable to them, as a 26 year-old Mr. Chuma demonstrates:

> *It funny when you hear some people telling you to be faithful! How on earth can you be faithful when you have not found the person to marry? Is it really possible to be faithful to yourself only?*

Other research participants like a 25 year-old Sabina saw "Be Faithful" not only to mean practising fidelity but to include aspects of a strong committed sexual relationship such as love, maturity and respect.

> *I think to be faithful means having total commitment in a relationship. Showing love and respect to the other person. And most important being mature that is not dogging your partner everywhere like small kids.*

Sabina's interpretation of "Be Faithful" as commitment in a strong sexual relationship was found to be similar among those research participants who were sexually active and those who were abstaining for religious and cultural reasons. In this case, whereas those research participants who were abstaining from sex for traditional and cultural reasons drew their interpretation from their belief system; interpretation for sexually active ones was mainly from the meaning attached to their sexualities. Therefore, the interpretation of "Be Faithful" as commitment to serious relationship seemed to exclude those who were engaging in sex for fun and friendship.

Some research participants also interpreted the meaning of "Be Faithful" to include concepts such as trust and being open to each other. According to this interpretation, "faithfulness" was only achieved through trusting one's sexual partner and assuring them of your trust, while for others it included sharing of private secrets.

> *To "Be Faithful" to someone means you must trust that person and that person must trust you. You must not also hide anything from each other* (Kwamboka).

The interpretation of "Be Faithful" in relation to trust was, however, found to take a gender dimension. Among male research participants, trust meant having sex with sexual partner

without any preconditions like using a condom. Also it entailed not abstaining from sex among sexual partners. This is captured by Mr. Chuma's sentiments:

> *Your sexual partner cannot claim to trust you if she is not willing to have sex with you. If she really trusts you why not have sex? Another thing I can say about trust is that if someone trusts and loves you she can't tell you to use a condom. Condoms are meant for those people who don't trust each other.*

However, among females, trust meant more than having sex or not using condoms. It meant to be frank, open, loving and sharing of secrets as explained by a 20 year-old Kerubo.

> *If someone says he trusts me, that person must be willing to understanding my views and respect them. For example, when I tell him I don't want sex he must understand and wait. Also, he should not hide anything from me like his past love affairs, family background and many others.*

"Be Faithful" as religious and cultural practice

Among research participants especially females, "Be Faithful" was interpreted in religious and cultural beliefs. Those who subscribed to Christian teaching interpreted "Be Faithful" as sticking to only one man as ones husband until death. In this case, monogamous sexual relationship was emphasized and an extra marital affair was seen as a punishable sin. A 26 year-old Motorekwa explained what she understood by being faithful:

> *As a practicing Christian and who is saved, to be faithful just means loving your husband only. You should not engage in adultery. The bible forbids this.*

Among unmarried female, "Be Faithful" meant not engaging in premarital sex (not indulging in fornication).Unlike married females who saw faithfulness in relation to sticking to their married man, unmarried females saw it in terms of living to church guiding principles on sexuality. For example, 20 year Linet believed her body symbolized the holy Christian church. Therefore, to "Be Faithful" meant keeping her body holy by not indulging in sex until she is married as Jesus Christ thought.

> *When you are not married, you should maintain your body holy by not indulging in sex. You should dedicate all your body to the church. The church should be like your husband until you find your God given husband. This is when you can proclaim that you are faithful.*

Those research participants who subscribed to cultural interpretation saw "Be Faithful" in two dimensions. First to "Be Faithful" was seen as a requirement of being a good wife. In this case

"Be Faithful" was rearticulated to encompass traditional attributes of "a good wife" like consulting her husband before making any decision; showing respect, being loyal, not flirting and meeting the husband's emotional needs satisfactorily. This was captured by Bonareri when she was asked what "Be Faithful" meant to her.

> *To be faithful means respecting your husband by not sleeping with other men. This way, you are a good wife. Also since he is the head of the family you must always follow his decisions and ask for his guidance in anything you are doing.*

Second, interpretation of "Be Faithful" was also done in relation to the impact of women sexuality on men's dignity and identity. As noted, some female participants saw being faithful as the most important avenue of not injuring the reputation of their husbands in the eyes of community members. As Janet explained; for example, her being faithful was solely driven by the shame her husband would bear in front of other men if she slept with other men. To Janet also being unfaithful was an indicator that the husband was either not meeting sexual or material needs of the wife like food or clothing.

> *Come to think of it that everywhere your husband goes people point to him that he is unable to control his wife. How will you feel as a wife? So it is better to persevere by sticking with him.*

The significance of Bonareri's and Janet's cultural interpretation of "Be Faithful" is that it tended to make faithfulness as a sole responsibility of women. Worse still, it was practiced not for the benefit of women themselves but their men only. This explained why women and men got a different treatment whenever they were found to be unfaithful. For example, women were harshly treated in cases of unfaithfulness while men's cases were rationalized as normal and manly and even earned them repute. Consequently, "Be Faithful" messages in relation to HIV/AIDS prevention were perceived not relevant to most male participants. For example, when research participants were asked if "Be Faithful" message had any relevance to them; thirty females in comparison to only six males answered in affirmative.

The cultural interpretation of "Be Faithful" was found in this study to enhance women marginalization and stigma in relation to HIV/AIDS. For example, it was found that whenever a man died of HIV/AIDS, the widow was blamed for his infection and death. This was clearly captured by a 24 year-old Lizy:

> ..... *I had known no any man in my life until I met him. At first, I feared having a relationship with him but he told me he has never had any love relationship with*

any woman. I was happy to have met a man who was a virgin like me. He told he had a lot of love to me. Since I thought he was a virgin, I saw no need to have protected sex with him from day one... He introduced me to his people. After "pushing" with him for about six months I came to realize I was not the only one he was seeing...when I confronted him about this he beat me.... I remained faithful to him and moved to his house in town. While staying with him he started becoming frequently sick. When he was tested, he was found to have AIDS....His health continued deteriorating and I continued taking care of him... washing him like a baby. When he died I was accused by his relatives that I am a whore who infected their son with AIDS... was chased like a dog....going to my home all my sibling did not want to see me as I have caused them disgrace..... had nowhere to go but to move to a far town to eke a living as a hawker....

Lizy's sentiment fits well with Barnett's *et al.* (1992) observation in Uganda that women are generally blamed for the spread of HIV/AIDS. As such they are viewed generally as "pollutants" to men who have sex with them. Also, women are blamed as "contaminated vessels bearing condemned babies" when they give birth to a child with HIV (Basset and Mhloyi (1991:146).

"Be Faithful" as sexual abnormality

According to many male participants, "Be Faithful" was interpreted as sexual abnormality and hard to practise. This interpretation was noted to arise from cultural construction of male sexuality and perceived attendant functions associated with concurrency sexual relationship. For example, most male participants considered having more sexual partners as a symbol of success. This success was equated to the ability to manage and control women. Therefore, men who were faithful to their sexual partners were seen as unsuccessful and controlled by their partners' attributes which were considered not manly and thus abnormal.

As a man one thing which separates you with women is your ability to deal with many of them at one go. This demonstrates your capability and management in other social issues like leadership. Take for instance, very old men who besides their wives have many young female lovers. Most of them are rich. Even young people who are celebrities have many lovers. This is unlike men who are very faithful to their sexual partners. To me I think there is a correlation between many sexual partners and success in men (Onchiri sentiment on "Be Faithful").

My friend if you want to know a man who is controlled by a woman you need not look further. Just observe whether that man has any woman apart from the main sexual partner (25 year-old Mr. Atika).

Onchiri and Atika sentiments seem to draw from social construction of polygamy among Abagusii. According to Shadle (2006); Nyamongo (1998) and Akama (2006c) among Abagusii

polygamy was seen as symbol of social status and leadership. However, due to social and economic changes which have bedevilled the community like economic hardship, reduction of land acreage and influence of modernity, polygamy has been rendered unattractive. Despite this, the values accrued from polygamy continue to be upheld by many men. As a consequence men nowadays prefer to engage in concurrent sexual partnership which is seen as an alternate to polygamy. In this regard, "Be Faithful" messages were perceived to advocate monogamous sexual relationship which was contrary to perceived benefits associated with concurrent sexual partnership and thus seen as abnormal.

Other participants saw concurrent sexual partnership as "opportunity of sampling variety" which "Be Faithful" does not accord. When asked what "Be Faithful" means to him; Moi who is married, said that "Be Faithful" denied him an opportunity to have sexual experience and fun with different sexual partners. To him, having sex with one sexual partner was like eating one type of food every time which is both boring and monotonous.

> *If you eat sukumawiki (kales) from Monday to Monday you will definitely be bored. You won't even have appetite for it. This is the same when you have sex with one woman every time. To be successful in your sexual life you need some spare part somewhere to replenish you.... this way your sexual partner will not only benefit from renewed energy but experience accrued from your spare part.*

However, among unmarried female participants, "Be Faithful" was interpreted as an obstacle to access material wealth or meeting basic needs from males. According to Beatrice Law, the willingness to have more sexual partners was motivated by the desire to get money to meet her basic needs like good clothes. The desire to access and satisfy these needs was noted to overshadow the risk associated with unfaithfulness:

> *As a female student it is extremely hard to meet all womanly needs. My parents can try to but they won't meet all my needs. Yes I do have a fellow student as my lover but equally he won't meet all my needs. So I have a sugar dad who is very rich and very generous. He meets all my needs as long as I am there to meet his sexual needs. As you know our "thing" (referring to female sexual organ) does not get finished like soap, so it is the resource for us to make us comfortable. So, if you can't use it then I think you must be crazy!*

The interpretation of "Be Faithful" as abnormal sexual practice among men was also found to be due to oppositional interpretation of cultural and religious role of men in reproduction. According to this interpretation, many male participants perceived as their God given duty to

assist Him in filling the world with mankind. In this regard, they justified their being unfaithful by selectively arguing that God had commanded Abraham (man) in the bible to go and fill the world and not his house. Consequently, it was ungodly for man not to have many sexual partners in the effort of filling the world. Therefore, "Be Faithful" messages were seen as abnormal in relation to God's ascribed role to men as Mr. Onsarigo explains:

> *I am a Christian and fully believe in the bible. Abraham who is almost the father of every person in this world was asked by God to go and fill the world. Nowhere in the bible had God said "you Abraham go and fill your house with children." This means Abraham had to engage in sexual relationship with other partners other than his wife. So God knew man should not be faithful to his wife if His desire was to be accomplished. So, you see how this advocacy of faithfulness in sexual relation is anti-God!*

Although participants like Mr. Onsarigo were aware of the risk associated with their sexual behaviour, they used oppositional interpretation of "Be Faithful" to rationalize their actions. For example, when Onsarigo was asked if he was aware that his sexual behaviour was putting his main sexual partner at risk of HIV/AIDS infection, he answered in affirmative. However, he justified his action by referring to the division of roles among men and women. As a man, he argued his role was to search and the wife was to keep[95]. Therefore, if by bad luck he was to be infected by HIV/AIDS in the course of his duty (while performing his roles as a man), the wife was also expected to play her role as "*omokungu*", that is, accepting the outcome of his action and taking care of it.

Other male participants justified their risk sexual behaviour (unfaithfulness) by referring to masculinity discourses as elucidated in circumcision songs. Doggy Mac, a university graduate, argued that once one has undergone circumcision, he must be brave and ready to take risks. This braveness and taking of risks was best demonstrated by indulging in sex with many sexual partners. In this context faithfulness to one sexual partner was seen as cowardice and unmanly.

> *As a man you must be brave. That is why immediately after circumcision the circumciser sang for you that "He, who doesn't believe, let him come and witness; Witness the bright one, emerging from its hiding hole." You see now, as a man you should not fear anything that comes from women sexual organs since your penis has been sharpened.*

[95] Among Abagusii a man is referred to as "*Omosacha*" which literally translates as one who looks or searches for food and wealth for the family. A woman is also referred as "*Omokungu*" which means one who keeps or takes care of what the man brings back from his searches. The reference of man and woman among Abagusii therefore denotes their ascribed roles in division of labour.

Interpretation of Condomise (use of condoms)

Promotion of the use of condoms as prevention strategy remains one of the most used strategy in the fight against HIV/AIDS (except among religious and moral inclined organisations like PEPFAR). In Kenya, for example, safer sex is construed to mean condoms use in every sexual intercourse. Consequently, the government has taken every effort to improve both the accessibility and availability of condoms to all those who are sexually active (MoH, 2001b). To achieve this goal, the government has; first, made arrangement with International development partners to get free supply of condoms, second, it has ensured that all imported condoms are given waivers for customs and exercise duty so that they be commercially available at reduced cost, and three engaging social marketing campaigns which is aimed at increasing condoms acceptability and usage.

Despite all these efforts, there is still low condoms use which is also characterized by incorrect and inconsistent usage among sexually active people. For example, in this study data majority of the youths indicated that they do not use condoms during sexual intercourse. This finding raises doubt on the effectiveness of overlying on this strategy only in the fight against HIV/AIDS. Due to this, this study sought to understand how youths interpreted Condomise messages in relation to HIV/AIDS prevention. Research findings, however, showed that there was no clear separation between the social construction of Condomise messages, that is, the socially constructed norms and meanings regarding condom use and how young people interacted with Condomise messages.

Condom use as HIV/AIDS prevention

Among sexually active participants, Condomise messages were interpreted to mean consistent condom use to prevent HIV/AIDS infection. This interpretation reflects the connotative meaning that is underlined in the ABC strategy.

> *We are all at risk of dying from AIDS. There is no way with your naked eyes you can tell who is infected. So for me, consistent condom use is the only sure way to avoid being infected by this killer disease* (25 year-old, Oncharo).

Similarly, Jamal interpreted Condomise message as the first rule in HIV/AIDS prevention. To him, consistent condom use is the surest way of avoiding being infected by HIV/AIDS and re-infection for those who are already infected. He explained:

There is no way the war against AIDS can be won without people being educated that they must consistently use condoms. This the first rule. Even if you trust your partner, you must still use condoms until you know each other status. For those of us who are already infected it is equally important to consistently use condoms even if the other partner is also infected.

Nancy, a 20 year-old female who was living positively also interpreted Condomise messages to mean consistent condoms use among people who were already infected. This is in spite of misconception that those people who were already infected could have unprotected sex with those of same status.

It is extremely important for those who are already infected to consistently use condoms even with their partners of the same status. Take my case for instance, when I discovered my status I was so much distressed to the extent of losing interest in sex. This was particularly when my CD4 count was too low. After taking medicine from hospital, my health improved and was living positively with my status. As my health improved, I started having sexual feelings. So, I decided to befriend another man who was also positive. After dating for few days we started having unprotected sex since we were already infected. My brother this act of having unprotected sex suddenly lead to deterioration of my health despite adhering my treatment schedule. When I went to hospital I was told that the man infected be with another type of AIDS which was not responding to the treatment I was under in.

Nancy's interpretation of Condomise message was more to do with her personal experience. This is because as established in this study most Condomise messages in HIV/AIDS prevention campaigns were intended for people who were not infected. As a result Condomise messages excluded those people who were infected. This exclusion created the perception among those who were already infected that they can have unprotected sex with people of the same status.

Despite interpretation of Condomise messages emphasized consistent condom use, among some participants this emphasis had varied meanings in day to day life experience. For example, some male participants interpreted consistent condom use to mean consistent condom use after having unprotected sex with a new sexual partner. In this case consistent condom use was only applicable after having unprotected sex with sexual partner as 20 year old Nyakundi explained:

Yes it is important to consistently use condoms in every sexual encounter. This will definitely protect you from AIDS. However, this practice can only be practical with someone you have already had unprotected sex with.

Nyakundi's interpretation of consistent condom use was established to do more with the perceived role of male sperms in new sexual relationships. As noted among male participants, sperms were constructed to play a major role in cementing and fortifying new sexual relationship. This role was important as it determined the success of such relationship. As noted from Nyakundi, when a man ejaculates into a woman, the sperms go straight into the woman's blood where they mix with. This mix makes the woman to be more loving and caring to the man.

> *You can consistently use condoms with someone you have already had sex with. Before this it is all use useless. I say so because if for the first time you use condoms with new sexual partner that relationship will not go anywhere. That woman will not have any feelings for you. ... You see when your sperms mixes with her blood they make her body to have some good feelings for you. So before you talk about consistent condom use you must first ensure you create a foundation for the relationship.*

Among female participants consistent condom use was interpreted in relation to the construction of ideal sexual relationship. This construction of ideal relationship entailed love and trust as integral components. Consequently, some female participants would engage in unprotected sex with their new partner as a way of proving their love and trust which was important in ideal sexual relationship as a 20 years-old Faith explained:

> *If you ask your boyfriend to use condoms in the first time he will say you don't love or trust him. This way he will just abandon you and maybe he was the one to marry you. So it is better to have unprotected sex for the first time and maybe after one or three encounters you can ask him to use condoms.*

It is evident from Faith's explanation that females seemed to be more concerned with what males wanted and expected. They seldom talked about their own expectations and desires. The use of conditional "*if*" by Faith suggests that males' declaration of love is conditional and would demand anything to please him including having unprotected sex.

Interestingly, female participants saw their interpretation of consistent condom use in relation to ideal sexual relations as a more practical way of protecting themselves from HIV/AIDS. This is because as Faith argued, in an ideal sexual relationship which was characterized by love and trust from the start, there was a high likelihood of reduced sexual risk among partners.

> *If it is true that AIDS is gotten from sex then it is important to use the same sex to prevent it. You see men stray because their partners never showed them love and trust from the start of the relationship by mostly demanding that they must use condoms. So, if you have unprotected sex in the first time of your relationship,*

your partner will feel more loved and trusted. This love and trust will make him not to engage in other relationships. Also it will be easy for you to ask him to start using condoms in subsequent encounters for he won't feel offended.

Condom use as the last option

Among some research participants, condom use was understood as HIV/AIDS prevention strategy that should be used when Abstinence and "Be Faithful" options can't work. According to Sarah Mochenu, Condomise messages means that if you have no option, then one should use a condom. This view appears to rank Condomising as the last in the chain of HIV/AIDS prevention.

In HIV/AIDS prevention campaigns it clearly stated that if you can't abstain then be faithful. If again you can't be faithful then use a condom. So to me, condoms are the last option for those who do not have any other alternative.

Sarah Mochenu perspective underlies some of the ABC and VCT campaigns like those funded by PEPFAR. According to PEPFAR funded campaigns present Abstain only until marriage and sometimes "Be Faithful" to the youths as the only effective ways of preventing HIV/AIDS infection. Condoms are presented as "prevention other" and their failure rates as HIV/AIDS prevention options are highlighted instead of their effectiveness.

The interpretation of condom use as the last option was found to be influenced by various sources. In campaigns sponsored by secular organisations, condoms were ranked as the last option to HIV/AIDS prevention. Similarly, in campaigns spearheaded by non-secular organisations, condom use was highlighted as the last option. In this case therefore this interpretation of Condomise can be seen as both dominant and negotiated interpretation depending on the source from which the participant obtained information about HIV/AIDS prevention.

Male participants' interpretation of condom use as the last option was also established to be influenced by male's social status and identity in the eyes of sexual partner and peers. Among Abagusii the reputation of men and identity depended on their prowess in sexual activity (Levine, 1959). This prowess was not only indicated by how many times he would perform coitus with sexual partner but also resilience to have sex with any female who is in need of it. In the latter, it was considered unmanly for either a man to refuse to have sexual intercourse with a woman who wanted to have sex, or who has given consent to sexual relationship. In light of this,

some male participants used condoms as the last option when the social cost of not having sex with a willing sexual partner was more compared to perceived cost of having unprotected sex. This was clearly captured by Mr. Ondigi in the following interview:

Researcher: What do condoms mean to you?

Ondigi: Condoms eeeh! (Laughs a bit). These are things as a man you use when you have no any other way out.

Researcher: What exactly do you mean?

Ondigi: I do not understand why you as a man you are not getting this simple thing. You see there are situations where a woman has consented to sex and at the same time you realize to do so you are more likely to face more negative consequences..... As a man to fail to have sex with a willing woman is out of question for it is not manly..... You will be like a social misfit in the eyes of other men. So as a man you can resort to condoms given that *Eye koroma ngete egosererwa* (You use a stick to remove that which has potential of biting).

As evidenced from above interview, the interpretation of condoms as the last option was more influenced by the social cost of not having sex among males. This means that males were only willing to use condoms solely to protect their social status and identity and not for preventing HIV/AIDS. This was made clear by Mr. Ondigi used the metaphor "*Eye koroma ngete egosererwa*" (You use a stick to remove that which has potential of biting). In this case condoms were perceived as last option of dealing with a situation which had potential of injuring males' social status and identity as a result of not having sex with a willing female partner.

The interpretation of condom use as the last option among female participants was: however, found to be influenced by the economic cost of having unprotected sex in particular situations. Mary Kali who saw herself as a trader and men's helper[96] indicated that she used condoms as last option in situations where in her own assessment, having unprotected sex with her male client posed risk to her trade. This assessment was; however, not based on medical reports but physical assessment like whether the client looked health.

[96] Since prostitution or commercial sex is tabooed among Abagusii, most women who were commercial sex or prostitutes referred to themselves as traders or people who help men emotionally.

> *As a trader you must protect your business at all costs from any risk. So, there are situations where you strongly feel that although this person is willing to pay you very well, he may make you lose big afterwards. Take this case for example. One day the business was very low. At around to 2a.m. some man approached me. He wanted me to spend a night with him. Since I had not made any money that night I obliged. When we reached his room, I carefully examined his body and felt that he was not healthy. So I told him he must use a condom. The man won't believe that since he had paid me very well I will insist on a condom. So he continued tempting me with more money, but I stuck with my decision. I was willing to forgo the money but protect my source of livelihood.*

As evidenced, Mary Kali's interpretation of condoms as last option was more influenced by the negative cost of having unprotected sex to her trade. In this case, condoms were not basically seen in terms of protecting one's health but their source of livelihood. This means individuals would only use condoms as the last option when their livelihood is threatened.

Similarly, Beatrice Law indicated that she only used condoms as the last option when the consequences of unprotected sex were obvious.

> *If you love someone you cannot use condoms in every sexual act. Therefore I only use condoms when it's very clear that failure to use them will make me conceive. This happens when my lover wants to have sex and I am in my bad days. Since I cannot refuse him to have sex with me, we use a condom as the last option.*

Condoms use as lack of trust

Majority of research participants associated condom use to lack of trust among sexual partners. This was indicated by the use of the metaphor "*Jino moja muswaki ni wa nini?*" (Why need a tooth brush when you have only one tooth?), by majority of participants when asked what they understood with Condomise messages. Onsarigo, a teacher by profession, argued that he only used condoms with someone he didn't trust.

> *Yeah I can't rule out condom use in my case. However, what I am certain of is that I can't use it for someone I trust like my wife. I think even my wife cannot allow me to use a condom with her. So this means condom use is strictly restricted to those whom I do not trust.*

Similar view was shared by Kwamboka who indicated that she would only condomise when she has lost trust in her sexual partner:

> *You see in a relationship build on trust you cannot use condoms. However, if I start hearing stories that my lover is sleeping with so and so, then I will ask him to use condoms.*

Onsarigo and Kwamboka sentiments are consistent with the findings of Hearst and Chen (2004), Parker *et al.* (2004) and Preston-Whyte (1999) which established that condom use was socially understood as an indicator of lack of trust between sexual partners. As established further in this study, this social construction was fortified by three but interrelated factors: first, in Kenya condoms are promoted as effective means of preventing sexually transmitted infection including HIV/AIDS. The promotion of condoms from a disease prevention framework has imposed bad reputation on condoms. Citing the example of the advertisement "*Men can make a difference*" as promoted by the Ministry of Health and other organisations campaigning against HIV/AIDS, the Head of Bonchari Constituency AIDS Control Committee noted that men are advised to be honest and monogamous in their sexual encounters to prevent HIV/AIDS. Condoms are only advised when men establish other sexual relationships outside their regular relationship.

To add on that, in public health education messages on HIV/AIDS prevention in mass media, condoms are introduced in the context of promiscuous sexual relationship to prevent HIV/AIDS. This is contrary to Christian religious teachings which emphasize monogamous sexual relationship. Therefore, in religious contexts, condoms are seen as embodiment of immorality which is antithesis of trust as Irene Moraa Observed:

> *God's teachings on morals are clear. You must trust your sexual partner only. Therefore when you start using condoms it is clear you do not trust your partner.*

Furthermore, because HIV/AIDS is transmitted mainly through sexual intercourse, it provides scope for moralization. Culturally, among Abagusii, all sexually transmitted infections have been stigmatized because they symbolize social disorder and moral decadence. Consequently, HIV/AIDS is experienced as a shameful disease. This construction, thus, attaches stigma to the disease and produces the dominant view that HIV/AIDS is a disease for immoral, promiscuous and irresponsible people. Therefore, the promotion of condom use as a strategy of preventing HIV/AIDS makes condoms acquire the cultural signification of HIV/AIDS. This was clearly captured by Samson sentiments:

> *You do not need an umbrella to protect yourself from rain in dry season. So why do you need a condom if you have nothing to do with AIDS. So it is an open secret when you see someone carrying condoms here and there it shows that he must be having AIDS or having sexual relations with people who are immoral, promiscuous and irresponsible like prostitutes.*

Although research participants constructed condom use to lack of trust, this study; however, established that there were varied interpretations of what trust meant. Among some research participants, trust was viewed in terms of their sexual partner not "cheating on them". Within this perspective, a sexual encounter would begin with the position of "trust" which implied that there was no need to use a condom. Condoms use would only be initiated when that "trust" is lost, as Rosemary explains:

> *At the beginning of a relationship, it is very difficult to ask your sexual partner to use condoms. It will send wrong signals like you do not trust him. However, with time if you discover he has other women, then the trust ends. At this point you must ask him to use condoms.*

For other participants, "trust" was conceptualized in terms of commitment towards a long term relationship or marriage. In this case trust was associated with strong bonding based on the perception that the relationship was not just casual or short term. As established from research findings participants who subscribed to this interpretation would often use condoms in the first few instances, but once they are convinced that their partner was serious or committed to the relationship they would develop trust and thus stop using condoms. This was captured by Linet's explanation when asked what she understood trust to mean in sexual relationships:

> *You can't just allow a man to have unprotected sex with you when you first start a relationship. Some men are only out to have fun and nothing more. For me it is a must that when I give consent to sex in first occasions, he must use a condom. This will accord me an opportunity to know him better. If with time I realize he is good, loving and serious we can stop using condoms.*

The interpretation of trust by Linet was further established not to be based on knowledge of the partner's HIV/AIDS status. Instead it was based on mere perception of the partner's commitment to the relationship.

As established in this study, the interpretation of condom use as lack of trust was a major factor that hindered condom use among research participants. For example, fear of loss of face and family put many research participants into a lot of pressure not to use condoms. A 27 year-old Mr. Ochomba who was HIV positive feared using condoms with his wife because that will disclose his HIV positive-status:

> *I know my HIV status but how do I start using condoms with my wife without raising suspicion? This is the question which keeps confronting me every time I want to use condoms. You see if I attempt to use condoms she will either think*

that I see her as a prostitute or worse I will be betraying myself as that I am sick. All these will make her not have any passion to me.

Ochomba's account supports Nelson's (1993) and Cohen's (1991) findings that unsafe sex is sometimes used in search for the enhancement of trust particularly in long standing sexual relationships. This is because condom use is identified as denoting mistrust of either man or woman. In this case, condoms are perceived to contradict the dominant view that both parties are "clean" and should have uninhibited sex. In a sense, the condom introduces a "social distance" between sexual partners, and puts into question the very basis of the relationship, which is trust.

Similarly, Mr. Nyandika, 24 years, married with two children, feared losing his wife and children if he disclosed his sero-positive status. He, therefore, sought to conceal his status by not using condoms.

Researcher: Don't you think you are risking your wife's life by indulging in unprotected sex since you are positive?

Nyandika: Yes, but you see if I am sick now definitely my wife is also sick. So if I start using condoms she will suspect that I am sick. This will mean her leaving me. So what will I have achieved? Nothing but more stress as I will have none to care about me.

Researcher: What if you were to become sick and she finds out the nature of your illness?

Nyandika: I am aware of this but let her find out by herself or someone else tells her. I don't think I will have the guts to tell her directly.

Despite Nyandika's knowledge that unprotected sex posed potential risk to his wife, his decision not to disclose his sero-status to his wife illustrates the problem of introducing condoms in marriages. Other studies also, though mostly on women, have shown that the introduction of condoms into a relationship carries an implicit admission by the introducing partner of having an affair outside marriage (Nelson, 1993). In Nyandika's case; however, it is the fear of losing his wife's trust which can lead to separation.

Among unmarried research participants also, the demand for safer sex was noted to introduce ideas about risk that could threaten the relationship. For example, Faith who said she had more than five boyfriends purposely for financial assistance had problems in demanding safer sex. This is how she presented her problem of negotiating for condom use:

> *I find it extremely difficult to use condoms even with a new boyfriend. The problem I face is how to introduce the talk..... Sometime I can succeed by cheating that I will get pregnant. But what will I tell him next time we meet again! So I find myself under pressure and have to do without condoms. In some occasions I can demand my boyfriend to use condoms but at the end of it all he accuses me of being immoral and threatens to leave me. So I choose carefully who I go with so that I do not encounter this problems.*

Faith's account illustrates the problems encountered in introducing condoms use. As noted this problem relates to the symbolic meaning of condoms. In this case, the person who introduces the talk of condom use risks being labelled promiscuous or sick. This fits well with "clean/unclean" framework advanced by Waldby *et al.* (1993: 34) whereby the suggestion of condom use open up the sexual history of a person, and threaten images of promiscuous person.

Condom use as ineffective in HIV/AIDS prevention

Condoms use as a strategy for HIV/AIDS prevention was conceptualized by some participants who were sexually active as ineffective. This reasoning was established to be premised on the failure rate of condoms as highlighted by religiously inclined organisations like those sponsored by the Catholic Church and PEPFAR. Accordingly, some participants like Omae: any penetrative sexual engagement was a gamble with life since condoms did not guarantee absolute protection from HIV/AIDS.

> *Scientifically condoms have been proved to have very minute pores. These pores are smaller than the molecules of water. Therefore water cannot pass through them. However, it's proven also HIV/AIDS viruses are even minuter than the pores on the condom. This essentially means that condoms can manage to prevent sperms from entering into the woman reproductive organ but not the AIDS virus.*

Similar view was shared by Sarah Mochenu who indicated that even in advertisements which were meant to encourage condoms use among young people, there was some agreement that use of condoms to prevent HIV/AIDS was not 100% effective.

> *Condom use as a magic bullet for AIDS is a big white lie. As a practicing Christian I hate making non factual allegations. This is why I am telling you this and I ask you to listen carefully to any advertisement promoting condom use. At*

the end of each advertisement people are warned that condoms are not 100% guarantee in protecting AIDS. So what more do people need to be told!

To further demonstrate how ineffective condoms were in preventing HIV/AIDS, a 28 year-old Mr. Nyangau used what he called proven scientific experiment to do so. He explained his experiment as follows:

> *My friend condoms are not at all effective in preventing AIDS. If you want to know, take a condom and pour in urine. Then mark the level of urine in the condom. After that hang it in a cold place for a night. In the morning you will find the level of urine in the condom has gone down. This logically means that the urine passed through the condom. So imagine what happens to something smaller than urine like the AIDS virus. Simple, it will have a field day!*

The construction of condoms as ineffective in preventing HIV/AIDS was found to be more prevalent among male participants. As established in the study; however, this construction had nothing to do with the effectiveness of condoms in HIV/AIDS prevention. Instead the alleged ineffectiveness was used as a reason for not using condoms as most of them believed that sex with a condom was not all sex. Onsarigo explains:

> *As educated person to be fair and honest, condoms are effective in AIDS prevention. Leave out this and that experiments us men do cite to women like ooh! Condoms have big hole, ooh! Condoms are laced with AIDS virus! All these are absolute nonsense. The truth is us men hate condoms with passion especially if you are having sex for the first time with a particular sexual partner. This coz' when you are using a condom it is like you are not having sex with your partner but your partner is only aiding you to funk yourself!*

Apart from using alleged "*scientific*" findings to construct condom use as ineffective in HIV/AIDS prevention, other participants were found to use what I call "*The government condom myth*" to do so. According to this myth, public sector free condoms were perceived as ineffective when compared to commercial brands sold in pharmacies or shops. Oira; for example, described free government condoms like *Sure®*, *Hakikisho®* and *Hot®* as not only smelly and unsafe but infectious when compared to commercial brands like *Trust®*.

> *In more than three occasions I have used government "Sure® condoms" they smell so badly until you lose interest in sex. Also when using them they not only rapture easily but afterwards you get some infection on your penis. This is not the case with condoms like "Trust®" which you buy from shops. So, with this experience, I can confidently say government condoms are ineffective in protecting one from AIDS.*

Oira alleged infectiousness of government condoms can be explained by allergic reaction towards latex condoms as reported among some users (Shur, 2006). Despite this, it was established that the perception that government condoms were of poor quality was firmly engrained among many youths. This perception was further fortified by the government decision to ban the use of *Hot condoms®* due to perceived poor quality[97].

The perception that government condoms were ineffective in preventing HIV/AIDS was; however, found in this study to be reinforced by three factors. Firstly, ideological conflict emerging from promotion of condom use through generic and branding advertisements. Generic advertisements seek to promote condoms use among sexual active people as the most effective strategy of preventing HIV/AIDS. These advertisements are not associated with any particular brand. On the other hand branding advertisements tend to promote particular brands of commercial condoms as being most effective in preventing HIV/AIDS. Therefore, condoms promoted under generic advertisement are casted as less effective. Consequently government free condoms which form bulk of generic advertisements were thus perceived by majority of young people as less effective.

Secondly, the common philosophy that "*nothing good comes easily*" was found to influence common perception among research participants that free condoms were of poor quality and thus ineffective in HIV/AIDS prevention. As established among research participants, price was often regarded as an indicator of quality among competing products. Consequently, majority of research participants perceived free government condoms as of less quality compared to pricey brands.

Thirdly, the perception that government free condoms were ineffective in HIV/AIDS prevention was found to be influenced by symbolic status accorded to them by some research participants. According to this account, government free condoms symbolized lower status as compared to commercial brands. Consequently, government free condoms were associated more with poor people. However, due to high prevalence rate of HIV/AIDS among the poor, it was thus taken

[97] Daily Nation Nairobi: 9th September 2009 "*Hot condoms banned in Kenya*". Although the government through National AIDS Control Council tried to explain that the ban was occasioned by poor handling of a particular consignment of imported *Hot® condoms* during loading process, there was general perception among sexually active people that they were of poor quality.

that government free condoms were ineffective in protecting them from HIV/AIDS as Onsarigo vividly explains:

> *Statistically, poor people form the greatest percentage of those who are infected with or die from AIDS. This is not because the poor don't use condoms. On the contrary, many of them use condoms because they are free and readily available. For example here in our market place you can hardly walk over 100 meters without seeing a box of government free condoms placed somewhere for anyone to pick. This in itself shows that people are using condoms. But the question is; why then do you get many poor people dying or infected with AIDS? The answer then lies with the condoms they are using. If then this is not the case why is that the rich who prefer using commercial brands are not affected the same way as the poor?*

Onsarigo explanation was also supported by Mary Kali who said that she would rather have unprotected sex with sexual partner than Condomise with government free condom. She stated:

> *It is all useless for someone to Condomise with Sure® (government free condom) in the name of preventing AIDS. It doesn't help. Instead of pretending it is worth having unprotected sex for it will always linger in your mind that you had really sex even if you were infected.*

The symbolic status accorded to either government free condoms or commercial brands was also found to influence their use among some research participants. For example, Mr. Omosa indicated that he used either government free condoms or commercial brands depending on the perceived status of female sexual partner. In this case if a female sexual partner was perceived of "high social status" he preferred to use commercial brands so as to be identified with the perceived status. In these circumstances, Omosa indicated that he would rather engage in unprotected sex with female of perceived high social status than use government free condoms. Omosa explains:

> *It is important to Condomise with every sexual partner you are involved in. However, in some circumstances it doesn't work..... You can have a date with a girl who looks extremely good and she is not like this ordinary village girls. In this situation you cannot use Hakikisho® (government free condom) to have sex with her. The girl will not only see you as useless but not serious. To avoid all this embarrassment you better have sex with a condom.*

Similar view was shared by Faith who indicated that she would judge the value and seriousness of their male sexual partner towards the relationship by the type of condom they used.

> *If a man values you and is seriousness, he must sacrifice something for the relationship. So if I give a man a date and agree to use a condom, then the type of condoms he comes with tells me a lot on how he values me. This is so because sex*

is something so intimate and means a lot to you as a person. Therefore, if a man wants to use these free condoms on me, I definitely know he sees me as useless.

Other participants like Sabina used the type of condoms a male sexual partner used to judge his socio-economic status. For example, males who used free government condoms or commercial brands whose cost was perceived as low were taken to be of low socio-economic status as compared to those who used pricey commercial condoms.

A man cannot claim to be of means when he can only afford to have sex with free government condoms.

Condom use as solely male's decision

Among female research participants condom use was a preserve of males only. Therefore, it was only men who will decide when and how to use it. This was evidenced when Kwamboka was asked to state what she understood about Condomise messages. She had this to say:

To me condom use does not make any sense to us women. You have no control over it is use. It is your man to decide if he wants to have sex with or not.

A similar view was shared by Nyaboke, a widow who was infected by her late husband. According to Nyaboke, her late husband was involved in extramarital affairs with many sexual partners. Despite her complaints, he did not change. Therefore, Nyaboke decided to ask her husband to use condoms whenever they had sex. Her suggestion was; however, met with threats of violence. This made Nyaboke resign to fate, and it was only after her husband was diagnosed HIV positive that he realized the risk he had been taking.

Men are naturally promiscuous and you cannot do much about it. I know I was faithful to my late husband but he decided to have many concubines all over the village. I warned him severally of the risk of his behaviour but he did not change. So I decided one day to confront him that if he can't change he will have sex with me using a condom. On this day, he almost killed me. From then henceforth, I had nothing to do but to live with it since I was married to him.

Nyaboke's interpretation of condom use is more influenced by women's lack of power to influence or control a husband's sexual behaviour. This is compounded by threats of violence. This is clearly demonstrated by Nyaboke's argument that *"From then henceforth I had nothing to do but to live with it since I was married to him."*

Nyaboke's interpretation of condom use was further fortified by Bisirieri's argument that it is hard for women to determine condom use in sexual relationship because of their disadvantaged

position both economically and socially. Economically, among the Abagusii women depend on men to access resources like land through marriage. Also socially, woman gain their proper identity and status through marriage (Shadle (2006). Due to this, women have no power to influence men's sexual behaviour especially on condom use as demonstrated in the following interview with Bisirieri:

Bisirieri: When you ask a woman to decide on how and when to use a condom with a man is like a rat telling a cat on what to do when they meet.

Researcher: What exactly do you mean?

Bisirieri: Are you not a man? Then why are you pretending by asking that question? All the same it is the nature of all men. Nevertheless what I mean is us women cannot make any decision especially that which touches on sexuality without considering how it will impact on our relationship with men. This is the case for both married and not married women. Take my case for instance I am single and getting old. So I must look for a man to marry me so that my children can have a place to call home. Also very soon I know people will start calling me *ritinge* (concubine) if I don't getting a man to marry me. In all these circumstance do you think I will have the guts to tell a man that if we must have sex he must use a condom?

Evidently from Nyaboke's and Bisirieri's accounts, it is clear that HIV/AIDS campaigns which encourage women to act assertively to control the course of their sexual encounters to prevent the spread of HIV/AIDS cannot be effective in this context. This is because such campaigns do not take into account constraints on women's abilities to control condom use and the disadvantage of women's assertiveness on condom use.

Other research participants interpreted condom use as a preserve of men only because of the symbolic meaning of condoms in sexual relationship. According to a 27 year-old Janet, suggestions of condom use by females especially in a marital union was seen to be equivalent to suggesting that a man's conduct was careless and presented risk to the family. This in itself was construed as challenging male authority in sexual relationships: Janet explains:

> *There is absolutely nothing a woman can do as far as condom use is concerned. When you are married, it's a must you respect your husband. One way of showing respect is by not challenging how he wants to have sex with you. He is the head of*

> *the home. So, when you start asking him to use condoms, are you not challenging his authority? Aren't you questioning his morality? To me, therefore, to use a condom is solely a man's decision.*

On the basis of Nyaboke's, Bisirieri's and Janet's accounts, it can therefore be argued that marriage does not protect women from HIV/AIDS infections instead it makes them more vulnerable to risks of infection. This is because marriage binds them in unequal power relationship where their choices are limited by cultural beliefs of subordination, and where "good" women are constructed as those who do not challenge male authority.

The interpretation of condom use as a preserve for men was also established in this study to be influenced by HIV/AIDS campaigns promoting condom use. As observed, most advertisements promoting condom use depicted males as active participants in decision making on condom use. In these advertisements; for example, it's only men who were shown to be making decisions on condoms use. In cases where females were featured, they were either depicted as passive participants or mere objects on which condoms could be used by men when they (men) have made a decision to use them (condoms). This was further amplified by the kind of language these advertisements used like "*Prezzo (male musician) ana yake, je una yako?* (Prezzo the musician has his condom, do you have yours? *Real men who care use a condom; men can make a change by using condoms.*

Condom use as not sex

Majority of research participants interpreted condom use as not sex. This interpretation was established in this study to be influenced by young people's meaning of sex and the perceived role of sperms in sexual relationships. Among research participants like Ombui, sex was seen as natural and a symbol of emotional intimacy among sexual partners. This naturalness and emotional intimacy was to be depicted by body to body contact (BBC) among partners. Consequently, condoms were perceived as barriers as they tended to avoid body contact (ABC) which was not natural as Ombui explains:

> *There is emotional intimacy and love in having sex the natural way. Therefore, there is no need to place barriers to this naturalness.*

Similarly, Samson, a married man aged 21 echoed Ombui sentiments by arguing that sex is a pure and natural thing which emanates from physical and emotional closeness with a sexual

partner. This physical and emotional closeness according to Samson was only realized when a man ejaculates into a woman's genitals.

> *When a man engages in sex with a woman for love and emotions, he must feel her deeply. That is by ejaculating into her during sexual intercourse. This is real sex which is pure and not adulterate. Therefore, anything which hinders the flow of sperms into a woman's body makes the whole act not to be sex.*

Other research participants constructed condom use as not sex because it reduced sexual pleasure. However, this concept of reduced pleasure was found to have diverse meanings among research participants. John Nyabs, for instance, claimed that he experienced genital desensitization whenever he had sex with a condom. This desensitization reduced sexual pleasure.

> *Whenever I put a condom on my erected penis that good feeling one has before sex disappears. By the time I start having sex, my erection is no more. Although sometime I can go ahead and have sex, I can honestly say I do not enjoy or have any satisfaction at all.*

John Nyabs experience was claimed by many male research participants. This was noted to discourage many of them from using condoms in sexual relationships. Ondigi also reported that he distasted condom use because it denied him the right to enjoy sexual pleasure after spending a lot of time and economic resources to woo a woman into sex.

> *You know very well that nowadays no woman can allow you to have sex with her without compensating her with money. Even though this is the norm, still women ensure you spend a lot of time seducing her as a way of protecting herself from looking cheap and easygoing. So after spending all this time and resources to woo her it is absolutely crazy to again use a condom as you won't enjoy at all.*

On the basis of Ondigi's account, sexual pleasure to him meant the right to enjoy sexual pleasure without a condom especially with a sexual partner whom he had spend time and economic resources in order to have sex. Therefore, his construction of sexual pleasure was grounded on his economic right as a consumer who had spent time and resources to acquire a commodity (sex).

The construction of sexual pleasure was also found to be influenced by male socialisation on sexual issues. According to Monyenye (2006) and Le Vine (1959), Abagusii young men were socialized especially during circumcision that their identity, dignity and social status as men depended on their ability to satisfy any woman sexually. This sexual satisfaction was not only

seen in terms of how many times a man ejaculated but also on his ability to excite her during sexual intercourse. On the former, this study therefore found that many male participants believed that the more they ejaculated was in itself an indicator of their sexual potency as real men. Consequently, condoms were portrayed as barriers to this feat as Peter explains:

> *You cannot claim to be a man by ejaculating in a woman only once. If you do so, any normal woman will just despise you as weak. Some will just hate you for wasting their time and worse more for making them dirty for no tangible benefit. In my case whenever I use a condom I am unable to go beyond one round. So, coming to think of how this portrays me in the eyes of my sexual partner as a man, I decided not to use condoms any more.*

Peter's interpretation of sexual pleasure was also found to be motivated by pornographic movies which were commonly watched by many research participants. As found out from research participants, no actor in pornographic movies wore condoms. Each episode of sexual intercourse without a condom lasted around twenty to thirty minutes; communicating the notion that sex without a condom as normative sex for sexually potent "real men". Abagusii youths; therefore, visualized sex without condoms as "real man's" sexual standard and a reflection of actual "sexual potency".

As established among male research participants, men wanted to have a lengthy sexual intercourse without a condom to show female partners that they were "real men". In this case, sexual skills and performance were seen as attributes of "masculine" men. Consequently, sexual intercourse as portrayed in pornographic movies was taken as proof of masculine sexual skills. Therefore condom use was compromised in order to proof masculine sexual potency as reported by Mr. Ondigi.

> *It is true that whenever I use condom there is lose of penile sensation. This makes me to take at least ten minutes to ejaculate. However, I only take a maximum of two minutes when I do not use condoms. As a man I am supposed to take at least ten minutes to ejaculate unaided. So as real men I do see in pornographic movies, I am trying to achieve the same feat without being aided by condoms. Consequently, as the saying goes that practice makes perfect, I have made it a rule to have sex without a condom so as to become a real man.*

Regarding sexual excitement, most male participants believed that women also ejaculated when they are sexually excited. They believed that when a woman's vagina is filled with sexual secretion, then she is enjoying sex. However, for this excitement to take place, a woman must

feel the feeling of uncovered penis. Therefore, men's perception of sexual pleasure in this case was constructed in the context of women's sexual enjoyment.

> *When you are having sex with your female partner and she secrete a lot of vaginal secretion then you know she is enjoying sex and having all the excitement. When this happens then you are a real man. However, from my own personal experience, this does not happen whenever I use a condom. This means that as a man I have failed to perform as expected* of *me sexually. This in itself is not good to my reputation* (18 year-old Moses).

Moses's sentiment underscored the crucial dimension of men's perception of sexual pleasure which indicates masculine idea of sexual performance. According to this perception, masculine idea of sexual performance can only be achieved by an uncovered penis through which a man could feel the secretion of sexually excited women.

Onchiri also reported that if his semen was not discharged inside his wife's body, she would not get the "ending pleasure" of "real sex" which makes the whole act incomplete. According to him, his wife wanted him to ejaculate inside her vagina because she enjoyed the "hot sensation of semen". Onchiri explains:

> *My wife hates condoms with passion. Whenever I have sex with her with a condom, she complains that she does not enjoy at all. She says that if she does not feel the hot sensation of semen that is not sex. More so the condom creates a lot of friction which makes the whole act not enjoyable.*

Onchiri explanation was also fortified by Kwamboka's suggestion that sexual intercourse that does not involve exchange of seminal fluids cannot be construed as "pleasurable" sex. Kwamboka, 25, a single woman reports:

> *... I cannot enjoy sex with a condom, and I am not ready to change my lifestyle. Of course, I have sex with all my three boyfriends, but I am often more worried of pregnancy than with AIDS. So I abstain when I am at risk of pregnancy.*

Kwamboka's suggestion expresses two issues: the ranking of risk and the influence of personal tastes. First, sex with condoms is "unpleasurable" sex, which means she would rather have no sex than use condoms. Threats of infection have to be weighed against personal habits, and the notion of pleasure. Secondly, Kwamboka ranks risk of pregnancy as higher than that of HIV infection although AIDS poses a greater risk to life than pregnancy[98]. All these two issues

[98] See also Daily Nation 13th September 2009 " Teenage sex study shock for parents" In this report by Centre for Adolescent Study most teenagers are more worried about pregnancy than AIDS.

underscores the fact that risk is a relative term that varies according to social perception and membership to social groups with the additional variable of time (life stage interacting with history) complicating the picture further (Hart, 1993: 74). Therefore, the definition of risk and ranking of risks depends on a wide range of perceptions, and the social contexts within which people act.

Nancy, 20 year old HIV positive also reported that most women disliked condoms but were afraid to say so in public. She reported:

> *Honestly, most of us women do not like condom at all. I know many of my female friends who say that they had better have sex without condoms, or use a banana or carrot but in public they would say they all use condoms. I used to have similar attitudes towards condoms until I got this disease.*

The interpretation of condom use as not sex was also found to be influenced by the social construction of fluid exchange (sperms) and its symbolic importance in sexual relationship. As established among many research participants, these social construction and symbolic importance of sperms transcended beyond the cultural significance of sperms in procreation. Among female research participants, sperms were perceived as important in helping them to mature physically like developing breasts and hips which are a mark of beauty. Consequently, they referred to sperms as "*pure natural proteins*" which were important for their growth. Therefore, frequent condom use was seen as denial to women essential nutrients for their growth and subsequently their beauty as a 19 year Evelyn explains:

> *After I was circumcised, many of my older female friends told me it was very important to have sex so as I can develop good looking breasts and hips. They told me men's sperms were essential for this. However, whereas I cannot categorically say whether the sperms had any role for the development of my breasts or hips at that time, but all that I can say of now is that most young women believe sperms do have a role.*

A similar view was shared by a 20 year-old Nyanchera. According to Nyanchera, sperms were important in giving women their feminine soft and smooth skin especially when they are absorbed through the vaginal walls. Therefore, when sperms are removed from the sexual act by use of condoms, it was taken as not beneficial to women as Nyanchera absorbed:

> *You see there is something in sperms which is very important in making women's body skin supple. This thing in sperms makes all the difference among women who have sex and those who do not. From my own experience and observation women who have a lot of sex with no condoms have very good skin. Take for*

example prostitutes; you cannot compare their body skin with ours. So it defeats logic to satisfy a man emotionally and you do not benefit anything especially when he uses a condom.

Among some male participants, the exchange of sperms was seen as important in fortifying a new sexual relationship. According to a 25 year-old Mr. Mosota, sharing of sperms between two sexual partners was important as it created a strong bond between partners. To him, this exchange of sperms was like a Covenant as both parties demonstrate their intimate and close feelings which should not be broken. Mosota explains:

You see male semen is like blood in its purified form.....As you know when two people share blood they not only demonstrate their close and intimate relationship but also their promise to each other to continue with that relationship forever. Therefore, when you have sex with your partner without a condom it demonstrates your commitment to the relationship.

Aura, a 26 year-old male also reported that exchange of body fluids (sperms) among sexual partners during sexual intercourse enhanced their commitment and unity to the relationship. He claimed that when sperms are exchanged between a man and a woman during sexual intercourse, it increased sexual desire which led to love and commitment in the relationship.

Other participants like Hare Moturi, 26; male argued that exchange of sperms during sexual intercourse was important in controlling women temper and thus ensuring their obedience and subordination to men. He notes:

Women have very high tempers and they need to be controlled. Unless you do so you cannot claim to be in control as a man. So the only way you can control a woman is by having a lot of sex with her without a condom. Actually, the more you ejaculate into her body the more she becomes calm, passive and not emotional. Actually, women who are starved of sperms are very emotional and hard to control I tell you!

The construction of exchange of sperms as an emotional stabilizer was also held by a number of female participants. Janet, 27, married, reported that men's emotions are easily controlled when they have sex and ejaculate into a woman's body severally. According to Janet, when men ejaculate into women's bodies during sexual intercourse, they realize "unproductive energy" which makes them temperamental and unfaithful to their partners. Janet reported:

Men's bodies work like a car engine. When the engine has a lot of pressure, it would not work properly. This is the case with men's bodies. When there is a lot of blood in their body, they become emotional and immoral. So when they (men)

ejaculate into a woman's body, they reduce unnecessary blood which makes them emotional and hard to control.

Interpretation of Voluntary Counselling and Testing (VCT)

In HIV/AIDS campaigns VCT is still considered as an important component in HIV prevention and treatment. It entails encouraging people who are either sexually active or about to be sexually active to know their HIV status. This is considered crucial in enhancing other HIV/AIDS intervention services like primary prevention, Prevention of Mother-to-child Transmission(PMTC), antiretroviral therapy, management of HIV related illness, tuberculosis control and psychosocial support (Sweat *et al.* (2000).

In HIV/AIDS intervention, VCT services have been found to reduce substantially the incidences of STD and increase condom use especially in developed countries with epidemic in core groups (Hogan *et al.*, 2005). In sub-Saharan African countries with generalized epidemic, some researchers have; however, raised doubts about the connection between voluntary counselling and testing and sexual behaviour change. Van Dyk and Van Dyk (2003), for example, revealed that even though majority of people are not, in principle, opposed to VCT, existence of stigma within their communities and their perceived inabilities to deal with psychological challenges following a positive diagnosis; influenced their resistances to undergo HIV testing. Similarly, in this study majority of the youths indicated that they had not visited VCT centres to know their HIV status. Despite these observations, this study examined how Abagusii youths interpreted VCT services as a strategy for HIV/AIDS prevention.

VCT as knowing your HIV status

Findings from this study indicated that majority of Abagusii youths understood VCT services as voluntarily counselling and testing for HIV which individuals undergo at free will.

> *I think for me VCT means knowing your HIV status at the hospital or designated centres at your free will* (26 year-old Jared)
>
> *Yes VCT means testing for HIV/AIDS before you start any sexual relationship like marriage* (20 year-old Irene Moraa).
>
> *From what I have been taught from antenatal clinic, VCT means getting yourself tested for HIV before you conceive. In case you are found to be HIV positive, you are then registered in special clinics where you will get free treatment for your condition* (27 year-old, Janet).

These accounts reflects a connotative interpretation that has not been altered in any significant way, hence the participants seem to interpret it exactly as intended in ABC and VCT strategy. Further, these interpretations were noted to be influenced by the source the individual got that information from. For example, the 20 year-old Irene Moraa's interpretation was more influenced by a non-secular organisation which advocates that sex should only take place in marriage. Therefore, those who wanted to get married must first of all know their HIV status. Also Jared understanding of VCT was influenced by various campaigns by secular organisation promoting VCT as a strategy for HIV/AIDS prevention. In these campaigns individuals are asked to visit hospitals or designated VCT centres to know their HIV status so that they can make informed decisions on their sexual behaviour.

VCT as unnecessary evil

Some research participants interpreted VCT services as unnecessary evil which had more harm than good to an individual. This interpretation was found to be influenced by the fact that HIV/AIDS has no cure and it leads to death. Therefore, some participants were of the view that it was not worth to know your HIV status when there is no cure. To them this would lead to more psychological problems [99]which will hasten one's death. This thinking was justified by the use of the metaphor "*Hata ukipimwa hakuna dawa*" (Even if you are tested there is no cure).

Ochieku, a 30 year-old married man, reported that knowing HIV status would hasten one's death. To prove his point, Ochieku claimed that one of his close relative died within four months when he was told of his sero-positive status at the hospital. This is despite the fact that the relative looked healthy before the test. According to Ochieku, the death of his close relative was; thus, hastened by HIV positive test.

A similar view was found to be shared by many research participants. Nyanchama, 27, single woman; for example, argued that knowing your HIV status is like "*knowing that you are a living corpse waiting for it's time to be buried*". This knowledge alone according to Nyanchama, is more traumatizing than HIV/AIDS itself. Nyanchama explains:

[99] In VCT centres clients undergo pre-testing counselling before being tested for HIV by trained counsellors. After testing also regardless of the outcome of the test, they also undergo post counselling to enable them adapt to the results. However, most participants were of the view counselling does not help when one knows the disease he/she is suffering from has no cure.

> *There is nothing bad as knowing you are on your way to death from a shameful disease. This will just make you think that every time you are having flu, it is the start of your death. This thinking alone will kill you. So to me I better remain ignorant of my status and continue with my lifestyle as it is.*

The association of "knowing your HIV status" and "hastening death" among research participants is contrary to VCT promotion campaigns. In VCT campaigns "knowing your HIV status" is promoted as being crucial in prolonging life as those who are found to be sero-positive are given free HIV treatment (ARV) which can protect them from opportunistic infections which lead to early death. Also "knowing your HIV status" is seen as enabling one to make certain future life decisions in relations to his/her HIV status. For example, those who are HIV negative can change their sexual behaviour to suit their status. These two factors are perceived important in mitigating the negative impact of HIV/AIDS.

However, in this study the associated benefits of VCT were inconsequential when compared to high HIV/AIDS stigma. As established those individuals who tested HIV positive were socially ostracized by members of their social networks:

> *The minute you test HIV positive people will kind of get scared of you. No one will want to be associated or identified with you. You will be all alone and even some of your former close friends will start using you as an example of warning others against HIV/AIDS infection. Worse still others will go full throat gossiping about your imminent death* (22 year-old Carol).

Consequently, participants like Carol saw VCT benefits such as prolonged life through HIV treatment (ARV) as another effort of extending an individual suffering for a long time. This is because HIV treatment using ARV does not entail curing HIV virus but extending life which means long period of stigmatization. Carol further explains:

> *Yeah it's good to know your HIV status. I do agree kabisa (completely). But come to think of it, it's all useless. It is true once you test positive you can be given some medicine not to cure you but enable you to live longer. You know what this means? You will live longer with AIDS but also more time to be stigmatized!*

VCT as "Facing the Reality"

Among some sexually active research participants, VCT was seen as a way of coming into terms with the reality of possible HIV infection. In this case, some felt that "knowing your HIV status" like a positive diagnosis signalled uncertain future which participants such as a 24 year Ombogo likened to as "*knowing you are a living dead*":

Getting tested for HIV is not a simple thing as VCT campaigns portrays. This is so especially if you have been having unsafe sex with a number of partners. In this case your sexual behaviour makes it very difficult for you to trust yourself. So when you go for the test and you are told you are positive, it becomes worse. You can kill yourself or you won't live a good life for it will be in your mind that you are going to die soon.

Similarly, Beatrice Law reported that that every time she hears about VCT, she experiences fear:

There is nothing which scares me in a relationship like when my partner tells me we go to VCT. I don't know why I fear, maybe because I have more than two guys I am seeing sexually. So whenever that suggestion is made I will either ask him to leave me or have unsafe sex so as we may have nothing to fear about each other status. I think these two options are better than going to VCT.

Fear of knowing one's HIV status was also cited by head of Bonchari Constituency AIDS Control Committee as a major handicap to utilization of VCT services. According to her, most youths who have engaged in unprotected sex shied away from VCT services for fear of knowing their status:

In this place we have two VCT centres which exercise utmost confidentiality for any client seeking the service. Sadly, however, very few youths come for the service. Our experiences in these centres have informed us that those who come for the service are mostly those who have never engaged in unprotected sex. Youths who have engaged in unprotected sex see it as not necessary because they estimate that they have very minimal chances of not being infected. So they fear to know their HIV status.

VCT as taking responsibility

To some research participants undertaking VCT amounted to taking responsibility for their sexual behaviour and that of their sexual partner's HIV status. For those youths who undertook VCT as a way of taking responsibility for their sexual partners' HIV status, they indicated that the idea of being tested positive evoked the feelings of guilt for infecting their sexual partner. According to Ombui, sexually active youths do not go for VCT because they believe they owe their sexual partners an explanation in case they test HIV positive:

I don't think I can go for VCT anytime soon since I am involved with more than three girls sexually. You see if I go there and get tested HIV positive how will I explain to all of them when each of them knows that I don't mess myself with any other woman? So going for this test means you will owe somebody some explanation. More so you will have some guilt conscience that you are responsible for somebody's sickness.

The fear of taking responsibility of their sexual partner's HIV status was established to prevent individuals from going for VCT. This was; however, found to be more prevalent among women. As noted in this study most women feared going for VCT because of fear of being accused of unfaithfulness by their spouses in case they tested HIV positive. This was clearly captured by Mary Bonchaberi, 33, a widow who explained that her late husband accused her of unfaithfulness and " bringing AIDS to him" when she was tested HIV positive in antenatal clinic[100]. She said:

> *My world collapsed when I visited antenatal clinic where I was tested HIV positive and later informed my husband. At hospital the doctor assured me that I will give birth to health baby and live longer if I adhered to his advice. This made me to take my condition positively. However, when I informed my husband about what I had found out at the hospital, he became violent by accusing me of being unfaithful and thus infecting him. He eventually chased me from our home. I only returned here when he died because as tradition demands I was to be there to bury him as my husband since he had paid dowry.*

A similar view was shared by a 26 year-old Kwamboka. According to Kwamboka, her long time sexual partner whom they had planned to wed accused her of being unfaithful and abandoned her because of visiting VCT. She reports:

> *We were so tight with my boyfriend and we were planning to live as man and wife in two months time. Since I knew once a woman has been married she must get pregnant almost immediately so as to cement the union, I visited VCT to know my status. Luckily, I was HIV negative. With all this happiness, I went to my boyfriend's house to inform him of the good news. Alas! Instead of celebrating with me the good news, he accused me of being unfaithful to him. According to him by visiting to VCT I was either unfaithful or immoral. So he just ended our relationship.*

Kwamboka and Mary Bonchaberi's experience in relation to seeking VCT underscores the role of men in determining women's health seeking behaviour. As in their case, this being a patriarchal community, it was men who were supposed to make decisions regarding their health seeking behaviour (Masese, 2002). Therefore, their actions of visiting VCT Centres without the blessing of their male spouses was either interpreted as disrespect to their males' authority or their action were done with ulterior motive.

[100] HIV testing is routine in programmes for the prevention of mother-to-child transmission (PMTC) of HIV, and most hospitals offer it as part of antenatal care.

Other female research participants who didn't want to antagonize their spouses reported that they undertook an HIV test only when there was mutual consent from their sexual partner. However, the study established that this strategy did not work when HIV test results were positive among sexual partners as a 20 year-old Nancy narrated:

> *After pushing for some time with my boyfriend, I started hearing stories that he was seeing other women. I was so much depressed. However, because of too much love I had for him I decided to keep it to myself. This did not help me for long because I came to realize he had infected me with syphilis. When I confronted him about this, he was so apologetic. So I forgave him immediately after seeking treatment in a local clinic. After three months I sweet talked him that we should go for HIV test. He agreed to my suggestion and we visited one VCT which was away from our village. At the VCT we were counselled and thereafter we were tested. Unfortunately the test revealed that both of us were HIV positive. This made my boyfriend to be mad with me accusing me of all sorts of things like I am a prostitute who wants to ruin his good life. This is despite the fact he is the one who had earlier infected me with syphilis.*

Nyamira lady, a married HIV discordant woman, 25 years old also reported that she was divorced when she tested HIV positive and her husband tested HIV negative. According to Nyamira lady, her husband had tested HIV negative during one of the mobile VCT services in a nearby market. So with this good result, he rushed home and asked her to accompany him for the test also. Unfortunately, after undertaking the test, she was found to be HIV positive. This made her husband to divorce her immediately.

Sufficing from Nancy's and Nyamira lady's experience, it's clear that taking responsibility of partner's HIV positive status tended to disadvantage women. This is despite the fact that there was prior mutual consent among sexual partners to undertake HIV test and in cases where it was evident that the man's sexual behaviour was responsible for HIV infection. This finding; therefore, blends well with studies by Baylies (2000); de Bruyn (1992) and Barnett *et al.* (1992) in sub-Saharan Africa which show that women are often blamed for the spread of HIV/AIDS.

Blaming women for misfortunes was also found in this study to be influenced by oral mythologies which tended to explain the origin of misfortunes in the community. According to these oral mythologies, women were taken as the genesis of all evils and misfortunes. Due to this, women were easily blamed on as the cause of HIV/AIDS.

The interpretation of VCT as taking responsibility for the other sexual partner's HIV positive status was found in this study to discourage many youths from seeking VCT services. This was because many youths believed that knowing their HIV status was more disadvantageous to them as individuals. This belief was established in the study to be influenced by two factors. To begin with, among women, knowing HIV status was perceived as being equivalent to "wilful act of losing husband, sexual partner, family and most importantly resources particularly land". All these meant that a woman will lose her proper identity in the community and social capital for her children. Due to this, many women indicated that they were more satisfied with not knowing their HIV status as captured in their often used sentiments: "*There is wonderful bliss of being ignorant of your HIV status*"[101].

Additionally, many youths were also dissuaded from knowing their HIV status because of their interpretation and understanding of "HIV and AIDS prevention and control bill 2006". Although this bill deals with many issues on HIV/AIDS like protection from discrimination of any person infected or suspected to be infected from HIV/AIDS and creating public awareness of HIV/AIDS, some youths were concerned with criminalization of wilful transmission of HIV by the bill. As established in the study some youths took that one can be accused of wilful transmission of HIV if she or he is the first one to know her or his HIV status and communicates the same to his/her partner. In this case the latter partner can accuse the other partner who had undertaken HIV test first that he/ she had prior knowledge about his/her HIV positive status but went ahead to wilfully infect her/him. This accusation can lead one to imprisonment for at least ten years- which was seen as punitive by many research participants.

Other research participants interpreted VCT as taking responsibility for their past sexual behaviour. As established this, interpretation was common among participants who had engaged in risk sexual behaviour before. As a consequence they wanted to change their sexual behaviour. Abigail, 23, single woman who confessed that she was a commercial sex worker for four years , reported that she went for VCT when one of her closest colleague died from HIV/AIDS. With

[101] See also IRIN/PlusNews, 22nd October 2008: "Kenya: Fear of HIV testing keeps pregnant women at home". Available at http://www.plusnews.org: Accessed on January 14th 2010.

her friend's death she wanted to know her HIV status so as she can change her sexual behaviour in order to avoid dying like her friend. Abigail reports:

> *After I gave birth to my son at the age of 16 years my parents refused to support me. So I had to fend for myself and my son. The only way to do this was to trade my body for money with any man. In the course of my trade, I got a lady who was doing the same. So we became very close friends. However, after four years of being close, my friend's health started deteriorating. Fearing for the worst she went to hospital where she diagnosed was as HIV positive. I think this shocked her and in less than six months she passed on. This scared me so much and made me to vow that I will stop this trade if I am still HIV negative. So when I visited a VCT centre and found that I was HIV negative I changed my sexual behaviour completely. At the moment I am saved and I sell "mitumba" (second hand clothes).*

VCT as doubting health status

Among some research participants, going for a VCT was associated with poor health. Consequently those participants who considered themselves as health did not see the need to go for VCT. For some, like Osoro, 27, married man considered himself to be in good health and therefore did not see the need of going for VCT:

> *Aaah! Why go for VCT when I am health? My wife gave birth to a health looking son two months ago, I have never suffered from any illness like Tuberculosis and most important my weight has never reduced. In fact, I have no problem with my health as you can see. So why do I waste my time going to VCT when I am so healthy!*

Similarly, when asked whether he had visited VCT to know his HIV status, Omae, 26, single man who worked as church layman, replied:

> *Why visit such places when I know I am safe from HIV/AIDS. Those who visit such places are those people who indulge in immorality. As a Christian, I am not immoral and subsequently I am healthy.*

VCT as a life changer

In this study, few research participants who had sought VCT services were found to interpret VCT as a life changer. This interpretation was established to be influenced by the kind of results an individual got after HIV test. Among some research participants like 32 year-old Mr. Nyandusi, reported that he was forced to abandon his carefree lifestyle when he found that he was HIV positive. Although he conceded that he was initially traumatized, he latter accepted to live positively after he underwent post counselling session in a local hospital. Ironically,

Nyandusi reported that his HIV positive status has made him to invest and care for his family unlike before he knew his HIV status. He explains:

> *Before I discovered I was HIV positive, my lifestyle was horrible! I was a womanizer, drunkard and extremely violent to my wife and children. All my earnings were spent in entertaining my lovers. However, this has changed since I visited VCT and knew my HIV status. At the moment I am more concern on how to maintain my health, invest for my family and show all my love to my wife. To be honest, all this investment you see now I have done them after I was tested HIV positive. So I do not regret being HIV positive since this status has made me to do wonderfully good in life.*

Similar view was shared by Sarah, 29, single woman who was HIV positive:

> *I used to hate condoms whenever I had sex with any of my many men lovers. However, this is not any more. I have only one lover now who is also HIV positive and we consistently use condoms.*

Other participants who had visited VCT and tested HIV negative were noted to engage in more risky behaviour especially those who had exposed themselves to risks before. Aura, 26, single man; for instance, indicated that he started engaging in unprotected sex with all his four sexual partners after he tested HIV negative. To him, the HIV negative test assured him that he was not at risk of being infected by HIV. He explained:

> *For about a year I was involved in a relationship with a girl who I later learnt was promiscuous. This scared me until I gathered courage and went for VCT. Luckily to my surprise, the test was negative. With this result I made a resolution that I will never engage in a relationship with a woman who to me looks immoral. So I carefully select my sexual partners. For example, I can say with certain that all my current sexual partners are risk free.*

Some participants were also noted to use HIV negative results as a license to indulge in unprotected sex with multiple sexual partners. Chero, 23, single woman who tested HIV negative three years ago reported that she and her sexual partners felt more secure to have unprotected sex. She reported:

> *You see it is this girlish thing in school that made me to go for HIV Test. I remember on that day we were teasing each other about our HIV status. So I and my two close friends went for HIV test. Since that time I have indulged in unprotected sex with at least three guys. Sometimes I fear this can make me get AIDS, but I comfort myself it is not possible coz I have already tested negative. In some case my partner will be willing to use condoms. But when he asks me if I have ever gone for VCT and I say yes, he abandons using a condom.*

In HIV/AIDS campaigns, one goal of VCT is to facilitate the adoption of safer sex. However, as evidenced from Chero and Aura, it is of great concern that HIV negative test was associated with increased risk behaviour in terms of partner acquisition and non-condom use. Perhaps a more encouraging observation was that those participants who tested positive adopted safer sexual behaviour like increased condom use with regular partners. This difference in behaviour response was noted to be either due to the way testing and counselling was conducted or psychological effect of receiving a negative test. For example, receiving a negative test was interpreted as permission for more risk. This reinforces the fact that risk alone does not have a detrimental consequence in HIV/AIDS prevention.

Section II: Social construction of Sex among Abagusii Youths

Results discussed from the previous section have illustrated that Abagusii youths interpretation of ABC strategies are most often shaped by their socially constructed meaning of sex rather than their knowledge and attitudes towards HIV/AIDS prevention. This section; therefore, builds on these findings to seek more understanding on how Abagusii youths made sense of sex in their daily life experience. This understanding is deemed important because ABC and VCT strategies of HIV/AIDS intervention aim at modifying the notion of sexuality by categorizing sexual behaviour into either safe or unsafe.

Sex as liberation from parental control

Some research participants interpreted sex as a form of liberation from parental control especially before circumcision. According to Mosota, 25, single man, engaging in sex for youths symbolically represented freedom from parental control:

> *I think when one gets circumcised a lot of things change. They are considered as adults and therefore free from parental control. So, most of them will tend to do what their parents refused them to do. Consequently, some will engage in sex as it depicts freedom.*

Mosota's understanding of sex as a form freedom from parental control can be traced to sexual socialisation among Abagusii. According to Siberschmidt (1999) and Akama (2006), premarital sex was strictly restricted before one was circumcised by parents. This restriction; however, subsided after circumcision. Before circumcision; for example, Akama (2006c) argues that the uncircumcised were considered as children who needed parental guidance in everything they did.

Further, it was considered a taboo for the uncircumcised to sire or give birth as it was considered as "a child giving birth to a child".

However, after circumcision one was considered an adult. This acquired status of adulthood entailed power to make individual decisions and freedom from parental control. This was further fortified by social moral code of avoidance "*chinsoni*" which forbade parents from controlling their children who were considered adults. Consequently, research participants like Mosota interpreted engaging in sex as a demonstration of their freedom from parental control which was there before circumcision.

The interpretation of sex as liberation from parents' control was; however, established to impact negatively the adoption of safe sex practices among youths. Results findings showed that youths who interpreted sex as liberation from parental control were against the adoption of safe sex practices like use of condom. This was because they viewed adoption of safe sex practices as a continuation of outside forces controlling their sexual freedom. Onsibema, 19, single man explains:

> *As an adult you know what is good or bad to do. That is why immediately you are circumcised, your parents stop monitoring you in issues of sex. Therefore, it is totally unacceptable to gain your sexual freedom and at the same time lose it by following other people's prescription on how to do sex. For example, oh, if you have sex, you must use a condom. My friend is this freedom!*

Sex as a sign of adulthood

Research findings showed that many research participants engaged in sex almost immediately after circumcision. As it emerged in the study, many of them were under enormous pressure from their peers to engage in sexual activities as an indicator that they were adults. Yusuf, 22, single man explains:

> *After circumcision, I was under a lot of pressure from my peers to have sex. Initially, I never took this serious until it downed on me that most of my peers were regarding me as a child. In any discussion we had for example, my views were not taken serious as I was regarded as a child. This is despite the fact that I shared with them the same circumcision knife. So I decided to have sex with one of my classmates to prove I was an adult.*

Nyambeki, 24, single mother also reported that she engaged in sex due to pressure from her close friends as a sign that she was no longer a child. She reported:

You see in school especially after weekends most girls will talk on how they had sex with their boyfriends. Most of them would describe how enjoyable the act was. Among my close friends I was the odd one out because I did not have any boyfriend. This made most of my friends to see me as a child. So whenever I happened to join them when they were sharing sexual experiences, they would abandon the talk. Some would even tell me to my face to move away from their group because they were talking "adult things". Because I was getting isolated by my friends, I had to have sex so as to acquire adult status and acceptance in my social group.

The interpretation of sex as a sign of adulthood was found to be influenced by masculinity and femininity notions. Among male participants; for instance, sex was socially constructed as "cool"[102], hence those who abstained from sex were considered as "not being cool". Due to this, some male youths indulged in sexual activities in order to gain social acceptance by proving they were also "cool". In this case, sex was seen as a ritual through which individuals were initiated into the "cool" group

Among female participants, engaging in sex was seen as a way of asserting oneself sexually. In this case, female participants who were not approached by males for sex were considered unattractive[103]. Consequently, some females like 22 year-old Risper engaged in sexual activities in order to prove to their peers that they were also attractive to men.

When men do not approach you as a woman for sex then you know definitely there is something amiss with you. So you must prove you are also attractive to men by having sex with them. This will make you be considered as a woman of substance by your peers.

Sex as a sign of love and trust

Among some female research participants, sex was seen as the only means of proving their love for their sexual partner and ensuring a continued relationship. According to Lucy Keumbu, 20 year-old female student reported that her desire to love and be loved was the only reason of having sex:

You see a guy will not say you love him if you don't sleep with him. So you must sleep with him to assure him of your love. After this he will now start loving you.

[102] Cool in this case referred to all socially accepted attributes of a man. These attributes include but not limited to: brave, wise, powerful, steady, emotionless and sexually attractive to women.

[103] To be unattractive among female participants is not feminine quality and in this case it referred to not being physically beautiful and mature.

Similar view was shared by Faith, 20, single woman who reported that most girls perceived unprotected sex as a way of proving their love. According to her, unprotected sex was seen as insurance for benefits such as emotional intimacy and trust. She said:

> *Yeah you can have sex with your man to prove you love him. However, this is not enough for men. You must have unprotected sex as a way of proving complete love and trust to him.*

As evidenced from Faith's sentiment there is a direct relationship between unprotected sex and complete trust and love, and that each implies the other. This means that women will indulge in unsafe sex as a way of demonstrating their love and trust to their partner.

Among male participants, the study found that they tended to be silent in linking sex with love. When they tried to link it, they mainly talked about love as something that girls were interested in. To them, sex was instead talked of as feelings of physical contact with sexual partner as Ondigi reports:

> *Men are not interested in love. All they want is "flesh to flesh" so that they can feel what their partner feels for them.*

As noted from Ondigi's sentiment, the first "feel" refers to men's physical contact and the second "feel" refers to a woman's emotional response. This therefore implied that for men, having a partner was more associated with access to sexual pleasure.

The difference in interpretation of sex between men and women can be said to be due to gender socialisation. As a patriarchal society, men are socialized not to show emotions especially towards women as it is considered unmanly. However, among women, showing of emotions like love was considered as a good feminine attribute. In relation to HIV/AIDS prevention, these differences of interpreting sex can compromise adoption of safe sexual practices. For example, women will fear to introduce condom use into a sexual relationship because it not only suggests distrust and lack of love in their sexual partner, but also a sense of promiscuity.

Sex as means of accessing High lifestyle

Some female research participants engaged in sexual relationship with multiple partners for economic reasons. The desire for idealised modern lifestyle was established to motivate some female participants to engage in sex in exchange for expensive lifestyles. This was noted led them to get involved in casual or long term concurrent sexual relationship with partners

considered to have material wealth. This is illustrated by the response given by Beatrice Law when asked what sex meant to her:

> *You see I come from a poor background. My parents cannot afford many things which as a university girl I require. As you know in campus I need to live up to certain expected standards if I have to command some respect from my peers. So to get what my parents have failed to provide for me I get involved with some men of means. Since those men have stable families and income they only take care of my needs as long as I satisfy them emotionally.*

Beatrice Law account regarding sex is not peculiar to Abagusii youths only. In Urban Mozambique, a study by Monjate *et al.* (2000), also found that sex was used as a means of survival for women with no or low income. As noted in the study, the fewer the resources women had access to the more sexual partners they had.

Sex as "meeting basic needs"

Many research participants interpreted sex as an avenue of getting basic needs. However, unlike conventional definition of basic needs which include food, shelter and shelter, in this study they were defined more in cultural needs like status, identity and access to resources. Among many male participants, sex was seen as the only means of getting status and identity as a man in society as illustrated by the responses of Ondigi and Obure:

> *I think the difference between a really man and any man is how well they satisfy their woman sexually. If as a man you fail on this and your wife is allover with other men, then you are nothing in the eyes of everyone. To me if this happens, I better die than carry that stigma of a useless man* (28 year-old Obure).

> *It is very disturbing that as a man you are unable to sire a son. Everywhere you go no one respects you. You may have a very good house, eat and dress well but people will see you as useless. Some will see you as infertile even if your wife has given birth to millions of girls* (25 year-old Ondigi).

These two accounts by Obure and Ondigi clearly demonstrate that conventional needs like food, clothes and shelter are not important when compared to individual social status and identity. This, therefore, means that an individual will go to any length to meet those culturally defined needs. Evidently, these efforts of meeting cultural needs can compromise HIV/AIDS prevention efforts. For example, as evidenced earlier on this chapter, Obure is mostly likely not to use condoms because such use was socially constructed as not sex.

Other male participants like Nyangwa, 25, single, security man saw sex as an avenue of demonstrating manly attributes like the ability to manage efficiently:

> *When you have more than three sexual partners it definitely show your ability to manage. As you know women are jealous of each other when you have a sexual relationship with them. So if you can deal with them without any of them causing any problem then you are really man.*

Among female research participants, sex was also interpreted as a means of accessing resources and security. Maria, 24, single woman reported that it was only by having sex that a woman can get a husband who in turn will give her a place to call her home and land for her children to inherit.

> *Waaaa! Your question is hard to answer mister but let me be frank since it has an obvious answer. As a woman, it is definite that there is no way a man can marry and trust me with land before having sex. For us women, sex is the key to a man's heart and latter to his land for our children.*

Maria's account is informed by the fact that in the community all resources like land are under the custody of men. Women access these resources through marriage only[104] (Masese, 2006a). In this context Maria, like other female participants, believed that the only means available to them to access resources under men's custody was through sex. These believe was established to be justified by the construction of sex as the first step towards long term sexual relationship among youths.

The construction of sex as a means for women to access resources under the custody of men was also noted to be common sense knowledge among all youths. As established in this study, there was common understanding that women are more advantaged in accessing "anything" held by men due to their biological makeup. This was clearly illustrated by the following sentiments by Faith and Chuma:

> *As long as you are beautiful and you have "it", there is absolutely no way you can fail to get what you want from any man even if he is the president. However, the only difference among women is that some do not have the brains on how to use this natural resource* (Faith, 20, single woman).

> *In this world you cannot compete with a woman. You can have all your degrees but I tell you frankly if a woman wants something even if she has no degrees she*

[104] Access to resources is restricted to user rights only. For further details refer to Chapter three, the section dealing with "Access to property."

can get it. All she needs to do is to show some willingness to have sex with whoever has that thing (Chuma, 26, single man).

Although many youths constructed sex as a means for women to access resources, some female participants; however, observed that this was not always the case. According to Mosweta, a single mother of three children, some men took advantage of their position as custodian of resources to have sex with women by pretending that they will marry[105] them. She narrated her experience as follows:

> *I was in this relationship with this man who kept promising that we shall get married soon. Since I was getting old, I trusted him. So I never cared of conceiving as I thought that will even hasten our marriage. However, I was totally mistaken. When I realized I have conceived and informed him, he just denied that he was not responsible for my pregnancy. Actually this was the last time we saw each other. As if the gods had conspired against me, I gave birth to twin boys. This meant I had to find another man who was willing to marry me so that my boys can have a place they can call their home. With my desperation some men will come and promise that they are willing to marry me. However, immediately I met their sexual demands they will disappear into thin air. These experiences were just a tip of an iceberg. There is this man who is the father of my third born. He came as an angel, very caring and understanding. Whenever he visited us he showed a lot of affection to my boys. As if that was not enough he promised to marry me. Blinded by all these acts, I again conceived. When he realized I have conceived he quietly moved to unknown place. Up to now I do not know where he is although some people say he went back join his family in upcountry.*

Mosweta's experience validates Hakansson (1994) findings that the Abagusii women continue to be disadvantaged in using marriage as an avenue to access resources. As found out by Hakansson, men have taken advantage of changes in marriage like reduction of payment of bride wealth to engage in multiple sexual relationships in the pretext of looking for an ideal partner to marry with no recourse for their action. This is because despite the changes witnessed in marriage; there have been no changes on the norms and principles governing payment of bride wealth. For example, the legality of marriage in terms of traditional rights and obligations is only realized upon payment of bride wealth. Therefore as in the case of Mosweta, cohabitation or elopement provided her with no rights to a man's resources.

[105] Marriage is the only means for a woman to access land and attains proper status and identity in society. For further details refer to Chapter three in the section dealing with "Marriage."

Sex as health therapy

Most research participants interpreted sex as not only essential for normal functioning of human body but also an indicator of good health. However, in this case good healthy was seen to transcend beyond mere absence of illness or coming into contact with pathogens. Consequently, sex was conceptualized among research participants as essential for (or an indicator of) the body and mind to be in a state of well being recognized and accepted by both the individual and society.

Mary, 28, married woman reported that sex to her manifested both the physical and physiological well being of her husband. In this case Mary argued that through sex she was able to know whether her husband was well both emotionally and physically. She explained:

> *You know sex is both physical and emotional. When any of these ingredients is missing you cannot have good sex. Therefore by having sex with my husband I can tell when he is well or has some problem. As you know men don't like sharing their problems with women and therefore they prefer to pretend that everything is fine. But when you have sex you can surely tell that there is something amiss given the fact you know his sexual performance.*

Similar view was shared by Sabina, 25, single woman who reported that she used the sexual performance of a man to tell whether he was healthy or not. According to her, any man who has low sexual urge or cannot perform well sexually was considered as not healthy.

> *Men by nature are sexually active. So it is abnormal to get a man who has no interest in sex even when an opportunity presents itself. Similarly if a man is terribly poor in bed definitely you know he is sick.*

Also Bwari, 26, single woman who was living positively with HIV reported that after her boyfriend died of HIV/AIDS, she decided to indulge in sex as a way of knowing whether she was healthy or not. Her indulging in sex was borne from the belief that people who are infected with HIV/AIDS are unable to "have sex" or conceive. So she engaged in sex as a way of ascertaining her healthy status. She narrates her experiences:

> *I was so shocked when my boyfriend died and many people started saying he died of AIDS. This devastated and forced me to move away from our village. After about five months I decided to confirm if indeed I had AIDS. So I decided to engage in sex first and later try to conceive. I knew if I had AIDS I won't conceive and also I will experience some difficulties when having sex due to vagina dryness due to AIDS. In my first sexual encounter, I was extremely happy because I had very good sex. So I embarked on my second mission of conceiving. Fortunately*

after three months of active sex, I conceived. This gave me confidence that I was healthy. My joy and happiness of being healthy was, however, dashed when I visited antenatal clinic and found to be HIV positive.

Similar views as Bwari's were noted in a study conducted by Rutenberg *et al.* (2000) among reproductive women in Ndola Zambia. In this study it was found that HIV positive women used pregnancy to demonstrate the absence of HIV infection and continued health.

Other participants like a 27 year-old Mandizi interpreted sex not only as an indicator of good healthy but also as a gauge of their relationship status with supernatural world. According to Mandizi, when an individual fails to sire or conceive a baby despite consistent sexual encounters with a sexual partner, it was an indicator of strained relationship with his/her ancestors due to either commission or omission of some acts. Mandizi observed:

It is not normal to have sex consistently with a woman and she can't conceive. That shows that there is something wrong somewhere. For example a woman cannot conceive if either she or the husband has strained relationship with ancestors. Take the case of one of my friends. He was married for over four years without the wife conceiving. However, when they lubricated their relationship with their ancestors by offering some sacrifices, the wife conceived almost immediately.

Onchonga, 23, single man and a teacher by profession also reported that he confirmed he was healthy when his girlfriend conceived and gave birth to a baby boy. According to Onchonga, when a man gives birth to a baby boy, it indicates that he has more "manly qualities" which is a sign of good health. This thinking was noted to emanate from common shared knowledge that in conception, a man and a woman contributes to manly and feminine qualities respectively. These qualities are important in determining the gender of the child. Therefore, when one gets a baby boy, it shows a man's qualities are more powerful than a woman's; which is seen as normal/healthy because it resonates well with masculinity attributes.

Some research participants interpreted sex as a healthy therapy which was essential for normal and proper functioning of the body. As established among many research participants, the body was likened to an engine which requires constant servicing for it to work efficiently. In this case sex symbolized this required service as Onchiri explains:

You know very well that a car needs constant service for it to work properly. This is the same with our bodies. As a man; for instance, you need sex regularly to

remove some of the excessive "blood" which accumulates at the backbone; which if not removed can lead to a severe backache.

Mogaka, 20, unmarried man also reported to have engaged in sex regularly in order to prevent his reproductive organ from blocking as a result of none use hence too much accumulation of sperms. This blockage according to Mogaka can lead to infertility which is very stigmatizing. He explains:

> *A normal man produces a lot of sperms which are then stored in the body vessels. However, if they overstay in the body they can make some body vessels to block. This is very dangerous as it can cause infertility given that this blockage takes place in the reproductive organ. So it is very important to have sex regularly to clean these blood vessels.*

Among female research participants, sex was also seen as essential in maintaining the body equilibrium for proper functioning. According Biyaki, 20, single woman, human body contains a lot of fluids which essentially determine an individual's emotions and reasoning. When there is disequilibrium for instance on the fluids determining emotions, an individual can experience stress which can cause poor health if not attended to. In this regard, Biyaki reported that sex was the only natural way of maintaining the body fluids equilibrium:

> *Sex is very essential for any normal human being. You see when a woman engages in sex, the exchange of body fluids during the act stabilizes her body. This makes her to be emotionally stable and reason clearly. So any woman who doesn't engage in sex is more likely to be emotionally unstable. As a woman this is not good.*

Summary and Conclusion

This chapter has examined how Abagusii youths interpreted Abstinence, "Be Faithful", Condom use "Condomise' and Know your status "VCT" messages as offered by HIV/AIDS prevention strategies. Consistent with social constructionist theorists, research findings have shown that the youths' interpretation of Abstinence, "Be Faithful", Condom use and VCT messages oscillated between connotative and dominant meanings depending on their social, cultural and economic contexts. For example, the study findings found that the interpretation of Abstinence, "Be Faithful", Condom use and VCT were most often contrary to the connotative meanings that were intended in the ABC and VCT campaigns. Similarly, in some cases where dominant interpretation of these messages was observed, it was evidenced that youths interpreted the

meanings of these messages from alternative frameworks that resulted in negotiated meanings and in some cases, oppositional ones.

In this regard, the interpretation of Abstinence, "Be Faithful" and Condom use in particular was found to be influenced by the socially constructed meaning of sex. For example, among youths who subscribed to religious and cultural ideals of pre-marital chastity, abstinence was understood as a religious, moral practice and virginity preservation. In this regard, these youths perceived abstinence as an effective way of avoiding HIV/AIDS even though abstaining was primarily motivated by the desire to uphold cultural or religious ideals rather than avoiding HIV/AIDS infection. On the other hand, youths who never subscribed to religious or cultural ideals of premarital chastity interpreted abstinence appositionally as sexual abnormality or denial of sexual pleasure.

Similarly, among some participants, condom use messages were interpreted connotatively to mean the use of condoms to prevent HIV/AIDS. This interpretation is perfectly symmetrical with the connotative meaning intended in the ABC campaigns. Among other participants, the interpretation of condom use was; however, influenced by the socially constructed meanings relating to the use of condoms. For example, many youths were found to interpret condom use as not sex because of their social meaning of sex and perceived role of sperms (exchange of body fluids) in sexual relationships. Also female participants interpreted condom use as solely males' decision because of their powerlessness in issues of sexuality due to social and economic incapacitation.

The interpretation of VCT was also found to reflect both the dominant and negotiated meanings. For example, some research participants understood VCT from the same connotative meaning as intended in the VCT campaigns as undergoing voluntary counselling and testing to know your HIV status. However, some understood VCT from different perspectives like "facing reality" of possible HIV infection, "unnecessary evil" and taking responsibility for one's partner's HIV/AIDS status. Unlike in Abstinence, "Be Faithful" and Condom use where negotiated meanings were influenced mostly by social construction of sex, in VCT it was the stigma associated with HIV/AIDS. For example, some research participants reported that they feared

knowing their HIV status because they will be socially ostracized if they tested HIV positive; thus, they interpreted VCT as "unnecessary evil."

Last but not least, this chapter establishes that with few exceptions, both the dominant and connotative interpretation of Abstinence, "Be Faithful", Condom Use and VCT were also greatly influenced by the social, cultural and economic factors governing sexuality. Because of the ways in which sexuality is socially constructed and gendered, males and females had different connotative and dominant interpretations in relation to HIV/AIDS prevention messages. For example, female participants tended to interpret abstinence from the same connotative meaning as intended in ABC approach to HIV/AIDS prevention; as avoiding having sex until marriage. This was because such interpretation resonated well with culturally defined ways of practicing sexuality among females. However, among male participants, abstinence was interpreted in such a way that it met the cultural definition of male sexuality and at the same time to be in line with HIV/AIDS campaigns intended meaning of abstinence. In this regard, most male participants interpreted abstinence to mean postponing having sex in certain circumstances like when the sexual partner is perceived not to be "healthy".

In sum, it can be argued that the interpretation of Abstinence, "Be Faithful", Condom use and VCT messages among Abagusii youths vary. This variation depends on their social, economic and cultural contexts and the meanings attached to sex and sexual behaviour. All these factors supply the interpretative repertoires through which youths engage with and make meaning of Abstinence, "Be Faithful", Condom use and VCT messages.

CHAPTER EIGHT

PREVENTING HIV/AIDS USING ABC AND VCT STRATEGIES

Introduction

With no cure yet for HIV/AIDS, the control of HIV transmission seems to entail in changes in sexual practice. However, change in sexual practices entails redefinition, reorganization, and restructuring of prevailing notions of sexuality (Weeks, 1986; Plummer, 1988). Consequently, the Kenya government has committed a lot of resources in an attempt to change peoples' sexual practices and beliefs through information supply and promotion of safe sex. The information supplied is aimed at educating the public on the dominant ways through which HIV/AIDS is contracted, and educating them on how the risks of infections can be minimized.

However, as established in chapter six and seven, youths "make sense" of these intervention strategies in various ways; depending on their perception of the risk of HIV/AIDS infection and compatibility of such strategies with sexual meanings and practices as embedded in their social and cultural contexts. According to social constructionists (Berger and Luckman, 1967; Garfinkel, 1967), the way people make sense of phenomena is important as it drives their everyday action. In this case the way HIV/AIDS campaign messages will influence individuals' responses and actions towards HIV/AIDS will depend on how they make sense of such messages. In this regard this chapter examines how Abagusii youths' understanding of sex and ABC and VCT strategies influence their responses and actions in addressing the HIV/AIDS threats in their everyday life experiences.

HIV/AIDS prevention: Interplay between meaning of sex and ABC and VCT

The difficulties of meeting the meaning of sex and preventing sexually transmitted infections among Abagusii has been appreciated since the first case of sexually transmitted infection was recorded in the community in 1945. This appreciation was depicted by the songs which were composed and sang at that time. For example immediately after Second World War in 1945, the song *Nyaboke*[106] was composed to show the predicament of a young woman in meeting culturally prescribed gender and sexual roles, like getting married, so as to get proper identity

[106] The song *Nyaboke* has already been cited at the introduction of this thesis.

and securing rights of access to resources and risk of being infected with sexually transmitted diseases.

The song *Omokenene,* which was composed immediately after the advert of sexually transmitted infection among Abagusii, also showed the dilemma of meeting culturally defined sexual roles and risk of infection. The song *Omokenene* is shown below:

Ekegusii	***English translation***
Solo: *Omokenene okaranda*	the berry shrub spread
Chorus: *Ogatebia omosangora ing'a*	and told the "let us produce".
twame	let us produce and
Toribie enchera nyagoseta	bar the hunting route
All: *Oraiyaa, Oraiyaa chingero*	Oraiyaa, oraiyaa song
Bonyangero.	real songs

In this song, *Omokenene* are scrambling thorny *Rubus spp*, which grow wild in the bush land or forest edges. They form impenetrable barriers because of their thorns. *Omosangora* is *Rhus vulgaris,* a plant that has a profuse production of fruits; thus, *gosangora* figuratively means to produce in profusion. The combination of the two symbolically refers to the risks associated with meeting the social function of reproduction in the era of sexually transmitted infections. In the song the risk of sexually transmitted infection is symbolized by *Rubus spp* and its thorns whereas *Rhus Vulgaris* represents reproduction. In this case accessing or meeting the social functions of reproduction has been made risky because of the impenetrable barrier created by *Rubus spp* and its thorns.

In the era of HIV/AIDS songs have also been used by various artists to show the predicament of meeting the meaning of sex. The song "*Kipenda roho*" by Remmy Ongala[107] highlights the

[107] Remmy Ongala was a Tanzanian guitarist and singer. He was born in 1947 in Kindu, Democratic Republic of Congo. He started playing music in 1980s with Orchestra Super Matimila. His kind of music was commonly referred to "ubongo", the Swahili word for "brain". "Ubongo" music was usually perceived by artists and listeners alike as "Conscious" music, one that actively dealt with social, economic and political issues affecting people. Ongala died on 13th December 2010 in Dar- es salaam, Tanzania.

centrality of sex in human beings and life. For example, it is through sex that one gets proper identity, acquires social status and companionship in society. However, the advent of HIV/AIDS, which the artist rightfully says is "sexually rooted and transmitted", has made indulging in sex a risky affair. This, according to him, "has made the survival and existence of man perilous." Therefore the artist wonders how man will survive and exist without sex; will he abandon sex all together? If he does so what will happen to him as a man? Or what strategies will man use to avoid contracting HIV/AIDS as he practices his sexuality?

The dilemma of meeting the meaning of sex in the context of HIV/AIDS is due to the fact that sex is more than a biological function. Among Abagusii, for example, sex is gendered and it accords an individual social status, security and identity. In this regard individuals may engage in sexual risk behaviour or adopt certain strategies in pursuit of these goals. However, the rational choice theory which informs HIV/AIDS intervention programmes is based on an essentialist model of sexuality that overlooks the social character of sexual relationships and power relations.

Consequently, HIV/AIDS intervention programmes have focused on the degree to which individuals' actions comply with biomedical/scientific strategies for HIV/AIDS prevention like Abstinence, Be Faithful, Condom use and VCT. However, using interview accounts of Abagusii youths, this study shows that adoption of safer sexual practices (ABC and VCT) depends on power relations, sexual identities and the social meanings of sexuality as hereafter discussed.

"HIV/AIDS protection" using "abstinence strategy"

In this study Abstinence as a strategy for HIV/AIDS prevention was found to be more appealing to female research participants than males. This was established to be due to the fact that abstinence messages resonated well with cultural expectations of women sexuality as discussed in chapter seven. In this regard many female research participants used various strategies in practising "abstinence[108]" as hereafter discussed. However, it is worth noting that these strategies

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The song "*Kipenda roho*" was composed in 1994 when HIV/AIDS prevalence was at its peak in East African countries. Its theme centres on the contradiction of pursuing the goals of sex in the era of HIV/AIDS. The song is song number 10 in his 10th album.

[108] Abstinence in this context does not only refer to not having sex.

used were more to do with meeting the cultural expectations of women sexuality than as a strategy for HIV/AIDS prevention.

Going to church or getting saved

Many female research participants indicated that they resorted to going to church or getting "saved" as a way of avoiding indulging in sex or to be seen as abstaining from sex. This was evidenced when research participants, like Irene Moraa, was asked how she practiced abstinence in her day to day life experience. She said:

> *To avoid men disturbing me with requests of sexual relationship I decided to get baptized and become an active church member. By doing this most men avoid approaching me in issues touching on sexual relationships. I can recall some instance for example I overheard some men describing me as Mary the virgin (Mother of Jesus Christ) because I am strict with church teachings at the expense of relationships.*

The association of going to church or getting saved with abstinence is due to the fact that Christian moral teachings emphasize pre-marital chastity until after marriage. In this case those female youths who were identified more with the church were taken as upholding religious moral teachings on sexuality. Consequently, they were seen not as potential sexual partners for casual relationships as evidenced in Irene Moraa sentiment. Therefore, going to church or getting saved in this case acted as deterrence to men who just wanted casual sexual relationships.

Although going to church or getting saved was mentioned by many female research participants as the only viable means of practicing abstinence, these actions were established to be motivated more by female culturally defined attributes of potential marriage partner than HIV/AIDS prevention. According to Shadle (2006), Cardinal Otunga Historical Society (1979) and Silberschmidt (1999), among the Abagusii, women who were perceived as sexually immoral were not taken as potential marriage partners. Due to this, going to church or getting saved was taken as an indicator of upholding sexual morality given the fact that the church is more associated with advocy for sexual morality among believers. This was evidenced when Irene Moraa when asked to explain what actually motivated her to be saved:

> *Most men nowadays don't want to marry any woman because most of them believe all women are immoral. Therefore, women who are saved or churchgoers are at least perceived as morally upright. So at my age I decided to get saved so as to attract a potential marriage partner.*

Irene Moraa's account was fortified by men's responses when they were asked to enumerate good qualities of a potential marriage partner. Many of them indicated that they would prefer to marry a woman who, if not saved was a regular churchgoer. This was because of the belief that women who were saved or churchgoers were more likely to be morally upright, caring and respectful as the church emphasizes these virtues.

Some female research participants were also found to use going to church or getting saved as a way of protecting themselves from undue pressure of engaging in sex with potential marriage partners until such a time they had known each other fully. This strategy was established to be motivated by lack of power among women on issues of sexuality because they are socially and economically disadvantaged. Therefore women used religious teaching on morality which emphasized pre-marital chastity until marriage to ward off any pressure of indulging in sex until they were sure that that sexual relationship would lead to long-time commitment and eventually to marriage. As 23-year old Bonareri explained, this strategy ensured that a woman was not exploited sexually by men and accorded her an opportunity to assess whether the man met all the requirements of a potential marriage partner:

> *Before I was saved many men took advantage of me sexually. Some would tell me they were in love with me and wanted to marry me. So with this bait I would give in to their sexual desires because no man would like to marry a woman before they had sex. However, after sex most of them had nothing to do with me. With time I realized I was being taken advantage of because of my position as a woman in society. Worse still my reputation as a potential marriage partner was diminishing. So I decided to get saved in one of the local churches where I became a very active church member. After one year my current husband sent to me one woman who was our church elder that he wanted to marry me. Since we were both church members he never pressured me to have sex with him. Instead he preferred that we know each other more with the help of church elders. So after seven months of dating we wedded in church.*

Acting young and innocent

In many communities in Sub Saharan Africa, women are supposed to be ignorant and passive on issues of sexuality. It is believed that ignorance and passiveness on matters of sexuality is a sign of purity and innocence, while having too much knowledge about sex is a sign of 'easy virtue' (Gupta, Weiss and Mane, 1996). Therefore as established in this study, some female research participants used various strategies to depict themselves as ignorant and passive on matters of sexuality which in this study was taken as an indicator of sexual purity.

The first strategy was that some female participants indicated; that they feigned ignorance of simple things on sexuality especially when approached or in the company of potential sexual partners. Mary Kali, a 25-year single woman, for example, reported that most men preferred to have sex with women whom they perceived innocent. To these men ignorance and innocence were indicators that the woman had never engaged in sex. As a result, Mary Kali reported that she was forced to act ignorantly on matters of sex whenever she was approached by a potential male client.

The social construction of ignorance or innocence on matters of sexuality as equivalent to abstinence was established to be taken as one of the good attributes of a potential sexual partner among many youths. However, this social construction can be argued to compromise HIV/AIDS prevention efforts in at least two ways. One, the association of ignorance and innocence with sexual purity may make some men not to practice safe sex. Two, women fear demanding safe sex from their sexual partners because this will betray their innocence on matters of sexuality.

The second strategy utilized by female research participants was influenced by male social construction of female virginity. As established in this study most male research participants took female virginity as an indicator of good sexual morals among females. Therefore, most males preferred to have sex with females they considered virgins not because they considered them to be of good sexual morals but also because this elevated their social status as men. In this regard any female who was perceived as a virgin by her male sexual partner on the first sexual encounter was taken as a potential long term sexual partner.

In this study, however, female virginity among male research participants was not much defined in terms of lack of penile penetration but rather by the tightness of the vagina and lack of vaginal secretion[109] during first sexual encounter. Therefore in order to meet males' criteria of virginity, some female research participants reported that they inserted some herbal medicine (some poured lemon juice) into their reproductive canal to tighten and reduce secretion of vaginal fluids during sexual encounter. As Faith, a 20-year single woman explained, the reason for this is to

[109] Tightness of the vagina and lack of vaginal secretion was taken as an indicator that the woman has not indulged in sex with many sexual partners.

hoodwink potential male sexual partner for long term sexual relationship with the belief that the woman had either never indulged in sex or involved in sex with multiple partners.

The preference of males for women who had either not indulged in sex or with multiple partners was informed by two interrelated factors which centred on masculinity. One, male social status in the eyes of his peers was enhanced if he was taken to be responsible for breaking a woman's virginity. Two, the social dignity and identity of a man depended on the women he indulged with sexually. That is, if a man engaged in sex with a woman who was perceived as sexually immoral or loose he was despised as not man enough. This thinking was also reflected in the metaphor, *"as a man you eat what you painfully hunt and not what has already been hunted by others"* in reference to sexual relationships among Abagusii male youths.

Avoidance

Some female research participants indicated that they were able to practice abstinence by avoiding situations which would put them into undue pressure to indulge in sex. Some of the situations mentioned to be avoided included being in private places with a man alone, walking at night alone and accepting a lot of favours from a man like money, lunch and night entertainment dates. These situations, according to Irene Moraa, 20, a single woman compromised a woman's ability to assertively say no to sex to a male partner:

> *Men are like vultures; they are very patient in waiting for opportune time to strike. A man can pretend to you that he is not interested in sex when you first meet him. He will tell you he is only interested in companionship. For many days he will never ask you for sex until you actually develop a lot of confidence in him. When this happens he will take you to a private place and before you realize he will have already had sex with you. Also some men can sacrifice to do anything for you like giving you money, taking you out and being extremely nice to you. All these things soften your will to refuse to have sex with him by justifying your action by saying why refuse him sex when after all he has been too good to me.*

Other females avoided companies of peers who were already active sexually or with multiple sexual partners. This strategy was based on the impact of peer pressure on one's behaviour. Kerubo, 20, single woman observes:

> *If you don't want to steal you must avoid at all costs being in the company of thieves. Therefore if you keep the company of girls who are involved in sexual relationships with*

multiple partners, definitely they will influence you to indulge in sex. So if you want to avoid indulging in sex you must choose your company wisely.

Kerubo's understanding of avoidance as a strategy of not indulging in sex was, however, established to be used by sexually active women as a strategy of avoiding being labelled as immoral. Sabina, 25, single woman, for example, reported that although she was sexually active with at least two men, she avoided the company of women who were known to be engaged in multiple relationships as a way of hiding her sexual behaviour:

No man will want to have a relationship with a woman who has other sexual partners. As a single woman this is not possible given the fact that you don't know which man can marry you. Since I have at least two lovers I have taken every precaution not to taint my name as immoral. So the first thing I have done is to avoid associating myself with women who are well known to have more than one lover. Two, whenever I am involved in a sexual relationship with any man I keep it discreet as much as possible.

Sabina's action can be argued to do more with the problem of impression management in sexual relationship than avoiding indulging in sex. This fits well with Goffman's (1970) and Tseelon's (1993) arguments that social interactions are sustained through manipulation of appearances, and only appearances present the "true" self of a person. Goffman (1970) for example, treats the social world as a theatrical stage where people display actions whose meanings can be discerned through the interpretation of these "stage managed" appearances. To Goffman, there are no privileged positions or differences between people and all people are "equal" actors, the world being the stage. Therefore each person has repertoire of "faces" each activated in front of a different audience, for purposes of creating and maintaining a given definition of the situation.

Other participants also indicated that they avoided indulging in sex by resorting to magical measures which were believed to result to failure of a man to have sexual intercourse. These magical measures were resorted to when a woman believed that a certain situation would compromise her ability to say no to sex. These measures included chewing charcoal or phallic pod commonly found in pastures *Endwani*, putting a needle on the head, putting a knotted piece of grass on the bed the man intends to use for sex and twisting the banana flower. Most of these measures by women were taken before any meeting with a man.

The use of magical measures as a strategy for avoiding indulging in sex among women was established to be informed by two factors; one, lack of power to making personal decisions on issues of sexuality. This was evidenced when Kwamboka, 25, a single woman was asked why she resorted to magical measures in avoiding having sex. She responded:

> *It is difficult in some situations to deny a man not to have sex with you. If you assertively do so, the man may take you as not having good qualities as a woman. Also as you are aware it's a norm even if a woman refuses a man to have sex, the man will go ahead to do so because it's believed a woman's refusal means acceptance.*

Two, the socially constructed notions of male sexuality that perceives males as having uncontrollable sexual urge to engage in sex: as some females research participants observed men are unable to control their sexual feelings, especially when they are psychologically set for sex. In these circumstances if a woman tries to prevent them from having sex they will resort to violence. Stella, 25, a single woman explains why females use magical measures to avoid having sex:

> *You see you cannot refuse a man sex when he has made up his mind. When a man is sexually aroused or excited he is very wild like a wounded lion. He is blind to reason and can do anything to have sex. So as a woman what do you expect us to do? You see you can't fight him for definitely he will overpower you. So given our limited options, we women resort to these non-violent [referring to magical measures] means.*

Joining economic empowerment groups "Sebokia[110]"

As discussed in chapter three, all family resources among Abagusii were under the custody of men. Women had only user rights to these resources through marriage. Even in marriage a woman would not be the custodian of family resources even with the demise of her husband. Instead she would only be allowed to hold those family resources in trust for her sons if they were minors at the time of widowhood. If she did not have a son, she would be inherited by her husband's close relative mostly a brother or cousin. This relative would sire with her a son who would later be the custodian of family resources.

[110] "Sebokia" means to assist to prosper economically. In the study site and generally in Gusii "Sebokia" refers to a group of people who have come together to assist each other economically. The group works in "a merry-go-round system" where members contributes stipulated a mount either every fortnight or monthly to one member in rotational basis. This system has been adopted by people living positively with HIV/AIDS especially young women who do not want to be re-infected due to economic vulnerability. The group also provides social support to its members.

However, it should be noted that regardless of whether the woman had a son or not, it was obligatory that she be inherited if she wanted to be regarded as a member of her husband's lineage. In some cases a woman could refuse to be inherited but due to lack of resources and social support[111] she would be forced to especially if she had a young family to take care of. In these circumstances, female research participants who were widowed and living positively with their HIV/AIDS positive status joined "*Sebokia*" groups whose members were mostly people of same status for economic and social support. Nyaboke, 27, who lost her husband when she was 22 years through HIV/AIDS, was denied rights to her husband's land by her in-laws for refusing to be inherited. However, with her determination not to infect someone else with HIV/AIDS or be re-infected, she joined *Sebokia* for economic support. She reported:

> *Everyone knew my husband died of AIDS and definitely then I was infected. However, my brothers-in-law insisted that my husband was bewitched. They reasoned that if indeed he died of AIDS why was I looking healthy. So one day they all came to my house to inform me that from then henceforth my youngest brother-in-law would take me as a wife. Therefore they expected me to meet all obligations as a wife. Since I had already been counselled at hospital on the consequences of engaging in sex with my status, I said no to their suggestion. This annoyed them and they withdrew with immediate effect all my user rights to my husband's land. They knew very well by doing this I would yield to their demands. To avoid falling prey to their demands which I knew would entail engaging in sex with my brother-in–law, I joined Sebokia. Sebokia has assisted me to meet my family needs and thus prevented me from having a reason of engaging in sex.*

A similar view was shared by Rhoda, a widow aged 23. According to Rhoda, she was under constant pressure from her late husband's friends to have sex with them whenever she sought help from them in meeting certain social roles, like repairing her grass thatched house. However, since she joined *Sebokia* she is able to get support from members without undue pressure for sex. She shared her experience as follows:

> *Honestly I cannot understand men's behaviour or thinking! You see someone knows very well that what killed your husband is AIDS. Instead of this person taking care not to be infected, he wants to have sex with you especially if you have sought his help over some chores. This is what I experienced for the first one year when my husband died. His friends wanted me to pay them for any help they gave me, like thatching my grass thatched house, with sex. However, thank God I joined Sebokia. All my problems like repairing my house and fencing my farm are done by members.*

[111] I have used social support here in relation to division of task among Abagusii. In this case there are some roles which women are not allowed to perform like repairing houses, clearing bushes and performing some traditional rituals. In this context a widow will be forced to have a man who will help her perform these roles.

"HIV/AIDS protection" using "Be Faithful strategy"

In HIV/AIDS prevention strategies, "Be Faithful" is aimed at encouraging individuals to practice fidelity in marriage and other sexual relationships as a critical way of preventing HIV/AIDS risk. Consequently, as established in this study due to power gender relationships, identity and social meaning of sex, many research participants used various strategies in practicing "Be faithful" in relation to "HIV/AIDS prevention" as hereafter discussed:

Monitoring

In this study both married and unmarried research participants indicated that they overtly or covertly monitored their sexual partner to ensure that he/she was not having other sexual partners. Nelly, 24, single woman who was engaged with a man who was working and staying in a distant town said she usually made abrupt visits to where her boyfriend stayed to ensure he was not cheating on her. Apart from these abrupt visits, Nelly also reported that she requested one of the neighbours of her boyfriend to discreetly spy on him especially on women who visits him and whether he sleeps out. As Nelly explained this strategy acted as deterrence for her boyfriend to cheat on her:

> *Before a man marries you he is not yours. You have to fight to keep him to yourself. So since I know men are easily tempted, I have made it my duty to visit him when he least expects me. This has actually made my boyfriend not to bring any woman to his house. Also I pay one of the neighbours to monitor him especially on women who come to see him.*

A 28-years old Oranjo said he sometimes called his girlfriend at odd hours to know where she was and with whom. When calling her girlfriend, Oranjo also confessed that he sometimes called using an anonymous number or used somebody like a friend to call. All these were aimed at getting her girlfriend unawares if she was unfaithful. Oranjo explains:

> *My girl stays far away from me and we only meet on weekends. So to be sure she is not having an affair with someone else I normally call her when she least expects my call. During my calls I will be keen on how she communicates with me because if she will be with another man she won't be free and open with me. Also when we are together I will be keen on who calls her and how she responds. Secretly I will also go through her mobile phone to know who she has in her phonebook, who she calls and who calls her and all message communications.*

In this study it was, however, established that most of the married female research participants preferred to covertly monitor their partners. This was because among the Abagusii, it was

morally wrong for a wife to monitor her husband in any circumstance. According to Monyenye (2006) such an act was taken as a sign of a wife trying to load over her husband. This attracted severe consequences like a beating or divorce by the husband. Due to this most of them resorted to covert means to know whether their sexual partners were cheating on them. Bonareri highlights these techniques:

> *As a married woman I cannot dog my husband here and there over his love affairs. If I do so I am more likely to lose out. Therefore whenever my husband comes home, especially when I suspect that he had an affair with another woman, I just pretend I am busy doing something and I hand over our kid to him. If he takes the kid then definitely he had not indulged in any affair. However, if he refuses and rushes to shower then he must have had an affair. You know this strategy works because if a man had an affair with another woman and he holds his child before showering the kid may be harmed. So this strategy not only assists me to know if my husband is cheating on me but also deters him.*

As found out in this study, most research participants preferred monitoring as the best strategy in ensuring faithfulness among partners. However, further investigations revealed that monitoring was motivated more by gender expectations and values associated with sexual relationships than HIV/AIDS prevention. Among females, monitoring was more to do with protecting one's "territory from encroachment by competitors" due to social construction of sex as an initial step towards long term relationships or marriage among youths. This was evidenced when Nelly was asked why she monitored her boy friend. She replied:

> *You think it is me alone who monitors my man! This thing is common among women both married and single. Nowadays good marriageable men are very few. So every woman wants to get married to these few good men. So if you are lucky to have found a good man you must ensure you ward off other women competitors. If you can't protect your territory others will encroach and at end you will lose. This is not restricted to unmarried women alone. Married women are most affected.*

However, among male participants monitoring was more to do with avoiding the shame associated with sharing a partner with other men as Jared, 26, single man reports:

> *It is shameful as a man when you are involved in a relationship with a woman who also has other men. People will despise you. Even yourself you won't feel good. So it is worth taking some measures like monitoring to deter her from having other affairs when you are still involved with her.*

Going to church

Socially, among the Abagusii, women are disadvantaged because they depend on men to acquire identity and social status. Economically also it is through men that they acquire user rights to resources like land. Due to this women have no power to influence men's behaviour especially those touching on sexuality. As noted from female participants' testimonies in this study most of them feared influencing men's behaviour directly because that would be construed as trying to control a man. Among the Abagusii, it was not manly for a man to be controlled by women. Also it was considered as a bad feminine attribute for a woman to try to control a man.

In relation to the above, women tried to control and influence men's behaviour indirectly. As found out among female participants, most of them used the church as a way of influencing their partners to be faithful to them. In this case they indirectly influenced their partners to be church members in the pretext of knowing God more and seeking His blessings. However, since the church advocates for faithfulness in sexual relationships this acts as deterrence for men to be unfaithful to their partners since they were church members. Florence, 30, a teacher and a mother of three children reported that for the first four years of marriage, her husband was unfaithful. However, when she managed to influence him to be a church member he drastically changed his sexual behaviour. According to Florence the fact that he was a church member deterred him from being immoral because the church teaching abhors to immorality.

Use of mass media like music

Conventionally, personal communication involves exchange of messages between two people. However, among the Abagusii this exchange is dictated by gender rules as stipulated in moral avoidance behaviour principles "*chinsoni.*" Chinsoni stipulates a hierarchy of authority. In this regard men were ranked higher than women. Therefore in communication women were not allowed to directly communicate to men especially on issues which required men to act in a certain ways, like change of behaviour. This was contrary to the chain of authority or command which required that a man be the one to direct or influence the behaviour of a woman and not vice versa.

Also *chinsoni* forbade direct communication between people of different hierarchies on issues touching on sexuality. Such communication was taken as a sign of disrespect especially on those of higher hierarchy. Therefore any communication between men and women especially that which demanded change of sexual behaviour was greatly constrained because of their ranks.

However, due to the foregoing, Levine *et al.* (1994) observes that Abagusii women overcame these constraints placed by *chinsoni* in communication by resorting to non - direct communication. In this study it was also found that female participants used non-direct means to demand faithfulness from their partners. Tabitha, 32, a married woman for example said that she played music at the presence of her husband from various artists touching on the negative impact of unfaithfulness at this era of HIV/AIDS. Although Tabitha confessed that she never discussed the messages contained in such music with her husband, she nevertheless assumed that by her husband listening to such music he would be influenced to be faithful.

Nelly, 24, single woman also reported that she indirectly demanded her boyfriend to be faithful by listening, reading and watching together various articles/episodes in mass media on the importance of faithfulness in sexual relationships. Nelly for example said she preferred articles/episodes in the mass media which highlighted that HIV/AIDS was more prevalent among youths. According to her, such articles/episodes acted as deterrence for her boyfriend to have other sexual partners. Like Tabitha, Nelly did not discuss with her boyfriend the messages contained in those articles/episodes.

In this study it was, however, established that men did not demand their partners to be faithful to them either directly or indirectly though they expected them to be. This was because such demand was seen as being equivalent to confessing one's inability to control the sexual behaviour of his sexual partner. Otieno, 30, a married teacher explains:

> *As a man you cannot ask your sexual partner to be faithful. This is an obvious thing expected from her. However, if you find a man telling his partner either directly or indirectly to be faithful then there is something terribly wrong. For me it means the man can't manage to control his partner sexually. This is not manly at all.*

Use of magic-religious measures[112]

Some research participants said some people used magic religious measures to ensure that their partners were faithful to them. According to these participants these magical religious measures relied on the use of charms or performing certain practices on the partner, though discreetly, to ensure she/he remains faithful. These measures were of two kinds: One those which aimed at ensuring faithfulness by either making the partner more "loving" to the other partner or lose interest in other sexual partners, and two, those which acted as deterrence for the partner to be unfaithful.

In the first category research participants said people used charms, which they referred to as "*amaebi*" or "*kababa*", to ensure that their partners were faithful to them alone. These charms were mostly obtained from traditional medicine men or some known people who were specialized in "love" charms. These charms were entirely used by women on men. They worked by either controlling or making male sexual partner lose interest with other sexual partners. Controlling in this sense meant that the male partner was made not exhibiting any masculine characteristics like aggressiveness, being outgoing and independent in decision-making. According to many female research participants these three masculine attributes were responsible for male unfaithfulness.

As established in this study administration of these charms took many forms. Some of these forms were: mixing these charms discreetly with food meant for the partner alone. Here, it was believed that if the partner ate that food he would be more "loving[113]" to the administering partner. Others included placing of charms on the bed where sex took place, putting them in reproductive canal before having sex with a partner and showering with them before encountering a partner sexually.

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[112] In this section I have generally discussed the use of magic religious measures without attributing the information contained herein to any research participant. I have done so because of the sensitiveness of the issue among Abagusii as evidenced by media reports of many cases of people being lynched because of being suspected of practicing witchcraft. Among Abagusii use of magic religious measures in sexual relationship is also classified as witchcraft. Ethically also I had assured my research participants before they gave me consent that all the information they gave me on this issue will be held in confidence.

[113] Loving in this context is more to do with controlling.

Other practices in controlling a partner were more centred on "religious" beliefs than use of charms. These mostly centred on mixing body fluids with a partner's food. For example, some female respondents said that they knew some women who mixed their menses with food given to their partners or used water they had used to wash their underwear clothes to cook food for their partners. Others were reported to mix any drink given to their partner with their saliva. These practices, according to female participants, were meant to influence male partners to not desire any other sexual partner apart from them.

Although the efficacy of these magical religious measures was not proved empirically by the researcher, there were nevertheless many testimonies among research participants on the same. For example, some research participants indicated that they had heard of cases where a man had gone to bed with another partner who was not his main partner and was unable to have intercourse. According these participants, his failure to have intercourse was because his main partner had used magical religious measures to ensure that he would never have successful intercourse with any other sexual partner other than her alone. Other research participants used examples of various men they knew of who were once very aggressive, outgoing and independent but now were "controlled" by their sexual partners.

The efficacy of these measures was also demonstrated by the various strategies used by men to avoid being victims of these measures. For example, some male participants said that they did not eat any food prepared by their partners if they were not eating that food also. Others said they avoided eating any food prepared by their partners when they knew they were on their menses.

In the second category, magical religious measures were used as deterrence for a partner not to be unfaithful to the main partner. This method was mostly used by married men either covertly or overtly on their partners. In this method male partners use traditional medicine men[114] to perform some magic religious practices which made their partners to be caught red handed in the act of being unfaithful. According to research participants when a man has taken these measures, if his wife cheats on him with another man they will stick with each other in the same position

[114] Research participants indicated that this type of magical religious measures is sought by local people from the Kamba people of Eastern province, Kenya.

they were when having intercourse. That is, the man will be unable to get out of the woman even after intercourse. If he tries to, both will experience a lot of pain. However, they would only get out of intercourse position if the main partner spits his saliva on them. As found out from research participants' testimonies these cases were on the increase, especially in urban and trading centres. In most cases a male partner who had been cheated on demands a lot of money as compensation before spiting on them. This has deterred married women from cheating on their husbands.

The use of magic religious measures as a strategy to ensure faithfulness among partners was found to be motivated more by other gender specific factors in relation to sex than HIV/AIDS prevention. Among females, these measures were more to do with ensuring individual security to resources under the custody of males. For example, some female participants indicated that fear of their main partner getting another sexual partner would entail them either losing user rights or sharing of a man's resources. However, among males it was more to do with their identity. That is, it was shameful for a man's wife to have sexual relationship with other men. This was taken as a failure of the man to control and satisfy his wife sexually, which was demeaning to his identity.

Meeting a partner's needs

Some research participants believed that people become unfaithful to their partners because their needs are not met. However, as established in this study these needs were gender specific. Among males they believed that their partner would be faithful to them if their "physical needs" are met by them. These physical needs were mostly centred on material satisfaction and they included but not limited to food, clothing, and shelter. For example, when Samson, 21, a married man was asked how he ensured his wife was faithful to him he replied:

> *Women are more attracted by physical things. For example, if you do not buy your wife good clothes or provides her with food she will easily be tempted by other men. In my case I have tried very much to see my wife is well dressed and gets any food she wants. I know for instance she likes meat, soda and bread. So I sacrifice the little money I get to provide her these things at least once in a week. This way she is not tempted to seek them from other men.*

However, among females these needs were found to be based on emotional satisfaction. As found out, most female research participants believed that most male partners become unfaithful because they are not sexually satisfied, do not feel loved and cared for by their main partners. Billian, 25, married woman explains:

> *Men are like young kids who must be pampered to remain faithful to you. So if you want your man to be faithful to you first and foremost ensure you satisfy him sexually. Men like sex more than food. So I know there are times you do not feel like doing it, but for the sake of your life do it. Also try to show love to him. Most important do care for him. For example, if he comes from a long journey just warm for him water to shower even if he has not asked you to.*

A critical look at Samson and Billian accounts reveals this strategy was based on the division of roles among the Abagusii. Among the Abagusii, for example, men were supposed to materially provide for their wives while women were to emotionally support them. Therefore faithfulness among partners would only be achieved when each partner plays his/her social role as prescribed in the division of roles.

Protecting the other partner

Some research participants argued that they ensured that their partner was faithful to them by taking measures which aimed at either preventing their main partner from knowing their unfaithfulness or deterring their main partner from being unfaithful. In the first case some research participants argued that they perceived themselves faithful to their main partner as long as their main partner was not aware of their unfaithfulness. This thinking was rationalized by the belief that a partner is more likely to become unfaithful if he/she suspects the other partner is unfaithful. In this regard these participants used various strategies to prevent the other partner from knowing their unfaithfulness. However, these strategies were not based on ensuring faithfulness as a strategy of HIV/AIDS prevention but of maintaining "good/clean" image on the other partner.

Beatrice Law, 23, a single woman student was involved in sexual relationship with other two partners apart from her main partner who was a fellow student. To ensure that her main partner remained faithful to her, Beatrice Law took measures which ensured that he was not suspicious

that she was unfaithful. According to her, these measures were based on keeping the main partner ignorant of the existence of the other partners. She explains:

> *Yeah my boyfriend is faithful to me though I am not. It is not my wish to be unfaithful. I know if he knows that I am not faithful he can either boot me or become unfaithful also. To prevent this I have taken some measures. First and foremost in my mobile phone I have not saved the number of one of my sugar daddies. Instead I have just memorized it. This is because he likes calling and writing short messages of love to me. So if he calls or writes a message when my boyfriend is there I easily argue it is a misplaced call or message. The other one never calls until I do. So in my phone I have saved him as my uncle. So even if I call him my boyfriend won't be suspicious.*

Gatura, 32, a married man with three children also said he feared his wife would either become unfaithful or divorce him if she knew he was unfaithful to her. Consequently, he took some measures aimed at preventing his wife from knowing his unfaithfulness. He reports:

> *Whenever I have extra-marital affair I must take a shower before going home. This is because my wife may suspect me and may wish to give me my young kid to hold as a way of proving her suspicion. So by taking a shower I can't harm my kid. However, I do not use any soap when showering because soaps in lodgings have a certain scent which my wife can easily smell. Also if I realize my wife wants to have sex with me I feign headache to avoid having sex with her. This is because she can easily know that I had an affair with another woman based on my performance.*

Other participants used strategies which were meant to deter their main partner from being unfaithful to them. These strategies were established to be used more by male participants and centred on creating a bad or unclean image on their possible sexual competitor. Oranjo, for example, reported that whenever he suspected a certain man was interested in his girlfriend he would go and tell her many negative things about the man. These negative things, although not true, centred mostly on the man's sexual behaviour and in the process giving indication that he was more likely to be infected with HIV/AIDS. All these were meant to deter or discourage the main partner having any relationship with possible competitor.

"HIV/AIDS protection" using "condom use strategy"

In HIV/AIDS prevention discourse condom use is mostly promoted as safer sex. According to Plummer (1988:44) the concept of safer sex represents "sexual experience that advocates bodily pleasure sex without exchange of bodily fluids." In safer sex discourse sexual activities may pose high, medium or low risk. Safer sex can also represent ways of dealing with negative images of sexuality by being innovative about sexual practices (Plummer, 1988:44). However, in this study the practice of "safer sex strategy in HIV/AIDS prevention" among the youths was influenced by assessment of risks based on lay logic and experience, power relation and social meaning of sex as hereafter discussed.

Quick sex or one night stand

While some youth knew that seminal fluids could transmit HIV/AIDS, they believed that their vulnerability to HIV/AIDS infection required "huge quantities of semen" which can only be acquired through long and repeated acts of sexual intercourse. This view of invulnerability was reported by Moturi Mangera, 21, a single man who worked in transport industry. He said:

> *Whenever I have sex with a partner I don't know very well, I have a very quick round, and immediately I take a shower or wash up my penis. You see a woman is likely to infect you in the process of her releasing her vaginal secretion. So the trick here is to ensure you have dry sex. It may chance that some of her vaginal secretion may have gotten into your penile opening but because you are having quick sex this may be pushed out when your sperms comes out. In this technique everything must be quick.*

A similar view was shared by Sabina, 25, a single woman. According to her she protects herself from HIV/AIDS infection by having only one round (stand) with any new partner. After that she takes a shower. Sabina explains:

> *Sometimes it is very difficult to deny a new partner who looks promising sex. Also you cannot ask him in the first time to use condoms. So to protect myself from HIV/AIDS infections, we only have only round. After this I take a shower immediately.*

Moturi Mangera and Sabina seem to share a view that limited bodily fluid exchange cannot predispose an individual to HIV/AIDS infection. The risk of HIV/AIDS infection is seen as rising progressively with the number of rounds of sexual intercourse, and brief encounters are constructed as safer sex. Contamination and predisposition to HIV/AIDS is tied up to "visible" amounts of fluids. This contention overlooks the fact that the HIV virus which causes AIDS is not visible to the naked eye, nor does it require concentrated amounts of fluid for contamination

to occur. Within their construction, the act of washing or taking a shower which leads to physical cleanliness also leads to "clean sex." Thirdly, these accounts, particularly Moturi Mangera's, seem to suggest that women being receptors of seminal fluids may be more vulnerable to HIV/AIDS infection. Moturi Mangera's lay view may have some scientific basis in that it links quantity of seminal fluids to the "risk" of infection. As Helman (1994) has observed, sometimes lay beliefs about disease explanations overlap with those of health professionals.

Further investigations revealed that the use of this strategy in HIV/AIDS prevention was also influenced by the social meaning of sex, especially among male youths. As found out male youths who used this strategy mostly associated condom use as not sex. This was evidenced when Moturi Mangera when asked why he preferred to use "quick sex or one-night-stand strategy" to protect himself from HIV/AIDS infection. He responded:

> *I do not think there is a man who can say having sex with a condom is sex. So men will prefer to have quick sex than have long and repeated intercourse with a condom. Quick sex is more exciting after all than using a condom.*

However, among female youths this strategy was influenced by cultural expectation of women sexuality. In this case women were expected to be passive and ignorant on matters of sexuality as a sign of purity and innocence. Therefore some female youths preferred to have quick sex or one-night-stand with any partner than being assertive on condom use as it betrayed their innocence and purity.

Reversal of sexual intercourse positions

Fitzpatrick (1990) has suggested that popular or lay beliefs are syncretic in their origins, having origins in a variety of disparate sources. Mary Kali, 25, a single woman who had many sexual clients for money said that she protected herself from HIV/AIDS infection by swapping sexual positions with her "suspicious" clients. She said:

> *There is a time when business is extremely low especially at mid month. At this time many working men are broke meaning getting a client for your service is extremely hard. Actually it is at this time when you find that those who want your service on your own assessment look "unhealthy." What is funny is that these people often pay more but hate using condoms. So since I need money I insist to lie on top of him during intercourse. This way there is greater probability he won't infect me. This is because of he won't ejaculate a lot of semen into me.*

This account was the only one reported in the sample of 100 subjects. However, it proposes another way of practicing safer sex. This validates Ingham *et al* (1992:166) argument that:

> *Feelings of invulnerability are enabled and maintained through a wide range of conceptions and misconceptions, in many cases indicating an understanding of particular parts of the "received wisdom" and filling out the gaps with "knowledge" gained through media, from friends or from "common sense."*

Mary Kali's account contains two issues: One, a linkage between appearance and disposition to HIV/AIDS (see below section on sex with "clean" people) and, two, it is consistent with Moturi Mangera's and Sabina's arguments which link quantity of fluid exchanged and vulnerability to HIV/AIDS infection.

Sex with "clean" people

Sabina associates sexual risk with "unhealthy and suspicious looking men" who pay extra for sexual services. However, those who look healthy, Sabina feels, are likely to be free from HIV/AIDS. Those who look healthy get unprotected sex, at less cost, while those who look suspicious and unhealthy are charged more, and have to be subjected to improvised "sexual technique."

Carol, 22, a single woman with secondary level education, who worked as a "trader", also said that she protects herself from HIV/AIDS by having sex with "clean" people. She reports:

> *Before I have sex with any man I must convince myself that he is healthy. So I observe him keenly to see if he is sick but concealing. Normally what I do is to ask him few questions like has he been adding or losing weight in recent past, why he shaves his head clean or why his hair is thinning and I can pretend to be admiring his skin then I ask him if his skin has been like that or it started being "good" in recent past. Also I observe if he has white thrash on his mouth or swollen glands. All these things are indicators that the person is sick and are avoided.*

Carol's account on "clean" people is based on lay persons' understanding of AIDS symptoms and side effect of antiretroviral therapy (ARV). In this case, losing weight swollen glands and white thrash in the mouth are taken as symptoms of AIDS. Weight gain, abnormal softening of body skin and thinning of hair which makes most people to shave are associated with the impact of using ARV.

Bosi, 27, a single man also said he protects himself from HIV/AIDS infection by having sex with "clean" people. However, his definition of "clean" people unlike in the case of Carol transcended lay persons' construction of a healthy person to include culturally prescribed attributes of female sexual partners. He explains:

> *Yeah before I even go to bed with a woman I can tell whether she is good or not. Take for instance you get a woman on the first day and within few minutes she is willing to have sex with you. What can you take of that woman! A clean woman must first and foremost resist all your advances and it takes time for her to accept you. But any woman who is immoral or sick just gives in almost immediately you make advances. Also before I start having sex with a woman I insert my finger first into her vagina. If it is extremely warm and it smells badly then she is sick. So I stop having sex with her.*

In Sabina, Carol and Bosi's accounts, construction of "safer sex" is sex with "clean people" whatever form of attribute one decides are sufficient to define a prospective sexual partner as "clean." Sabina's, Carol's and Bosi's conceptualization of sexual partner as clean and unclean illustrates what Waldby *et al.* (1993) found in Australia. In their study of AIDS discourse among young heterosexual men in Australia, they found a tendency to "create reassuring hierarchies of infectiousness, to give a predictable shape to the processes of transmission by designating certain categories of people to be more infectious than others.

This process of dividing, ordering, and creating hierarchies of the "clean and "unclean" is reiterated in biomedical assumptions, and in HIV/AIDS prevention programmes, leading people to identify themselves "invulnerable" through the avoidance of those they have socially labelled as *risky groups* (Abrams *et al.*, 1990). The avoidance of people known to have particular occupational, economic or physical attributes such as sex workers, the " promiscuous ", the " physically weak" or the " dirty" is part of a conceptual framework based on familiar medico-moral discourses which form part of AIDS prevention campaigns. Seropositivity is socially diagnosed by lay people, not through clinical symptoms or HIV antibody test results, but through social attributes. It is physical and social appearance which constitute the threat (Panos Dossier, 1990:24).

In the West, Ingham *et al.* (1992) observe that notions of safe partners and invulnerability to HIV are perpetuated through arguments such as: they are not "promiscuous"; they are "faithful"; they had only "serious" relationships previously; that they gave the "impression" of being safe

through their appearance; general personality, family and/or job; they had been tested; they were "known" by the respondents; or if the partner had AIDS they would have told me" (Ingham *et al.*, 1992: 166).

Further investigation revealed that most youths used "sex with clean people" strategy because of two reasons: One, cultural difficulties surrounding the discussion and negotiation of sexual interaction, and two, gender based power differentials in sexual relationships. On the former factor, most youths expressed difficulties in finding appropriate cultural language to negotiate sexual health histories with their partner. As noted among youths sexual interaction was more of "good image representation of self and the other." In this case sexual pasts are avoided either during first dating or sexual intercourse encounters. Maina, 25, a single man who worked as a foreman indicated that he preferred to have sex with "clean people":

> *It is indeed not good for you to start asking a person you want to have a relationship with about his/her past sexual encounters. In the first case it creates an image that the person is immoral or sick. Also the other person may also see you in bad light. Similarly in first sexual encounter it's equally difficult to introduce the issue of condoms. Due to all these it is much more easy and practical to deal with only clean people sexually. For me this is a better strategy to protect myself from AIDS.*

Other youths, especially females, indicated that they preferred to use "sex with clean people strategy" because of their powerlessness in negotiating for safer sex. Carol reported:

> *Women have no power to demand safer sex with any partner. You see like this trade of ours the man has money and you need it to meet your needs. In this situation it is the man who has power to call the shots. Due to this, it's important you choose keenly who to have sex with if you don't want to die of AIDS. Sometimes some men can agree to use condoms but once you go to the room they will refuse because they have paid you. So in this case if the man is not healthy he will give you AIDS.*

"Prevention of HIV/AIDS" using "VCT strategy"

As indicated in chapter Seven, VCT entails encouraging people who are sexually active or about to be sexually active to know their HIV status. This process is entirely voluntarily. However, due to high stigma associated with HIV/AIDS diagnosis some youths used various strategies in practicing VCT. These strategies were influenced by either fear of undertaking HIV test or coping with HIV positive test.

"My partner's HIV status is mine also"

Some research participants indicated that they feared going for HIV test because of psychological impact if they tested HIV positive. Therefore they relied on their sexual partners' perceived HIV status to "know their status". This strategy worked on the assumption that if a partner is infected then definitely the other partner is infected also. Faith, 20, a single woman who was involved with more than two sexual partners reported that she was not HIV positive because one of her sexual partner's wife tested negative to HIV in antenatal clinic. However, data revealed that Faith was not aware of HIV discordant cases among couples or sexual partners.

Onsarigo, a teacher with post-secondary level of education also feared going for HIV test. However, he knew he was not HIV positive because none of his sexual partners was sick or died of HIV/AIDS. He explained:

> *I have no AIDS because all my sexual partners are healthy. This means I am also healthy. I think this is the best way to tell your health. You see if you go to hospital and you know your status it will really affect you if you turn positive. However, with this strategy you silently know your status in a more humane way.*

Ambivalence

Ambivalence strategy was used by some research participants who were diagnosed HIV positive. As noted, these participants took ambivalent view of HIV diagnosis by redefining the diagnosis in a language that plays down the negative impact of the diagnosis. However, the accuracy of the biomedical aspects was not contested, but the social implications of overlapping a self-diagnosis with the biomedical diagnosis was an important way of managing HIV positive test. This is reflected by Roinyi, 33, a single man regarding his HIV positive test/diagnosis:

> *The doctor told me I have HIV but not AIDS. In this case I am healthy as long as I take care of myself. So if I avoid sex with people who may infect me with other diseases I can't develop AIDS.*

Roinyi's account reveals how HIV/AIDS can create social distance amongst and between those diagnosed to have the syndrome. In this case Roinyi goes through cognitive process of redefining HIV diagnosis by differentiating that he had HIV and not AIDS. In this process he perceives himself to be "healthy."

Roinyi's case of self evaluation was characteristic of many people diagnosed to have HIV/AIDS according to the head of Bonchari constituency AIDS control committee. This also fits well with Sontang's (1989:28) observation that, from the beginning, the construction of AIDS has depended on the notions that separate one group from the other; "the sick from the well", people with ARC from people with AIDS, then from us- while implying the imminent dissolution of these distinctions. In this case, to be HIV positive is not a matter of viral infection, instead it is contingent on interpersonal interaction and definitions. Therefore Roinyi's definition can be seen as tacit of avoiding acquiring a spoilt identity associated with HIV/AIDS diagnosis. This was, however, observed by the head of Bonchari constituency AIDS committee to be counterproductive in HIV/AIDS prevention:

> *I know some people who have tested HIV positive but still argue that they are healthy. To demonstrate their healthiness these people continue to engage in multiple sexual relationships while others, like women, try to conceive. All these efforts are meant to conceal their HIV positive status and show they are healthy.*

Denial

As found out in this study, some people who tested positive to HIV would not come into terms with their status and did everything possible to push it out of their minds. In most cases such people were noted to develop competing lay theories or behaved in ways which were aimed at concealing their HIV/AIDS status.

Moi, 27, a married man who was HIV positive had adopted denial as strategy for dealing with his HIV seropositive status. His interview account revealed a combination of strategies ranging from denial to ambivalence as he tried to shrug off his HIV positive diagnosis. He said:

> *I am sure I am being bewitched because of my involvement in crime prevention in this area. I strongly believe my aunt is responsible given I apprehended her son for stealing farm products. She vowed to teach me a lesson. Although prior to my being tested, I suffered from TB but I do not think that is AIDS. So I suspect my aunt has used some witchcraft which made me to test positive to HIV. I am saying this because I know some of my friends who have more sexual partners than me and have not tested positive to AIDS.*

It is clear from Moi's account that his discourse of denial is drawn from biomedical and traditional theories of disease causation. As evidenced in his accounts he explains his diagnosis by invoking first and foremost a "witchcraft theory"; a theory which is more powerful in the lay

culture of explaining disease causation. The strength of this theory lies in its unverifiable character which then absolves the individual, by attributing blame to some "evil aunt". It also serves to explain why a specific individual and not the others get ill.

In denying his HIV positive status, Moi trades his self-diagnosis against biomedical knowledge in trying to validate his claims that he had suffered from tuberculosis but not AIDS. Further, he is keen to know how he and he alone out of his friends, whom he presents as more promiscuous, could contract HIV. Within biomedicine, this relies on the doctrines of specific aetiology, this question of "*why me*" cannot be answered. The germ theory only explains that disease is a result of causative agent, but may not explain *why* a particular person and not others fall ill.

Acceptance

Some research participants were not surprised when they test positive to HIV. This was because of their past sexual history. For example, Jamal, 32, who was involved in multiple sexual relationships said:

> *Testing HIV positive was not a surprise. Actually my surprise will have been if I tested negative. I think my lifestyle and the friends I kept with prepared me for this eventuality.*

A similar view was shared by Nyaboke, 27, a widow who said:

> *I had complained to my husband about his behaviour but he never did anything. I heard many stories that some of the women he was seeing were sick from AIDS. So when he started ailing I knew he would die of AIDS. Since I was his wife definitely I knew I was infected.*

Further investigation revealed that some youths, like Jamal, who had accepted their HIV positive status were actively involved in HIV/AIDS prevention activities by going public about their HIV positive status. As found out in this study, going public was used as a tacit of managing HIV stigma as Jamal explains:

> *When I was tested and later my wife died many people did not want to associate with me. I realized this would affect me. So I decided to go out in public places and talk about my experience with HIV/AIDS. Initially people dismissed me given my status. I remember I was even denied entry to one of the local churches. With time people realized I was playing an important role in preventing AIDS. So nowadays many people have accepted me as one of their own who is playing an important role.*

Summary and Conclusion

This chapter has examined the ways in which Abagusii youths prevent HIV/AIDS using ABC and VCT. Because sexuality is socially constructed and gendered, the chapter notes that effective intervention on HIV/AIDS using ABC and VCT does not lie in rigorous depersonalized HIV/AIDS prevention campaigns. This is because sexual practices are culturally produced and mediated. Therefore predicting sexual behaviour on the basis of assumption of "rationality" as advocated by ABC and VCT approach is misleading. Instead the chapter observes that adoption of safer sex practices especially Abstinence, Be Faithful and Condom use depend on power relationships, identities and social meaning of sex. However, the adoption of VCT was more influenced by stigma associated with HIV/AIDS. In sum sexual behaviour advocated by ABC and VCT approach to HIV/AIDS prevention can only be achieved when they are built on lay social construction of sexuality and on the ways youths make sense of those approaches in their lives.

CHAPTER NINE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter discusses the main findings generated from 100 in-depth conversational interviews with Abagusii youths. These findings are in relation to the study objectives which were; to find out how youths accessed HIV/AIDS prevention strategies information, the impact of HIV/AIDS prevention strategies on meaning formation with regard to sex and HIV/AIDS prevention, how youths interpreted cultural meaning offered by HIV/AIDS prevention texts and how youths social construction of sex influences the interpretation and action towards ABC and VCT. These findings are interpreted in relation to social construction theory which informed this study. These interpretation provides the basis for generating new ways of understanding how youths make sense of HIV/AIDS prevention texts namely Abstinence, Be faithful, condom use and VCT targeting them from their own cultural perspective. The chapter begins with a summary of key findings of the study by highlighting the discrepancy emerging with regard to youths' engagement in risky sexual practices despite their near-universal knowledge of HIV/AIDS prevention strategies. The chapter then discusses how youths make sense of the cultural meanings of Abstinence, Be Faithful, Condom use and know your status (VCT) and in particular it examines the processes and structures which youths use to generate meanings of sex and HIV/AIDS prevention strategies. In doing so, this chapter illustrates that the interpretation of Abstinence, Be Faithful, Condom use and Know your status which determines individual action towards HIV/AIDS is influenced by the social construction of sex in particular social, cultural, economic and political contexts. This process of meaning formation in essence undermined individual- centered approaches such as the ABC and VCT HIV/AIDS prevention strategies because individuals' knowledge and practices were socially and culturally sanctioned through the collective lens of the group. Lastly, the study gives recommendations and recommends areas for further research.

Knowledge, Attitudes and Practice: The missing gap

In Kenya HIV/AIDS campaigns programmes have focused on information supply and promotion of safe sex practices. These campaign programmes are based on theory of reasoned action or planned behaviour change. The assumption in these theories is that people fail to adopt new ideas

or to respond positively to risky situations because they lack information. Consequently, most HIV/AIDS campaigns targeting the youth aim at empowering them with information on the mode of HIV transmission and ways of avoiding risk of HIV infection. By doing so, these programmes assume that a person will make rational decision in avoiding risky of HIV/AIDS infection. To effectively reach youths, HIV/AIDS campaigns used both mass media and interpersonal communication strategies.

Consequently, this study found that youths accessed HIV/AIDS information from mass media such as posters, leaflets, Billboards, newspapers, television and radio; and interpersonal communication media such as peer counselling, public meetings, seminars, workshops and conferences and funerals. In regards to mass media, this study found that HIV/AIDS information was found to rely on top-bottom approach where information only flows from one direction that is from implementers of HIV/AIDS campaigns with no reference or input from those targeted. In this case mass media were noted to be universally executed with no regard to the target group social, cultural, economic and political contexts. This negation was found in this study to affect youths' access to HIV/AIDS information, interpretation and practices towards HIV/AIDS prevention. For example, cultural and economic factors were found to negatively affect youths' access to HIV/AIDS information in mass media. That is mass media sources such as newspapers which attracted economic cost for one to access HIV/AIDS information were avoided by youths. This avoidance was also found to be influenced by cultural gender norms governing dissemination and access of information.

On the other hand, interpersonal communication media was found to involve closer interaction where issues were debated between implementers of HIV/AIDS campaigns and target groups. Interpersonal communication media were either forma or informal. Formal interpersonal campaigns were characterized by well structured organization with clear objectives and methodology. They were mostly conducted by people who had undergone some form of training or had some know how on HIV/AIDS and they included peer counselling, public meetings, conferences, workshops and seminars. Informal interpersonal communication media on the other hand was a form of endogenous communication system where people used informal media for personal and group information sharing and discussions. In this case they utilized values,

symbols, institutions as contained in their social system to communicate. Example of informal media in this study was funerals.

Despite massive use of these strategies, research findings revealed a discrepancy between youths' perception of HIV/AIDS prevention strategies and their adoption of these strategies in their lived experiences. For example, despite the fact that majority of the youths were aware of abstinence from sex, Being faithful, condom use and knowing one's HIV status (VCT) as realistic ways of preventing HIV/AIDS infections, research findings, however, revealed that majority of the youths had engaged in sex with a person of opposite sex and were involved in multiple concurrent sexual relationships. Consistent condom use was also found to be significantly low with majority reporting none use of condoms.

The discrepancy between youths' perception of HIV/AIDS prevention strategies and adoption of these strategies in their lived experiences was found to be due to the way HIV/AIDS prevention campaigns targeting them were organized and executed. As evidenced in this study HIV/AIDS prevention campaigns targeting the youths were greatly influenced by biomedical approach whereby HIV/AIDS prevention strategies were universally promoted to all people with no regard to their social, cultural, economic and political contexts. The negation of these factors was found to affect negatively youths' perception to HIV/AIDS, HIV/AIDS prevention strategies and sexual behaviour.

As this study found out most youths never identified themselves with either HIV/AIDS messages or HIV/AIDS prevention strategies partly because of the language used. Given the fact that language goes hand in hand with social and personal identity, the use of Kiswahili, English or *Sheng* and celebrities which most rural youths did not identify with, made them not to identify themselves with such HIV/AIDS information. Instead most of them perceived HIV/AIDS as either a problem not affecting them or HIV/AIDS prevention strategies which were being advocated as not targeting them. All this affected negatively the adoption of HIV/AIDS prevention strategies. This finding to a large extent validates Parker (1994) finding that media cannot be divorced from social processes that seek to promote change. Therefore if media is to

be functional to these processes, it must incorporate community perspectives in production of its products.

In addition, the use of single universal language to disseminate HIV/AIDS information with no regard to individuals' socio-cultural contexts, made such information to be misinterpreted. Worse it fortified certain sexual behaviour which such information aimed to change. In this study, for example, some HIV/AIDS campaigns promoting condom use and partner fidelity were noted to use language which depicted women as passive participants in sexual decision making. This depiction fits well with values, rules and norms in most patriarchal societies such as the Gusii where women are supposed to be passive on issues of sexuality. Therefore such language fortified women's subordinate position in issues of sexuality instead of empowering them. Consequently, this not only influenced how youths made sense of HIV/AIDS prevention strategies but also how they practiced their sexuality in relation to HIV/AIDS prevention in their lived experiences. As evidenced in **chapter seven**, for example, due to the language used to promote condom use, most females interpreted condom use as solely a male decision. This interpretation was found to influence most women not to demand safer sex from their partners even when they are at risk of HIV/AIDS infection.

Similarly, the use of single universal language in all HIV/AIDS campaigns in different social, economic and cultural contexts was found not to bring about desired sexual behaviour change among youths. As a fact, the way language is used in communication is important in determining whether that which is intended to be communicated is understood by recipient. Consequently, this study found that the use of single language to disseminate HIV/AIDS information in different contexts created different meanings/ interpretation among youths. These meanings/interpretations in most cases were noted to be contrary to campaigners' objectives. This is because meaning in language use is context dependant. For example, the use of euphemisms and lexemes such *Manyake* (**see chapter six**) which among Abagusii youths meant meat to encourage condom use and fidelity, was instead found to encourage concurrent sexual relationships because of the belief and knowledge among many youths that meat from different animals tastes differently. Therefore in this context many youths interpreted such messages to infer that sex with different partners gives one different sexual experiences which is contrary to HIV/AIDS prevention campaigns intended meaning and sexual practice.

Apart from language, this study found that the top-bottom approach which was adopted in the organization and implementation of HIV/AIDS prevention campaigns made most youths to have unfavourable attitudes towards HIV/AIDS and HIV/AIDS prevention strategies. In this top-bottom approach, HIV/AIDS prevention campaigns were organized and implemented with no reference to people's socio-cultural, economic and political factors. For example, it was found that most HIV/AIDS campaigns which were carried out by the radio and television were done shortly before broadcasting of daily news in the evening so as to have wider reach. However, carrying HIV/AIDS campaigns at this time when all family members were gathered for the day's news made most of them not only uncomfortable but also distaste such messages. Consequently, most of them did not want to be associated with such messages because they failed to respect the social principals governing social behaviour which forbids discussion or talking of issues related to sexuality among people who exercise different moral constraints.

In similar vein, lack of appreciation of youths' socio-cultural, economic and political factors was also found not only to influence how they made sense of HIV/AIDS but how they adopted prevention strategies. For example, most females were powerless to adopt HIV/AIDS prevention strategies like abstinence, condom use and faithfulness because of these strategies did not take into account rules, norms and values governing gender and sexuality. Consequently, most females resorted to adopting various strategies which did not contradict the rules, norms or values governing gender and sexuality such as going to church, use of magical measures, avoidance and joining economic empowerment groups "*Sebokia*". Most of these adopted strategies, however, were contrary to those advocated by HIV/AIDS campaigns.

Results from this study also showed that most HIV/AIDS campaigns targeting the youths individualized risk of infection and adoption of prevention strategies. Yet in non-western communities like the Gusii, risk is not experienced, anticipated and countered in relation to individuals, but to a network of social relations. Due to this, individuals emphasized different risks. For example, in this study risk to HIV/AIDS infection was seen as secondary when compared to individual identity and social status arising from practicing sexuality. Also individuals were not ready to adopt HIV/AIDS prevention strategies like condom use or Being faithful when their social status or identity in the eyes of their social network was at stake. Instead, as noted in this study individuals were more than willing to adopt counter "HIV/AIDS

prevention strategies" which enabled them to meet socially and culturally prescribed obligations at the expense of disease prevention.

Lastly, this study found that youths risk sexual activities were entwined in the pattern, processes and structures that underpinned meaning formation with regard to sex, HIV/AIDS and HIV/AIDS prevention. As noted from study findings, youths sexual practices were often predicated upon an understanding of sex and HIV/AIDS that was based on frame of reference which drew from a variety of competing discourses. These discourses contributed to the formation of sexual identities and subcultures which supplied the frame of understanding through which youths made sense of HIV/AIDS prevention strategies. However, as illustrated from study findings, most HIV/AIDS campaigns did not take account meaning-making processes in different social, cultural, economic and political contexts thus rendering such campaigns ineffective.

Meaning Formation of HIV/AIDS Prevention Strategies

This study established that youths understanding of sex, HIV/AIDS and HIV/AIDS prevention strategies (Abstinence, Be faithful, Condom use and VCT) was influenced by their daily experience within their social groups. In this regard their understanding was found to draw from various competing discourses, ideologies, structures and social norms within their social network. In this regard, for example, abstinence among youths who were not sexually active was understood from moralistic perspective as virginity preservation, chastity and cultural and religious obligation. Among sexually active youths, abstinence was understood as sexual abnormality.

"Be Faithful" was found to be understood as "commitment to serious relationship or to a serious marital relationship. This interpretation was found to exclude those who engaged in sex for fun and friendship. "Be faithful" was also understood by others as protecting main sexual partner. Among this group, individuals practiced faithfulness by undertaking steps to protect their main sexual partner from either HIV/AIDS infection by using condoms during sexual intercourse with concurrent sexual partners or emotional harm by discreetly engaging in concurrent sexual relations. Others understood "Be faithful" as sticking with one sexual partner and as religious and cultural practice. However, some understood "Be faithful" as sexual abnormality.

Condom use was found to be understood as HIV/AIDS prevention and as a last option. Others understood condom use as lack of trust especially among youths in a serious sexual relationship. Among other youths, condom use was interpreted as not sex. This interpretation was established to be influenced by young peoples' meaning of sex and the perceived role of sperms in sexual relationship.

VCT, on the other hand, was socially understood as 'taking responsibility', 'facing reality' and as a sign of poor health. Some youths argued that they did not want to undertake VCT because they were not ready to face the reality of possible HIV infection, whilst others thought that their partners would hold them responsible for their HIV status, hence they were not ready to take this responsibility by testing. Some youths argued that they had not tested for HIV because they were not sick.

The meanings generated by youths in relation to their sexual behaviour and HIV/AIDS prevention strategies were found to be intersubjective in nature (Berg and Luckmann, 1966). This subjectivity was noted not only in the nature of meaning but also in how those meanings were expressed by individual youths. As evidenced in **chapter seven**, for example, individual youths tended to interpret HIV/AIDS prevention strategies in relation to others in their social, cultural, economic and political context. This kind of interpretation clearly illustrates a frame of reference that draws from the collective rather than individual meanings and identities as found in most African communities. That is group reference is more dominant as expressed in most African communities maxim" *I am because they are*" (Foster, 2006; Mbithi, 1974).

Similarly, drawing from Mead's concept of symbolic interactionism, Berg and Luckmann (1966) argue that individuals construct their own identities through social construction with others. Therefore in this study collective identities were found to define how individuals interacted with HIV/AIDS prevention strategies messages. That is they not only defined individuals roles in meaning formation but also the strategies used to understand HIV/AIDS prevention strategies and subsequent practice/action in particular context. Consequently, individuals were found to make sense of HIV/AIDS prevention strategies through multiple interpretive strategies as defined by the socially constructed meanings of sex and HIV/AIDS. The discourses of sex and

HIV/AIDS were therefore found to provide individuals with interpretive repertoires through which they made sense of their sexual practices and of the texts relating to HIV/AIDS prevention.

In relation to the above observation, this study found that sexual identities played significant role in both the interpretation and subsequent sexual behaviour in relation to HIV/AIDS prevention. Sexual identity in this context, however, does not refer to sexual orientation that is in homosexual-heterosexual dichotomy. It instead relates to either engagement or non-engagement in sexual relationship within heterosexual collective. In this study two distinct cultural categories were noted among youths based on either engagement in pre-marital sex or not. These two categories drew their interpretative repertoires from their social construction of sex as contained in traditional or religious discourses. For example, among youths who had not engaged in premarital sex and considered themselves religious perceived premarital sex as immoral or sinful. On the other hand, those who were sexually active considered engaging in sex as cool and therefore saw non engagement in sex as abnormal.

In these two distinct cultural categories, this study found that a form of power relationship existed which was defined in terms of social inclusion or exclusion. This power relationship was evident when each cultural category tried to subvert hegemonic power of the other category by generating their own meanings of the texts. For example, those youths who were abstaining were considered "abnormal", "not mature", "naive" and "not sexually attractive" especially among females. Consequently, those who were abstaining were seen to be of lower social status within youths' social hierarchy system as demonstrated by 25 years old Mr. Ondigi:

> *Few months after seclusion period many of my peers started despising me whenever I told them I had not "slept" with any girl. Whenever we were discussing anything my opinion was not taken serious simply because to them I was still a child. Some of my peers even went further to question if indeed I was functional sexually after circumcision. Worse still even girls started telling me into my face I was infertile "riteba" and other men would help sire me children. I had to do something to save my status and identity by having sex with a girl who was my classmate*

As evidenced from Ondigi's sentiment, it is clear that social exclusion was used by youths to pressurize non- sexually active counterparts to engage in sex in order to attain certain prescribed social identity.

On the other hand, social inclusion was also used by non-sexually active youths to justify abstinence. In this case social benefits were used to justify the practice of abstinence. For example, those females who interpreted abstinence as preservation virginity saw abstinence as the only sure way of being ideal marriage partners given the fact that culturally a woman who was perceived as promiscuous was not regarded as a potential marriage partner. This potentiality was determined by whether a woman was a virgin or not. Therefore, given the central role of marriage in a woman's life such as; it accords her proper identity, enables her to access resources, abstinence is then seen as functional.

Although the nature of power dynamic was important in influencing youths' engagement or non-engagement in sexual activity, this study found that it was youths' sexual identities that supplied discourses for making sense of sexual practices and HIV/AIDS prevention texts. That is the interpretation of Abstinence, Being faithful and condom use was found to be predominantly influenced by youths meaning of sex as contained in religious and cultural discourses. For example, among youths who subscribed to religious and cultural ideals of pre-marital chastity, abstinence was interpreted as a religious, moral practice and virginity preservation. This interpretation was more common among females and was more motivated by the desire to uphold cultural or religious ideals of sexuality than avoiding HIV/AIDS infection. These ideals emphasized that a female's social reputation and status as potential wife depends on her ability to avoid engaging in sex from early age or with multiple partners. On the other hand, male youths interpreted abstinence as postponing having sex in some occasions due to certain prevailing circumstances. This interpretation of abstinence therefore met the cultural definition of manliness which was denoted by sexual activeness and at the same time indicating that an individual was taking precaution sexually.

Similarly, this was also reflected in the interpretation of "Be faithful". For example, among the youths who were engaged in multiple sexual relationships, "Be faithful" meant protecting the main sexual partner from HIV/AIDS infection by practicing safe sex with other partners. In this

case concurrent sexual partnership was permissible as long as one undertook steps to ensure that the main sexual partner is protected. In this study, however, protecting the main sexual partner was found to be influenced by gender and marital status. Among married women, protecting of sexual partner was more influenced by supernatural retribution associated with marital infidelity than HIV/AIDS, while in men it was do with image maintaining like being seen as caring by not hurting the main sexual partner emotionally by engaging in concurrent sexual relationship discreetly.

The adoption of HIV/AIDS prevention strategies was also found to be influenced by youth sexual identities as contained in religious and cultural discourses of gender and sexuality. For example, those females who were sexually non-active and interpreted abstinence as either religious / cultural moral practice or preservation of virginity practiced abstinence by either going to church or getting saved. These strategies of practicing abstinence were, however, found to be motivated more by cultural and religious construction of gender and sexuality than HIV/AIDS prevention. As noted in this study the church was associated more with Christian moral teachings which emphasize pre-marital chastity until marriage. These teachings are consonant with cultural attributes of potential marriage partner. Consequently going to church or getting saved confers to (saved) female churchgoers the good attributes of a marriage partner. Going to church or getting saved also acted as a strategy of warding off undue pressure of engaging in sex with potential marriage partner because of lack of power in issues of sexuality due to their social and economic disadvantaged positions. Therefore women used religious teachings on morality which emphasized pre-marital chastity to ward off any pressure of indulging in sex.

Among those sexually active youths who interpreted "Be faithful" as commitment, protecting sexual partner and as religious and cultural moral practice used monitoring, magic-religious measures, meeting a partner's needs and going to church strategies in practicing faithfulness. These strategies, however, were found not to be motivated by HIV/AIDS prevention but the social construction of sex as contained in religious and cultural discourses. For example, among females monitoring and use of magic-religious measures was more to do with protecting one's "territory from encroachment by competitor" due to social construction of sex as initial step towards marriage. Marriage in this case is constructed as a means of accessing resources which

culturally was under the custody of men. However, among men monitoring and use of magic-religious measures was more to do with protecting one's identity by avoiding the shame associated with sharing a partner with other men.

In addition, this study found that the adoption of condom use as HIV/AIDS strategy was influenced youths' social construction of sex than HIV/AIDS prevention. For example among youths who interpreted condom use as not sex preferred to protect themselves from HIV/AIDS by having sex with "clean people." Sex with clean people in this context was based on lay persons understanding of AIDS symptoms and side effect of antiretroviral therapy. Sex with "clean people" was preferred to condom use because most youths believed that for sex to be complete it must involve the exchange of body fluids. Exchange of body fluids like sperms in this case was constructed more in terms of their symbolic importance in sexual relationship than biological functions like procreation as discussed in **chapter eight**.

Similarly, the adoption of VCT as HIV/AIDS prevention strategy was found to be done in a manner that rationalized why individuals within groups refused to undergo HIV test. For example, those who interpreted VCT as "taking responsibility" which meant that in case one tested HIV positive, he/she will owe explaination about their HIV status. In this case, undergoing VCT was seen as collective decision rather than individual. Consequently, to avoid undergoing VCT some youths were found to depend on their partner perceived HIV status to know their status.

This study also found that there was overlapping in interpreting and adopting of HIV/AIDS prevention strategies among those who were sexually active and not sexually active in relation to their social construction of sex. This overlapping was noted to allow individuals to participate in, and draw meaning in interpreting and adopting HIV/AIDS prevention strategies from either category simultaneously. For example, females who were not sexually active practiced abstinence by either avoiding situations which will put them under undue pressure to indulge in sex such as being in private places with a man alone or being in a company of peers who are sexually active. Among sexually active females, this avoidance strategy was, however, used more for impression management than indulging in sex. That is these females used avoidance as a strategy of avoiding being labelled immoral so as to achieve culturally prescribed attributes of

ideal sexual partner. Therefore this overlapping was influenced not only by construction of sex as signifier of social identity but, also, as a ritual through which an individual obtains acceptance to a certain group.

This study further found that the nature of interpretations of Abstinence, Be faithful, Condomise and VCT among sexually active and not sexually active youths often took the form of negotiated and, in some instances, oppositional reading. Abstinence was often interpreted through the moralistic code as a religious issue or virginity preservation. In this case, Abstinence was conceived as appealing only to those who subscribed to such religious or traditionalist ideals. For others, however, Abstinence was perceived as 'abnormal', 'sexual naivety', or as 'denial of sexual freedom'. These oppositional interpretations were seen mainly as a response to the way abstinence was presented, rather than the concept itself. This is underscored by Mr. Onchiri argument that, "*some people who think they have monopoly over young people have gone ahead to decide on how to manage our life. From telling us not to seek political leadership for we are future leaders, now they have unashamedly gone ahead to decide for us on how to practice our sexuality. Everywhere and every time they keep on telling us, "young man, young woman and young what! Do not engage in sex; abstain as sex is for the future and old people." Yet they forget sex is a private issue and we have freedom to decide what to do with our life.* In this case, the moralistic discourses of sex are perceived in terms of power as instruments of control.

Be faithful was often interpreted as a commitment to a serious or marital relationship. The majority of participants argued that they were not practicing "Be faithful" because they were not in serious relationships. This understanding, therefore, redefines "Be faithful" in such a way that it is perceived as being aimed only at those who are in a serious relationship and who are intending to marry, eventually. For others, "Be faithful" meant 'protecting' the sexual partner, hence; one could have more than one sexual partner as long as the main partner was protected from HIV infection by having protected sex with the other partners. These interpretations re-define the notion of "Be faithful" in a manner that produces new meanings, which then formed the basis through which individuals determined whether "Be faithful" applied to them or not.

The interpretation of Abstinence, Be faithful, Condom use and VCT was also found to be influenced by moralistic code which was perceived as "disciplinary power". In this case, the discourse of morality acts as apparatus of surveillance and control through what Foucault refer to "discipline". According to Foucault, "discipline" is a form of social repression instituted by societies through discourses that seek to normalize certain practices while constructing others as preserve (Foucault, 1977). For example, Be Faithful among male was interpreted as sexual abnormality and hard to practice. This interpretation arose from cultural construction of male sexuality as contained in religious and cultural discourses and attendant functions of concurrency sexual relationship such a symbol success. Therefore men who were faithful to their partners were considered as unsuccessful and controlled by their partners- attributes which were not manly. On the other hand women were expected to be faithful to their partners because culturally it was perceived as a good attribute of being a good wife and being their sole responsibility. Consequently, "Be faithful" in this case was rationalized as being applicable to women only. This rationalization was normalized by values, norms and rules governing gender and sexuality. For instance, as found in this study married women were supposed to be faithful to their partners as away of protecting them from supernatural retribution "*amasangia*" associated with marital infidelity. In this case "Be faithful" was seen as "panoptic watchtower" through which religion and culture institute their power of control over individuals' sexuality. Therefore, women understood faithfulness in terms of conformity with religious and cultural discourses governing gender and sexuality.

In some instances, however, the disciplinary power was also found to locate the meaning of sex and HIV/AIDS prevention strategies within the discourse of power and resistance. For example, among sexually active male youths who perceived themselves as having been under strict social control by parents prior to circumcision, engagement in sex was understood as a symbol of freedom and adulthood. Others, similarly, rejected the notion of abstinence, arguing abstaining denied individuals biological pleasure. These interpretations show that abstinence was thus oppositionally interpreted as a means of restricting individual's engagement in sexual pleasure. In this case also, abstinence was interpreted as "panoptic watchtower" through which religion and culture instituted their power of control over individuals' engagement in sexual pleasure.

Therefore, they understand their engagement in sex as a resistance to the power of religious/traditional cultural discourses.

Arising from this perspective of power and resistance, it is clear that opposition interpretation of HIV/AIDS prevention strategies did not result from polysemic nature of ABC and VCT. As found in this study, most youths understood the connotative meaning of HIV/AIDS prevention strategies. However, they deliberately mobilized interpretative strategies that generated meaning which rationalized their engagement in sexual practices. This rationalization was influenced by the meanings of sex as contained in religious and cultural discourses.

Lastly, the interpretation and adoption of HIV/AIDS prevention strategies was found to be influenced by the discourses of power. These discourses of powers drew their authority from norms, values, rules and taboo governing gender and sexuality. In this case these discourses of power created social conditions that influenced how individuals interpreted or adopted HIV/AIDS prevention strategies. For example, in this study women were found to interpret Abstinence, Be Faith, Condom use and VCT in relation to their power relationship with men. That is, due to their subordinate position, they tended to interpret HIV/AIDS prevention strategies in ways that were not in conflict with men's authority and power in issues of sexuality. Therefore in most cases women were found to interpret HIV/AIDS prevention strategies in away that met culturally prescribed rules, norms and taboos of gender and sexuality. This was also reflected on how they adopted HIV/AIDS prevention strategies as discussed in **chapter eight**.

In summary this study has shown that youths make sense of HIV/AIDS prevention strategies (ABC and VCT) in relation to their social meanings of sex. In particular, the study has demonstrated that youths drew their interpretative codes from their group membership which was defined by their sexual identities. Sexual identity in this context was construed in terms of engagement or non-engagement in sexual relationship within heterosexual collective. Consequently, youths constituted themselves into two cultural groups that is those who have engaged or not engaged in sexual relationship. Each group therefore supplied its members with discourses and interpretative strategies for making sense of their sexual practices, HIV/AIDS and HIV/AIDS prevention strategies in relation to their social meanings of sex.

These discourses and interpretative strategies in each cultural group were, however, characterized by power relations with social hierarchies and system of control such as social exclusion and inclusion. Due to these power dynamics, individuals' behaviour was often aligned towards group meaning rather individual volition. This means that the interpretation and adoption of HIV/AIDS prevention strategies was determined by group membership. Therefore this study argues that that HIV/AIDS prevention campaigns which appeal to individual action are ineffective in the context where individual behaviour is determined by collective frames of understanding as defined by social, cultural, economic and political factors.

In conclusion, while appreciating the vital role of structural and contextual factors in influencing sexual behaviour, it is equally important to take into account meaning formation process in understanding individuals' behavioural responses to HIV/AIDS prevention campaigns. As evidenced from study findings in order to understand the impact of HIV/AIDS prevention campaigns among the youths its important to take into account the mediation process involved in making sense of HIV/AIDS prevention strategies than focusing on changes in individual's knowledge, attitudes and practices related to HIV/AIDS. This shift is important because it will not only help in understanding how individuals make meaning of HIV/AIDS prevention strategies, but also the structures involved in meaning formation. By focus on this, it will be easy to understand why HIV/AIDS prevention campaigns fail to bring about sexual behaviour change among youths in different contexts.

Recommendations

This study acknowledges the important role played by various sources of HIV/AIDS information in the fight against HIV/AIDS among the youths. However, access to these sources was found to be negatively affected by social, cultural, economic and political factors. Therefore this study recommends that HIV/AIDS prevention programmes should take into accounts these factors when targeting the youths in different contexts. One way of achieving this is by coming up with affirmative action which aim at empowering the youths socially, culturally and economically at different contexts. This is important because dissemination of HIV/AIDS information especially that involving mass media wrongly assumes that all youths irrespective of their diverse social,

cultural and economic status can be reached and influenced by same medium of communication. However, this is not possible given this study found that different youth from diverse social, cultural and economic contexts were influenced and accessed differently HIV/AIDS prevention information from mass media. For example, the radio was found to be a common source of information but women had limited access to it because of gendering of information associate with the radio. On the other hand, print media like newspapers and posters were apt among educated youths; however, the use of English, Kiswahili or *Sheng* excluded many of them. In this sense it is important to for HIV/AIDS campaigns to use various forms of mass media for different target groups. These forms of mass media should be compatible with target groups' social, cultural and economic contexts. To achieve this, HIV/AIDS campaigners should develop a feedback system through which they can understand the reaction of the audience towards their programmes as promoted by various sources of media. This will enable them make necessary adjustments so as to suit the needs of the targeted groups without necessarily changing the content of their messages.

As evidenced from this study the transmission of HIV/AIDS can be argued to be facilitated through social relation and institutionalized cultural values. HIV/AIDS prevention thus demands change in these social relations and alterations in these institutional values, and norms. This is because the decision to adopt HIV/AIDS prevention strategies such as Abstinence, Be faith and Condom use is not an individual autonomous decisions. However, HIV/AIDS prevention strategies targeting the youth were found to promote rational decisions on sexual behaviour at individual level while ignoring the wider social framework in which sexual relationship are constructed and gendered. This negation was found by this study to make HIV/AIDS prevention strategies ineffective. This is because the adoption of HIV/AIDS prevention strategies was found to be influenced by social meanings of sex and symbolic meanings associated with HIV/AIDS prevention strategies. Consequently to make HIV/AIDS prevention strategies to be effective, HIV/AIDS prevention campaign programmes must do the following:

First, the social meanings of HIV/AIDS prevention strategies which are not conducive to HIV/AIDS prevention must be changed. For example, as evidenced in **chapter seven**, condoms carry a host of social meanings which impacted negatively the use of condoms. Therefore

changing these social meanings associated with condom use is essential for successful condom use promotion campaign. This can be achieved by promoting the act of using a condom as fashionable and a sign of care among sexual partners.

Second, the imbalance in gender power relations may need to be addressed so that women can have power to make decision on issues of sex. This is crucial despite the fact that gender inequalities have legitimacy in local cultures. To achieve this, this study recommends for enactment and in some case strengthening of existing legislations that safeguards the rights of sexual partners, by securing the right of an individual to refuse sexual advances if they have cause or reason to suspect their sexual partner present a risk of infecting them. However, it is important to recognise the fact policing private sexual behaviour; even by enacting laws that protect individual rights is not panacea to the transmission of HIV/AIDS. Therefore this study advocates for transformation in sexual culture, and the organization of sexual and social relationship. One strategy is to take advantage of indegeneous sex education and health discourses which act as disciplinary power mechanism which determine how individuals practice gender and sexuality. These disciplinary power mechanism as noted in this study were reinforced by language, values, norms, rule and taboos as contained in social institutions. For example, in this study values and social norms legitimizes men as decision makers and protectors of women especially their wives. Therefore using men's cultural roles, HIV/AIDS prevention campaigns should empower men to understand that they have responsibility to protect women health and reduce the transmission of HIV/AIDS and meet their wives basic needs. This means programmes which aim to empower women from women-gender perspective are not likely to succeed especially in relation to HIV/AIDS prevention activities. As behaviour change theorists rightly point out, before anyone can change their behaviour they need to know and realise the need to change behaviour and this is always done in relation to one's cultural values and beliefs. It is therefore important to empower the men to dictate safe sex practices by providing them with discourses that appropriate, rather than resist, existing ones.

Given that the current HIV/AIDS information, education and communication are perceived as externally imposed and culturally alienating, an understanding of traditional sex education can be analysed to identify indigenous role models. This can be achieved by HIV/AIDS campaigners

identifying various aspects within traditional sex education which are in line with objectives of various HIV/AIDS prevention strategies. This congruence between traditional sex education and objectives of HIV/AIDS prevention strategies can then be used to bring about sexual behaviour change. For example, HIV/AIDS campaigns can use the religious and cultural understanding of faithfulness as protecting a sexual partner to promote "Be faithful" in relation to HIV/AIDS prevention. In religious and cultural interpretation, protecting of sexual partner is more influenced by supernatural retribution called "*amasangia*" which can cause death or harm to family members due to marital infidelity (**see chapter seven**). Therefore in promoting faithfulness, HIV/AIDS campaigners can base their promotion on local understanding of "amasangia" to bring about sexual behaviour in relation to HIV/AIDS prevention.

Similarly, in promoting Abstinence especially among young women, HIV/AIDS campaigners can take advantage of female socialization of sexuality. Given the fact in HIV/AIDS prevention discourse, abstinence is means not engaging in sex, it resonates well with culturally defined way of sexual practice among women. That is, female's social reputation and status as potential future wives depended on their ability in avoiding engaging in sexual activities from early age or with multiple partners. Therefore HIV/AIDS campaigners can use this knowledge to promote abstinence by highlighting how HIV/AIDS can negatively impact their reputation and status as potential wives.

The fact that both the family and community play a key role in sexual matters, and the respect for their culture is manifested by all people in the Gusii, should be seen as advantages that might be tapped for effective HIV/AIDS prevention strategies. The importance and power of the family and community is not unique to the cultural dimensions of sexuality in the context of the Gusii as evidenced in **chapter three**. This study has shown that among Abagusii, people's place in social life is not in any direct sense a product of the things they do, but rather the meaning their activities acquire through social interaction especially on issues of sexuality. Therefore, the family and society should be a crucial resource in facilitating youths' health and empowerment. This study therefore recommends that empowerment in relation to HIV/AIDS prevention should not focus on individuals but the whole family and community. This can be achieved by taking advantage of community gatekeepers. Community gatekeepers such as clan elders (*etureti*) act as

opinion leaders in the community. They have power to mobilise the community towards achieving certain goals. Their power emanates from communal authority which bestows to them magic religious power[115] to ensure compliance. This magic religious power was in form of cursing those who do not comply.

In relation to above observation, HIV/AIDS campaigners should use community gatekeepers to promote HIV/AIDS prevention strategies or promoting sexual behaviour change. Among the youth, these gatekeepers are crucial to bring about change because of the communal authority and the requirement that youths must respect elders and comply with their wishes. This compliance and respect is emphasized by *chinsoni* principal governing social behaviour (**see chapter three**).

This study also appreciates that behavioural change is still crucial for HIV/AIDS prevention among youths. However, as this study found behaviour change alone is ineffective in the fight against HIV/AIDS. Therefore this study argues that HIV/AIDS prevention campaigns should endeavour to understand how individuals make sense of these campaigns and how various structures influences this meaning formation. This is important because as this study found out the way individuals make sense of HIV/AIDS prevention campaigns influences behavioural responses to HIV/AIDS prevention strategies. Therefore there is need to identify how indegeneous knowledge system and traditional sex education impacts on individuals interpretation and adoption of HIV/AIDS prevention strategies. This understanding is vital in the empowerment of people in relation to HIV/AIDS prevention.

Lastly this study recommends that HIV/AIDS prevention policies should be based on culturally specific education principles that seek to mobilize people to seek solution within their diverse cultural contexts.

[115] See also chapter three Marriage

Further Research

This study has shown that interpretative research, and in particular the use of ethnographic data is important in understanding HIV/AIDS prevention policy. However, there is need for further research, particularly targeting youths who are already infected by HIV/AIDS by focusing on they make sense of HIV/AIDS prevention strategies. Such a study would not only form a basis of comparison with findings in this study, but could provide insights into how one's HIV positive status impacts on risk reduction.

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APPENDICES

Appendix 1: Boys Circumcision Song

Ekegusii	English translation
Oyo-oyo-o-o! x 2	Here he is! Here he is!
Omosia omoke mbororo bwamorire bwamorire.	(the circumcised) little boy is experiencing pain.
Omoisia omoke ateta, ngina!	The little boy, copulate with his mother!
Oyo-oyo-o-o! x 2	Here he is! Here he is!
Omoisia omoke mbororo bwamorire	(the circumcised) little boy has had pain.
Omoisia omoke ateta ng'ina. x 2	The little boy, copulate with his mother.
Samokami oirire 'mboro chiaito x 2	Circumciser has taken our penis
Tiga aire mbororo bwamorire x 2	Let him take he is angry with us.
Oyotarochi tigache kwerorera x 2	He who does not believe, let him come and witness.
Kwerorera enyamweri ekorwa engoro ime x2	To witness the bright one, emerging from its hiding hole
Mboro chiaito indokore rwekonoire. X 2	Our penis are like a green tree with its park pealed off.
Oyo-oyo-o-o-o! Oyoo! x 2	Here he is! Here he is! x 2
Otureirwe itimo x 2	He has been given a spear. x 2
Na nguba mbibo x 2	And a big shield x 2
Arwane Sigisi x 2	Fight the Kipsigis country x 2
Arwane Maasai x 2	Fight the Maasai country x 2
Arwane Sugusu x 2	Fight to the north x 2
Arwane Irianyi x 2	Fight to south. x 2
Arwane bobisa x 2	Fight the enemy. x 2

Appendix 2: Girls Circumcision Song

Ekegusii	English translation
Eyaeeoye, eyaeeoye	Eyaeeoye, eyaeeoye
Goko okorire buya	Granny has done well
Totongorere egeisero	So that we may taste our first harvest
Totongorere amaboba	So that we may start to cultivate our second crop
Eyaeeoye, eyaeeoye	Eyaeeoye, eyaeeoye
Omokebi oirire ebisono biato	The circumciser has taken our clitoris
Goko akorire buya	Granny has done well
Orenge mokabaisia	She was the wife of the uncircumcised boys
Obeire mokabamura	She is now the wife of the young men
Abaraete egaita	She can now pass through the cattle pen gate
Simbore yeito yarure rogoro	Our *esimbore* song comes from yonder.

Appendix 3: Song Manyake

Artists: Circuite & Joel
Year: 2004

Kiswahili/Sheng	**English Translation**
Stanza 1	
Manyake.... all sizes	Female genitals.... all sizes
manyake ... kama prizes	Female genitals.... like prizes
Manyake... kama 'loons na maji	Female genitals... like waterly loos
Juala ndio wahitaji x3	A condom is what you need X3
Stanza 2	
Ok alright ungejua *manyake*	Ok alright, if you knew (what) *manyake*
Sawa definitely za mchick msawa ndio *manyake*	Definitely yes, one for a good lady are *manyake*
Blow job, tembelea wasee	Then do the job, visit friends.
This is what they usually say.	This is what the usually say
Tunashare *manyerere* X2	We share girls X 2
Mikono juu kuworship *manyerere*	We raise up hands to glorify the girls
Kwanza tutumie protection	But first let us use protection
Au sivyo disease ije haraka kama injection	Otherwise disease will crop in fast like an injection
African men wakiwa obsessed na manyake	When African men are obsessed by girls.
'Opposed? ... what's up?	Are you opposed to this? What is up?
Do you have have some *juala* X2	Do you have some condoms? X2
Ama sivyo ucheki ceilling ya mochari kama fala	Otherwise you will stare at a mortuary ceilling like a fool.
Tumia protection yoo!	Friend, use a condom.
Refrain	
Juala ni *ashuu* tuu!	A condom costs only ten shillings
Na bado mnacheza na maisha mandugu	And friends you are only joking around with life
Hata kama *manyerere* ni *poa aje* jua ndio wahitaji.	It (condom) is what you need even if the girls are too good.
Stanza 3	
Cheeki hizi facts na hizi figures	Look at the facts and figures
Wasee soo tano wanadedi dailly	Five hundred people die daily
It's like wanabondwa na madinga	It is as though they are being crushed by vehicles
Ati you want bila protection,	If you want it (sex) without protection,
mimi napinga haa!	I oppose it
Hiyo napinga wee mjinga	You fool, I oppose it

Bila protection napinga	Without protection I oppose
Stanza 4	
Ee naongea kuhùsụ manyake	Yes, I am talking about *manyake (*female genitals)
na si zile za butcher	Not those of a butcher
manyake zinapita mtu anakula kucha	When they (girls) pass byone bites his nails
si unajua zile zenye zimefura	I hope you know those "swollen" ones
kama zako hazijafura unafaa uende ukule mtura	If there are any that are not swollen, then go and eat ***mtura*** (local sausage)
halafu ungoje, pengine watu watakupigia kura	Then wait, perhaps people will vote you in
manyake loo! Mtu anaweza kuziworship	Yes female genitals, one could worship them
manyake zinafanya mtu alose friendship	They could lead to one losing a friend.
Ebu enda kwa club, watu wanafight kwa nini	Just go to a club and find out why people fight.
Pastor alikosana na wife kwa sababu ya nini?	Why did the pastor quarrel with his wife?
Lakini usichanganishwe akili kwa sababu ya mwili	Do not lose your mind because of bodily wants
Tumia juala ama utaharibu mwili	Use a condom otherwise you spoil your body
Hiyo ni ukweli joo!	That is the truth friend!

Appendix 4: List of Research Participants

	Name of Participant	Gender	Age	Marital Status	Level of Formal Education	Occupation	HIV/AIDS Status
001	Nyambura	Female	22	Single	Primary	None	Unknown
002	Kwamboka	Female	25	Single	Secondary	None	Unknown
003	Mabeya	Male	30	Single	Primary	Tout	Positive
004	Samson	Male	21	Married	Primary	Farmer	Unknown
005	Roinyi	Male	33	Single	Secondary	Bank Clerk	Positive
006	Kemunto	Female	28	Married	Primary	Farmer	Unknown
007	Nyandusi	Male	32	Married	Secondary	Farmer	Positive
008	Jared	Male	26	Single	Secondary	Farming	Unknown
009	Pastor	Male	24	Single	Primary	Farming	Unknown
010	Moi	Male	27	Married	Primary	Farming	Positive
011	Moses	Male	18	Single	Secondary	Student	Unknown
012	Nyaboke	Female	27	Widow	None	Farming	Positive
013	Lizy	Female	24	Single	Secondary	None	Positive
014	Mary Bonchaberi	Female	33	Widow	None	Farming	Positive
015	Tom Masagiro	Male	22	Single	primary	No response	Unknown
016	Moturi Mangera	Male	21	Single	Primary	Transporter	Unknown
017	Lucy Keumbu	Female	20	Single	Secondary	Student	Unknown
018	Jamal	Male	32	Married	Secondary	Farming	Positive
019	Aura	Male	26	Single	Post Secondary	Student	Unknown
020	Mary	Female	28	Married	Secondary	Farming	Unknown
021	Sarah	Female	29	Single	Primary	None	Positive
022	Mary Kali	Female	25	Single	Primary	Trader	Unknown
023	Onsarigo	Male	24	Married	Post secondary	Teacher	Unknown
024	Chuma	Male	26	Single	Post Secondary	Farming	Unknown
025	Onchiri	Male	29	Married	Secondary	Farming	Unknown
026	Hare Moturi	Male	26	Single	Primary	Farming	Unknown
027	Janet	Female	27	Married	Secondary	Farming	Unknown
028	Kerubo	Female	20	Single	Secondary	Student	Unknown
029	Ndanu	Male	26	Married	None	Farming	Unknown

030	Oira	Male	27	Married	Post Secondary	Teacher	Unknown
031	Sabina	Female	25	Single	Primary		Unknown
032	Ombui	Male	29	Single	Primary	Farming	Unknown
033	Nyabunto	Male	22	Married	Primary	Farming	Unknown
034	Faith	Female	20	Single	Primary	None	Unknown
035	Bisirieri	Female	19	Single	Primary	None	Unknown
036	Osindi	Male	25	Single	Post secondary	None	Unknown
037	Grace	Female	20	Single	Primary	None	Unknown
038	Bosibori	Female	21	Single	Primary	None	Unknown
039	Nyangau	Male	28	Single	Secondary	None	Unknown
040	Nyanchama	Female	27	Single	Primary	None	Unknown
041	Oncharo	Male	25	Single	Post Secondary	Community Worker	Unknown
042	Omosa	Male	22	Single	Secondary	Farming	Unknown
043	Cosmas	Male	30	Married	Primary	Waiter	Unknown
044	Rosemary	Female	20	Single	Secondary	Teacher	Unknown
045	Jomo	Male	29	Married	Primary	Farmer	Unknown
046	Nyakundi	Male	20	Single	Primary	Farmer	Unknown
047	Linet	Female	20	Single	Primary	None	Unknown
048	Evelyn	Female	19	Single	Secondary	Student	Unknown
049	John Nyabs	Male	21	Single	Primary	Farming	Unknown
050	Irene Moraa	Female	20	Single	Post Secondary	Student	Unknown
051	Sarah Mochenu	Female	19	Single	Primary	None	Unknown
052	Nyanchera	Female	20	Single	Primary	None	Unknown
053	Ondigi	Male	25	Single	Primary	Farming	Unknown
054	Beatrice Law	Female	23	Single	Post Secondary	Student	Unknown
055	Nancy	Female	20	Single	Secondary	Business	Positive
056	Marita	Female	21	Married	None	Farming	Positive
057	Nyandika	Male	24	Married	Primary	Security	Positive
058	Kayaga	Male	35	Widower	Primary	Farming	Positive
059	Omae	Male	26	Single	Secondary	Church layman	Unknown
060	Ochomba	Male	27	Married	Secondary	Accounts clerk	Positive
061	Peter	Male	24	Single	Secondary	Farming	Unknown
062	Mosota	Male	25	Single	Primary	Farming	Unknown
063	Ochieku	Male	30	Married	None	Casual worker	Unknown
064	Carol	Female	22	Single	Secondary	Trader	Unknown
065	Ombogo	Male	24	Single	Secondary	Teacher	Unknown
066	Nyamira lady	Female	25	Married	Primary		Positive

067	Abigail	Female	23	Single	Primary	Business	Negative
068	Osoro	Male	27	Married	Secondary	Driver	Unknown
069	Chero	Female	23	Single	Secondary		Unknown
070	Doggy Mac	Male	28	Single	University	Teacher	Unknown
071	Atika	Male	25	Married	Secondary	Casual worker	Unknown
072	Bonareri	Female	23	Married	Primary	Farmer	Unknown
073	Motorekwa	Female	24	Married	Secondary	Clerk	Unknown
074	Onsibema	Male	19	Single	Secondary		Unknown
075	Yusuf	Male	22	Single	Primary	Farming	Unknown
076	Nyambeki	Female	24	Single	Secondary	Business	Unknown
077	Risper	Female	22	Single	Primary		Unknown
078	Obure	Male	28	Married	Secondary	Business	
079	Nyangwa	Male	25	Single	Secondary	Security man	Unknown
080	Maria	Female	24	Single	Primary	Business	
081	Mosweta	Female	26	Single	Primary	Business	Unknown
082	Mandizi	Male	27	Married	Secondary	Clerk	Unknown
083	Bwari	Female	26	Single	Primary		Positive
084	Onchonga	Male	23	Single	Secondary	Teacher	Unknown
085	Mogaka	Male	20	Single	Primary	Farming	
086	Biyaki	Female	23	Single	Primary		Unknown
087	Stella	Female	25	Single	Secondary	Business	Unknown
089	Rhoda	Female	23	Widow	Primary	Business	Positive
090	Nelly	Female	24	Single	Secondary	Student	
091	Oranjo	Male	28	Single	Secondary	Business	Not Sure
092	Florence	Female	30	Married	Post Secondary	Teacher	
093	Tabitha	Female	32	Married	Primary	Farmer	Unknown
094	Otieno	Male	30	Married	Post secondary	Teacher	
095	Billian	Female	25	Married	Secondary	Nurse	Negative
096	Gatura	Male	32	Married	Secondary	Clerk	Unknown
097	Bosi	Male	27	Single	Secondary	Farming	Unknown
098	Maina	Male	25	Single	Secondary	Foreman	Unknown
099	Matonda	male	26	Single	Secondary	Teacher	Unknown
100	Morry	Female	24	Single	University	Student	Unknown

Notes: Blank space indicates no response

Appendix 5: Guiding questions for in-depth conversational interviews with Abagusii youths

Introduction

Good day to you. My name is Masese Rosana Eric; a doctorate candidate in Anthropology at Universite de Pau et des Pays De L'Adour.. I am carrying out a research on: "The social construction of HIV/AIDS prevention strategies among Abagusii youths." This research is part of the requirement for the award of Universite de Pau et des Pays De L'Adour Doctor of Philosophy in Anthropology. Therefore I humbly request your participation and cooperation. All your views will be held confidentially and will be by no means used for any other purpose outside this study. Thank you.

Background information

1. Date of birth (age)
2. Gender
3. Level of formal education
4. Marital status
5. Occupation
6. Which disease is rampant in this area?
7. What is HIV/AIDS?
8. What causes HIV/AIDS?
9. How does one get HIV/AIDS?
10. Is HIV/AIDS a major socio-economic and medical problem? (why)
11. Who are the most affected by HIV/AIDS in this area? Explain.
12. As an individual, do you think HIV/AIDS is a major problem?(Why)
13. Who is (are) more vulnerable to HIV/AIDS) (Why)
14. Has an individual do you consider yourself vulnerable to HIV/AIDS infection? (Probe why)
15. How do you avoid getting infected by HIV/AIDS as an individual?
16. At community level, how do people avoid getting infected by HIV/AIDS?
17. Do you know your HIV/AIDS status?
18. From which sources do you get information about HIV/AIDS in this area? (Probe)
19. Which themes do these sources of HIV/AIDS information disseminate? (Probe)
20. Do those themes on HIV/AIDS information concerns/target you? (Why)
21. What factors either at community or individual level impact on your accessibility to HIV/AIDS information? (Probe factor in terms of cultural, economic and political)
22. Do you participate/take part in HIV/AIDS activities? Probe
23. What is the impact of HIV/AIDS information from various sources on your perception towards HIV/AIDS and sexual behaviour? Probe

24. What do you understand by the following HIV/AIDS prevention strategies? Questions and answers to follow the format as indicated in the table below

HIV/AIDS prevention strategies	**Meaning**	**Why that meaning**	**Is the strategy relevant to you? Why**	**Is the strategy effective for HIV/AIDS prevention (Why)**
Abstinence				
Be Faithful				
Condom use				
Voluntary counselling and Testing (VCT)				

25. Do you think as a man/woman is it important for you to (a) Abstain (b) Be Faithful (c) Condom use (d) Know your HIV status (VCT) (Probe reasons for each answer)
26. What does sex mean to you as an individual? (Probe)
27. What is the role of sex to you as an individual and to the community at large? (Probe)
28. When is sex, sex to you? (Probe)
29. As an individual what is conventional way of practicing sexuality?
30. How has HIV/AIDS influenced your understanding of sex?
31. Has HIV/AIDS affected the way you practice your sexuality? (How and why?
32. In relation to your understanding of what sex means what then is Abstinence, Be faithful, Condom use and VCT as used in HIV/AIDS prevention campaigns? (Probe)
33. How do you protect yourself from HIV/AIDS infection using Abstinence, Be faithful, condom use and VCT (Probe).
34. What are your views on youths' way of practicing their sexuality and HIV/AIDS prevention?
35. How can HIV/AIDS prevention strategies especially among the youths be improved?

Thank you for your time and cooperation.

Appendix 6: Guiding questions for key informant interview interviews.

Introduction

Good day to you. My name is Masese Rosana Eric; a doctorate candidate in Anthropology at Universite de Pau et des Pays De L'Adour. I am carrying out a research on: "The social construction of HIV/AIDS prevention strategies among Abagusii youths." This research is part of the requirement for the award of Universite de Pau et des Pays De L'Adour Doctor of Philosophy in Anthropology. Therefore I humbly request your participation and cooperation. All your views will be held confidentially and will be by no means used for any other purpose outside this study. Thank you.

1. What are major problems facing youths?
2. Is HIV/AIDS a major problem among the youths? Why
3. Who are most affected by HIV/AIDS problem and why?
4. How is HIV/AIDS problem tackled in this area?
5. Who are involved in solving HIV/AIDS among youths?
6. What are some of HIV/AIDS prevention programmes targeting the youths? And what are their objectives/themes
7. How are HIV/AIDS prevention programmes organized and implemented?
8. Do you think the way HIV/AIDS prevention programmes are organized or implemented affect the success of these programmes?
9. What are some of the factors either at individual or community levels that affect HIV/AIDS programmes among the youths?
10. What influences youths participation in HIV/AIDS activities?
11. How do youths understand ABC and VCT in relation to HIV/AIDS prevention?
12. What factors influence their understanding to ABC and VCT?
13. How will you describe youths' sexual behaviour in this area?
14. What factors are important in influencing youth sexual behaviour?
15. How do youths practice their sexuality in relation to HIV/AIDS prevention?

UNIVERSITE DE PAU ET DES PAYS DE L'ADOUR

Faculté de Droit, d'Economie et de Gestion

THE SOCIAL CONSTRUCTION OF HIV/AIDS PREVENTION STRATEGIES AMONG ABAGUSII YOUTH-KENYA

Thèse de Doctorat en Anthropologie

Présentée et soutenue par

Monsieur Rosana Eric MASESE

Le 15 décembre 2011

Jury:

M. Joshua J. AKONG'A: Professor of Anthropology Moi University, **Rapporteur**

Mme Anne-Marie MOULIN: Directrice de recherches au CNRS – Paris, **Rapporteur**

Mme Laurence KOTOBI: Maitre de conférences en Anthropologie à l'Université Bordeaux Segalen

M. Abel KOUVOUAMA: Professeur d'anthropologie à l'Université de Pau et des Pays de l'Adour, *Directeur de recherche*

M. Hervé MAUPEU : Maître de conférences en Sciences politiques à l'Université de Pau et des Pays de l'Adour, *Co-directeur de recherche*

M. Christian THIBON: Professeur d'Histoire contemporaine à l'Université de Pau et des Pays de l'Adour

Résumé

Le V.I.H/ SIDA continue à être un problème important, tant socio-économique que sur le plan physiologique qui affecte les jeunes au Kenya, et ce, en dépit des politiques de prévention qui visent à donner les moyens d'éviter la contamination. Ceci a suscité plusieurs études sur les facteurs contextuels régissant ce fléau. Ce qui manque dans ces études, c'est l'examen du processus de formation des représentations à l'origine des comportements sexuels dans les différents contextes culturels. En ce qui concerne la sexualité et le V.I.H / SIDA, cette étude traite des structures et des processus de formation de ces représentations à l'intérieur des groupes sociaux. Elle traite aussi des significations produites qui influencent l'interprétation et l'adoption des stratégies préventives à l'égard du V.I.H / SIDA. Employant la théorie de la construction sociale, cette étude examine la compréhension des stratégies de prévention du V.I.H / SIDA telle que le Programme « Abstinence, Fidélité, Utilisation des Préservatifs » (AFP) et le Programme de Connaissance de son statut (VCT) parmi les jeunes Abagusii dans leurs expériences vécues. Spécifiquement, l'étude examine comment les significations sociales à l'égard de la sexualité et du V.I.H / SIDA influencent l'interprétation et la prise de mesures concernant l'AFP et les approches de prévention de V.I.H / SIDA. Les données de cette étude ont été obtenues auprès de 100 jeunes Abagusii au moyen d'entretiens intensifs et d'observations participantes. Des données supplémentaires ont été obtenues auprès des animateurs sociaux. Les résultats de l'étude montrent que les jeunes Abagusiis comprennent les stratégies préventives qui touchent le V.I.H / SIDA (AFP et VCT) en relation avec leurs significations sociales de la sexualité. En résumé, alors qu'elle apprécie le rôle important des facteurs structuraux et contextuels qui influencent le comportement sexuel, l'étude soutient qu'il est important de tenir compte des processus de formation des représentations, afin de mieux comprendre les réactions comportementales des individus au sujet des campagnes préventives concernant le V.I.H / SIDA dans des divers contextes culturels, et pour s'assurer de leur efficacité.

Abstract

HIV/AIDS continues to be a major socio-economic and medical problem affecting youth in Kenya. This is in spite of the massive prevention interventions which aim at empowering the youth with information on how to avoid being infected. This has therefore created impetus for investigating contextual factors driving the pandemic. However, missing in these studies are the processes on how meanings which are vital in influencing sexual behaviour are generated in different cultural contexts. This study therefore focused on the structures and processes of meaning formation within social groups, with regards to sex and HIV/AIDS, and how the produced meanings influence the interpretation and adoption of HIV/AIDS prevention strategies. Using the social construction theory, the study examined emic understanding of HIV/AIDS prevention strategies such Abstinence, Being Faithful, Condom use and Knowing one's HIV status (VCT) among Abagusii youth in their lived experiences. Specifically, the study interrogated how the social meanings of sex and HIV/AIDS influence the interpretation and action towards "ABC" and "VCT" HIV/AIDS prevention approaches. Data for this study was obtained from 100 Abagusii youth using in-depth conversational interviews and participant observation. Augmentative data was also obtained from key informant interviews. Findings from the study showed that Abagusii youths make sense of HIV/AIDS prevention strategies (ABC and VCT) in relation to their social meanings of sex. In conclusion, while appreciating the vital role of structural and contextual factors in influencing sexual behaviour, the study argued that it is equally important to take into account meaning formation processes in understanding individuals' behavioural responses to HIV/AIDS prevention campaigns in diverse cultural contexts for them to be effective.