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The implications of young people's perceptions of sexual risks in Kenya

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ABSTRACT

This paper examines the social context of perception of risk of HIV infection among young women and men in Kenya. The data are from 14 focus group discussions and 29 in-depth interviews with 15-29 year olds conducted in March 2001. The worry and acknowledgement of risk was universal among focus group discussants and this was attributed to the prevalence of risky sexual behaviour, risky cultural practices, the difficulty in knowing the infected, and denial and fatalism. In-depth respondents employed different ways of assessing risk with the first sexual partner, lifetime partners and recent or current partners that also influenced AIDS prevention strategies. Denial of risk was more rife among individual respondents and this was justified on the basis of safety and familiarity of the partner and aspects of own behaviour considered safe. Perception of AIDS risk at each stage of young people's sexual lives reflects their knowledge about AIDS and the type of AIDS prevention strategies adopted with different sexual partners. Young people's responses to AIDS include use of condoms, uptake of HIV testing, abstinence and monogamy. The findings imply realistic perceptions of risk among young people and the success of AIDS education and prevention programmes in the communities of study.

The context

AIDS is the main sexual and reproductive health concern in Kenya. Young people aged are most affected and so understanding patterns of their sexual behaviour is important in determining the future course of the epidemic. About 75% of the AIDS cases in Kenya occur in the age group 20-45 years, peaking at ages 25-29 years for females and 30-34 years for males. Young women in the age groups 15-24 years are 2 to 3 times more likely to be infected than males in the same age group (Baltazar et al., 1999; Kenya et al., 1998). Young people are the most economically productive hence their deaths constitute a significant social and economic loss. These are the reproductive ages at which most are raising young children so that the numbers of orphans are likely to increase.

Although studies in Kenya have explored young people's perceptions of sexual risks, the social and cultural subjective measures of estimating AIDS risk among young people are poorly understood

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(Nduati and Kiai, 1997). Studies indicate that perceptions of AIDS risk, considered important as the first stage towards behavioural change from risk-taking to safer sex, have consistently been low among the young people in Kenya (The Futures Group, 2000; National Council of Population and Development [NCPD], Central Bureau of Statistics [CBS] and Macro International [MI], 1999; Ingham and Holmes, 1991). The 1998 Kenya Demographic and Health Survey (KDHS) shows that among the sexually active, 46% of females and 40% of males aged 15-19 years perceived themselves at no risk of HIV, though condom use was higher among young males and females.

The public AIDS awareness campaigns in Kenya emphasise change in sexual behaviour (abstinence or monogamy outside marriage, monogamy and fidelity in marriage, condom use, and reduction of sexual partners). The assumption is that people will respond to AIDS risk in a way that reflects their AIDS awareness levels. This assumption relies heavily on the Health Belief Model (Becker, 1974). Recent studies indicate that AIDS awareness is high among all sub-groups of the population in Kenya, though risky sexual behaviour is prevalent particularly among young people (Futures Group, 2000; NCPD, CBS and MI, 1999). For along time AIDS messages were generalised to all categories of young people without proper targeting of the different groups of youth with varied needs and lived sexual realities. Thus, the entire population has been consistently under general exhortations, which often did not fit the circumstances under which young people live. As a result, many young people engage in risky pre-marital and extramarital sexual relationships and are susceptible to sexual risks such as sexually transmitted infections, including HIV, unintended pregnancies, sexual coercion, and induced abortions.

Literature suggests that although knowledge and awareness of HIV/AIDS is a necessary condition for behaviour change, it is not enough in itself (UNAIDS, 2000). Previous research has shown that people seem to make judgements about risk on the basis of a host of social and cultural factors operating within the environment in which they live and not just on their knowledge of sexual risk (Nzioka, 2000; 1996; Ingham and van Zessen, 1992). Perceptions of risk and sexual behaviour of young people are likely to be linked to the social and cultural construction and interpretations of risk, attitudes about sex, gender differences in sexual behaviour, and a host of economic factors operating in their environments

This paper examines the social and cultural aspects of perception of AIDS risk among young women and men aged 15 to 29 years. The paper broadly focuses on: a) young people's perception of AIDS risk under different contexts and stages of their sexual lives; b) the factors that explain the levels of perceived AIDS risk among women and men in the communities of study; and c) the implications of young people's perception of risk on AIDS messages and sexual behavioural change. Although there are many sexual risks, the focus of this paper is on the risk of HIV infection. No attempts are made to generalise the results of this study to the wider Kenyan population, as the social interpretations of AIDS risk are specific to the communities of study.

Data and Methods

The data used are from 14 focus group discussions and 29 in-depth interviews held with young women and men aged 15 to 29 years in the month of March 2001. The study was conducted among two communities in two districts in Kenya: a rural community of Kisumu district in Western Kenya and a peri-urban community of Kiambu district on the outskirts of Nairobi city, Central Kenya.
Focus group discussions (FGDs) were used to explore the community norms and discourses surrounding AIDS risk, where participants did not necessarily need to reveal their personal

information. FGDs were used to gather general attitudes and opinions about the social context of AIDS risk and the community responses to the reduction of the spread of the disease. The FGDs, therefore, reflect community perceptions of AIDS risk, the social and cultural factors thought to expose community members to the risk of getting HIV and the challenges faced in adoption of AIDS prevention strategies. On the other hand, IDIs explored the ways in which individuals personalised AIDS risk and subjectively assessed their risk of HIV infection based on their past and current or recent sexual behaviour and how these estimates are used as a basis of adoption of risk aversion strategies. The IDIs were also used to validate the opinions raised in FGDs. In so doing, the study explores why young people might perceive AIDS as a great threat to the community and yet see themselves as invulnerable.

Focus group discussions were conducted with a total of 122 participants, 6 groups among young unmarried women and men (15-24 years), 4 among recently married women and men (15-24 years married for 5 or less years), and 4 among married women and men (30 or more years and married for 6 or more years). Women and men were stratified by age, marital status, and residence in order to capture views from different sub-groups. The two groups (unmarried and married) were selected in order to examine differences in sexual experiences and attitudes towards AIDS risk at different stages of sexual lives. The groups of women and men aged 30 or more years were used to compare and contrast the changes over time, if any, in individual interpretations of AIDS risk. The focus groups for the unmarried women and men comprised the sexually experienced and inexperienced. A pre-designed question guide was used to explore a range of topics such as sources of sexual information, AIDS awareness, community attitudes towards premarital sex, motivations for premarital and extramarital sex, expectations of sexual relationships, sexual decision-making and negotiation, attitudes about condoms, perceptions of sexual risks, and responses to AIDS risk.

In-depth interviews (IDIs) were used to understand the more personal and sensitive issues of sexual relationships and the subjective measures of AIDS risk at different stages of young people's sexual lives. The IDIs were used to collect detailed individual information on first sexual intercourse and recent or current partnerships of respondents aged 15 to 29 years in order to understand the social and cultural transitions that may have taken place as young people move through different sexual experiences. The first and recent or current sexual partnerships were chosen in order to minimise recall errors. It is assumed that the first ever intercourse is a memorable event in which circumstances surrounding it are unlikely to be forgotten. Similarly, activities in a recent or current partnership can easily be remembered compared to those of intermediate partnerships. The aim of the IDIs, therefore, was to explore how the risk of HIV infection was considered at initiation and at recent or current partnerships and not examining detailed sexual histories. Due to the small sample size (29 respondents interviewed in-depth), generalisations according to characteristics such as gender, age, marital status and ethnicity are not emphasised except for seemingly notable differences. Thus, we examine the subjective criteria of risk assessment and not necessarily the prevalence of each criterion across sub-groups.

The theme of perception of AIDS risk was captured at different sections of the question guide. These include: a) individual assessment of general sexual experiences; b) reasons for the choice or non-use of contraception at first and most recent or current sexual intercourse; c) whether respondent thought her/his past sexual life might have put her/him in danger of HIV infection; and d) whether respondent thought she/he was currently in danger of contracting HIV. The other topics discussed include sexual

decision-making and negotiation, communication about contraception particularly condoms and AIDS, and AIDS prevention strategies. The IDIs involved a one-to-one interview between a respondent and the interviewer following a pre-designed question guide. Only those with sexual experience qualified for the IDIs. The qualitative software, Nudi*st was used for data analysis.

The study sites

Participants in Kiambu were recruited from one sub-location and those in Kisumu were recruited from 4 selected sub-locations, of the 4 divisions of Kisumu district. All the participants in Kisumu were from rural areas. The FGD and IDIs participants were identified through the local chief in Kiambu district and through the District AIDS Co-ordinator in Kisumu District. This form of selection may have introduced bias in recruitment since previous research has shown that chiefs tend to recruit only their relatives or friends or the 'best looking people' in the community. However, our fears were, in part, allayed during informal talks with the participants; some of who did not know others. We had also taken care to explain to the chief and the AIDS co-ordinator the importance of having differentiated groups. Nonetheless, it is almost impossible to do research in any part of Kenya without going through the local administration.

The two communities from Kisumu and Kiambu districts were selected purposively for comparative purposes, to reflect the influences of different social and cultural factors and the HIV prevalence rates on young people's perception of AIDS risk. The two communities are referred to as 'Kisumu' and 'Kiambu' throughout this study for privacy purposes. Kisumu district is predominantly inhabited by the Luo ethnic group and is situated in the Nyanza province. Kiambu is predominantly Kikuyu and is situated in the Central province. Kisumu and Kiambu were chosen because they have markedly contrasting economic and socio-cultural belief systems that tend to shape people's daily activities. The HIV prevalence rates in Nyanza province have consistently been high compared to rates in other parts of the country. For example, the 1999 estimates indicate that 32% of people in Nyanza were estimated to be HIV positive compared to 12% in Central Province (Baltazar et al., 1999). Culture is considered to be the major factor behind these differences.

Economic activity is more diversified in Kiambu than in Kisumu district. Kiambu is a tea production zone and so most people are employed in tea farms and factories. Kiambu attracts many labour in-migrants from other parts of Kenya. Another majority of people in Kiambu earns their living by working in Nairobi because of its proximity (less than 1 hour by public transport). In Kisumu, most economic activities are confined to small-holdings utilising family land. The largest town is situated about 50 or more kilometres away from the rural communities.

The quality and quantity of public services and infrastructure vary considerably between the two communities. Kiambu is well served by a network of tarmac roads; the majority of homes have electricity; public telephone booths and most homesteads have private water supplies. In Kisumu, almost all the rural roads are subject to closure during rainy season, hence poor communication facilities, and people depend upon local rivers and ponds for water supplies.

The two communities are further differentiated by access to health and reproductive health services. Kiambu is well served by both public and private health facilities and Nairobi is within easy reach. There are also two well-equipped private hospitals and a number of government hospitals, health

centres and private clinics. Kisumu, on the other hand, has basic health facilities the majority of which are situated in Kisumu town. Generally, utilisation of health services is poor in rural areas because of poor infrastructure, long distances to facilities and inadequate distribution. However, because of the differences in HIV rates, Kisumu has two major AIDS prevention projects namely the World Bank STI project and the HIV/AIDS prevention and care (HAPAC) project funded by DFID and managed by Futures Group Europe that conduct a range of AIDS awareness, prevention and care activities.

The cultural beliefs and practices vary considerably between the two communities. In Kisumu, the practice of widow inheritance and the belief in witchcraft and '*chira*'[2] have been associated with the rapid spread of AIDS. In contrast, in Kiambu the Kikuyu practice of widow remarriage has disappeared and the practice of traditional circumcision of boys and girls has shifted from the more traditional form of seclusion to the modern hospital environments. Polygyny that is a common practice in Kisumu is almost non-existent in Kiambu. The significance of the lineage system has declined markedly in Kiambu whereas it remains a strong element of people's lives in Kisumu.

Results

Profile of participants

Table 1 shows the characteristics of the focus group participants in two study sites, which depict fairly similar socio-demographic patterns. The majority of participants were aged 20-24 years. Whereas most women were married, the reverse was true for the men. Almost all participants had primary or secondary level of education. Only a few participants reported that they were students; perhaps because the study was conducted during school term. Most participants in Kiambu reported being in salaried/wage work, compared to Kisumu in which the majority is in small-scale farming or businesses activities. The commonest religions reported were Catholic and Protestant.

The focus groups included both sexually experienced and inexperienced never married women and men. Almost all never married participants were sexually experienced with little gender differences. Table 2 gives the summary of the sexual behaviour characteristics of the in-depth respondents.

Although the sample size is small, the findings depict some gender differences in the sexual behaviour of the study participants. Most reported first sexual intercourse between age 15-19 years. Most women reported 2-4 lifetime sexual partners compared to men who reported 4 or more partners. Almost all women and men reported one sexual partner in the last year and none or one partner in the last month. Most unmarried people reported not to have been sexually active in the last month.

The IDIs revealed that the most of the women had first sexual intercourse with someone five or more years older. This pattern was evident for both first sexual partner and recent or current sexual partners. On the contrary, the men reported to have had first sexual intercourse with slightly younger partners (1-2 years younger) or someone of the same age, and this pattern is the same for first and recent or current sexual partnerships.

Condom use is fairly low among all participants, more so in Kiambu. All Kiambu women and almost all men had never used condoms.

[2] '*Chira*' is a Luo term for a body wasting illness that is believed to afflict people who break cultural taboos.

Table 1: Profile of focus group participants' socio-demographic characteristics

Characteristic	Female (n=59)		Male (n=63)	
	Kiambu (n=31)	Kisumu (n=28)	Kiambu (n=32)	Kisumu (31)
Age	No.	No.	No.	No.
15-19	8	6	11	5
20-24	10	10	10	9
25-29	2	4	3	6
30+	11	8	8	11
Marital status				
Not in union	11	10	19	20
In union	20	18	13	11
Highest level of schooling				
None	3	0	1	0
Primary	18	10	17	8
Secondary and above	10	18	14	23
Occupation				
Salaried/wage employee	20	6	10	3
Business person	0	10	6	8
Farmer	6	4	5	11
Domestic worker	3	2	4	4
Student	0	1	4	1
Other	2	5	3	4
Religion				
Catholic	9	8	12	8
Protestant	22	11	19	22
Muslim/other	0	9	1	1
Among never married, sex experience				
Yes	8 out of 11	8 out of 10	19 out of 19	10 out of 11

Table 2: Profile of in-depth participants' sexual behaviour characteristics

Characteristic	Female (n=15)		Male (n=14)	
	Kiambu (9)	**Kisumu (6)**	**Kiambu (8)**	**Kisumu (6)**
Age at first intercourse	No.	No.	No.	No.
≤15	2	1	2	1
15-19	5	5	5	5
≥ 20	2	0	1	0
Number of lifetime sexual partners				
≤2	6	1	1	1
3-4	1	4	2	2
5-9	2	1	1	0
≥10	0	0	4	3
Number of sexual partners in last year				
1	9	5	5	5
2	0	1	0	1
3	0	0	3	0
Number of sexual partners in last month				
0	4	2	5	2
1	5	4	3	4
Age difference of first sexual partner				
Same age or 1-2 years younger	0	0	3	6
3-4 years younger	0	0	1	0
5-9 years younger	0	0	0	0
10 or more years younger	0	0	0	0
1-3 years older	2	4	4	0
4-5 years older	5	1	0	0
6 or more years older	2	1	0	0
Age difference of recent/current partner				
Same age or 1-2 years younger	0	1	3	2
3-4 years younger	0	0	1	1
5-9 years younger	0	0	2	1
10 or more years younger	0	0	0	2
1-3 years older	4	1	2	0
4-5 years older	3	2	0	0
6 or more years older	2	2	0	0
Condom use				
Never used	9	3	6	3
Used with first sexual partner	0	1	0	0
Used with recent/current partner	0	2	2	3

Community perceptions of AIDS risk – Findings from focus group discussions

Participants of FGDs unanimously acknowledged the severity of AIDS and considered it as a major problem in the communities. There were no differences in perception of high risk across sub-groups. When asked to what extent AIDS was a risk to the community or themselves, participants simply said *"to a great extent", or "it is a big risk"*. An unmarried man in Kisumu summed the views of many when he said:

> *"AIDS is a risk and is very common within the community. Very many people already have the disease as reflected by the number of orphans who end up being street children (referred to as 'ninjas'). The number of widows is also on the increase. Most of their husbands have died of AIDS but some people who are the traditional die-hards do not accept this. When knowledgeable people are dying within the community, this is a sign of risk to the community. AIDS is indeed a threat to the community" (Kisumu, FGD, unmarried male)*[3].

Participants cited the fatality of HIV infection as the most worrying consequence of AIDS. All FGD groups recognised that AIDS is decimating families, the old and the young, married and unmarried and that *"it is a problem to everyone; the infected and the affected" (Kiambu, FGD, married male).*

The participants expressed their realistic fear and worries about AIDS in terms of the social and economic impact of AIDS to families. All groups and individuals mentioned, in unison, orphaned children as a major effect of AIDS to the families. The death of parents was stated to leave children to fend for themselves or under the care of the elderly and other relatives who may be unable properly care for them.

Participants repeatedly mentioned that families incur loss of earnings through household expenditures for medical expenses and funeral costs when the breadwinner dies. The FGD discussants frequently mentioned that AIDS has led to the disintegration of the family unit. There was strong evidence of stigmatisation and ostracism of HIV infected individuals and affected children and families of people who got sick or died of AIDS in the as it was mentioned several times.

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

Some groups alluded to the escalation of poverty because of the reduction in labour productivity both at the macro and micro levels, attributed to the time spent caring for the sick or seeking for care. The views of other participants suggested that AIDS has led to low levels of development in the communities since the disease kills people of productive ages and causes children to drop out of school.

FGD discussants attributed the severity of AIDS in the community and their high personal vulnerability to HIV infection to various factors. The themes that emerged in almost all FGDs were: prevalence of risky sexual behaviour; difficulty in knowing who is infected and deliberate transmission of AIDS; and

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

a sense of denial and fatalism. As would be expected, the role of cultural practices such as widow inheritance, circumcision, shaving practices, belief in witchcraft, polygyny and fertility demands was strongly echoed among participants in the Kisumu site. Other factors mentioned in one or two groups were rape, labour migration, alcoholism, idleness among young people, and non-sexual forms of transmission such as infected blood, sharing of shaving and cutting instruments, and circumcision.

Prevalence of risky sexual behaviour: The discussants were aware of the role of sexual intercourse in HIV transmission and so believed strongly in their vulnerability due to the prevalence of risky sexual behaviour. This emerged as a recurrent theme throughout the FGDs. The types of risky sexual behaviour recited in almost all groups were multiple partnerships, premarital sex, extramarital sex, sex in exchange for monetary and material favours, and rape (mentioned in only one male group).

The theme of promiscuity and existence of multiple partners was strongly expressed by all participants and was stated to be common among the unmarried and married women and men. The main cause of worry was that though one may remain faithful in their relationships, the behaviour of their partners puts them at risk of HIV. Further examination of the motivations for risky sexual behaviour revealed that sex for monetary or material favours between young and older people was prevalent and was widely believed by the participants to heighten young people's vulnerability. Young unmarried people were described as *"agile"* and to have *"hot blood"* or high sexual urge and this makes them highly vulnerable to HIV infection.

There was a recurrent theme in every FGD that poverty influences men and women to have sex in exchange for material and monetary favours. Participants admitted that whether married or not, poverty impels young people to engage in sex for exchange of favours, money or gifts.

> "*You see as a married woman you may be in a financial problem and so get an outside partner who may infect you with AIDS" (Kiambu, FGD, married female).*
>
> *"Sugar daddies look for young girls and also sugar mummies look for young men" (Kisumu, FGD, unmarried female).*

When married women were asked if young unmarried people are at risk of AIDS, all admitted that they were at high risk because they had multiple partners and could catch AIDS from older partners *("sugar daddies or sugar mummies*") and spread it to their young partners.

There was evidence to suggest that children orphaned and women widowed by AIDS contribute to the spread of the disease in the communities of study because poverty drives them to engage in sex for monetary and material favours. Participants alleged that well to do widowed women lured young men into sex for favours.

On the other hand, the theme of unfaithful partners was strongly exemplified by married women and men, though a few unmarried participants also mentioned it. Extra-marital sex is linked to the high rate of HIV infections among faithfully married women in most of sub-Saharan Africa (FHI, 1999; UNAIDS, 1999; 2000).

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

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

What emerges is that though women and men were suspicious of their partners' fidelity, almost all felt they were exempt from the risk of HIV. Generally both women and men took trust as being personal, stating that they, themselves, did not engage in casual or extramarital affairs but that they had doubts about their partners. The women and men alike qualified their statements and placed emphasis on their partner's behaviour as their main source of worry.

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

Participants did not make it clear if commercial sex workers (CSWs) could be a major source of worry about AIDS in the communities of study, though a few groups considered CSWs a high-risk group. The difficulty of defining commercial sex in the sub-Saharan African context could, in part, explain the participants' indifference towards commercial sex. In Kenya, material and monetary favours are almost an implied element of most sexual relationships. Therefore, having sex in exchange of material or monetary favours is not necessarily considered commercial sex.

Though not a common theme, a group of married men in Kisumu said that rape places many young girls at risk of HIV. This is not surprising given that IDIs suggested that women, more often than not, are coerced into sexual intercourse.

The difficulty in knowing who is infected: All participants appeared to concur that anyone is at risk of getting AIDS and so it is difficult knowing *"…who has it and who does not" (Kiambu, FGD, unmarried female).* There was evidence that some infected people were not aware of their HIV status and so continued to spread the disease unknowingly, making most people vulnerable. Yet, some groups maintained that some people spread the disease deliberately in order not to die alone. The issue of deliberate transmission of HIV was a recurrent theme in most groups and has been noted in previous qualitative studies in Kenya (Fapohunda and Rutenberg, 1999).

Some participants mentioned that some people are reluctant to go for HIV testing before starting sexual relationships. An unmarried man stated, *"This is because when you get your girlfriend and you move on to have sexual intercourse, none of you is willing to open up and inform each other about his/her health (HIV) status. In fact, many people will probably go for a test after they have had sexual intercourse…" (Kiambu, FGD, unmarried male).*

There was evidence that the cost of the HIV test and the stigma attached to those who have the test are constraints to people who want to undergo the test as implied by an unmarried man in Kiambu:

M: Have you ever had HIV test?

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

Cultural practices: The theme of cultural practices was dominant among Kisumu participants than in Kiambu. Some of the Luo cultural practices are associated with the spread of AIDS in the community. The practices identified as enhancing people's vulnerability to AIDS are widow inheritance; marriage patterns such as polygyny, the demand for children and the social expectation to be married; the belief in witchcraft and "*chira*"; sharing of shaving and cutting instruments; and circumcision.

Among the Luo of Kisumu widow inheritance is a common practice. A widow has to be ritually cleansed before she can be inherited or remarried. The cleansing process involves having sex with the brother-in-law or other relative of the deceased, or a hired man. The same form of cleansing is also performed to a dead woman before burial, and it is executed irrespective of the causes of death of the deceased. Thus, the ritual is considered a significant agent of HIV transmission. Women in Kisumu in particular expressed their fear of this practice, which they seemed to have no control over. A married woman summarised the fears of other vulnerable women when she observed, *"…According to the Luo custom, if my husband dies even if its of AIDS, and my son also dies, I will have to be inherited first so that my daughter-in-law can also be inherited" (Kisumu, FGD, married female).*

Both married women and men in Kisumu added that according to the culture of the Luo most activities in the community have sexual connotations. A group of Kisumu men shared these fears as if to express the dilemma in which they find themselves:

R7: Most of the Luo culture, our culture goes with sex…If I am a man, the first born and I don't have a wife I will be forced to look for a woman to open the way for the others.
R9: If you are in your home sexual practices also guide many activities. If you are to start ploughing you have sex; planting also requires that you have sex. Harvesting can also not take place without sex. All these are finished with sex (Kisumu, FGD, married males).

Marriage patterns and practices also emerged as a recurrent theme among participants in both sites, but more so, in Kisumu. Polygyny was considered common among the Luo in Kisumu and participants reckoned that a polygynous man might influence his wives to have extramarital sex because he may not be able to sexually satisfy all the wives or he may abandon older wives for younger ones. This makes the whole family vulnerable to contracting HIV. An unmarried woman in Kisumu added marriage by abduction as another reason for high perceived risk of AIDS.

A childless marriage might be highly scorned in most communities in Kenya and for most couples the demand for children rather than AIDS prevention is of primary concern. A group of female discussants in Kisumu alleged that cases of infertility in marriage might indirectly increase a couple's vulnerability to AIDS because the husband could allow the wife to sire children with her brother-in-law or anyone else. The other women who maintained that the practice still happens discounted a woman who attempted to say that the practice no longer existed.

The societal expectation to be married seemed to be an overriding factor in perception of risk of a few female participants in both Kiambu and Kisumu. Marriage in Kenya is almost universal and often community members may become concerned if a woman or man shows no interest in getting married. An unmarried woman and man said:

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

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

Sense of denial and fatalism: The theme of denial of the reality of AIDS was sometimes explained by a few participants in Kisumu in relation to the belief that AIDS is witchcraft or "*chira"* and not a disease. As if in agreement both unmarried and married women recited that young people don't take AIDS seriously because they believe that it does not exist. Some participants indicated that fatalistic attitudes are used to rationalise death and that many people said they will die anyway and there was nothing they could do about it. Denial and fatalism could make individuals more vulnerable to HIV infection because of lack of the need to change behaviour.

Perception of personal risk of HIV infection – Findings from in-depth interviews

Unlike in focus group discussions in which all people perceived themselves at high risk of HIV, the findings of IDIs revealed that risk is conceived differently at different contexts and stages of people's sexual lives. Table 3 shows that the in-depth respondents employed varying subjective measures of risk at first sexual intercourse, recent or current partnerships, and for past sexual experiences that also influenced their risk aversion strategies. Individuals, therefore, could interpret their own risk in a range of ways, sometimes with contradictions, so that a person could acknowledge and also deny risk at different points of the interview, but these are not examined in detail. Reasons were often given for acknowledging or denying risk. Thus, it is not easy to simply categorise individuals into those who perceive and those who do not perceive themselves at risk.

Table 3: Individual interpretation of AIDS risk at different contexts and stages of sexual lives

Context and stage of sex life			
First sexual partner	**Most recent or current partner[4]**	**In your opinion, do you fear that your sex life might have put you in danger of getting AIDS?**	**Would you say currently you are in danger of getting AIDS?**
No AIDS risk because (25/29): - Partner was young and inexperienced or virgin - Partner was not promiscuous - I knew the partner for a long time/we grew up together/went to the same school - Partner was faithful and I trusted partner - Partner promised marriage - I didn't think of risk or condoms/didn't know about condoms - Partner didn't like condoms/reduces pleasure or connotes promiscuity -I loved partner and didn't want to annoy **- 4 women reported rape**	***Yes at AIDS risk because (2/29):*** - Partner may be unfaithful/has other partners ***But no risk because (29/29):*** - We have a trusting and faithful relationship - We intend to get married - I don't have multiple partners or extramarital sex - I have been tested for HIV so I am not infected - I always use condoms - I am abstaining	***Yes at risk because (13/29):*** - Partner unfaithful/had other partners - I had unprotected sex - Condoms are not 100% safe - I had multiple partners or extramarital sex ***But no risk, because (29/29):*** - I used condoms with those I didn't trust - I trusted my partner and partner was faithful - I have not had multiple partners or extramarital sex - I have been tested for HIV so I am not infected - I would be sick by now	***Yes at risk because (12/29):*** - Partner may be unfaithful - AIDS is prevalent - I have to marry - I can get AIDS from non-sexual sources - AIDS is got through sex ***But no risk, because (29/29):*** - I don't have multiple partners or extramarital sex - Partner is faithful and I trust my partner - I am abstaining - I/we have had HIV test - I always use condoms - I would be sick by now
Most important risk			
Pregnancy	AIDS then pregnancy	Only AIDS prompted	AIDS then pregnancy
Risk avoidance strategies			
- Hormonal (pills or injectables) and natural contraception (withdrawal, safe days) - Condoms (only 1 Kisumu unmarried woman)	- Condoms - HIV testing - Abstinence - Fidelity within or outside marriage - Hormonal and natural contraception	Not probed	- Condoms - HIV testing - Abstinence - Fidelity within or outside marriage -Hormonal or natural contraception

Note: Figures in parentheses are the number of respondents acknowledging or denying risk. However, all individuals who acknowledged AIDS risk also denied it at different stages of their sexual lives.

Interpreting sexual risk at first sexual intercourse: Findings from IDIs revealed that at first sexual intercourse almost all individuals were least likely to perceive themselves at risk of HIV. For most people pregnancy and not sexually transmitted infections were of primary concern. The analysis of the context of the first sexual intercourse revealed that young people are highly motivated to have sex by the social and cultural expectations for men and women to prove their manhood, to identify with their peers, to satisfy their sexual needs or curiosity, to prove their love, promises of marriage, and for material or monetary favours. Therefore, the motivations for first sex seemed to override any concerns of HIV risk. At first sexual intercourse, the emphasis was placed on a partner's characteristics, which were mostly used to judge the partner as being safe from disease.

[4] The sexual partnership was considered recent if it terminated in the last 12 months before the study and current if it was still ongoing or involved a marital union.

The timing and choice of contraception methods adopted with first sexual partners (natural or hormonal methods mostly the pill and injectables) and the way sexual risk was conceived also suggests that pregnancy and not AIDS was of primary concern. Almost all women and men mentioned that they did not use or think of contraception at first sex, though some individuals later adopted hormonal or natural methods with their first sexual partners. When asked why they used natural or hormonal methods or did not use condoms with their first sexual partners, most men reported that they trusted their partners because they were young and were virgins. They also reported that they had known their partners well since they had grown up together in the same neighbourhood or even gone to the same school. Some men added that they knew their partner's were not promiscuous and had no other partners, or else someone could have told them. A few men stated that they had marriage intentions and so did not even fear pregnancy. Similarly, some women alleged that their partners did not use condoms because they intended to marry them and so did not fear pregnancy. On the contrary, most women reported that they loved their partners, they did not want to annoy their partners because condoms connote promiscuity and mistrust, and that their partners did not like condoms since they reduced pleasure. The following dialogue with an unmarried male in Kiambu outlines the different ways in which risk was assessed with the first sexual partner, and the contradiction between knowledge and behaviour:

M: Did you talk to your first sexual partner about her past sexual experiences?
R: No, The lady was trustworthy. Her movements could not be doubted. Her life was not promiscuous. The lady asked me if I had another girlfriend but I told her that I did not have any other girlfriend.
M: Did you seek information about your sexual partner from anyone?
R: Yes, I sought information from friends who knew the lady and they encouraged me very much. I enquired both from girls and boys. All the same it did not require much enquiry because the girl was my sister's friend. I therefore trusted her.
M: Did you use any form of contraception the first time you had sex?
R: No, I did use any. We both trusted each other and we believed none of us could get sick. We did not even fear pregnancy.
M: After first sex, in which you did not use contraception, did you consider using any form of contraception later in you relationship with your first sexual partner?
R: No, I did not use any contraceptives in later sex.
M: Why do you think you never used contraception at all with your first sex partner?
R: I was serious with the girl. I did not therefore fear making the girl pregnant because I was ready to marry her. I was ready to accept her.
M: Did you talk about contraception with your first sexual partner?
R: Yes, we talked about contraception and condoms but we arrived at an agreement that none of us had a disease. We were both fine.
M: Who initiated the talk?
R: The lady, my partner. She talked about disease prevention and this was just before sex.
M: Can you remember how the subject was started?
R: The lady was from the rural area while I stayed within the town centre. She did not know my lifestyle in town and she therefore decided to talk to me about condoms. She had the mentality that those from the shopping centre were promiscuous.

In the above excerpt, though both partners were aware of the risk of unprotected sex they did not bother to act on such knowledge basing their judgement on trust and familiarity with each other. The individuals gathered information of a partner's sexual history either directly from the sexual partner or through informal networks, relatives and friends or what can be termed as 'gossip' that could be extremely deceptive. Besides, knowing a partner's sexual history was not consideration for being at risk of HIV infection and often not a serious aspect as one man claimed, "*I just used to ask jokingly.* Surprisingly 2 women who reported that their partners had had sexually transmitted infections (STIs) still argued that they trusted their partners and considered them safe from infections.

Some respondents said they just did not think of condoms or AIDS risk whilst others stated that they were ignorant about AIDS risk and condoms at the time. This might be a reflection, in part, of the context in which first sex took place. A man who had first sex with his cousin's partner who was visiting illustrates this:

> *"The room of my cousin had condoms but I never thought of it…I was overwhelmed. I cannot say I was carried away because if she never accepted I could not have done it…(M: Are you saying you never talked about contraception with your first sexual partner?) There was no time to talk. I think she thought if she asks me I would have told her let's not do it (not have sex)" (Kiambu, IDI, unmarried male).*

The IDIs revealed that women could be at risk of HIV infection right from the beginning of their sexual lives since their first sexual partners were usually older sexually experienced men. The age at sexual debut reported in IDIs by young women ranged from 13-22 years with an average of 16 years, and for the men the range was 10-20 years with an average of 15 years. Most women reported to have had first sexual intercourse with someone older by 5-9 years. For most men first sexual partners were of the same age or slightly younger by an average of 1-4 years.

The gender differences in sexual decision-making and negotiation at first sexual intercourse also precluded adoption of AIDS risk reduction strategies. The IDIs suggest that for most women the first sexual intercourse was neither intended nor negotiated. Most men seemed to have planned for their first sexual intercourse, yet from the fears expressed during first sex, pregnancy but not disease was of concern to both partners. When asked if they wanted to have sexual intercourse the first time they did so, almost all women except three, reported that they did not want, compared to men who all said they wanted to have first sex at the time. And when asked what sexual risks they feared most women reported that they feared the pain associated with breaking of virginity and pregnancy and only one woman said she feared getting a sexual disease. Most men reported they wanted to have sex the first time they did so and their greatest fear was making the girl pregnant.

For most women initiation of sexual intercourse appears to have involved a man creating situations that would easily end up in the woman agreeing to have sex even if this was not in her mind in the first place. Typically, the woman is invited into a boy's house, a friend's house, or to an isolated field/place. Women appear to agree to this, not knowing that consenting to the boy's proposal is likely to lead to sexual intercourse. Some men interpreted the woman's consent to visit as accepting to have sexual intercourse. Even where women agreed to have sex, they were coerced into having first sexual intercourse, though it often took subtle manipulative forms. When asked who decided that first sex

should take place women simply stated: *"He did"; "He tricked me"; "He kept on insisting"; "He forced me"*.

The IDIs suggest that most women reported to have engaged in first sexual intercourse not because they wanted to but because they felt obliged to do so. The opinions expressed suggest that coercion is gradual, in which a woman is persistently pressured to a point she relents to sexual intercourse. Most of the women acquiesce to sexual intercourse for fear of termination of the relationship and sometimes because sex is synonymous with love and is therefore used to please men. Most women reported that they agreed to have sex because the men insisted and they did not want to annoy them. Four women stated to have been raped. One woman said,

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

Some women stated, *"I was forced"* or *" He just grabbed and raped me"*, and mentioned they did not resist because of being in an isolated environment and the fear of repercussions of being sexually uncooperative. In addition, the secrecy surrounding the visit made the women remain silent even after the rape and more so because "*nobody would have believed."*

Among the men initiation of sexual activity appears to have been driven more by the desire to experience unprotected penetrative sexual intercourse in order to prove their manhood and be like other men and not the expression of "love" or the result of "force" as stated by the women. To that end, the men took advantage of opportunities that arose to accomplish their motives. Almost all men expressed the same reasons for having had first sexual intercourse.

> *"Yes, I had sex in order to make the girl remain mine because…without sex, there is no love. I also wanted to prove to my friends that I could do it. I wanted to prove my manhood." (Kisumu, IDI, unmarried male).*

Evidence from IDIs suggests that men always played the leading role in deciding when, where and how first sexual intercourse took place. The men concurred with women on the views regarding sexual decision-making. When asked who decided that sex should take place, most men simply said, *"it is me"*, or *"I did"*, and some men expressed how they persuaded the woman:*"It is me. I had to struggle. It wasn't easy…She lacked self-control, and I took advantage of that" (Kisumu, IDI, unmarried male).*

An unmarried man reported that his first sexual partner was a female domestic worker in his home. Though he did not know what he was doing he was categorical that his first sex was exciting and enjoyable. When asked if he had protected sex, he admitted that he was young at the time and never knew about condoms, and so did not even think of sexual risks.

Conversely, it should not be presumed that women's first sexual intercourse was always unwanted. Some women remarked that though they were scared and felt pain at first sex, they did not mind having sex and so *"after all the touching actually started enjoying it and so I allowed him to go all the way."* Some women said, *"I did it because I loved him"* and others said *"I had not done it before so I wanted to try in order to know how it feels."*

The nature and meaning attached to the first sexual relationship evolved with time and AIDS risk was not considered whether or not the first partner was thought of as a casual (known as "*hit and run"* or *"use and dump"*) or serious partner. Through probing respondents perceived their first sexual relationships as casual if it did not last long (less than 6 months) and if the motive was purely for sexual pleasure, to prove manhood or due to peer pressure (*"not to be left out"),* and was not meant for love or marriage. On this note, the men were more likely than women were to perceive their first sexual partnership as casual. Women, more often than not, perceived their first sexual partner as serious because with sexual intercourse the relationship was thought to entail elements of emotional attachment, trust, fidelity, and marriage. The women's ultimate goal was marriage until they realised that the partner did not think of the relationship in the same way.

It is apparent from these findings that the motivations for first sexual intercourse and the circumstances under which it took place, precluded the adoption of AIDS prevention strategies.

Interpretation of sexual risk of during the recent or current sexual partnerships: In contrast, at recent sexual encounters almost all individuals did exhibit that they perceived AIDS risk but at the same time denied being at risk because they alleged to have instituted risk aversion strategies. At recent or current partnerships individuals worried most about AIDS, followed by unwanted pregnancy. The context of recent partnerships also supported the adoption of AIDS prevention strategies. The IDIs revealed that for most women recent or current sexual experiences were almost always intended and sometimes negotiated. Because most women reported to have wanted to have sex with their recent partners there was evidence of some women (mostly the unmarried) taking assertive roles in sexual-decision making and negotiating use of condoms. All unmarried women considered their recent/current relationships to be serious because most had lasted over one year and that they had marriage intentions that had been discussed with their partners. And so having sex was part of the deal. Some unmarried and married women intimated an element of coercion while others were able to negotiate whether or not to have sex as illustrated in these remarks:

> *M: Do you always want to have sex whenever you have it with him? R: Not always, only sometimes.*
> *M: What then influences you to have sex when you are not ready for it?*
> *R: He influences me when he insists too much until I give in" (Kiambu, IDI, unmarried female).*
>
> *R: No, when he wants only, that is when we have sex. Sometimes I don't want to. Sometimes we plan especially when I don't want to have sex too often" (Kisumu, IDI, married female).*

When asked why she had sexual intercourse with her current partner, an unmarried woman in Kiambu said: *"Because I want to be married. I love him and he loves me."* Nearly all men expressed similar views as women did except for two men in Kiambu who considered their relationships to be casual because they suspected their partners had other partners and therefore used condoms for protection against HIV infection. Some women said they have sex to prove their love or because *"it is the normal thing for men."* One unmarried woman in Kisumu reported she has sex for economic favours, though she added that they have planned to marry and so did not see the need for condoms.

Similar to first sexual partners, most women reported recent/current partners that were older by 5-9 years and men's current partners were of the same age or younger by 1-4 years. The persistence of large age differences between partners suggests little or no change in the sexual partnering culture of young people in the two study sites. As noted earlier the sexual behaviour of young people, particularly for women, might be driven by economic motives.

On the other hand, nearly all the married and the unmarried men maintained that they decided on when to have sex with their recent or current sexual partners even though some said they negotiated with their female partners or that the woman decided: *"Me. It is a man's responsibility to do so" (Kisumu, IDI, unmarried male).*

The choice of contraception methods with recent or current partners were the same as with first sexual partners. The timing of adoption of contraception at the beginning rather than at a later stage of the relationship suggests that at later sexual lives young people recognise the importance of protecting themselves against HIV infection. There was evidence from the IDIs to suggest that the young people in Kiambu and Kisumu rely on different AIDS prevention strategies. Notably, sexually active unmarried participants in Kisumu relied more on use of condoms or abstinence to protect against HIV and those in Kiambu relied more on fidelity and HIV testing strategies. All unmarried women and men in Kisumu reported that they consistently used condoms with their partners and recognised the dual role of condoms, for prevention of pregnancy and STIs. Only 2 unmarried men in Kiambu reported to have used condoms with their recent/current sexual partners, though one of them used condoms only for one week and stopped because he *"went to the doctor and was tested HIV negative."* When his partner suggested that they continue using condoms even after HIV testing, he said: *"I felt let down, she made me realise that she did not trust me."* All the unmarried women in Kiambu reported that they used safe days or natural contraception methods to protect against pregnancy and none of them had used condoms. When asked of the reason for non-use of condoms, they simply said *"we trust each other with my partner"*, suggesting that they worried more about pregnancy than STIs. Men in Kiambu held similar views as the women.

All married women and men mentioned that currently they relied on fidelity as protection against HIV and on hormonal or natural methods to protect against pregnancy. One married woman in Kisumu mentioned that her husband used condoms during her unsafe days to prevent pregnancy. Thus, married individuals did not mention abstinence and condoms as options for protecting themselves against HIV infection.

Nonetheless, there was encouraging evidence to suggest that for some individuals the uptake of HIV testing and abstinence strategies compensated the non-use of condoms. HIV testing seemed an obvious alternative to the use of condoms in established trusting and monogamous relationships within or outside marriage. HIV testing was definitely more pronounced among all sub-groups of Kiambu participants than in Kisumu. Out of the 17 participants of IDIs in Kiambu, 11 (5 women and 6 men) had undertaken HIV test for various reasons – to know their HIV status and therefore maintain monogamous relationships, for medical, pregnancy and education purposes. In comparison, of the 12 IDI participants in Kisumu only 2 men had done HIV test; an unmarried man who wanted to know his own HIV status and decided to abstain from sex and another for marriage purposes. None of the women in Kisumu had done the HIV test. On a positive note, participants who reported taking the HIV test for other purposes apart from sexual reasons alluded to have changed their sexual behaviour based

on the test results by being faithful to their partners. The HIV test was usually meant to allay fears of an infection. For unmarried individuals HIV testing usually preceded abstinence and sometimes fidelity in relationships. Some married people alluded to undertaking HIV testing as a basis for maintaining fidelity within marriage. Six of the men and women who had not had HIV test stated that they considered having one (3 in Kiambu and 3 in Kisumu), and 9 expressed that it was not necessary and so never thought of a test as stated by a woman in Kisumu:

> *"I haven't just thought about it; perhaps if I fall seriously ill then may be I could go for HIV test." (Kisumu, IDI, married female).*

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

There was clear evidence in both Kisumu and Kiambu of shared gender roles in sexual decision-making, negotiation and discussions about contraception and HIV/AIDS, though the emphasis of such discussions differed in the two sites. Both married and unmarried women and men in Kisumu admitted to have discussed contraception with their sexual partners, particularly condoms for fear of pregnancy and STIs. Even among married partners in Kisumu, condoms seemed to be tolerated in men's extramarital relations, though a woman could not question her husband's behaviour. For example, a married woman in Kisumu recounted with ease how her husband used condoms with her full knowledge, as if it were such a normal thing to do.

> *M: Have you ever talked about condoms?*
> *R: Before he got saved (became a Christian), we used to talk about them. Now we don't. During the period when he was unfaithful, he used to have them. When he was going on a journey, he used to carry a lot of condoms. He didn't even care. He even used to sleep out and I wasn't allowed to question.*
> *M: During that period when he used to carry condoms, what did you discuss?*
> *R: I knew that for someone to use condoms, we didn't trust each other. He thought he could infect me with a STD and vice versa.*
> *M: Did he use condoms with you?*
> *R: No, he never used them with me (Kisumu, IDI, married female).*

On the contrary, the discussions about contraception and AIDS noted among some Kiambu respondents were often limited and did not include talking about condoms because of lack of freedom among partners or because of the negative attitudes towards condoms. Some remarked:

> *M: Did you talk about condoms?)*
> *R: No, we did not…I was scared of suggesting them to him" (Kiambu, IDI, unmarried female).*
> *R: No, he does not like them" (Kiambu, IDI, married female).*
> *R: I told her that I hate them…And she knows I don't like them and she also told me they are not comfortable for her…I told her that she should forget about condoms in our love span. So I made a declaration which she supported" (Kiambu, IDI, unmarried male).*

Individuals were also directly asked whether or not they thought their past sexual lives had put them in danger of AIDS and whether or not they currently perceived themselves at AIDS risk. Most people did

not perceive themselves at risk of HIV. And individuals who acknowledged that their past sexual lives were risky or were currently at risk of HIV infection immediately allayed their fears by purporting that currently they were not at risk because they had instituted AIDS prevention strategies. Such claims were often made in complete disregard of past risky sexual experience and lack of knowledge of own HIV status, though for some people HIV testing claims supported denial of risk. Current denial of risk was mostly based on own behaviour that was considered safe. The reasons individuals gave for perceiving or not perceiving themselves at risk were the same as for first and recent or current partnerships and these are broadly summarised in Table 4. The reasons include: a) factors associated with the partner's behaviour; b) factors associated with own behaviour; c) non-sexual factors; and d) social and cultural factors. The first two categories were more commonly mentioned than the last two. Though some of these factors may appear unrealistic, it appears to be what young women and men use to estimate their risk of HIV.

Table 4: Summary of characteristics individuals consider for interpretation of personal risk of HIV infection

Characteristics associated with partner's behaviour
Perceives risk because:
Partner may be (was) unfaithful
Perceives no risk because:
Partner is (was) not promiscuous or has (had) no other partners
Partner is (was) young or virgin
Partner is (was) known the partner for a long time or grew up together
Partner is (was) faithful
Characteristics associated with own behaviour
Perceives risk because:
I had casual unprotected sex
I had extramarital sex
Condoms are not 100% safe
Perceives no risk because:
I use (used) condoms always or with those I don't trust
I trust (trusted) my partner
I am abstaining
I don't (didn't) have multiple or extramarital partners
I have been tested for HIV
I would be sick by now
I didn't think of it (risk or condoms).
Non-sexual factors
Perceives risk because:
I can get AIDS from blood and sharing of cutting instruments
Social and cultural factors
Perceives risk because:
I have to marry
AIDS is prevalent

Reasons for perception of personal vulnerability of HIV infection

a) *Partner may be unfaithful:* The issue of partner's infidelity as in FGDs, was the only recurrent theme among individuals who assessed themselves to be at risk based on their partner's sexual behaviour. Almost all married and some unmarried individuals raised this concern, though for a few individuals it was not an outright statement but rather as supposition that their faithful partner could have been (or may be) unfaithful. The quotes below illustrate the different ways individuals interpreted their AIDS risk based on a partner's unfaithfulness:

> *"Yes, I know I am in danger of contracting that disease because may be if my husband meets a girl suffering from AIDS that means I will also get infected" (Kiambu, IDI, married female).*
>
> *R: I know I am well protected since I am not promiscuous. I have a wife. We trust each other so I do not see why I should be worried.*
> *M: But do you consider yourself in danger of contracting AIDS?*
> *R: I may be in danger since my wife may become promiscuous. She may go out there, get seduced and she agrees (Kiambu, IDI, married male).*
>
> *"…I don't think I can get AIDS. But I can't really say because may be he has other partners. I pray to God that I don't get the disease" (Kiambu, IDI, unmarried female).*

b) *Own sexual behaviour was (is) risky:* A few women and men gave unconditional reasons for perceiving themselves at risk due to their own past sexual behaviour. The sexual reasons were having had casual, extramarital or unprotected sex. But such acknowledgement of risk was readily denied because AIDS was allegedly not prevalent at the time. Some individuals claimed that though they used condoms consistently they were not 100% safe.
c) *Risk from non-sexual sources:* Some married people averred that currently they are at risk because of the likelihood of infection through non-sexual sources such as blood transfusion, sharing of cutting instruments, syringes, and circumcision. They completely ruled out the risk from sexual intercourse and asserted that they had changed their sexual behaviour to maintaining trusting and faithful relationships. None of the unmarried people raised this concern.
d) *High HIV prevalence:* A few unmarried people acknowledged the high prevalence of HIV/AIDS in the community and viewed it as a serious threat that could put them at risk of infection, information seemingly obtained from the media. This concern was similar to what was echoed in the FGDs.
e) *The need to marry:* As in opinions expressed in FGDs, the community expectation of marriage made a few individuals worry about HIV risk.

Reasons for individuals perceiving themselves at no risk of HIV infection

As noted earlier, individuals were more likely to deny than to perceive HIV risk. In addition to safety based on the partners' characteristics discussed under first sexual intercourse, individuals had several statements to justify their own sexual behaviour as safe. The claims of own safe sexual behaviour were more prominent in assessing risk within recent and current relationships than in past sexual life.
b) I trust my partners: This was the most recurrent theme used to justify own perceived safety and complemented that of '*my partner is faithful'*.
c) I always use condoms or I use condoms with partners I don't trust: Some unmarried participants

admitted that they used condoms consistently with current or recent partners and this conformed to what they had spoken earlier. Though, one male had a lapse, and as if to exonerate himself of blame, he had not use a condom because *"the lady insisted so much on having sex" (Kiambu, IDI, unmarried male).* Some people reported that they used condoms only in casual sex or at the beginning of the relationship and once trust was established condoms were disregarded. Most people reported reliance on the natural forms of contraception because of the fear of side effects of the hormonal methods.

d) *I am abstaining:* A common theme among unmarried respondents for denying risk in current relationships was the fact that they were abstaining, though for some the risk of HIV infection of previous sexual partners was often ignored. Some people abstained after having HIV test, *"I am not in danger now because I went for a test and it turned out to be negative. I now don't have a sexual partner" (Kisumu, IDI, unmarried male).*

e) *I do not have multiple partners or extramarital sex:* Most respondents also argued that they were safe because they were sticking to only one sexual partner or were not having extramarital sex, *"Since I began taking the issue of AIDS seriously, I do not take any risks. In fact, I have completely refrained from extramarital sex" (Kisumu, IDI, married male).*

f) *I have been tested for HIV:* As noted earlier, 13 people, more so in Kiambu, reported to have been tested for HIV and were assertive that they were not infected. Some even claimed to do the test frequently, *" Let me say that I usually go for medical tests including my wife. And we have been found to be uninfected" (Kiambu, IDI, married male).*

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

h) *I did not think of risk or condoms at the time:* For some, the fun of having sex overrides the concern of AIDS risk, *"…I didn't event think about the risk involved in unprotected sex because I was having so much fun" (Kiambu, IDI, unmarried female).*

i) Some individuals simply admitted to have been ignorant because they were young and had not heard about condoms or AIDS.

Implications of young people's perceptions of AIDS risk

There is no doubt that the participants in this study recognised AIDS as a major threat to their communities. AIDS awareness is high and the level of worry and the realisation of AIDS as a problem of everyone conform to the high HIV prevalence rates in the country.

Implications on AIDS messages

People mentioned AIDS prevention strategies that epitomised AIDS prevention messages relayed through the media. Misconceptions about HIV transmission occurred with much less frequency, and whenever mentioned other group participants with more accurate information usually discounted them. Thus, it seems that AIDS awareness is not the problem but perhaps the content and the methods of delivery of AIDS messages are.

Evidence from FGDs reflected certain levels of misinformation about channels of AIDS transmission which seemed to lead people to unwarranted concern or denial and fatalism, belief in deliberate transmission, and stigmatisation and ostracism of infected and affected individuals. This suggests that efforts to promote realistic understanding of HIV transmission are pertinent in checking risky behaviour likely to result from false or distorted information.

The findings have suggested that young people in the communities of study have differentiated perceptions of AIDS risk under specific contexts and stages of their sexual lives. This suggests that it is important that the content and delivery of AIDS messages take into account the relational and contextual factors of perception of risk and behaviour change. The delivery of AIDS prevention messages calls for a multifaceted approach in order to address different segments of the population, which might have different sexual experiences. AIDS messages need to be categorised into those that address the general population; individual communities to account for differences in socio-cultural beliefs and practices; gender differences in sexual decisions and negotiation; young unmarried sexually inexperienced people, young unmarried sexually experienced individuals and people in marital unions.

The young people need interventions that are relevant to each stage of their sexual lives rather than being daunted with general messages that address the whole community. The results indicated that the individuals adopted specific measures of risk and AIDS prevention strategies at different stages of their lives. Given this evidence, young sexually inexperienced people might need to be targeted with messages of abstinence and delay of sexual debut, rather than condom messages that are irrelevant and likely to create confusion. Similarly, young unmarried sexually active individuals might need to be targeted with messages of condom use, fidelity in relationships and abstinence. Individuals in marital unions should be targeted with fidelity messages since advocating for abstinence or use of condoms in relationships that are expected to be faithful would seem unrealistic. This will ensure that messages are realistic and relevant to the experiences of the individuals.

The FGD results highlighted the influence of culture in perceptions of risk among the Kisumu participants. Previous research in Kenya has associated the high prevalence of HIV infections in Kisumu district to the practice of widow inheritance, polygyny, and belief in witchcraft and "*chira*" (Kenya et al., 1998; Ocholla-Ayayo, 1991). These results show that there is a need of targeting AIDS prevention messages to fit the social and cultural contexts of individual communities. One AIDS prevention message may be relevant in one context but totally irrelevant to another. On the evidence from this study, emphasis on the bio-medical and gender aspects of AIDS prevention messages may be where the need lies in Kiambu, whereas in Kisumu the need may lie more in addressing the socio-cultural aspects of AIDS prevention.

The sexual behaviour of young people at first sexual intercourse suggests that most individuals were more concerned about pregnancy than disease, but at later sexual lives all perceived AIDS risk and reported to have changed their behaviour. There could be possible explanations to this scenario. Perhaps the behaviour of young people at first intercourse reflected their lack of awareness about sexual risks and HIV/AIDS at the beginning of their sexual activity. Most of the young people involved in this study initiated sexual activity between the ages of 13-20 years, a time when the reality of AIDS in Kenya was only coming to light. Between the period 1988 to mid 1990s there was no public acknowledgement of AIDS as a threat in Kenya. The AIDS disease was still shrouded in mystery and people were reticent to talk about it. In addition, until recently AIDS messages did not target young people because sex education was alleged to promote promiscuity among them. Young people then entering into active sexual lives might not have been particularly informed or knowledgeable about HIV risk at the time. A number of AIDS interventions are now in place to address the sexual needs of young people in Kenya. It appears that AIDS messages have had an effect on young people's perceptions of risk of HIV and behaviour change. However, the extent of the success of these messages cannot be determined from a single study. There is need for further small-scale studies that examine

current levels of knowledge and conceptions of risk among both sexually inexperienced and also sexually experienced young people recently entered into active sexual lives.

Another possible explanation for young people's low perception of risk at first sexual intercourse may be related to the age of respondents at the time. At younger ages, individuals might not perceive AIDS as a threat simply because of their short-lived sexual realities so that they do not even think about death. But as people get older they might realistically conceive AIDS risk due to the influence of AIDS messages and their widening social networks.

Implications on behaviour change

Overall, individuals appeared to adopt risk aversion strategies that seemed to be influenced by the AIDS prevention messages and the different ways risk was conceived at different stages of sexual lives. When asked what they were doing to reduce their chances of getting AIDS participants of FGDs and IDIs concurred on the following: trust and fidelity in marriage or outside marriage, HIV testing, abstinence, and condom use. The other AIDS prevention mechanisms mentioned in two or three focus groups include avoiding multiple partners, communication with partner or others, becoming religious, and stopping widow inheritance (mentioned only in Kisumu). These strategies were easily recited and seemed to epitomise the AIDS prevention messages in the media and other sources. But through probing, contradictions were raised that revealed the gulf between what respondents knew about AIDS prevention and what they believed they could realistically do to influence behaviour. The AIDS prevention strategies are not discussed in detail since it is not the focus of this paper.

The widespread recognition of the general threat of AIDS in FGDs was, however, different from the perceptions of personal vulnerability among women and men. The majority of the women and men interviewed in-depth perceived themselves at no risk of AIDS. Fortunately, this lack of perception of risk is consistent with the type of AIDS prevention strategies reported by women and men. Generally, the type of AIDS prevention strategies adopted conformed to the AIDS prevention messages that emphasise fidelity in relationships, abstinence, condom use, HIV testing, and reduction of multiple partners. The long term goals of public awareness campaigns are to instil among communities realistic perceptions of risk. Individuals who are not sexually active or those who use condoms in risky sex or restrict sex to regular partners may realise that their behaviour minimises the risk of getting HIV infection. The reverse could be true for those who are sexually active and engage in risky sexual practices. If these results were taken as they are, they would signify a trend towards realistic assessment of risk and the success of AIDS prevention programmes. However, individual perceptions have to be viewed cautiously. There is a need to corroborate such findings with the incidence of STIs/HIV in the communities of study. So far, there is lack of enough evidence to show a declining trend, since declines in the incidence of STIs would be easily noticeable. Cleland (1995) notes that reports on behaviour change may be an admittance of the need to change as advocated by AIDS messages, rather than actual practice. In addition individuals may have decided to respond in a way that portrayed them as responsible and sensitive people. There remains a need to validate the genuineness of individual perceptions and reported behaviour change through repeated small-scale surveys and hospital based data.

Individuals interviewed in-depth relied on partners and social networks as sources of information about their partners' sexual histories. The fact that partners and social networks could provide unreliable information was not taken into account in risk estimations. Several respondents did not consider the problem of whether or not the partner told the truth. During the IDIs four respondents admitted not to have told the truth about their sexual histories because of the need to be seen as decent or not promiscuous. In addition, the fact that AIDS has a long latency period was not applied when sexual histories were used to assess risk, so that knowing a partner had other partners was somewhat ignored. Previous research has shown that partners are often hesitant or afraid to introduce the topic of protective sex early in the relationship for fear of being accused of mistrust or being labelled promiscuous (Fapohunda, 1999; Ingham, 1992). Sexual partners may feel more comfortable sharing information if the partnership is long term and partners 'know' each other well. The period between meeting and 'knowing' a partner potentially puts the partners at risk of HIV and it may be too late when eventually the issue of protective sex is broached. In addition, if both sexual partners expand their network of partners or if the relationships are of a short term and casual nature, little or no information may be gathered about a partner from the social networks. AIDS messages need to reinforce that any act of unprotected sex is risky unless it is a mutually monogamous relationship between uninfected partners.

The results of IDIs indicate that some individuals prefer HIV testing to the use of condoms in established and monogamous relationships. HIV testing was an option some women and men, within and outside marriage, particularly in Kiambu district, relied upon for maintaining trusting and monogamous relationships or abstinence. A number of respondents in Kiambu preferred HIV testing and fidelity to condoms. HIV testing appeared a less popular AIDS prevention strategy in Kisumu than in Kiambu and the reverse was true for condoms. All unmarried in-depth interviewees in Kisumu, and only two in Kiambu, reported that they used condoms consistently, whereas some reported that they were abstaining from sex. Although just about half of the in-depth interviewees, more so in Kiambu, reported to have had HIV test, it portrays a positive trend towards the need to know own HIV status. This has significant implications for AIDS prevention activities. Programmes need to encourage HIV testing and counselling and fidelity as important realistic alternatives to condom use in long-term relationships such as marriage.

It is unclear why young people in Kisumu depict responsiveness to condoms outside marriage and fidelity in marriage, and those in Kiambu prefer HIV testing and fidelity both within and outside marriage. Perhaps it is related to the mode of delivery and the emphasis of AIDS messages and the attitudes of the community towards different AIDS prevention strategies. As noted earlier, Kisumu site is situated in Nyanza, a region that has consistently had high rates of HIV prevalence in Kenya. In addition, Nyanza region has been flooded by NGOs offering a range of AIDS prevention interventions, but more so, the promotion of condoms. On the other hand, Kiambu area that for some period of time had slightly lower HIV prevalence rates than Kisumu might have been less targeted by NGOs, but served by public (government) AIDS awareness campaigns that may emphasise HIV testing, trust and fidelity in partnerships. Alternatively, it may be plausible to suggest that differences in attitudes towards condoms or HIV testing may in part explain the tendency of Kiambu and Kisumu respondents to prefer one to another. The stigma of testing for HIV might be more pronounced in Kisumu than in Kiambu whereas the reverse is true for condoms. This study did not explore the social context of HIV testing in detail and so would be an important area of further research.

Though based on a small sample, findings of IDIs suggest that in Kiambu, the need to promote safer sex, particularly use of condoms, is far more relevant as is the need to promote an understanding of how a person can be vulnerable to HIV infection in a relationship considered faithful, trusting and of a serial monogamous nature. In Kiambu, the promotion of the acknowledgement that every act of sex has an element of HIV risk and that both partners should take responsibility of preventing AIDS is where the need lies, and where perhaps the largest emphasis should be placed. In Kisumu, there is evidence to suggest that young people acknowledge the advantages of safer sex and shared responsibility in sexual decision-making as reflected by the willingness of young people to discuss and use condoms with their partners. Though nearly all women in Kiambu reported to have discussed contraception with their partners, they also stated that condoms are never discussed because they were *"not free to discuss such things"* or that men hate condoms. In Kisumu, therefore, the need might lie in how to make young people sustain safer sexual behaviour and supportive gender attitudes and roles, in addition to promoting uptake of HIV testing and counselling services.

Despite the concern about the risk of getting HIV infection in the communities of study, there was little evidence from the participants in this study for a greater reliance on condoms (also known as *"mobile"*) for dual protection against pregnancy and disease. Surprisingly, participants revealed a lot of contradictions in their attitudes to condoms. The same people who advocated condom use in risky sexual encounters later strongly rejected the idea of using them in their own relationships. There was little differentiation in opinion within or across groups. Individuals tended to start by agreeing that any woman or man has a right to protect oneself from AIDS but qualified their views with certain environments under which condom use is acceptable. All participants agreed that condom use is acceptable with casual or extramarital partners and prostitutes but not in long-term serious relationships or conjugal unions. Instead, participants advocated abstinence and fidelity in relationships. The negative attitudes towards condoms were more pronounced in Kiambu than in Kisumu. Most women were outright that men did not want to use condoms because they connoted promiscuity or mistrust. Similarly, most men expressed the same about women.

The study echoes challenges men and women face in trying to institute AIDS prevention strategies. The adequacy of these strategies as prevention mechanisms for both women and men is flawed with many erroneous assumptions. A look at the strategies that are being advocated shows that they are all under men's control. The influence of gender in sexual networking and decision making is an acknowledged fact in sub-Saharan Africa (Harrison et al., 1997; Moses et al., 1994; Orubuloye, Caldwell and Caldwell, 1993; Standing, 1992), and these intervention approaches have obviously ignored women's inability to negotiate safer sex within or outside marriage. The strategies tend to favour men whom society has given most of the leverage to decide on when, how and with whom to have sexual intercourse.

Men use condoms and few women in Kenya can ever negotiate use (Omondi-Odhiambo, 1997). The majority of women expressed their inability to use condoms since men do not want to use them. And when men were asked if they need permission to use condoms, they simply laughed with surprise and easily retorted, *"No", "Permission! For What?", Of course not!"* Previous research among young men and women in Nyanza province of Kenya showed that only some women, particularly those in commercial sex work, could ably negotiate condom use (Habema and others 1999). The FGD and IDI results have indicated that condom use is inhibited by the entrenched social and cultural attitudes. Condom use varied by context and stage of sexual life. AIDS prevention interventions need to take into

account the social and contextual construction of risk when promoting condoms for disease and pregnancy prevention.

The prevention strategies of trust, faithfulness and abstinence seem to be unrealistic among women living with men with much sexual freedom. Studies indicate that most women have no sexual partners other than their husbands who are becoming infected with AIDS (Reid, 1999; Family Health International, 1999). For married women abstinence and faithfulness of both partners in a relationship is not within their power to bring about. And for many other girls and women, sexual assault such as rape is a reality and this will increase the number of infected women as the number of infected men increases. There was evidence in this study to suggest that for most girls first sexual intercourse was coerced, forced or a rape. The girls did not have recourse for the emotional and psychological trauma they suffered. Behaviour change programmes need to address the social and psychological aspects of sexual initiation and later sex in order to protect young women from entering into unhealthy sexual activity.

There was good indication from the FGDs and IDIs that young unmarried people voluntarily initiated secondary abstinence as a response to the threat of HIV infection. In exploring the role of abstinence in HIV/AIDS prevention, it is important to distinguish between primary and secondary abstinence. Primary abstinence promotes the delay of onset of sexual intercourse whereas secondary abstinence is a choice made to forego further sexual relations for a period of time. This study did not explore the extent of the practice of primary abstinence because the in-depths focused on those with sexual experience. The FGDs may have captured the element of primary abstinence since a few participants were sexually inexperienced, though this is difficult to disentangle from group discussions. It might be important to focus at the primary abstinence level as an AIDS prevention measure given the lack of perception of AIDS risk at first sexual intercourse. In other words, given that individuals would naturally hesitate and be fearful to have first sexual intercourse, it would appear a more appropriate point of intervention. It might be plausible to state that once an individual is sexually experienced there is a considerably increased likelihood of further sexual intercourse. Nonetheless, evidence from this study has shown that targeting secondary abstinence, is an equally important HIV prevention strategy. Perhaps the belief that once one is sexually active it is difficult to abstain is unjustified because this is not necessarily the case. Arguably, though sexuality is a biological function, people's behaviour is also socially constructed. The fact that people grow up in a culture that expects them to behave in a specific sexual manner means that they are capable of learning and adapting to changes throughout their life course. The assumption that it would be difficult for sexually active individuals to abstain presupposes that human actions are driven by instinct rather than conscious choice. Emphasis on secondary abstinence may prove a more viable AIDS prevention measure than is generally thought.

There was a recurrent theme of older men (sugar daddies) initiating sexual relationships with younger women and older women (sugar mummies) with younger men throughout the FGDs and also in IDIs. Participants believed that poverty influenced men and women to have sex with older partners for material or monetary favours. Previous research in Kenya has frequently alluded to the prevalence of the sugar daddy phenomenon (Nduati and Kiai, 1997; Karungari and Zabin, 1995; 1993; Ajayi et al., 1991). The age difference between partners evident from the IDIs conforms to results from previous research in Kenya (Futures Group, 1999, 2000). The large age difference between partners has been associated with the high HIV prevalence among young people in Kenya (Okeyo et al., 1998). The older men act as a bridge whereby they infect younger women who in turn pass infections to younger men.

The prevalence of young men partnering older women (sugar mummies) appears to have gained prominence over the last few years. Perhaps, the shift towards gender sensitive studies and interventions has only just uncovered an old practice that tended to be ignored. This might form an important element of behaviour change interventions. Young people of both sexes need to be equipped with knowledge and skills of dealing with risky sexual situations.

Conclusions

Clearly, AIDS education and prevention programmes in the communities of study show evidence of success. Individuals exhibited high level of information and knowledge about AIDS and were motivated to change behaviour to avoid getting HIV infection. Perceptions of risk appear realistic since they were concomitant with reported behaviour change. However, it appears that efforts to change behaviour are constrained by social and cultural expectations of behaviour, as well as gender differences in sexual decision making and negotiation. The AIDS prevention strategies might need to address the normative component of behaviour change, which would empower women to play active roles in deciding and negotiating when, where and how sex takes place. This might call for interventions that aim at changing entrenched risky cultural beliefs and practices, which perpetuate gender differences in sexual matters. Such programmes need to focus both at the societal and individual levels. For AIDS prevention to succeed, men and women need to redefine and renegotiate their sexual roles.

Despite the challenges that young women and men face in AIDS prevention, the findings of this study are encouraging. Widespread denial or acknowledgement of risk with no concomitant change in behaviour would have been bad prognosis for the prevention of HIV infections. The policy and programme implications might involve designing interventions aimed at sustaining behaviour that reduces the risk of contracting AIDS among young people. In addition, programmes should focus on why and how young people initiate sexual activity and how they interpret AIDS messages they receive.

The findings have suggested that young people in the communities of study have differentiated needs under specific contexts and stages of their sexual lives. Programmes that aim to change behaviour in these communities will need to identify and target the social and cultural contexts under which AIDS risk is conceived and acted upon in order to design appropriate interventions for people at different stages of sexual life.

The frequency with which poverty and sex for monetary or material gain was mentioned needs particular attention in AIDS prevention efforts. AIDS prevention strategies in these communities must acknowledge and address poverty, which is the force behind young women’s partnering with older males hence making them highly vulnerability to AIDS.

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