

THE PERCEPTIONS OF RURAL SAMBURU WOMEN IN KENYA WITH REGARD  
TO HIV/AIDS: TOWARDS DEVELOPING A COMMUNICATION STRATEGY

By

PAULINE NASESIA WANYOIKE

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SUPERVISOR: PROF AC ALLAIS  
CO-SUPERVISOR: MR CP CILLIERS

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Student Number: 3535-916-1

I declare that THE PERCEPTIONS OF RURAL SAMBURU WOMEN IN KENYA WITH REGARD TO HIV/AIDS: TOWARDS DEVELOPING A COMMUNICATION STRATEGY is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Wanyoike

SIGNATURE

(Ms PN Wanyoike)

24/2/2011

DATE

## DEDICATION

I dedicate this work to my late sister Maryanne Kiranta. To my husband Frederick Ngoro for his prayers, company, support and “holding the fort” when I was engrossed in this work. To my children Zebidah Wanjiku, Alfred Ngoro and Rahab Naimutie for the patience and support they accorded me (Subira huvuta heri). To my parents Mrs P.Roimen, Mr & Mrs Wanyoike, Mr & Mrs Ngoro for their prayers and encouragement. To Njeri, Wairimu, Gathoni, Mainas, Manyaras, Kimanis, Ng’ang’as, Wambui and Munas for your support and prayers. And finally, and most importantly I give thanks to the Lord God Almighty who gave me life and strength to undertake this study.

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## **ABSTRACT**

The objective of this research is to explore the perceptions of rural Samburu women in Kenya with regard to HIV/AIDS in terms of their knowledge, attitudes, beliefs and opinions; to examine several HIV/AIDS awareness channels that have been used to communicate HIV/AIDS messages to the Samburu women to determine how effective they have been in effecting behaviour change. This study is an example of how a communication audit can be carried out on a certain sub-group of a community in order to suggest a tailor-made communication strategy in an effort to stop the spread of HIV among the Samburu women. This study is also a confirmation that the prevention strategies that have been in use to communicate to Samburu women have been inadequate and need to be revised to address the knowledge gaps that exist.

The study is located within a relatively new field of health communication where health messages are evaluated to determine whether target audiences are receiving these messages and changing their behaviour in order to live healthier lives. This area of study is also supported by behaviour change models such as the Health Belief Model (HBM), the Social Cognitive Theory (SCT), Diffusion of Innovations Theory, Cultural Models, and Strategic Communication.

A qualitative study was undertaken in 2008 by way of ten focus group discussions with Samburu women and eleven in-depth interviews with professionals who ran HIV/AIDS programmes in the Samburu district. The focus groups were constituted by means of convenience sampling whereas the snowball strategy was utilised for the selection of participants for in-depth interviews.

The questioning route for the focus group discussions for the Samburu women was guided by five themes namely: knowledge levels of the women; cultural aspects that made the women vulnerable to HIV/AIDS; beliefs about HIV/AIDS; attitudes towards HIV/AIDS; and the different channels of communication used to convey HIV/AIDS messages. The interview schedule for the professionals consisted of open-ended questions and face-to-face interviews were carried out using this schedule.

The methodology of this study was guided by the UNAIDS framework of communication which argues that contextual factors such as government policy, cultural and spiritual factors, gender relations and social- economic status should be considered when interventions are developed because people do not automatically change behaviour after receiving information. The importance of cultural and gender sensitive messages is emphasised. Targeting each segment of a community with appropriate messages is critical and builds on the latest school of thought that one should know their epidemic and the appropriate response. This study also takes into cognisance the fact that there is a paradigm shift in the way HIV/AIDS interventions are designed and implemented to more contextualised, culture sensitive and gender sensitive messages.

The study revealed that: (1) The Samburu women have insufficient information about HIV/AIDS to protect themselves; (2) cultural practices and rites make the Samburu women vulnerable to HIV/AIDS infection; (3) major HIV/AIDS prevention tools such as the condom are not acceptable to the Samburu women because it interferes with conception; (4) the Samburu women believe that HIV/AIDS is a curse and that as long as one follows the cultural obligations of the community they are safe from HIV/AIDS infection; (5) the inferior social status of the Samburu women prevents them from making any informed decisions about their sexuality. Gender norms that prescribe an unequal and more passive role in sexual decision making exacerbate the spread of HIV/AIDS; (6) most of the information the Samburu women receive is verbal; the videos and tapes that have been used to pass on information have been misinterpreted to give an impression that HIV/AIDS is a disease of the young people, town dwellers and the educated; (7) while the latest health demographic studies indicate that the radio is the most suitable channel to send HIV messages to the general public, the Samburu women have a limited access to the radio because it is owned and controlled by the head of the family.

The overall findings of the study indicate that the national strategy with its focus on HIV programmes that focus on prevention messages that concentrate on three aspects of behaviour: using condoms, limiting the number of sexual partners or staying faithful to one partner and delaying sexual début for young persons is in total

contradiction with the Samburu culture and therefore has little chance of succeeding. Although the national policy has worked in many communities in Kenya, there are regions where the prevalence rates are higher than others. This means that particular communities need to be studied and researched on so that culturally sensitive/relevant strategies that take into account the unique regional drivers of the epidemic may be developed.

It is hoped that the information and the suggestions, which are contained in this thesis, will assist government health workers, non-governmental organisations and faith-based organisations to tailor their communication strategies to suit the Samburu women as well as the Samburu community in general.

The data in this study also serves to strengthen the position of the communication theory that posits that culturally sensitive and gender sensitive communication interventions are crucial and that communities should spearhead the behaviour change interventions that they themselves as a community have developed and accepted.



## **Key Terms**

Perceptions, Focus groups, In-depth interviews, Health communication, Communication strategy, Socio-cultural factors, HIV/AIDS, Behaviour change model, Qualitative research, Rural women, and Samburu women.

## **List of Acronyms**

ABC	Abstinence, Be faithful, Consistent and Correct condom use
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARRM	AIDS Risk Reduction Model
ARV	Antiretroviral Drugs
CACC	Constituency AIDS Control Committee
DASCO	District AIDS/STI Coordinator
FBOs	Faith-Based Organisations
FGDs	Focus Group Discussions
GOK	Government of Kenya
HBC	Home-Based Care
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic Health Survey
MOH	Ministry of Health
MTCT	Mother-to-Child Transmission
NASCOP	National AIDS and STDs Control Programme
NACC	National AIDS Control Council
PEP	Post Exposure Prophylaxis
PMCTC	Prevention of Mother- to- Child Transmission
SCT	Social Cognitive Theory
STI	Sexually Transmitted Infection
TRA	Theory of Reasoned Action
VCT	Voluntary Counselling and Testing
UNAIDS	Joint United Nations programme on HIV/AIDS

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# CHAPTER 1

## INTRODUCTION

### 1.1 INTRODUCTION

The objective of this research was to explore the perceptions of rural Samburu women in Kenya with regard to HIV/AIDS in terms of their knowledge, attitudes, beliefs and opinions; and to examine several HIV/AIDS awareness channels that have been used to communicate HIV/AIDS messages to the Samburu women to determine how effective they have been in effecting behaviour change.

#### 1.1.1 Background to the study

According to the Kenya Demographic and Health Survey (KDHS) more than 99 percent of Kenyans are aware of the AIDS pandemic (KDHS 2010: 22). The predominant mode of HIV transmission in Kenya is through heterosexual sex where most new infections (44 percent) occur within a union or regular partnership, followed in magnitude by prenatal transmission in which the mother passes the virus to a child during pregnancy, delivery and breastfeeding (National AIDS and STDs Control Programme 2009: 31, 198).

Ninety percent of Kenyan men and women are aware that the chances of getting the AIDS virus can be reduced by limiting sex to one faithful partner (KDHS 2010: 22). Seventy-five percent of women and 81 percent of men know that using condoms can reduce the risk of contracting the HIV virus (KDHS 2010: 23). HIV prevalence is eight percent among women age 15-49 and four percent among men of the same age group, the peak prevalence among women is age 40-44 (14 percent) while prevalence among men is highest at age 35-39 (10 percent). This is considerably lower than that of women, while the national prevalence is at 7.4 percent (National AIDS Control Council 2009: 24; Kenya Indicator Survey 2009: 235).



Kenya has an estimated 1 million rural and 400,000 urban residents infected with HIV (KAIS 2009: 235). Studies indicate that young women are highly vulnerable to HIV infection compared to young men. For example, 3 percent of women age 15-19 are HIV infected compared with less than one percent of men age 15-19. While HIV prevalence is over four times that of men in the same age group (6.4 percent vs. 1.5 percent). Women of age 40-44 had a prevalence of 14.3 percent (KAIS 2009: 239). HIV prevalence is highest among women who are widowed (43 percent) (KDHS 2010: 24). There is a marked increase in prevalence among women although the national prevalence rates have continued to go down.

There are also a large number of misconceptions about HIV/AIDS, for example, that one could get AIDS through insect bites or wearing clothes of an infected person or by sharing food with an infected person, or by witchcraft or other supernatural means (Kekovole 1997: 69; KNASP 2009: 111) In some rural parts of Kenya people believe that AIDS is a curse for wrong doers and that the just and righteous will not be affected. Lack of sufficient information about HIV/AIDS leads to people living with HIV/AIDS being stigmatised and discriminated against in society, and being looked upon as outcasts, cursed by their ancestors for their past deeds (The People Daily 2004: 4).

There have been numerous HIV prevention campaigns in Kenya yet little is known about the effectiveness of these campaigns, whether they are reaching the intended audiences and whether the audiences are changing risky behaviour (Witte 1998: 345). It would appear that although awareness campaigns have been launched they have not been entirely successful, that is, people are aware of HIV/AIDS and its modes of transmission, but this has not resulted in any significant behaviour change. This leaves them exposed to HIV infection. It is, therefore, important to increase people's awareness of HIV/AIDS, but in a way that will promote behavioural change, particularly regarding risky behaviour (De Kat-Reynen 2001: 6). Imrie and Johnson assert that behavioural interventions are likely to remain the backbone of HIV prevention in the foreseeable future (2001: 99).

Access to information is essential for increasing knowledge and awareness that may eventually affect perceptions and behaviour. The latest studies in Kenya indicate that the radio is the most popular medium for both men and women (KDHS 2010: 59).

The KDHS (2010: 198) highlights several variables on which the future course of Kenya's epidemic is dependent: the levels of HIV/AIDS-related knowledge among the general public; the reduction of social stigmatisation; risky behaviour modification; access to quality health care services for sexually transmitted infections (STI); provision and uptake of HIV counselling and testing; and access to care and antiretroviral therapy (ART) (KDHS 2010: 198).

### **1.1.2 Women as a high-risk group**

Women continue to bear the brunt of the HIV/ AIDS epidemic and are considered a high-risk group due to several factors:

- Cultural practices, values and beliefs that underlie societies discriminate against women (Women's International Network News 2001: 73). Cultural practices which increase the risk for women include circumcision or female genital mutilation (FGM), early marriages, polygamy, practices related to cultural passage from childhood to adulthood, wife inheritance, preference for "dry sex", sexual abuse and violence including rape and drug abuse (Mati 1997: 51; Scott, Gilliam, Braxton 2005: 19).
- The social and economic disadvantages that women face make them more vulnerable to HIV infection due to the high-risk behaviour of their sex partners (Mati 1997: 50; UNAIDS 2004: 68).
- Poverty and low social status of women renders them dangerously vulnerable in sexual relationships. They do not have the authority to express or enforce their needs and are not able to negotiate safer sex practices (Van Dyk 2001: 21; UNAIDS 2005: 17).
- The lack of sufficient knowledge about the disease among rural women, who appear to be the least informed about the transmission of HIV/AIDS has rendered them particularly vulnerable (Harrison, Smit & Myer 2002: 5; UNAIDS 2004: 74).

- Women are more vulnerable to sexually transmitted diseases (STDs) in general, because of the mucous membrane that creates a thriving environment for any type of infection - including HIV (Van Dyk 2001: 21; Muganda 2004: 28; UNAIDS 2006a: 6).
- Young women whose age at first sexual encounter was before the age of 15, are more likely to report that their first intercourse was forced than those who initiated sex at an older age and would therefore be in danger of HIV infection (NASCO 2009: 274).

Since women are more at risk, particularly due to socio-cultural factors, it becomes essential to understand sexual behaviour in different socio-cultural settings and to design effective communication strategies that encourage self-protective behaviour, itself a fundamental campaign against transmission (Mati 1997: 111). Nyawade points out that “one way of fighting HIV/AIDS consists of the provision of knowledge on causation, transmission, and methods of control of the disease and ensuring that knowledge is internalised and translated into behaviour and obtaining feedback on behavioural change and practice” (Mati 1997: 111). Ultimately, all strategies must also take cognisance of the cultural contexts of the group among which they aim to effect behaviour change.

Ulin suggests that before asking women to change their behaviour or to lower the risk of contracting HIV/AIDS, it would be mandatory to first establish what AIDS means to them and whether it is a life threatening disease to them and whether they are aware it is preventable. It would also be prudent to establish which information deficits exist and how congruent information is from the healthcare system, the traditional health systems, religious authority and non-formal interaction with extended family and peers. This study acknowledges that it is important to ask women directly what information gaps exist and who they deem to be the best qualified to provide information and by what means (1992: 69).

## **1.2 RATIONALE OF THE STUDY**

The rationale for this study is underpinned by the vulnerability of African women in general, and the Samburu women of Kenya in particular, together with the failure of current prevention strategies to bring about behaviour change to curb the spread of HIV.

Ulin (1992: 64) points to the need to examine the unique problems that intensify the risk of HIV infection for the majority of African women and to explore their potential for greater involvement in efforts to slow the pace of the epidemic. It has also been noted that current prevention strategies, which promote monogamy, fidelity and condom use and even strategies like the ABC (which stand for Abstinence, Be faithful and use Condoms), have failed to control the spread of HIV (De Kat-Reynen 2001: 3; Mundia 2009: 6; KHDS 2010: 200). Continued research to determine the appropriate methods of communication with people of different educational backgrounds is essential. Research will also enhance the understanding of various socio-cultural beliefs and practices that influence perceptions and responses towards HIV risk so that culturally relevant and acceptable methods of communication can be developed. Scott and Brydon (1997: 424) point out that “communication is perceptual and that the process of perception is selective”. Unless an audience accepts a message one cannot assume that communication has taken place and that there will be some behaviour change. This means that a message has to be compatible with the audience’s perception and it should be consistent with their attitudes, beliefs, values and lifestyle”.

It was with this in mind that this study set out to explore the perceptions of the rural Samburu women towards AIDS and to come up with a tailor-made communication strategy in an effort to stop the spread of AIDS among the Samburu women of Kenya.

### **1.2.1 Background to the Samburu community**

The Samburu, also called Loikop or Sampur, are a tribe of 237,179 people (Ministry of Planning and Development and Vision 2030, 2010: 53). The Samburu live in the

north-eastern section of the Rift Valley Province just south of Lake Turkana. Administratively, the district is divided into six divisions namely Lorroki, Baragoi, Wamba, Waso, Nyiro and Kirisia. The total area of the district is approximately 21,126.5 square kilometres (Samburu Report 2008: 23). The Samburu language is one of the Nilo-Hamitic languages of Kenya. The Samburu are herders of cattle, goats and sheep in an area that has little rainfall or good vegetation. They are therefore nomadic in their lifestyle, setting settlements of 5-10 families for about five weeks and moving on to other grazing lands (Daystar 1982: 9).

The Samburu are closely related to the Maasai and, like the Maasai, depend on milk, meat and blood for their livelihood. In recent years the population has increased and the quality of pasture has declined because of overgrazing. This has made the traditional economy and the traditional social political structure weak although these institutions are still strong and have more influence over traditional Samburu than the new cash economy and imposed government structures (Daystar 1982: 1). It has been noted that just like the Maasai, they have resisted much of the change and development directed towards them because they have not seen its benefits. When change is clearly perceived to be to their advantage, they are not reluctant to make the needed change as shown by their acceptance of modern medicine and their present attitude towards education. The literacy levels of both men and women (5-7 percent) continue to be low and the school dropout rates are estimated at 80 percent due to early marriages for females and moranism (circumcision of young boys to become warriors) for males (Samburu District development plan 1997- 2001: 48). Sixty- eight percent males and thirty- two percent females enrol in secondary school (Samburu development plan 1997- 2001: 49) The Samburu district has a poverty index of 50.9 percent and is ranked the second poorest district in Kenya (Samburu District development plan 2002- 2008: 25).

The Samburu culture has three important institutions, namely marriage; age-set; and elderhood and moranhood (young, circumcised unmarried men who function as warriors in the community). The institution of marriage is important because this is where the issue of women and gender is most concentrated. The Samburu must marry outside their clan and outside their age-set. An age set is composed of all the

men who have been circumcised during a specific time (Spencer 1973: 80). Women do not belong to age sets but their transition takes place from girlhood through female genital mutilation (FGM) to womanhood. The system of moranhood delays marriage of men between 12-14 years. This delay in marriage for men results in a higher number of women being of marriageable age than men (Daystar 1982: 5). Polygamy is quite common and is a sign of wealth. The family structure is based on polygamy. Each wife builds her house within a family homestead and lives off the herd that has been allocated to her through her marriage. The marriageable age of girls is between 12-15 years (and then to older men) and the brides are usually circumcised a day before their wedding. Marriage is a serious matter in that widows do not remarry. Customs permit a woman to have discreet sexual relations with men other than her husband, in particular those in his age-set (Spencer 1973: 80). Spencer (1965: 231) observes that Samburu is a man's society and from the male point of view women are inferior and not politically influential.

### **1.2.2 Relevance of the investigation**

HIV/AIDS is a health threat to the Samburu community. The prevalence of HIV/AIDS had a high of 21.7 per cent in 1999 and 18 per cent in 2003 and has been coming down to 15 per cent in 2001, 8 per cent in 2004 to 4 per cent in 2005 and then 7 per cent in 2006 and currently stands at 6.1 per cent (NASCOP 2005: iv, KDHS 2010: 9). Although this data is based on the national sentinel surveillance sites it is important to point out that there is a high danger of prenatal spread of HIV/AIDS because 99 percent of births in the Samburu district take place at home and there is also very low attendance in ante-natal clinics by expectant mothers (Samburu report 2008: 13). HIV/AIDS poses a serious threat to the social and economic development of the Samburu district because it strikes those who are in the age group of 15-45 as shown in the table below (Kenya 2001: 27).

**Table 1.1: HIV/AIDS Cases 1996-2000**

Year	Tests Done(No.)	Positive(No.)	Percentage	Deaths(No.)
1996	1552	230	14.8%	41
1997	1814	396	21.8%	30
1998	1681	353	21.0%	77
1999	1774	386	21.7%	78
2000	1884	403	21.3%	104

Source: District Medical Office, Maralal, 2001

It may be argued that the Samburu women are susceptible to HIV/AIDS due to the culture in which they live in. Modern approaches to prevent the prevalence of HIV/AIDS - like monogamy - may not apply since this is a culture whose family structure is intricately woven by polygamy. Resistance to change, particularly change that is imposed from outside, is problematic. There have been objections to the way people are forced to change. Maimai protests very strongly that “people should not be administered like objects in matters that affect their lives without involving them in the decision-making process” (Global News 1998: 1). Igoe (2004), who has been doing research among the Maasai of Tanzania in conservation work cautions that Western values and models should not be imposed on people who have their own way of life that they are proud to conserve.

The indigenous culture is largely based on oral histories and traditions, much of which remains unwritten. According to Walter Ong in Panford et al (2001: 1560), working with orally-based cultures requires a conscious effort to address the cognitive mindset of audiences who are primarily listeners and speakers rather than readers and writers. Folk media, which is defined by Ansu-Kyeremeh in Panford et al (2001: 1560), as “any form of endogenous communication system by virtue of its origin from, and integration into a specific culture, serves as a channel for messages in a way and manner that requires the utilisation of the values, symbols, institutions, and ethos of the host culture through its unique qualities and attributes.” McDaniel,

Isenberg and Swift (1997: 170) argue that rural communities that heavily rely upon conformity may not easily tolerate new scientific ideas or alternative lifestyles now made more public by the AIDS pandemic. Panford et al (2001: 1560) observe that in areas where the majority of the people are non-literate, most health communication strategies become almost alien to the people.

There is therefore a need to explore the application of folk media in preparing messages that may use indigenous channels of communication. Current world trends recommend that culturally competent approaches include the willingness and ability to draw on community-based values, traditions and customs, to listen to and work with members so as to develop focused interventions and services (Scott, Gillian & Braxton 2005: 19).

### **1.2.3 Filling the gap**

This study is in line with the UNAIDS 2006 Report that observes that there is a need to promote programmes targeted at HIV prevention to key affected groups and populations (2005: 14). The UNAIDS 2006 Report states that:

- HIV prevention initiatives that are specifically tailored for women's needs can reduce women's risks of HIV infection.
- That few evidence-based prevention programmes exist that are designed for the particular needs of women and girls.
- That HIV prevention strategies have yet to grapple effectively with the gender dimensions of HIV prevention, treatment, and impact (UNAIDS 2006: 135).

The Gender Mainstreaming (2002: 5) document observes the fact that in Kenya "lack of gender sensitive surveillance data collection, processing and dissemination are not fully explored". This study is in line with this concern, albeit in a limited manner, because it concentrates on Samburu women who face two unique challenges: firstly, they are women in an already marginalised community and thus



face double marginalisation. Secondly, the social structure disadvantages women within the community and in the household (Futures Group 2005: 9).

Access to clear, factual HIV prevention information and to HIV testing is a fundamental human right (UNAIDS 2006: 287). This study responds to the concern of the UNAIDS 2006 report that prevention programmes are not reaching those in need (2006: 54). The Samburu women are indeed in need because HIV prevalence is rampant in this community that is characterised by “poverty, precarious health conditions, unemployment, discrimination, illiteracy, violence in all its forms and insecurity. Underdevelopment with its attendant levels of poverty, lack of education, poor health, and nutrition and economic insecurity increases vulnerability to HIV” (Futures Group 2005: 9).

#### **1.2.4 Relationship of the topic to the discipline of communication**

This study explores the perceptions of the Samburu women about HIV/AIDS. Perception plays an important role in the communication process. The success or failure of any communication behaviour is based on the nature of perceptions (Verderber 1984: 19). Perceptual theory tells us that the process of interpreting messages is complex and that these communicator goals may be difficult to achieve (Severin & Tankard 1997: 73). Samovar and Porter acknowledge that, “perception is the internal process by which we select, evaluate and organise stimuli from the external environment. In other words, perception is the conversion of the physical energies of our environment into meaningful experience” (1997: 15). Verderber (1984: 23) further points out that in the process of communication people select what they want to hear. They organise the information they receive and they also interpret the information they receive within their frame of reference. If the information is distorted, there is every likelihood for misconception that may lead to inaccurate, misleading and at times dangerous messages.

Scott and Brydon (1997: 27) identify three salient factors that influence perception: one, the background in which a stimulus is embedded can either facilitate or impede perception and communication. This then means that one cannot study a people in

isolation because there are aspects in the lives of those people that may determine the way a message is received; two, intensity which refers to how loud or bright a stimulus appears. (This does not mean that the louder, brighter or more vivid a stimulus, the greater the chances people will perceive it. Nor does it mean that there is always a direct and positive correlation between intensity and the meaning people give to a specific stimulus). This means rather that communicatively, messages need to be intensive enough that people may selectively perceive them, but that they should not be so intense that they violate people's expectations. Third, concreteness which means that messages that are unambiguous are much more concrete. They are more likely to gain perceptual favour than those that are highly abstract. Other factors that they mention are contrast and velocity, extensity and impressivity. All these factors should be considered when one wants to design a communications strategy for a specific group of people.

It is also important to note that 'blanket' messages no longer work. Harrison et al (2000: 289) note that focused, intensive and sustained interventions are needed to promote new messages and these should be given in the language and style of the target communities and in the context of the people's risk.

Were (2003: 14) also points out that the messages that are received whether verbal or non-verbal are culturally conditioned and influenced by one's experience in the social, cultural and economic and political fields. A study undertaken by the Future's Group in 2004 among pastoral communities of Kenya observed that "because of the conservative nature of pastoral communities, culturally and religiously sensitive approaches should be adopted in addressing the HIV pandemic" (2005: vii). Gender-neutral messages are not effective because they are not targeted at anyone in particular. This study takes cognisance of the fact that women and men need different messages because they grapple with HIV/AIDS in different ways and this will be expounded in other chapters of this study.

### **1.3 THE PURPOSE OF THE STUDY**

The purpose of this exploratory, qualitative study is to explore the perceptions of rural Samburu women in Kenya with regard to HIV/AIDS in terms of their knowledge,

attitudes, beliefs and opinions. In-depth interviews with professionals providing HIV/AIDS interventions and focus group discussions with rural Samburu women were conducted.

### **1.3.1 Research question**

What are the perceptions of rural samburu women of Kenya towards HIV/AIDS?

This research question covered knowledge levels, perceptions of samburu women towards HIV/AIDS as shown below.

#### **1.3.1.1 Knowledge of HIV/AIDS:**

- (a) What is the understanding of Samburu women about the causes of HIV/AIDS?
- (b) Do they know whether HIV/AIDS has a cure?
- (c) Do they know how HIV/AIDS is prevented?
- (d) Do they know what a condom is?
- (e) What knowledge do they have of the channels of HIV transmission?
- (f) What are their views regarding HIV/AIDS and circumcision?
- (g) Are the messages they have received about HIV/AIDS accurate?

#### **1.3.1.2 Perceptions the rural Samburu women have towards HIV/AIDS**

- (a) What do they believe HIV/AIDS to be?
- (b) What attitudes do they have about HIV/AIDS?
- (c) What are their views regarding early marriages and HIV/AIDS?
- (d) What are their views regarding HIV/AIDS and polygamy?
- (f) What are their views regarding HIV/AIDS and circumcision?

### **1.3.2 HIV/AIDS awareness channels of communication**

The other sub –problem of this study was to find out what HIV awareness channels of communication have been used in the past by the government of Kenya and non-governmental organisations that have HIV programmes in the Samburu district?

### **1.3.3 Communication needs**

The other sub-problem that guided this study was to determine the most appropriate communication strategies to communicate HIV messages to Samburu women.

## **1.4 DEFINITION OF KEY TERMS**

The key concepts used in this study are defined as follows:

- AIDS is defined as a syndrome of opportunistic diseases, infections, and certain cancers – each, or all of which, has an ability to kill the infected person in the final stages of the disease (Van Dyk 2001: 4).
- Perceptions, as employed in this study, refer to the knowledge, attitudes, opinions and beliefs of the Samburu women towards AIDS.
- Rural Samburu women are women of 15 years and above who live in the Lorroki and Kisima location of Samburu district.
- Communication strategy refers to the use of communication methods, techniques and approaches that will be suggested based on this study that will be used to communicate the AIDS message to the rural Samburu women so as to effect behaviour change.

## **1.5 METHODOLOGY**

This study uses the UNAIDS framework of communication that stipulates that HIV interventions should be guided by five domains namely the role of the government, cultural factors, spiritual factors, gender relations socio-economic factors. The context in which communication takes place is paramount. The study then adopts qualitative methods of research, which is any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification. It can refer to research about people's lives, stories, behaviour, social movements,

interactions, relationships, perceptions, feelings and knowledge (Strauss & Corbin 1990: 17; Patton 1990: 25). This study is a qualitative study because the researcher wishes to uncover and understand the AIDS phenomenon among rural Samburu women about which little is known. This is an attempt to understand the Samburu women from their own frame of reference (Strauss & Corbin 1990: 19; Taylor & Bogdan 1998: 3). Qualitative research is said to be especially effective in studying the subtle nuances of attitudes and behaviours and for examining social processes over time. As such, the chief strength lies in the depth of understanding it may permit and also the fact that the design plan may be flexible to suit the objective of the study (Babbie & Mouton 2001: 309).

The use of focus group discussions to interview the Samburu women was in tune with social behaviour in the African context in that group norms still operate in rural and semi-rural areas where the majority people live (Obeng-Quaidoo 1987: 62). Kitsinger (1994a: 116) asserts that the use of focus group discussions encourages interaction which highlights the respondent's attitudes, priorities, language and framework of understanding, encourages a great variety of communication from participants tapping into a wider range and form of understanding, helps to identify group norms, provide insight into the operation of social processes in the articulation of knowledge, for example, through the examination of what information is censored or muted within a group; can encourage open conversation about embarrassing subjects and facilitates the expression of ideas and experiences that might be left underdeveloped in an interview. Morgan (1998: 12) points out that the hallmark of focus groups is to produce data and insights that would be less accessible without the interaction in the group. Krueger (1994: 8) adds that the focus group approach is particularly appropriate to use when the goal is to explain how people regard an experience, idea or event. This method is the most suitable one to elicit information from the rural Samburu women about their feelings, views, and opinions about AIDS.

The study also held eleven in-depth interviews with both health professionals and other professionals having HIV/AIDS programmes in the Samburu district, who were purposefully sampled for face-to-face interviews regarding how Samburu women's perceived HIV/AIDS in terms of their knowledge, beliefs, attitudes and the role of

culture, as a form of triangulation. The in-depth interviews were used to enhance a deeper understanding of the Samburu women's perception and gave the interviewees room to express their views, experiences and opinions without being constrained or restricted to respond in a given way about what they knew about the Samburu women regarding HIV/AIDS. The interviews were recorded, transcribed and analysed using the content analysis method.

## **1.6 LIMITATIONS OF THE STUDY**

The foremost limitation was getting to the research sites due to poor infrastructure and insecurity in the region where cattle rustling, bandits and warring neighbours in the region were always a threat to the study. To get to Maralal town one needed an armed police escort for the first 100 kilometres of the 200-kilometre journey from Nyahururu town.

Time was also another limitation; the data was collected during semester breaks because the researcher had to continue working so as to raise resources to undertake this study since the study could not be extended to other divisions of the Samburu District. In addition, the researcher could not recruit more than two research assistants because of limited resources. Despite this limitation the focus groups were carried out and proved to be very informative.

Accessibility to professionals for the in-depth interviews was problematic. Getting appointments and for them to give an hour or more of their time was not always easy. In addition officially registered organisations were not always operational although they had been listed as groups having HIV/AIDS programmes and that is why the snowball approach was used to identify operational groups.

Another limitation was the translation work; the questioning process had to be translated from English to Maa. The recorded interviews of the focus groups had also to be translated and transcribed from Maa to English. Some information could have been lost in this process but the pre-testing did not indicate any substantial loss of meaning.

Another limitation was the presence of the researcher during the focus group discussions whereby the respondents might have been self-conscious of the responses they gave. The use of the eleven in-depth interviews with the health and other professionals to corroborate the information proved to be very useful to this study since the professionals had worked for a longer period and had a wider reach with the women because they interacted with the Samburu women in all the divisions of Samburu district.

The research approach - a qualitative study - was limited in that a small number of respondents were interviewed; therefore, this information cannot be applied to the whole Samburu community. The essence of the qualitative study, however, was to unravel the deeper insights rather than produce quantifiable items of behaviour.

## **1.7 SUMMARY**

Although the majority of Kenyans are aware of HIV/AIDS, there are pockets of Kenyan society such as the Samburu women who do not have sufficient knowledge about HIV/AIDS to make informed decisions about protecting themselves from HIV/AIDS. This is because the culture within which they live makes them vulnerable to HIV. The Samburu women live in a remote region that has challenges in terms of access to health services, information and infrastructure. This study is an attempt to investigate the various factors that make the Samburu women vulnerable to HIV/AIDS and to examine the types of HIV messages disseminated to them, with a view to informing culturally-sensitive effective communication.

## **1.8 OUTLINE OF CHAPTERS**

The rest of the thesis is organised as follows:

*Chapter Two* highlights the major factors that make women vulnerable to HIV/AIDS. HIV/AIDS has been called the feminine disease because the majority of people living with HIV/AIDS are women and 60 percent of them live in Africa (UNAIDS 2009: 21). Studies have shown that the spread and transmission of HIV/AIDS is not a random

event; it disproportionately affects women and adolescent girls who are socially, culturally, biologically and economically vulnerable (UNAIDS 2006a: 6). Women have been left out historically in the prevention interventions making the HIV pandemic more male centred. Most of the interventions have been directed at both men and women but it is now apparent that women and men have been differently affected by HIV/AIDS and therefore interventions have to be gender sensitive. Women have for long been accused of being “vectors” of HIV, which has led to violence, marginalising, stigmatising and discrimination against them. The literature review in this section focuses on the feminisation of HIV and the impact of gender inequality in terms of AIDS interventions.

*Chapter Three.* This chapter highlights the shift from biomedical, psychological, social cognition models to culturally-based HIV/AIDS health models. It commences with a discussion of the health communication domain followed by a critical examination of HIV/AIDS health models. Health communication is a relatively new domain that is involved in promoting health and disease prevention. Health communication is concerned with the application of communication concepts and theories to transactions among individuals on health-related issues. Health communication recognises the fact that perceptions of illness and disease and especially its prevention play an integral role in the prevention of HIV/AIDS. Health communication is also linked to participatory communication and strategic communication.

The HIV/AIDS health models examined in this section are the Health Belief Model (HBM) which was adopted by the Kenyan Ministry of Health for use to design HIV/AIDS interventions which advocates for behaviour change through rational decision making; Theory of Reasoned Action (TRA) which asserts that the most important determinant of behaviour change is a person’s behavioural intention and attitude; and the Social Cognitive Theory (SCT) which spearheads the idea that to achieve self-directed behavioural change, people need to be given not only the reason to alter risky behaviour but also the behavioural means, resources and social support to do so. These models are assessed in terms of their strengths and



weaknesses and their applicability in the context of the rural Samburu women of Kenya.

*Chapter Four* outlines the conceptual framework of the research based on the premise that culture is central to the planning, implementation and evaluation of health communication and health promotion programmes. The centrality of traditional and cultural factors for effective strategies is located within a discussion of the UNAIDS framework of communication which is based on a combination of relevant theories and models that focus on the contexts (cultural, socio-economic, status of women, government law and policy and spirituality) rather than solely on the individual.

*Chapter Five* describes the methodology used in this study and the procedures followed during data collection and analysis.

*Chapter Six* presents the findings of the qualitative field research as well as the qualitative survey research data gathered from the focus group discussions and the in-depth interviews to answer the research question. Data from the study was analysed qualitatively using descriptive and interpretive techniques based on the content analysis technique.

*Chapter Seven*, guided by the four main objectives of the study, presents the discussion, summary of findings and draws the final conclusions as well as the recommendations of this study.

## **CHAPTER 2**

### **THE PLIGHT OF WOMEN AND HIV**

#### **2.1 INTRODUCTION**

This chapter will highlight some of the major factors that make women more vulnerable to HIV than men and why HIV is referred to as a “feminine disease”. The chapter traces the historical background of women and HIV and AIDS and also identifies the biological factors that make women more vulnerable to HIV. The chapter underscores the fact that women who are hardest hit by HIV face economic and social disadvantages (UNAIDS 2004: 43). Other salient factors that have caused the increase in numbers of vulnerability are referred to as “silent perpetrators” such as limited access to education, domestic and gender-based abuse and early marriage (UNAIDS 2006: 6). HIV transmission is not a random event; the spread of the virus is profoundly influenced by the surrounding social, economic and political environment (UNAIDS 2004a: 16). Dr Piot the executive director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) asserts that although women account for the majority of new HIV infections in sub-Saharan Africa, this has not been reflected in the policies or the material resources committed to fight the disease and legal structures instead of protecting women further expose them to HIV vulnerability (UNAIDS 2004b: 4). The chapter also identifies culture as a major driver in the spread of HIV in women who are disadvantaged by a lack of comprehensive knowledge and awareness. Gender inequality is a significant factor in understanding, predicting and promoting AIDS prevention actions and needs to be explored more (Cline & McKenzie 1996: 396; National AIDS Control Council 2002: 3; UNAIDS 2008: 67). Culturally determined values and attitudes marginalise women and girls in such a way that they have limited access to health care and prevention methods. They have a low status and carry the burden of care. Culturally sensitive, gender sensitive and transformative approaches need to be promoted because the impact of HIV on women and girls is significantly different from that of men and that is why HIV is considered a gender issue which disproportionately affects women and

girls (KNASP 2001: 2; Ulin 1992: 64; Barlow 1992: 23; UNAIDS 2000: 46; Kalipeni 2000: 966; UNAIDS 2004: 16; UNAIDS 2006a: 6). The chapter then moves on to explore the current strategies that are in use such as the ABC strategy which advocates abstinence, being faithful to one partner and condom use.

Sub-Saharan Africa is home to 67 percent (22.4 million) of all people living with HIV (UNAIDS 2009: 21). Three quarters of all women living with HIV (15 years and older) are in sub-Saharan Africa (UNAIDS 2006: 15). Dr. Peter Piot, points out that the number of women living with HIV has been steadily increasing. Data collected in 1997 indicate that the number of women living with HIV was 41 percent, in 2002 the number increased to 50 percent and in 2005 the number rose to 59 percent (UNAIDS 2004: 22; UNAIDS 2006: 15). It is evident that women continue to bear the brunt of HIV/AIDS due to higher physiological susceptibility to heterosexual transmission and severe social, legal and economic disadvantages (UNAIDS 2009: 8). Out of the 75 percent of young people infected, the majority are young women and girls aged between 15 to 24 years. The Kenya National AIDS Control Council (NACC) reports that female prevalence of those aged 15-24 years is nearly five times higher than male prevalence (2005a: 5). This trend is most marked where heterosexual sex is particularly the dominant mode of transmission (UNAIDS 2004: 22). At the moment in sub-Saharan Africa, the women to men ratio is around 14 women affected by HIV to every 10 men (UNAIDS 2004: 14). It is also noteworthy that certain regions in sub-Saharan Africa have higher prevalence rates. Two cases in point are those of Busia with a 14 percent prevalence rate and 30 percent in Suba (both Kenyan regions) (UNAIDS 2006: 15). Although the national prevalence rates are said to be relatively low, 10 percent to 7 percent in 2004, then to 6.1 percent in 2005 and finally to 5.9 percent in 2006, and then to 7.4 percent in 2009, there are regions that should be of special concern. Although the national prevalence rates are low, young women continue to lead in new infections (Kenya National AIDS Control Council 2005: 5; World AIDS Day: 2006: 12; KAIS 2009: 235). For example, “3 percent of women age 15-19 are HIV infected compared to less than one percent of men age 15-19. While HIV prevalence among 20-24 years is over four times that of men in the same age group (6.4 percent vs. 1.5 percent). Women of 40-44 years had a prevalence of 14.3 percent (Kenya National Strategic Plan 2009: 239). From the statistics above it is

clear that women need special interventions and more research needs to be done because HIV disproportionately affects them despite the current interventions. The factors mentioned above will further be explicated in the rest of the chapter.

## **2.2 HISTORICAL BACKGROUND OF HIV AND WOMEN**

When AIDS first appeared in the 1980s in the United States of America it was considered a homosexual disease because the initial causes were primarily found among homosexual men and, in fact, the disease was referred to then as the “gay disease”. During the first decade of the epidemic, most of the research carried out by the biomedical community with an emphasis on epidemiological surveys therefore concentrated on the gay communities or communities that were referred to as risk groups that consisted of men (De Bruyn 1992: 250). During this time HIV detection in women was not taken seriously and that the disease could present itself in a different way in women was not explored. Interventions targeting women have lagged behind those of men historically. Women were left out of prevention efforts early in the AIDS epidemic (UNAIDS 1999b: 26). Many women may have died never having been diagnosed as HIV positive or they may have been diagnosed as having AIDS at a later stage and then died from it (De Bruyn 1992: 251; Amaro 1995: 437; Bury 1992: 19).

The first attention to the problem of AIDS among women was as a result of the concern that prostitutes were spreading the disease (Campbell 1990: 413). For a while AIDS was regarded as a prostitute’s disease. This was because the majority of the incidences of HIV infections were found in commercial sex workers. These women were seen as the potential sources of transmission and they were singled out as vectors of the disease rather than being its victims. They were seen as “vectors” of transmission or “reservoirs of transmission” to their children and male sexual partners rather than as people with AIDS (Cline and McKenzie 1996: 386). (In Thailand HIV is still referred to as the “prostitutes disease” and the prostitutes are held responsible for the spread of HIV). The clients who visit these prostitutes are not seen as possible vectors of the disease (De Bruyn 1992: 251; Campbell 1990: 413; Weiss & Gupta 1993: 170). Campbell is of the opinion that “far too much attention has been given to women as infectors than to the very real risks that they

face as “infectees”. It was late in the 1980s that the epidemic surged and shifted from groups of high-risk behaviour to the general population, to the marginalised and the poor (Lamprey, Wigley, Carr & Collymore 2002: 5).

Cline and McKenzie point out that another reason why women have been regarded as being invisible is because women are seen in relation to others – in particular their relation to sexual partners and their children. They reiterate that the tensions between women who are just seen as foetal vessels or vectors of transmission of disease to others permeate all of the current efforts to target women in HIV prevention work (1996: 386). Cline and Mackenzie observe that most of the AIDS work being done involving women concentrates on prenatal transmission only rather than on the effects of the disease on women such as stigma and coping with the disease itself (1996: 388). There has been an overemphasis on prostitutes and women as mothers to the detriment of those who do not fit into those two categories and who are the majority yet largely ignored by prevention programmes (Cline & McKenzie 1996: 395).

In Kenya HIV was ignored for most of the 90s and churches were up in arms fighting against the inclusion of sex education in the school curriculum. The government lacked the political will to recognise AIDS as a major social problem (Agha 2003: 750). However, the Republic of Kenya declared “total war against HIV/AIDS” (TOWA) in March 2003 under the leadership of His Excellency President Mwai Kibaki and brought all the religious leaders together in an effort to fight HIV, since these leaders were the opinion leaders of their religious groups. In July 2003, Her Excellency, First Lady Mrs Lucy M. Kibaki launched the Kenya Chapter of the Organisation of First Ladies against HIV/AIDS (OFLA). The Constituency AIDS Control Committees (CACCs) and District Technical Committees (DTCs) are part of the machinery that has been put in place to fight against AIDS (NASCOP 2005: 3). Another important structure to facilitate effective responses in the fight against HIV in Kenya is the development of the Kenya National HIV/AIDS Strategic Plan (KNASP). All the national and international stakeholders are under “The Three Ones Principle” which recommends that the country should have one national co-ordinating

authority, one national strategic plan, and one monitoring and evaluation framework (World AIDS Day 2006: 12).

In the formulation of Kenya's National HIV/AIDS strategic plan of 2000-2005, it was recognised that the impact of the epidemic on women was strikingly different from that of men. The incidence of HIV in Kenyan women was rising more quickly. The fact that HIV affects women differently implies that gender specific prevention programmes should be designed instead of the uniform preventive strategies that are employed and which are usually not effective (UNAIDS 2004: 7).

De Bruyn identifies three reasons why women have been neglected, as delayed diagnosis and treatment of HIV infections, women being treated as vectors of transmission and increased stigmatisation (1992: 251). Weeks, Schensul, Williams, Singer and Grier point out that AIDS research and prevention programmes for women have not been given due attention as a separate entity and that is why HIV infection rates among women have been escalating (1995: 262). It has been acknowledged that AIDS literature is also characterised by the invisibility of women and women have for a long time been ignored by AIDS education and prevention campaigns. Cline and McKenzie (1996: 385) have noted that women have been ignored as potential sufferers of AIDS because AIDS has largely affected males in the past, women who are HIV positive have been made to fit into a male profile (Campbell 1990: 413), or what Cline and McKenzie call the "male-centred paradigm" (1996: 385), or what Gupta refers to as neutral approaches and programmes that are cheap and directed at everybody and nobody (2000: 5). These concerns are discussed in detail below where the major factors that make women more vulnerable are highlighted.

### **2.3 BIOLOGICAL FACTORS AND HIV VULNERABILITY**

It is well-documented that the risk of contracting HIV through unprotected sex is four times higher for women than for men (Lamphey et al 2002: 5; UNAIDS 2000: 47; UNAIDS 2006a: 6). The lining of a woman's vagina and cervix contain a large hospitable environment for infection. The mucous membranes are thin tissues through which HIV and other viruses can pass to tiny blood vessels and the

microtrauma during intercourse make women more physically vulnerable to HIV. Infected semen contains a higher concentration of the virus than a woman's sexual secretions (Population Reference Bureau 2000: 2; Lamptey et al 2002: 5; Weiss & Gupta 1993: 170). It has been observed that a woman's biological make-up makes them more susceptible to HIV/AIDS long after the sexual act. When semen carrying the virus gets into the woman's vaginal tract, it can stay there for more than two days, giving the virus enough time to infect her (Okwemba 2007: 8). Heise and Elias point out that "it is likely that per-exposure transmission from man to woman during heterosexual intercourse is up to 2.5 times more efficient than from woman to man...the efficiency of HIV transmission appears even greater if the woman or her partner has another sexually transmitted infection" (932-933). Anatomical differences make transmission of the virus through sexual contact far more effective from men to women than vice versa (Population Bureau 2000: 6).

About 340 million women in the world are known to be more susceptible than men to other sexually transmitted infections (STIs) which if not treated, multiplies by ten times the risk of contracting HIV. (Lamptey et al 2002: 5; Campbell 1990: 408; Cline & McKenzie 1996: 385; UNAIDS 2006: 130). Lamptey et al (2002: 5-6) point out that "this is especially significant in women because most STI cases for women are untreated. Women's symptoms are often latent or difficult to see and many women who have been diagnosed with STIs have no access to medical treatment". Men are more likely to be admitted to healthcare facilities in many communities, many family resources are more likely be devoted to buying medication and arranging cures for ill males than for females (Muturi 2005: 80).

It has also been noted that while women are usually discriminated against when trying to access care and support when they are HIV positive, men are given preference. Women may also not be comfortable going to STI clinics for treatment that are frequented by men and female sex workers and as with health care in general, women are often too busy, too modest, or too poor to seek treatment for STIs (Heise & Elias 1995: 932; UNAIDS 2004: 43). Heise and Elias suggest that STI services for women need to be integrated with other health services because women are not willing to endure the stigma attached to visiting STI clinics. They also

point out that “The development of integrated services, in turn will require reorientation of service providers, improved clinical facilities and practical research aimed at identifying effective and sustainable service models” (1995: 939).

The state of women’s reproductive health especially in sub-Saharan Africa and the associated poverty of women makes them more vulnerable to HIV infection. This is because many women suffer from chronic iron deficiency, malaria, complicated pregnancies, and lack of access to safe and legal abortion that predisposes women to the need for blood transfusions which has been a major pathway for HIV infection (Heise & Elias 1995: 933; Raikes 1990: 448).

AIDS is a disease that is likely to be highly under-reported in women for several reasons: Firstly, diagnostic failures due to differences in manifestations of HIV disease in women and men. Secondly, it can be assumed that significant numbers of women remain undiagnosed directly due to the social construction of the disease that focuses on men (Cline & McKenzie 1996: 393). Cline and McKenzie (1996: 394) point out that “CDC in 1993 included invasive cervical cancer as a diagnostic criterion. Yet chronic virginites, yeast infections and pelvic inflammatory diseases that are resistant to treatment as well as abnormal Pap smears appear to be common symptoms of HIV disease in women, though they are not included in the diagnostic criteria.”

Tearing and bleeding during intercourse whether from coerced sex or due to prior genital cutting also heightens the risk of infection. The risk of contracting HIV is even higher for younger women who have immature cervixes that put up less of a barrier to infection. Girls are particularly vulnerable to the sexual transmission of HIV since they lack the information, confidence, or resources to decide on or negotiate condom use or other sexual matters. Girls are more likely than boys to be raped or enticed into sex by someone older, stronger, or who has economic power (Population Reference Bureau 2000: 4; UNAIDS 2004: 22).

Mother-to-child transmission is the most common mode of HIV infection for children below the age of 15. The frequency of transmission from an infected mother to her



foetus or newborn ranges from 20 percent to 42 percent (Ministry of Health 2002: 1). Uninfected as well as infected infants have been born to mothers who previously have given birth to an infected child (Campbell 1990: 409). HIV can be transmitted from the infected woman to her child either in utero, during labour and delivery or through breast milk (Cline & McKenzie 1996: 389).

A cause for concern about mother-to-child transmission of HIV is that those women who are documented to have high rates of HIV infection (15-24 years) also have high birth rates. The prevalence rate of women in Kenya for example is estimated at 13 percent; this translates to an estimated 50,000 to 60,000 children under five years who are infected with HIV per annum (Ministry of Health 2002: 1).

Motherhood legitimises a woman's sexuality and very often her very life. It has been documented that each day "1800 children become infected with HIV - the vast majority of them new-borns. More than 85 percent of children who are infected with HIV live in Sub-Saharan Africa" (UNAIDS 2006: 132). What is of concern is that many women do not know their HIV status and are not aware that a mother can prevent her child from contracting HIV. In sub-Saharan Africa fewer than 6 percent of pregnant women in 2005 were offered services for prevention of mother-to-child HIV transmission (UNAIDS 2006: 132). Many women are not aware that timely administration of antiretroviral drugs to an HIV-diagnosed pregnant woman and her new-born significantly reduces the risk of mother-to-child HIV transmission. Not many women are even aware that breastfeeding by an HIV infected mother significantly increases the risk of mother-to child HIV transmission (UNAIDS 2006: 285). It has been observed that majority of women who live in high prevalence countries are unaware that HIV can be transmitted from mother-to-child (UNAIDS 2005: 13; NASCOP 2005: 32).

Women continue to face obstacles in regard to mother-to-child transmission because they have inadequate prenatal services such as lack of medicine for the mother and the infant and lack of safe delivery options (UNAIDS 2005: 146). Some women give birth at home and therefore do not access any prenatal services due to poverty or having the health centres far away from where they live. The Kenya and Health

Demographic Survey reports that “two out of five births (43 percent) are delivered in a health facility, while 53 percent are delivered at home” (KHDS 2010: 22). This is a matter of concern because it is hard to establish whether the women who give birth at home attend antenatal clinics or whether they know their HIV status or want to know their HIV status for fear of stigma and discrimination and neither are they under any preventive medication (UNAIDS 2005: 13; KDHS 2010: 22). The Kenya National Strategic Plan 2009/10-2012 notes that one of the challenges that Kenya is facing is a “continuing high incidence of paediatric infection, due mainly to inefficient, inaccessible or underutilized prevention of mother-to-child transmission services” (2009: 4).

Access to programmes to prevent mother-to-child transmission are also concentrated in urban centres while it is the rural population that needs these services most because majority of those women who are HIV positive are rural based (KAIS 2009: 37). The UNAIDS 2005 report documents that a paltry 7.9 percent of pregnant women in low and middle income countries received services to prevent transmission to their new-born-compared to 7.6 percent in the year 2003 (287). This is an indicator that there were possibly many children who might have been born HIV free if their mothers had received therapy

The National AIDS and STI Control Programme (NAS COP) acknowledge that there is a need to address the low levels of information and awareness about mother-to-child transmission and prevention throughout all risk groups. Messages should be targeted not only at girls and women but also to boys and men (2005: 24). NAS COP also notes that there are low levels of knowledge regarding antiretroviral therapy, which is caused by low levels of AIDS awareness treatment throughout all risk groups (2005: 24).

Women have over the years been known to live longer than men throughout the world but this is no longer the case because of AIDS which has driven female life expectancy below that of men in four sub-Saharan countries: Kenya, Malawi, Zambia and Zimbabwe. Gender differences are evident in mortality that affects women’s fertility reducing it by as much as 25 percent- 40 percent. This is usually because of

co-infection with other sexually transmitted infections resulting in increased rates of spontaneous abortion. Many women do not know their status and even if they were to know they are HIV positive many would not change their behaviour patterns or take steps themselves to protect their partner or prevent pregnancy (UNAIDS 2006: 89-90). Many women are not able to make informed decisions about their reproductive health due to the cultural values and norms that will be discussed below.

## **2.4 CULTURAL FACTORS AND HIV VULNERABILITY**

This section gives a brief definition of what gender is and also what culture is and then goes on to explore the various cultural aspects that fuel the spread of HIV. Gender and culture are intertwined. The culture one belongs to determines the gender roles that one assumes.

### **2.4.1 Gender and HIV**

Gender is “defined as the set of characteristics, roles and behavioural patterns that distinguish women from men socially and culturally. Gender is a social and cultural specific construct that differentiates women from men and defines the ways women and men interact” (National AIDS Control Council 2002: 12). Gender is also defined “as the widely shared expectations and norms within a society about appropriate male and female behaviours, characteristics and roles which ascribe to men and women differential access to power including productive resources and decision-making authority. Gender roles vary over time and by class, caste, religion, and ethnicity and age” (UNAIDS 1999b: 5). Gender roles and relations, reproduction issues and social conditions that place women in dependent relationships and secondary status to men also limit women’s ability to see their own risk and to make changes in their lives and relationships to decrease risk (Weeks et al 1995: 262).

In many African cultures the men take care of the productive activities outside the home while the women take care of the reproductive and productive activities at home. Gender, specifically the status of women is important because it defines access to and control of resources, social roles and power relations within

households. These are some of the underlying causes that increase the vulnerability of women to HIV infection or decrease their access to treatment for AIDS (Boahene 1996: 610). These aspects play a very significant role in the reproductive health of the women where HIV is concerned because HIV and gender are closely related.

Gupta is also of the opinion that imbalance in power that exists between men and women in gender relations controls women's sexual independence and encourages male sexual freedom, thereby increasing women's and men's risk and vulnerability to HIV/AIDS (2000: 2). The main drivers of the AIDS epidemic in women are the social norms and values that relegate women to a lower status, where she is looked upon as a social minor or a second class citizen who cannot inherit or own property or make independent financial decisions. As a result of the lower status, women become vulnerable to poverty, exploitation, injustice and HIV infection (UNAIDS 2004: 8; Scott et al 2005: 19). The glaring lack of power of African women over their bodies and sexual life coupled with inequalities make them easy prey for contracting HIV (Population bureau 2000: 10; UNAIDS 2008: 67).

Gender differences in the epidemiology of HIV/AIDS can help devise gender specific or gender sensitive programmes relating to AIDS surveillance, prevention and care to empower and strengthen the rights of women. Ehrhardt and Wasserheit 1991 in Amaro add that gender roles obviously are important determinants in how sexual encounters are negotiated and spells out which sexual practices carry the day (1995: 440). Gender inequity is a fundamental factor behind both HIV/AIDS and violence against women (UNAIDS 2004: 24) and is culturally determined as will be seen in the role of culture and HIV.

#### **2.4.2 Culture and HIV**

Walters, Canady and Stein (1994: 447) define culture as:

The body of learned beliefs, traditions, principles, and guides for behaviour that are shared among members of a particular group. Cultural elements act as a sort of road map for individuals as they interact with others. Elements of culture such as values, language, rituals, and traditions evolve or change slowly over time and some elements take on new shapes and meanings among subgroups of people who share

a neighbourhood, religious tradition, sexual orientation, geographic origin, class or other characteristic.

Mazrui also defines culture as “a system of interrelated values active enough to influence and condition perception judgement, communication and behaviour in a given society” (1986: 239). Some cultural practices are perceived to be the main causes of the spread of HIV especially where women are concerned and the main challenge in prevention is the limited understanding of the social context of HIV (Scott & Mercer 1994: 81). Cultural beliefs and practices relating to fertility and sexuality may represent significant barriers to the adoption of HIV prevention strategies by women. Cultural values undoubtedly shape behaviour central to the AIDS epidemic (Mill & Anarfi 2002: 325). It is also important to note that there positive attributes of culture that can be identified and harnessed (UNAIDS 2001: 22).

Weiss and Gupta point out that some values and beliefs regarding the sexual behaviour of women and men influence the balance of power in sexual decision making - many socio-cultural factors enhance women’s vulnerability to STIs and HIV and are incompatible with attitudes, knowledge, skills and a sense of efficacy necessary for women to negotiate and practice safe sexual behaviour (1993: 172). There are a number of factors that make culture a key ally to the spread of HIV/AIDS where women are concerned.

There is a cultural expectation that “good girls don’t know about sex”. Women’s lack of general education and access to information also applies to sexuality. Young women have scanty information about their bodies, pregnancy, contraception and STIs. This lack of knowledge is supported by cultural norms that dictate that good women should not know anything about sex or the functioning of their sexual reproductive organs (Weiss & Gupta 1993: 172; Gupta 2000: 2; Futures group 2005: vii). Gupta refers to this occurrence as the “culture of silence” (Gupta 2000: 2). Gender determines how and what men and women are expected to know about sexual matters and sexual behaviour (UNAIDS 1999b: 2). These norms prevent women from being knowledgeable about their bodies, sexuality and STI and HIV prevention. This then constrains women from making informed decisions about their

sexual behaviour and sexual health. Lack of information also limits the women's ability to identify abnormal gynaecological symptoms that could signify sexually transmitted infections (Weiss & Gupta 1993: 172; Muturi 2005: 81; UNAIDS 2000: 44). In many cultures "women accept itching, burning, discharge, discomfort, and abdominal and back pain as an inevitable part of womanhood" (Weiss & Gupta 1993: 172).

Some traditional norms of virginity elevate ignorance about sex to being a sign of purity, yet boys are expected to be more knowledgeable and experienced. Young girls have no forum (except probably school) where they can inquire about sexuality. The assumption is that if they were given information they would definitely indulge in the sexual act. Virgins are even more in danger today because of the myth that prevails that if a man is HIV positive and has sexual relations with a virgin changes his HIV status to being negative to positive (Gupta 2000: 2).

The sexual communication taboo inhibits open discussion about sexual issues both between partners and between parents and children. Openly discussing sexuality is seen as encouraging promiscuity and is viewed as a violation of traditional values and cultural practices (Mills & Anarfi 2002: 334). The inability of families to discuss sexual behaviour within the family may lead to discomfort and inability to discuss sexual histories with prospective partners. Family patterns laid down within the family during childhood work to the disadvantage of women who may not know what questions to ask prospective partners or the most effective methods of protection (Rankin et al 2005: 13). Silence and denial have fuelled the spread of HIV just as cultural and religious taboos inhibit open discussion about sexual practices and preferences (Population Reference Bureau 2000: 2; UNAIDS 2000: 38). This is as a result of gender role expectations that vary from one community to another; unequal power relationships between men and women in sexual decision making, and fear of disrupting a relationship by bringing up sex issues such as condom use may make women passive sexually and in many other ways (Guinan & Leviton 1995: 75; Amaro: 1995: 440 ).

Attitudes and practices relating to sexuality may make women more vulnerable to HIV infection. This is because it is culturally acceptable for a man to have pre-marital sexual relationships and extramarital relationships that are socially sanctioned and common for men (Mills & Anarfi 2002: 326; Dawit 1993: 164; Gender Mainstreaming 2002: 9). A recent study done in Kenya to determine the modes of HIV transmission confirms that the determinants of HIV epidemic are strongly associated with culture mainly male circumcision and societal acceptance of concurrent/multiple partners (National AIDS Control Council 2009: V). Even when there are calls for monogamy, they do not make sense because many women are monogamous but their sexual partners are not (Mills & Anarfi 2002: 327). Heise and Elias point out that a number of campaigns tell women to: “stick to your partner, love faithfully’ give women a mistaken impression that if they remain monogamous, they will be safe from HIV” (1995: 933).

Many cultures allow for double standards that give men the license to be sexually adventurous while restricting female sexuality. The call for monogamy is unlikely to be heeded because polygamy is widely accepted in many African societies (Susser 2000: 1043). HIV prevalence in those who are in polygamous unions in Kenya is also said to be high at 13 percent compared to those who are in non-polygamous unions at 6 percent (KAIS 2009: 243). AIDS prevention programmes do not address this aspect of double standards but leave women in this situation without adequate information or skills to protect themselves from infection.

There is also the tendency for young girls to be partnered with older men and this increases the likelihood that they will be exposed to HIV (Longfield, Glick, Waithaka & Berman 2004: 125). This age gap is likely to increase as older men seek out younger and younger partners in the hope of avoiding AIDS (Heise & Elias 1995: 934; UNAIDS 2004b: 7; Rankin et al 2005: 6). These older men are likely to have had other partners and may be infected themselves.

Practices such as, body tattooing and piercing, use of unsterilized instruments in child birth, female genital cutting, male circumcision, surgery, wife sharing, wife inheritance, ritual cleansing, early marriages and also nutritional taboos are known to

fuel the spread of HIV (Futures Group Europe 2005: V). It has been documented that Female genital cutting is particularly widespread in sub-Saharan Africa and is associated with infections, complications in pregnancy and urination and psychological problems (Raikes 1989: 448; Kalipeni 2000: 973; Dawit 1993: 166; Futures group 2005: v).

The preference for male children and preferential treatment of the male child often results in the female child being undernourished and overworked and being subjected to early marriage. She then experiences the rigours of child bearing and carries out household chores. Early intercourse may represent an additional risk. As mentioned earlier if a young woman is exposed to HIV before genital maturation she may face a greatly augmented likelihood of HIV infection. This dynamic may account for the very high incidence of clinical AIDS among young women that are found in areas where sexual initiation with older men occurs at a very early age (Heise & Elias 1995: 934; UNAIDS 2004b: 7; Dawit 1993: 166).

It was observed in a 2006 study by UNAIDS in Kisumu, Kenya, an area that is documented as the epicentre of HIV/AIDS in Kenya, that the fact that girls having early sex with older men correlated strongly with a higher risk of HIV, and traditional early sexual initiation and early marriages was seen to contribute to the dramatic spread of the virus. Girls who married early were sexually active by the age of 15 and it is reported that “50% girls in Kenya according to the UNAIDS study have had sex by 18 years of age (20% premarital and 25% are pregnant by the time they are 18 years” (UNAIDS 2006a: 2). The prevalence rate of HIV for girls in the Kisumu region is as high as 30 percent (UNAIDS 2006a: 19).

Young girls face a number of problems where their reproductive health is concerned; they are disadvantaged because they are deliberately given limited knowledge about modern contraceptives and minimal information about the use of condoms and lack parental guidance, they may also not get access to STI/ARV therapy in health centres because they are ridiculed by health workers since they are purported to be “wajuaji” meaning that they purport to know too much and that is why



they are in trouble. The expectation is that they should not be knowledgeable (UNAIDS 2006a: 11).

Children are also viewed as a source of labour for the family and also a source of security for the parents in their old age. Weiss and Gupta note that to provide women exclusively with HIV prevention methods that contradict the fertility norm of most societies is to provide women with no options at all (1993: 176). A childless woman faces the risk of rejection from her husband, family and kin. The choice of women is in a dilemma because it is the choice between disease prevention and fulfilment of their reproductive role and also how to handle the mother-to-child prevention of HIV (Dawit 1993: 176; Mills & Anarfi 2002: 326).

Women are known to bear the brunt of HIV transmission even when it is universally known that it is men who are likely to have multiple partners (Eka 2000: 123). Mothers tend to suffer blame and stigma when their infants or young adults become HIV infected. Many women do not want to be tested because of the stigma and the difficulties they would face such as partner rejection and psychological stress as a result of the diagnosis. Eka points out that men and women experience stigma differently (2000: 123). In most cultures women are usually seen as the infectors as opposed to men who may be HIV positive and not diagnosed yet. The woman may have been discovered to have HIV before the man because of antenatal clinics, where mothers to be are tested for HIV (UNAIDS 2004: 68).

Wyatt argues that culturally responsive HIV educational material should identify relevant aspects of a particular culture in order to communicate with members of that cultural group. The materials should meet the following standards: the use of accurate information about a cultural group including the appropriate use of cultural images, language and depiction of values, activities and people; appreciate and utilise culture in a manner which accomplishes its primary health goals (1989: 447). The use of cultural elements in creating and structuring prevention messages is intended to overcome perceived barriers to communication to minority communities (1989: 449). This is referred to as cultural competency, which entails the critical

scrutiny of norms and values that sanction continued high-risk sexual behaviours and presentation of alternatives.

Cultural competency also involves the ability to develop an ability to appreciate and use knowledge about culture in order to assist in the resolution of a problem (Wyatt 1989: 449; Lum 2003: 6). Scott and Mercer conclude that effective community level AIDS prevention programmes, in addition to adequate time, funding and technical expertise, also require an awareness of the social and cultural factors affecting the interpretation, spread and prevention of HIV/AIDS (1994: 81).

The UNAIDS (2004: 43) report observes that; the effect of HIV and AIDS on women has devastating effects on women; women in countries that have high HIV prevalence face economic, legal and cultural disadvantages; they become care givers if members of their family get sick; it is girls who are withdrawn from school to care for sick relatives: if grown up children fall sick it is the women who take care of them and also become surrogate parents of their children; young women who become widows as a result of HIV lose property and land whether inheritance laws are in existence or not.

Although culture plays an integral role in the spread of HIV/AIDS, it is not the only factor that is fuelling the spread of HIV/AIDS. Pelto and Pelto are of the view that health system policy makers and practitioners do not take into account the cultural and knowledge systems of the people they serve. They do not see the link between anthropological descriptions and interpretation of cultural belief systems to health care services (1997: 148).

It is not only the cultural factors that affect vulnerability to AIDS but socio-economic factors are also as important as shown by the discussion below.

## **2.5 SOCIO-ECONOMIC FACTORS AND HIV VULNERABILITY**

Women who are vulnerable to HIV/AIDS are the world's poorest. Poverty is a key ally in the spread of HIV/AIDS and is in fact referred to as the "disease of poverty"

(Harrison, Smit & Myer 2000: 286; Raheim 1996: 412; Kalipeni 2000: 967; Ministry of Health 2002: 6). The UNAIDS report asserts that despite women's higher biological vulnerability, other factors such as the legal, social and economic disadvantages faced by women and girls in most societies greatly increase their HIV vulnerability (2004: 68).

The impact of socio-economic conditions in Africa such as poverty, poor health services, ignorance, sexual violence and sexual conditioning on HIV exposure have spurred the spread of the pandemic (Boahene 1996: 609; Ongwae 2004: 5; Lamptey et al 2002: 6). The Kenyan National AIDS and STI Control Programme observes that there is a direct link between poverty and HIV and it forms a vicious circle in the national response to the pandemic and increasing poverty levels continue to fuel the spread of HIV. The pandemic itself exacerbates those levels in households and families with people living with HIV/AIDS (2005: 9). Those who can afford costly anti-AIDS drugs treatment prolong their lives, while the world's majority who are women, die in overwhelming numbers (Population Bureau 2000: 2).

Though HIV is not confined to the poor only, poverty has contributed to its spread by creating yet another situation of vulnerability. The overwhelming majority of about 94 percent of all people living with HIV/AIDS at the end of 2000 were found in the less developed regions where a large proportion of the population are women. Sub-Saharan Africa bears a disproportionate burden of the epidemic. The region is home to 70% of the world's adults living with HIV or AIDS (Population Reference Bureau 2000: 3; Kalipeni 2000: 967). In what has emerged as a vicious cycle, AIDS deepens the poverty of households and nations, and poverty favours the spread of the virus, with few financial assets, the poor are often politically and socially marginalised and often have limited access to healthcare information and services.

Dawit points out that women's lack of access to basic health care are symptomatic of greater susceptibility to HIV exposure. From this perspective, HIV becomes not only a particularly harsh sexually transmitted disease but also a socio-economically determined one (1993: 163). Kenya as a country is giving one quarter of its HIV positive people free drugs that are available in urban areas while the rural folk, the

majority of whom are women, who are economically disadvantaged have none or lack access to the same services.

Scott and Mercer are of the view that HIV transmission in Africa is linked to the interaction of deeply rooted socio-cultural patterns and the disruptive course of colonial and postcolonial history (1994: 82). The social and economic conditions of women affect their overall health, their reproductive lives and the lives of their children in a complex process of interaction (Raikes 1989: 456). Ford, Odallo, and Chorlton concur that HIV is more than a health problem because its spread is determined by the availability and accessibility of basic services, the socio-economic and political dimensions of HIV/AIDS determine how and where it is spread and also how communities cope with it and adjust to its impact (2003: 600).

Many women lack economic autonomy thereby rendering them powerless to reject risky behaviour or to negotiate the most basic precaution against the disease (Population Reference Bureau 2000: 3; Dawit 1993: 164).

Women lack or have limited opportunities in regard to education, formal employment, credit, training and support and more resources and income generating projects are unavailable to women (Kalipeni 2000: 967). It is estimated that up to one third of households in developing countries have women as sole providers. Breaking this cycle will require not only greatly increased investments and more effective HIV prevention and care but also effective measures to combat poverty (Population Reference Bureau 2000: 3; Dawit 1993: 171; Susser 2000: 1043). Kalipeni is of the opinion that “behaviour change does not simply come through education and the dissemination of information: It comes through empowerment – providing opportunities to enable them to secure respectable livelihoods” (2000: 977). The international AIDS conference in Durban, South Africa recommended that improving girls access to education and information would give them more economic options and prevent them from going into the sex trade (July 2000). This would discourage them from early motherhood and also encourage reproductive health education and information, which remain the single most powerful preventive tools (Population Reference Bureau 2000: 14-15; UNAIDS 2008: 66).

As men and women leave their spouses and partners to work in the city or in a new country, they form new sexual networks that increase risks of HIV transmission (population Bureau 2000: 3; Mill & Anarfi 2002: 326; Dawit 1993: 171; Kalipeni 2000: 967). Most women with HIV /AIDS become infected during unprotected sex with their male partners. In many cases, infection is part of a long chain of transmission that begins when husbands or boyfriends contract the virus through relations with sex workers and other female sex partners (Population Reference Bureau 2000: 3; Susser 2000: 1043).

Female-headed families use sexual networking as an economic strategy as these women lack other avenues of earning income they could use to sustain themselves and their families. The women usually have multiple partners to gain access to resources that “they do not command themselves because of entrenched gender discrimination in gaining access to education, to credit, and to the formal economy” (Heise & Elias 1995: 935). Women living in poverty may adopt behaviours that expose them to HIV infection, including the exchange of sexual favours for food, shelter, or money or support for themselves and their families. Sexual networking is not seen as a pleasure-seeking experience and reducing the number of one’s partners is not only a question of exerting self-control. The truth of the matter is that:

Pleasure is surely a factor in many cases, but there is a need to replace partners lost through separation, divorce, or death. Likewise, for many women having more than one partner is an economic survival strategy that is central to their ability to support themselves and their children. ‘Stick to One Partner’ slogans ask many women living on the edge to forego income vital to meeting today’s needs to avoid an ill-defined risk of AIDS 10 years hence (Heise & Elias 1995: 934).

It has been documented that women who are widowed, divorced or separated also have high rates of HIV infection (NAS COP 2005: 10; KAIS 2009: 243).

Most adult women are in stable relationships with one sexual partner. The women’s vulnerability is determined by the heterosexual behaviour of their steady male

partners. Many women due to economic dependency are unlikely to jeopardise their relationships by raising these issues (Weiss & Gupta 1993: 171; Kalipeni 2000: 977). It has been documented that “more than 85% of women and (90% of men) with HIV are currently married or were previously married. Women’s vulnerability to infection within marriage is underlined by the fact that most men with multiple partners are married indeed 45% of married men had multiple partners compared with just 5% of women” (UNAIDS 2005: 29).

Women’s socio-economic status also increases the likelihood of women marrying early and to older men so as to uplift their standard of living. Young women may see this as an avenue of improving their lot or what is referred to as social mobility. Young women (14-24 years) from low-income families are particularly vulnerable to the older men called “Sugar daddies” who offer money and gifts. These younger women are documented as the most infected compared to older women (UNAIDS 2004a: 7; Weiss & Gupta 1993: 171). There has been an increase in the number of child prostitutes due to economic hardships as well as an increase in the number of HIV/AIDS orphans. Ninety per cent of those involved are teenage mothers who are likely to have been school dropouts who have been rejected by their families or those who have absconded from their homes (UNAIDS 2006a: 20). A unique feature observed in child prostitution in Kenya is the situation where people take in destitute children but instead of caring for them, they hire the children out as prostitutes from time to time. Child prostitution is reported in bars, brothels, massage parlours, streets and discotheques (UNAIDS 2006a: 20). Military bases such as Nanyuki and coastal regions that have foreign troops are known to be hot spots for child prostitutes and there is no legislation that strongly bars a foreigner from involving themselves with child prostitutes (UNAIDS 2006a: 20).

The UN report on violence says that Kenya has between 10 to 30,000 child sex workers mainly in the tourist areas. The study continues to enumerate that “the extent and effect of sex tourism involving children on the Kenyan Coast reveals 75% of informants (underage girls involved in prostitution) found the practice acceptable or actively approved of it. More than 45 percent of those interviewed began

transactional sex for cash, goods or favours between the ages of 12 and 13 years” (Barasa 2007: 8).

Sex workers are identified as a group that requires special attention and it is important to note that 27 percent of Kenyan sex workers are infected with HIV/AIDS (UNAIDS 2006: 107). Suffice it to say that majority of HIV interventions that address sex work are aimed at sex workers themselves, with insufficient attention paid to their clients or the contexts in which they work (UNAIDS 2006: 108). Sex workers say that “you die faster from hunger than from AIDS” so they would rather risk infection because it would take a longer time to get sick but fill their stomachs for the time being (National AIDS Control Council 2002: 11).

The UNAIDS 2006 report is concerned that many countries are failing to direct financial resources towards activities that address the prevention needs of the populations at highest risk such as women and young girls and opting instead to prioritise more general prevention efforts that are directed at no one in particular but are less cost effective and less likely to have an impact on the epidemic (2006: 125).

## **2.6 KNOWLEDGE, AWARENESS AND PREVENTION**

In much of sub-Saharan Africa, knowledge about HIV transmission is still sparse and women are generally less informed about HIV than men. This is more so in the rural areas than in urban areas. Young women in surveys carried out lacked comprehensive knowledge about HIV and young men were likely to have correct information about HIV (2005: 18). There is a need for knowledge, communication and interventions about HIV/AIDS to go beyond raising general awareness (NASCO 2005: 24).

Research has shown that many HIV/AIDS messages usually designed to change behaviour and reduce the risk of HIV transmission have been aimed generally at the whole population of male and female alike. In other words these “messages are “gender-neutral”. These messages have failed to take into account the specific needs of women and girls and the often-difficult reality of their daily lives. The result is that

we have targeted the symptoms of the pandemic rather than the underlying causes and the consequences of this failure have been catastrophic (General Secretary's Report 2004a: 6). The UNAIDS report notes that 25 years after the epidemic was first recognised most people at high risk of HIV infection have yet to be reached by HIV prevention, as many policy makers are not implementing approaches that have been shown to work (2006: 124).

Due to the fact that women have a secondary status, their educational levels and literacy rates are low and therefore they are reached less effectively by anti-AIDS campaigns relying on printed materials such as pamphlets, posters, and brochures. Women have less access to radio and TV. The Kenya National HIV/AIDS Strategic Plan 2005/6-2009/10 has observed that there is a need to use prevention strategies that adapt to the language and situation of a given group (2005: 8). There are misconceptions that it's not worth investing in educating a girl child because she will soon (14-18 years) be married off and educating her would be wasting resources which should rather be invested in a boy child who culture dictates will remain with the family. Keeping girls at school for a longer period is one of the strategies that are viable as this raises the status of the girl child and protects her from early marriage. When young women go to school they become more knowledgeable about their bodies and sexuality since this is taught in schools and they also become more economically empowered later on by getting employment in the job sector (UNAIDS 2004: 12; UNAIDS 2008: 66).

Studies done in Kenya and other sub-Saharan regions indicate that educational attainment has a strong effect on health behaviours and attitudes (KDHS 2010: 40). Data reveal that in Kenya the proportion of illiterate women is double that of men, 14 percent of Kenyan women age 15-49 cannot read at all compared to 7 percent of men in the same age group. This also implies that information access increases with educational attainment and wealth quintile for both men and women (KDHS 2010: 57-59).

It has been noted that there is lack of access to clear, factual HIV prevention information and to HIV testing, counselling and related services, in an environment



that is safe for confidential testing and voluntary disclosure of HIV status (Gender mainstreaming 2002: 20). It is common knowledge that few women are even aware that prevention technologies such as the female condom exists and even if they knew that they existed they would not be able to afford them and neither would they be available. Female condoms are said to be effective in preventing pregnancy and STI including HIV prevention (UNAIDS 2005: 15). Very few women are even aware that microbicides are being developed as a prevention technology that they could control so that they are not at the mercy of their partners at all times especially when they know that their partners have multiple partners.

The Intensifying HIV Prevention UNAIDS Policy Position Paper states that: "HIV prevention programmes must be differentiated and locally adapted to the relevant epidemiological, economic, social and cultural contexts in which they are implemented" (2005: 15). Adapting messages to the specific group under study is vital because if messages are not targeted, chances of the messages being fruitless are high.

HIV stigma and the resulting actual or feared discrimination based on lack of enough knowledge and misconceptions have proven to be the most difficult obstacles to effective HIV prevention. It has been observed that both stigma and discrimination reduce the efforts to control the global epidemic and create an ideal climate for further spread of HIV. HIV stigma emanates from fears and associations of AIDS with sex, disease, death and taboo behaviours that may be illegal, forbidden such as pre and extramarital sex and sex work. Stigma also accrues from inadequate awareness and knowledge about HIV that can lead to violence and abuse against certain people and groups. Stigma is further ameliorated by existing prejudices and patterns of exclusion further marginalises people who are already vulnerable to HIV infection (UNAIDS 2005:11).

Gender sensitive approaches are key to designing prevention programmes that seek to increase women's access to information and services (UNAIDS 2004: 68). Gender sensitive approaches recognise:

- That women and men have different prevention, care and support needs and therefore approaches that are suitable should be explored. Examples of possible approaches are diagnosing, and treating sexually transmitted infections that should be integrated with family planning/reproductive health clinics, and promoting female-controlled preventive tools such as female condoms and microbicides.
- That men and women can work together to change gender norms that disadvantage women or make them more vulnerable to HIV/AIDS such as the use of peer groups to discuss societal issues.
- That women and girls should be empowered by increasing women's access to assets and resources through the use of land and inheritance rights, facilitating women's networks and strengthening grassroots community organisations (UNAIDS 2004: 68).
- That it is vital to sustain HIV prevention efforts and to ensure they are adopted where necessary to target the most vulnerable who are women who are widowed, young women, sexual workers, orphans that society would rather discard instead of giving special attention.
- That AIDS literature is characterised by the invisibility of women and women have been ignored for a long time by AIDS education and prevention campaigns and the absence of "awareness and/or concern for women as potential sufferers of AIDS" (Cline and McKenzie 1996: 384).

## **2.7 LEGAL FACTORS AND HIV VULNERABILITY**

Some laws of many African countries are guilty of perpetrating the spread of the HIV either knowingly or unknowingly or by default. One major reason is that African social and legal structures are a conglomeration of three legal structures namely the

traditional, the colonial and post-colonial laws that further disenfranchise the African woman who is not fully represented in the national policy debates and decision making. The customary, religious and statutory laws exacerbate the already existing inequalities in regards to issues such as widow inheritance, widow sexual cleansing and property ownership (Struensee 2004: 1).

Although governments have signed and ratified a number of international laws and treaties, to eliminate all forms of discrimination against women, the impact of these laws have yet to be felt at the grassroots level. Inheritance laws make it easy for men to take advantage of women. It is very common for women who after being widowed by AIDS, lose their property to relatives and also find themselves abandoned by their families. The widow has to take care of her children in addition to buying drugs to manage her HIV status (if she is infected). Many countries lack specific interventions to address single-female-parent headed households in terms of property ownership and inheritance. Appropriate guidelines for marriage, separation, divorce, and ownership of property are also lacking (National AIDS Control Council 2002: 4).

Civil and customary laws deny women the right to own and inherit land or property. It is evident that there is a lack of strategy that addresses implementation of equitable inheritance rights (National AIDS Control Council 2002: 4). The fact that men pay dowry upon marriage strengthens their hold over women and property because the woman is seen as a commodity that has been purchased although paying dowry is also seen as a way of linking two families. This type of thinking has led to the lack of adequate consideration of policy and legal issues concerning sexual rights of women and girls (National AIDS Control Council 2002: 5; UNAIDS 2006: 286). Customary law is often interpreted in ways that effectively deny women fundamental rights to own or even access property. Women remain legal dwarfs upon marriage (UNAIDS 2004b: 33; National AIDS Control Council 2005: 4).

The fact that women can be left destitute can leave women prey to sexual exploitation and violence (UNAIDS 2004a: 7). Many widows turn to prostitution to

generate income, or they encourage their female children to take up prostitution (Population Bureau 2000: 10; Rankin et al 2005: 12).

The UNAIDS report on women and girls also observes that: “Ingrained social and cultural norms relegate women to a lower social and economic status and often treated as legal minors, barred from owning or inheriting property, unable to make independent financial decisions, women are vulnerable to poverty, exploitation, which lies at this causal chain of injustice” (2004a: 8). Since most lawmakers are men, the laws also mirror what the cultural thinking about women is and it is a fact that women have not been favoured. A case in point is during the review of the constitution of Kenya, one of the most contentious issues was the provision regarding land inheritance by women. The majority of Kenyans rejected the new constitution on the mere fact that it empowered women considerably and that it was challenging the social and cultural set-up where women have been relegated to second place (Referendum 2006).

Research conducted in 2006 indicates that women are not adequately represented in policy and decision-making on AIDS. It is only since 2007 that women have had direct representation in the local HIV committees and it is hoped that they will play an important role and not merely be fulfilling those distant conventions that countries have signed. Many treaties have been signed but the data on the ground indicates that very little has been done (UNAIDS 2006: 19).

National policy frameworks that encourage safe behaviour, reduction of vulnerability and effectiveness of HIV prevention services, promote gender equality and women’s empowerment and reduce stigma and discrimination is required in sub-Saharan Africa as a matter of urgency (UNAIDS 2006: 145). There is a critical need to contextualise policies based on emerging issues such as HIV/AIDS. African women are in a class of their own when it comes to denial of their rights and this is further complicated by the cultural and legal labyrinth in which they are trapped. Signing international conventions and treaties is the beginning of correcting past mistakes but are not an end in them. The changes should be felt at the grassroots level.

## 2.8 SEXUAL VIOLENCE AND HIV VULNERABILITY

Sexual violence is a leading cause of HIV infection. It is reported that one in every four girls in Kenya loses her virginity through force (Violence on females spreads Aids: Study 2007: 8). The Action Aid International Kenya Country Director Joyce Umbima says that violence is not a Human Rights issue only but also a national health issue (Violence on females spreads AIDS: study 2007: 8). A study carried out by Nyambura Ngugi and Rosemary Okello indicates that women living in rural areas are more at risk of both HIV infection and violence largely due to embedded social norms related to sexuality (Violence on females spreads AIDS: study 2007: 8).

Sexual violence, including rape and sexual molestation is a particular danger to the reproductive health of women and girls and heightens the risk of HIV infection (UNAIDS 2004: 22). Gender-based violence is common in homes, schools and the work place and other social environments. Not all young people have sex because they want to. A study carried out in Kenya of women between 12-24years indicates that 25 percent lost their virginity because they had been forced or were under social pressure to engage in sexual relations. Unwilling sex with an infected partner carries a higher risk of infection especially for young girls –since force is used, abrasions, and cuts are more likely and the virus can easily find its way into the bloodstream (Violence on females spreads AIDS: study 2007: 8). Young women are more vulnerable to HIV infection as a result of unprotected sexual relations due to power imbalance that limits women’s ability to negotiate or control safer sex especially to older men (Lampsey, Wigley, Carr & Collymore 2002: 5; KAIS 2009: 134). Gupta points out that violence against women contributes both directly and indirectly to women’s vulnerability to HIV. “HIV positive women bear a double burden: they are infected and they are women” (2000: 2).

The Kenyan law is said to be lenient on rapists who are likely to infect minors, young girls and sex workers (National AIDS Control Council 2002: 11). This is because the laws are influenced by the cultural thinking that women have no sexual rights. Women are also disadvantaged because they barely know which laws can protect

them and in any case they have little access to HIV information to know when laws have been infringed (National AIDS Control Council 2002: 11).

It has also been observed that despite the existence of laws criminalising sexual and domestic violence, women are reluctant to report these incidences. This has been attributed to the hostile attitude taken by the police, the law courts, and fears of hostile retribution after reporting and limited quality support both socially and legally. Women also fear more violence, the social stigma of pursuing a claim, or being considered greedy or a traitor to one's culture and this makes many women silent (UNAIDS 2004b: 31, 35). It has also been noted that culture and customs are used as an excuse to exonerate and perpetuate forms of family and sexual violence (UN Report 2007: 4).

Girls who are orphaned and taken in by relatives also face the danger of being exposed to HIV. Girls also suffer sexual abuse and violence at the hands of teachers, priests, peers and family members (UNAIDS 2006a: 2). It is also documented that "two out of 10 girls who are raped become pregnant; almost 3 out of 10 suffer from STI and nearly 4 out of 10 suspect that they may have HIV/AIDS" (UNAIDS 2006a: 27).

The UNAIDS report on Women, girls and HIV/AIDS clearly indicates that "unequal power relations often reinforced by coercion, abuse and violence prevent women and girls from making informed choices about their own sexuality and survival" (2004b: 7). It is also reported that in the majority of cases a girl's first sexual experience is usually coerced by an older man and chances of infection are usually high. In the latest UN study on violence against children it is reported that 75 percent of incest in Kenya's urban areas is by a father and that 83 percent of abuse occurs in the child's home. The report also says that 150 million girls and 73 million boys experienced forced sexual intercourse or other forms of sexual violence in the world in 2002 (UN Report 2007: 54). It is quite clear from the statistics above that girls are more vulnerable than boys in sexual violence at home or outside the home. The UNAIDS 2004 report indicates that there are "higher rates of HIV infection in women who are physically abused, sexually assaulted, or dominated by their male

partners. The study also produced evidence that abusive men are more likely than non-abusers to be HIV-positive” (22).

Sexual violence also increases the likelihood that a girl who has been sexually molested will engage in high-risk sexual behaviour later in life putting her at risk of infection (UNAIDS 2004b: 7; Gupta 2000: 3). Sexual assault does not only result in unwanted pregnancies, sexually transmitted infections including HIV but low self-esteem and depression. A study done in the US “found a significant correlation between childhood sexual assault and behaviour such as early initiation to sexual activity, having a high number of sexual partners, sex with a known risky partner, sex while intoxicated, receptive anal sex or abuse by a partner as an adult, STI history and engaging in sex work” (UNAIDS 2004b: 32). It has also been observed that when a relationship is characterised by violence, sexual negotiations for safer sex cannot take place nor can a woman insist on fidelity on the part of the their partner for fear of provoking further violence (Gupta 2000: 3; Gomez & Marin 1996: 355).

HIV infection can also lead to violence and not only can violence result in HIV infection, but HIV infection can lead to more violence. Violence can occur as a result of disclosure of HIV status. This is because women are often the first to test for HIV through antenatal services, and they are usually accused of bringing HIV into a household or community and it usually does not matter whether it is a partner who gave it to her or not. Many women who disclose their HIV status to partners, family members and communities are physically and emotionally abused as a result, some are even killed (Gupta 2000: 3;UNAIDS 2004: 33). Gupta points out that: “being ostracised, marginalised and even killed are very real potential consequences of exposing one’s HIV status” (2000: 3). Violence also increases in the home when household tasks are not done or completed due to the time taken to care for sick family members or because the caregiver is ill or when a household is affected by economic and food insecurity (Gupta 2000: 3; UNAIDS 2004b: 33 ).

Girls who marry before age 18 have the risk of increased physical, sexual and psychological violence at the hands of their husbands (UN Report 2007: 57). Married girls who experience sexual violence by an intimate partner “may be forced

to do something sexual that they find degrading and humiliating. In societies where the cultural norm is to have unlimited sexual access to women upon marriage, married girls are likely to experience forced and traumatic sexual initiation” (UN Report 2007: 59).

Globally between 10 to 69 percent of women have reported experiencing physical abuse by a partner often accompanied by verbal and/or sexual abuse (UNAIDS 2004b: 29; UNAIDS 2006: 10; McNair & Prather 2004: 109). Sexual abuse in marriage is not recognised socially and culturally in many societies. In the absence of legislation in Kenya outlawing domestic violence, a married woman is without recourse if her husband rapes and beats her (UNAIDS 2006c: 3). The fact that women have a disempowered status exposes them to violence. Fear of a partner’s anger in response to requests to use condoms is one of the reasons that condoms are not very popular (Amaro 1995: 444; Gupta 2000: 3). Questioning a partner’s sexual behaviour or asking them to use preventive measures can lead to physical, verbal or other forms of domestic violence. When women have been infected with an STI, they quietly go for medical attention and if they do not have resources for medical treatment they live with the infections hoping that the situation will somehow improve (Muturi 2005: 88).

There is also a need to educate women and girls on the importance of post-exposure prophylaxis therapy (PEP) that women undergo to protect them from HIV after they have been sexually assaulted. It has been reported from a local hospital here in Kenya that “1,483 rape survivors accessing medical examination in one hospital in 2004-2005, 1,239 were put on PEP treatment (those who did not receive PEP treatment tested HIV positive and were referred for ART” (Muga et al 2004 in UNAIDS 2006c: 24). It is therefore very crucial for women and girls to be knowledgeable about PEP therapy and to overcome the stigma and shame that is culturally associated with rape. When women are sexually assaulted they should not hide the fact that they have been assaulted and that they should seek medical attention immediately. Reports from the field indicate that women often lack information on Post Exposure Prophylaxis (PEP) and service providers often lack



training or the authorisation to dispense it. Girls who are legal minors may face added obstacles in receiving PEP therapy (UNAIDS 2004b: 31).

Female genital mutilation (FGM) is seen as a form of violence against young girls because most of them do not have a choice but according to the Samburu culture FGM is a very significant ritual that demarcates girlhood and womanhood. One hundred to one hundred forty million girls and women in the world have undergone FGM, their families insist that this is the cultural norm and it must be followed regardless of the risks. FGM is normally seen as a precursor to marriage. It is also regarded as protection of virginity and a beautification process. One major risk is the infection of HIV because of the use of un-sterilised instruments that are normally shared in the operation (UN 2007: 60).

Women who live in communities associated with conflict and displacement are also vulnerable to HIV/AIDS. In a study carried out of pastoral communities in Kenya in 2004 it was observed that pastoral communities in Kenya are known to be associated with ceaseless conflict. Conflict generates avenues of vulnerability to HIV/AIDS. Conflict is associated with rape and other forms of violence (Futures Group Europe 2005: v). The UNAIDS 2006 report acknowledges the fact that conflict and displacement can increase the affected population's HIV risk by "reducing their access to HIV prevention services, disrupting social support networks, increasing exposure to sexual violence, encouraging sex in return for food, shelter and other necessities or moving to a higher HIV prevalence location" (131).

The fact that Kenya does not have a national policy framework that addresses gender-based violence and more specifically linkages between HIV/AIDS and violence against women and girls curtails efforts towards addressing the issue comprehensively (Violence on females spreads Aids: Study 2007: 8). In countries where these strategies and policies exist, the major challenge is implementing and enacting and enforcement of the same without discriminating against women who are the most vulnerable among other groups (UNAIDS 2006: 69).

## **2.9 STRATEGIES THAT ARE IN USE IN COMBATING HIV/AIDS IN WOMEN**

The ABC strategies are insufficient for women who lack access to unobtrusive prevention methods under their own control (UNAIDS 2005: 143). As long as prevention technologies are controlled by men, women will continue being vulnerable to HIV/AIDS. Studies are still underway to develop new prevention technologies such as microbicides and vaccines for women. The ABC strategies are discussed below and their major weaknesses highlighted.

### **2.9.1 Abstinence**

“Abstain and delay sexual initiation” is an approach that is said to be of limited value (UNAIDS 2004:68). Abstinence within marriage is not a viable option. Many women and girls are not in a position to negotiate abstinence because they lack the social and economic power and live in fear of male violence (UNAIDS 2004: 68). Abstinence is especially recommended for young girls. The ABC approach does not go far since it does not distinguish the different needs of men and women and it fails to offer African girls and women real options that are realistic about their daily lives (Odero 2007: 6). The fact that this approach is not targeted to a specific sex is what Gupta refers to as “gender-neutral”. This approach does not take into consideration the different needs of men and women, which are based on their unique gender and sexuality (Gupta 2000: 5).

The UNAIDS report on women categorically puts it that abstinence is unrealistic in an environment in which boys are encouraged to be sexually aggressive and girls are kept in ignorance about their own sexuality. Calls for abstinence are meaningless when sexual activity is coerced, or when women and girls feel they must resort to sex as a matter of survival (2004b: 12). According to this strategy unmarried women are expected to be abstinent and therefore no prevention technologies have been considered for them (Gender Mainstreaming 2002: 15). The truth on the ground is that unmarried or single, widowed women continue to be at risk because they are usually sexually active. This strategy is only relevant to young

people who are sexually inactive to continue doing so until they are ready for marriage.

### **2.9.2 Being faithful to one partner**

Being safer by being faithful or reducing the number of partners is easier said than done. It has been documented that 80% of women who are HIV positive are in long-term stable relationships (Gender mainstreaming 2002: 2). Monogamy (one partner) is “a sensible strategy from an epidemiological viewpoint but only if monogamy is mutual and lasting and that the partners are sero-negative” (Kippax & Race 2003: 3). Being faithful only works if both partners play by the same rules yet prevailing norms encourage men to have multiple partners. Fidelity will do nothing to protect a girl or woman against HIV/AIDS if her partner is unfaithful; nor will fidelity to an older male who is more likely to be infected (UNAIDS 2004b: 12; UNAIDS 2005: 9).

The basic reality regarding the plight of women as far as monogamy is concerned is that it is women who are usually monogamous. Research has shown that 80 percent of cases where women in long-term stable relationships are HIV positive, they acquire the virus from their partners who become infected through their sexual activities outside the relationship or through drug use (Kenya National AIDS and STI control programme 2005: 2). It is the sexual behaviour of their partners that puts them at risk. For those women who are not monogamous having multiple partners is not a pleasure-seeking strategy but a way to gain resources that only men control, reducing partners for these women translates into reducing their resources, multiple partners are a key to their survival. Partner reduction messages assume that women are always in control of, when they have sex and with whom. Data on rape and coercive sexuality indicate otherwise (1995: 933; UNAIDS 2004b: 12). There are cultures where multiple partners are believed to be essential to men’s nature and for sexual release. Such beliefs challenge messages advocating for partner faithfulness or reduction in the number of partners (Gender Mainstreaming 2002: 13; Wilson 2004: 848).

### 2.9.3 Condom use

It is an undisputed fact that unprotected vaginal intercourse accounts for the vast majority of HIV infection globally (UNAIDS 2006: 126). The condom strategy for women has a number of limitations; that condoms are a technology that women may influence but cannot control because it hinges on a male decision. Condom use is also based on the fact that a woman must negotiate the use of the same with an often-unwilling partner. Social, economic, cultural, and emotional forces may limit a woman's ability to negotiate the use of condoms (Heise and Elias 1995: 936; Gupta 2000: 5). For the condom strategy to work, women must be able to discuss their use and sex with their partners, which is not the norm. Open communication about sexual matters is hardly evident in most relationships especially in sub-Saharan Africa.

Women may suffer abandonment, physical abuse, and accusations of infidelity if they bring up the use of condoms (Gomez & Marin 1996: 360). Psychological factors may also prevent a woman from raising the topic of condom use because they feel that they are immune to infection and that it cannot happen to them. It is the same dilemma that young girls believe that they cannot be impregnated or infected with the HIV virus, it only happens to other people (Heise & Elias 1995: 936; Gupta 2000: 3). There are also strong emotional barriers that may prevent a woman from discussing condoms because it hinges on matters of fidelity and trust. In many communities the use of condoms signifies distrust among partners rather than care and concern (Heise & Elias 1995: 936). When a couple does not use condoms it is a sign of intimacy. Women themselves have not warmed up to condom use because they find condoms unpleasant because they reduce sensation and they interfere with natural sex. Condoms are also seen to be inconvenient. Many women have misconceptions and negative perceptions about condoms and many women still think that being in a monogamous relationship automatically protects them from HIV (McNair & Prather 2004: 109). Sex workers also have expressed dislike for condoms because they are said to prolong intercourse, which can lead to dangerous friction sores (Heise & Elias 1995: 938).

The use of condoms has not gained much popularity in rural areas either (Maore 2004: 32; Futures Group 2005: 19). Strategies such as condoms are unrealistic in rural areas, where people do not have the money to buy them (Boahene 1996: 610; Cohen 2004: 13). The condom strategy in many parts of the world faces problems such as high cost, poor quality, limited availability, inconsistent use and improper use which impair the implementation of this important AIDS prevention strategy. Improved condom design, procurement and distribution are essential (Heise & Elias 1995: 936). Condom use in families poses a challenge to women who have been encouraged to ask their partners to use condoms. The first misconception has been that women can help their partners use condoms yet women do not have equal status to men for them to prescribe what they want as far as sexual matters are concerned (Heise & Elias 1995: 937; Gupta 2000: 5).

Vulnerable groups, such as young women and men, cannot access condoms easily because the thinking is that they should not be using them in the first place. The fact that it is the young people who are contracting HIV by the millions every day is an indicator that they are sexually active and are not using preventive technologies. It is interesting to note that the Catholic Church has allowed the use of condoms only this year (2010) while HIV/AIDS has been spreading for the last 30 years.

The advocacy of condom use has created its own bedroom politics. Dawit points out that many educational programmes that target women give them information about AIDS, supply them with a few condoms, and send them on their way; they do not address the essence of the problem. Simply distributing condoms whether to women or men is a dead-end approach that ignores the dynamics within a given relationship (1993: 164). Women have been asked to negotiate sexual relations and that this negotiation will ameliorate a large part of the problem of transmission of HIV and many other diseases. Unfortunately, the concept of negotiation assumes dialogue and barter, exchange and compromise and discourse. Negotiation of safer sexual relations presupposes equality between parties, be it social or economic; it presupposes the ability to negotiate in the first place (Dawit 1993: 164). Women are disadvantaged because they require male co-operation and this places women in danger of exposure to risky sex (Amaro 1995: 437).

The female condom was launched in the early 1990s and since 1997 more than 90 countries have introduced it (UNAIDS 2004: 77). The female condom was introduced to the Kenyan market in 2002. About 15,000 female condoms were used per month in 2002 and about 50,000 by the end of 2004 and over 60,000 were distributed in 2005. They cost KES 120 in pharmacies that is about 40 times the cost of a male condom from the private sector (NASCOP 2005: 44). The female condom although shown to be effective in pregnancy prevention, has not achieved its full potential in national programmes because it is not accessible, it is not fully acceptable and it is also expensive. The Kenya National Strategic Plan 2005/6-2009/10 makes two observations; that female condoms are not available in rural areas and are not viable protective options for rural women; that vulnerable groups do not have access to the female condoms (2005: 8). Very few young people go to the medical centres to get medication for STI, they would rather go herbal! (Egerton 2006) and yet very few would go to the health centres to get the female condoms even if they were available because of fear of reproach from the medical workers.

Amaro suggests that there is a need to develop an effective and safe method that is under women's control and can be used without the knowledge of the sexual partner (1995: 437). Women feel that they need a preventive method that they can control without asking the men as is the case of the male condom especially when it has been documented that sexual networking is rampant (Susser 2000: 1046).

A female controlled preventive technology such as microbicides then becomes viable. Microbicides are gels, creams or other substances that can be inserted in the vagina to reduce the risk of HIV transmission. There are more than 60 candidate vaginal microbicides under development including 5 that are now being tested in large Phase 3 human trials in 10 countries (UNAIDS 2005: 143). Microbicides offer the best promise of a prevention tool women can control. Microbicides can have substantial impact on the epidemic if and when they are approved for use. There are vaccine trials going on in Africa, Asia, Australia and Europe and if successful will also offer women another viable option (UNAIDS 2005: 16,144; UNAIDS 2004a: 92; Ramjee 2000: 283).

## **2.10 SUMMARY**

The position of women vis-a-vis HIV/AIDS has been extensively explored in this chapter. Stephen Lewis the UN secretary-general's envoy for HIV/AIDS in Africa aptly sums up that the world and the governments of Africa should realise that gender is at the heart of the HIV pandemic. The vulnerability of women is as a result of gender inequalities that are evident in the lives of African women. He singles out gender factors that fuel the spread of HIV as cultural oppression of women resulting in the greatest number of new infections; millions of women sexually subjugated to forced sex without protection, women without the power to say no to risky sex and without the right to negotiate safe sex (UNAIDS 2004b: 12).

The combination of historical, cultural, biological, socio-economical factors has fuelled the spread of HIV/AIDS in the lives of women especially in the Sub-Saharan region which is the epicentre of the disease. The legal structures of many African nations, instead of protecting women, seem to fuel and perpetuate the spread of the pandemic. Many treaties and international conventions protecting women from discrimination and the denial of their fundamental rights are yet to be enacted at any level. Other factors that render women at risk of infection are the laws which predominately champion the rights of men and without recognising that the laws disadvantage women. Even where laws have been enacted to protect women, they are not yet functional and there is also a significant correlation between violence and HIV/AIDS.

Prevention messages are blanket generic messages that do not take into consideration that women and men are different and have different needs. In conclusion, Gupta reminds us that: "sensitive, transformative, and empowering approaches to gender and sexuality are not mutually exclusive. They must occur simultaneously. We must continue to address the differing needs and concerns of women or men while we work on altering the status quo in gender relations in minor and major ways" (2000: 6). Knowledge and information are not sufficient. Women

will need tools to breach the culture of silence that surrounds issues of sexuality, and they will need the power to resist abusive and exploitative sex (UNAIDS 2004b: 13).



## **CHAPTER 3**

### **HEALTH COMMUNICATION AND HIV/AIDS HEALTH MODELS**

#### **3.1 INTRODUCTION**

This chapter deals firstly, with the health communication domain and secondly, with health models and the role they play in the fight against HIV/AIDS. The section on health communication highlights the important role of health messages. The current observation is that most health messages are directed at 'blanket' audiences and therefore do not reach their intended target audiences. These messages are important because they may determine whether one may be HIV positive or HIV negative or simply put they are a matter of life or death.

Section two explores some of the health models and theories that have been used in the fight against HIV/AIDS. Behaviour based theories are said to be popular because there is no known cure for AIDS and therefore the only choice left is to change high-risk behaviour. In Africa HIV/AIDS is largely transmitted through heterosexual behaviour and it can be prevented through appropriate behaviour changes (DiClemente & Peterson 1994: 1). Although behaviour based theories spearheaded the fight against HIV/AIDS, the observation is that these theories were more useful and relevant in some western communities that are more individualistic in nature than the African communities that are more community based. These models that originate from the west, but used globally, have had mixed results. These models do not consider interaction with social, cultural, and environmental issues as independent of individual factors (UNAIDS 1999a: 6). Cochran and Mays observe that some scientists are of the opinion that the current models should be discarded because they are incongruent with African worldviews because there is a clash between African values, which advocate for unity, cooperation and interdependence and western values which stand for individuality, independence and competition (1993: 150). It is increasingly doubtful whether the current communication approaches are adequate for health promotion and disease prevention, particularly HIV/AIDS prevention, care and support (Airhihenbuwa,

Makinwa & Obregon 1998: 326; Forster, Philips, Belgrave, Randolph & Braithwaite 1993: 124; Airhihenbuwa & Obregon 2000: 6).

This study recognises the fact that there has been a paradigm shift or what Campbell calls “a paradigm drift” (2003: 90) in the design of health based interventions so that communities themselves are involved in designing appropriate interventions that enable and support behaviour change. Interventions that have not been owned by particular communities have been seen as impositions and consequently rejected (Campbell 2003: 9; Airhihenbuwa & Obregon 2000: 6; Foster et al 1993: 125; Bayer 1994: 895).

Kalichman and Hospers posit that theories of behaviour change are inadequate because they do not address the issues of sexuality, sexual relations and sexual contexts within which HIV transmission take place (1997: S197). It is therefore imperative that theories and models that have been used in the past should be examined in relation to how adequate and relevant they are regionally as well as contextually (Airhihenbuwa et al 1998: 326; Airhihenbuwa & Obregon 2000: 6). The idea of cultural sensitivity is vital in the study and design of health interventions.

This chapter traces the shift from the biomedical, psychological, social cognition models to the culturally based models that have been used to design programmes and interventions in HIV/AIDS prevention. It also discusses the health theories that have been used to design HIV/AIDS interventions highlighting their strengths and weaknesses and their applicability in the context of rural Samburu women of Kenya.

### **3.2 HEALTH COMMUNICATION**

The area of health communication, which is a subset of human communication, is a relatively new area of study. This field of study came into being in the mid-70s when members of the International Communication Association adopted the label ‘health communication’. This field of study has developed rapidly in response to growing pragmatic and policy interests in health promotion and disease prevention in the

United States of America (Atkin & Marshall 1996: 479; Rogers 1994: 209). Health communication was created to address the pressing concern of alarming health problems such as smoking, substance abuse, poor nutrition and AIDS. The driving force of this area has been the needs and problems of public health (Rogers 1994: 209). Pettegrow (in Northouse & Northouse 1992: 3) defines health communication as a subset of human communication that is concerned with how individuals deal with health-related issues. In health communication the focus is on specific health-related transactions and factors that influence these transactions. In sum, health communication is concerned with the application of communication concepts and theories to transactions that occur among individuals on health-related issues. Health communication also focuses on the dissemination and interpretation of health-related information through the mass media; the role of interpersonal relationships in individual health communication; and the effects of social support on health and illness (Faure 2000: 269).

The aim of health communication has been to identify effective communication strategies for improving the society's overall health and to impart knowledge that can change health attitudes, perceptions and health related behaviours (Atkin & Marshall 1996: 480; Kreps 1989: 12; Markova & Power 1992: 111). One of the roles of health communication is to play a key role in the strategising, the selection of message content, the selection of appropriate media, audience analysis and in the timing of messages on AIDS to the public (Ratzan 1993: 3; Kreps 1989: 14). It is the role of health communication to ensure that educational information is communicated efficiently, effectively, ethically and efficaciously to the public (Ratzan 1993: 3). Cassata in Kreps (1989: 14) says that health communication draws from diverse disciplines and synthesises key theoretical and practical principles in the health care system to meet the demands of health care delivery. The ultimate goal of health communication is to reinforce or change a health-related behaviour (Fishbein & Yzer 2003: 165).

Health communication assumes that communication is a transaction as opposed to the earlier views that communication is a one-way process. Transactional communication assumes that communication is a system. A system is defined by

Scott and Brydon as “a collection of interdependent parts arrayed in such a way that a change in one will effect a change in all others” (1997: 5). This system has important components that act as determinants of the outcome of the communication process. These components include:

- The environment in which people communicate—communication between people is determined by the environment in which they communicate thereby determining the content and the manner in which the content is exchanged.
- The number of people communicating — this determines the manner in which the message will be conveyed, just as one’s communication to one person is different from the way one would consider communicating the same message to a group of people.
- Their backgrounds---a group of people may receive the same message but the interpretation could be altogether different because of their frames of reference which are based on their past experiences. This also alludes strongly to the role of perception which refers to the way people make sense out of and give meaning to the messages they receive, bearing in mind that people choose or select what they want to give meaning to based on the values, beliefs that have been inculcated into a person, from the time they are born to the time they die (Jandit 1995: 136; Scott & Brydon 1997: 28; Novinger 2001: 28; Singer 1998: 10). Communication styles may also be different which may be hinged to cultural styles of self-expression and modes of interaction (Yep 1997: 224).
- The content and relational sides of the messages people communicate—the content aspect of a message entails the choice of words that have been used. Some of the major barriers of communication regarding HIV/AIDS prevention have centred on what Rogers calls ‘taboo communication’ whereby sex and sexuality are not discussed openly (Dearing, Meyer & Rogers 1994: 81; Yep 1997: 225). The relational aspect includes the words as well as gestures, vocal pitch, eye contact, and touch (Scott & Brydon 1997: 5).

Transactional communication is said to be simultaneous and ongoing rather than the one-way system where people take turns to communicate. In transactional communication:

Each individual is both a source and a receiver at the same time. As person A constructs a message for person B, A is receiving cues from B that influence how A formulates the message. The transactional approach forces us to look at the simultaneous interplay between the sender and the receiver of a message and the emphasis that relationships between the professionals and client are important (Northouse & Northouse 1996: 4).

The emphasis in transactional communication is that the relationship between the professional and the client is important as opposed to the older view where the professional assumed an upper hand; an overbearing hand; a no nonsense approach. Where the professional is the 'know it all' and the client is an empty slate or a dummy (Smith 1989: 18).

Another important factor that is recognised in health communication is that communication is seen as multidimensional; that communication takes place at two levels; the content dimension and the relationship dimension. The content dimension "refers to words, language, information in a message and the relationship dimension refers to the aspect of a message that defines how participants in interaction are connected to each other" (Northouse & Northouse 1992: 6). The relationship one has with the person one is communicating with will determine whether the message will be received or not. (Windal 1997: 23) cites the example of research conducted among African-Americans which revealed that messages that were communicated by non African-Americans were hardly received even though the messages contained correct information regarding HIV/AIDS. The messages were treated with a lot of suspicion and mistrust because of the kind of relationship based on their past history.

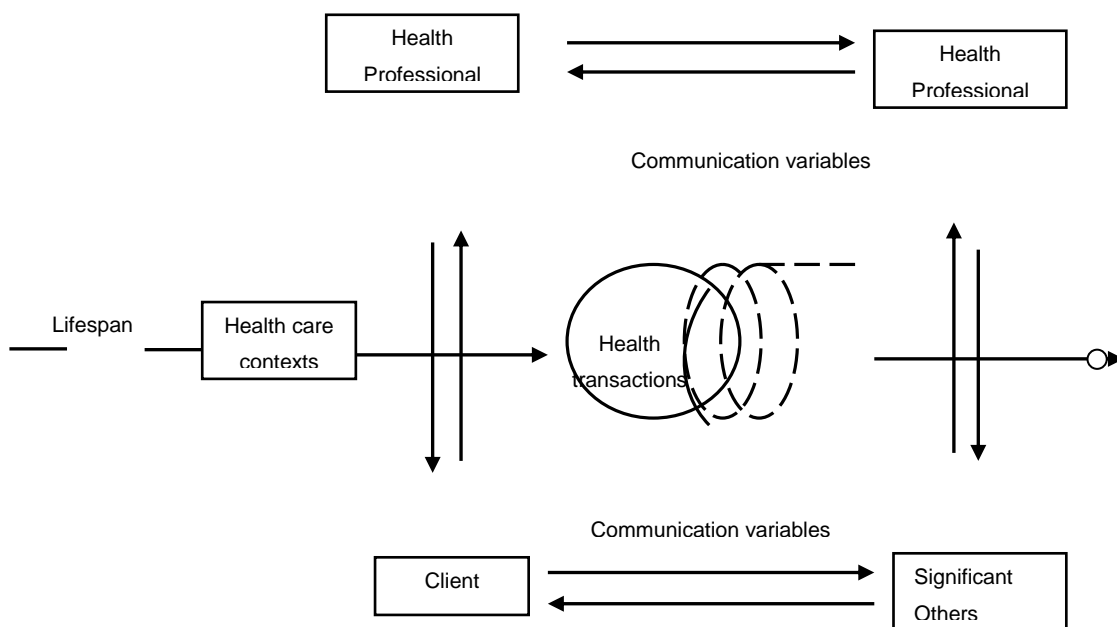
The main concern of health communication is to investigate the different kinds of relationships that exist in the health care environment. Northouse and Northouse identify three main factors of the health communication process as relationships,

transactions and contexts that are demonstrated using the health communication model developed by Northouse and Northouse discussed below (1992: 17).

### **3.2.1 The Health Communication Model (HCM)**

The Health Communication Model (HCM) better explains the factors identified above.

- Relationships: there are four types of relationships: professional-professional, professional – client, professional- significant other and client – significant other (Northouse & Northouse 1992: 16). When an individual is involved in health communication he/she is involved in one of the four types of relationships mentioned above. The term health professional refers to any individual trained to provide health services to others, for example, nurses, health administrators, social workers, physicians, health educators and other specialists. A client refers to individuals who are the focus of the health care services that are being provided. The client's significant others are instrumental in helping the client and they could be members of one's family, friends, or the community.
- Transactions: Health transactions refer to health-related transactions that occur between participants in the health communication process. They also involve transactions between health-related information and these health transactions may include both verbal and non-verbal communication. Health transactions may include both content and relationship dimensions of messages. How a client seeks to attain and maintain health transactions is established within the various relationships presented by the model below:



**Figure 3. 1: The Health Communication Model (Northouse & Northouse 1992: 16).**

According to the model, messages should be interpreted in the centre of the health transactions represented by the circle from which a spiral emerges. This shows that communication is continuous and feedback constantly moves backwards and forwards and communication can be adjusted and readjusted (Northouse & Northouse 1992: 18).

The model illustrated above has the following components that need to be highlighted:

- Context—Healthcare contexts do determine how a message will be received and interpreted. Northouse and Northouse view contexts at two levels: level one refers to health care settings in which the communication takes place because this affects the health transaction. The second level is the number of participants involved, for example one-on-one situations, triads, small groups or larger groups of people. This will also affect the reception and delivery of a message and can also determine how a message will be received or interpreted.

The role of the context is important in health communication in that contextual variables must be considered for effective communication. The context must also include the “historical, social, and personal variables of all variables involved in the communication engagement” (Gabbard-Alley 1995: 49). Health contexts need to be considered in the light of the situations in which they take place.

The HCM is based on the Health Belief Model, King’s interaction model, Shannon–Weaver model, SMCR model and Lear’s model. The three important elements discussed above namely: relationships, transaction and context illustrate that health communication is a transactional multidimensional process by which individuals (both professionals and clients) interact with each other on health-related issues in mutual effect to maintain the health of the client (Northouse & Northouse 1992: 19-20).

### **3. 2.2            The role of culture and health communication**

Another imperative factor in health communication is the role of culture, which will be discussed here briefly. Later in this chapter, cultural models will be discussed at length. Faure points out that health beliefs are strongly influenced by cultural backgrounds and experiences (2000: 278). Health beliefs influence health choices and decisions and therefore health professionals must be sensitive to “different culturally-based health beliefs, values and attitudes that influence the interpretation of healthcare” (Faure 2000: 279). Kreuter and McClure (2004: 439) assert that public health and health communication sectors have acknowledged the fact that culture plays a significant role in determining health and health behaviour and it also determines how successful health communication programmes and interventions are. It has also been observed that different communities have their own epidemics, so to speak, based on their respective beliefs, values and behaviour. This therefore means that if cultural characteristics are understood, health communicators will be in a better position to customise health programmes according to the needs of any given community.



Healthcare professionals should make an effort to learn about their patient's symbolic interpretations of the illnesses that they have and also provide relevant information and feedback to help them understand their condition (Faure 2000: 279).

People's perception of illness and disease, especially regarding its prevention, plays an integral role in the prevention of HIV/AIDS. Perception is seen as an integral component of culture –Perception is defined as “the internal process by which we select, evaluate, and organise the stimuli of the outside world. From the time we are born we learn our perceptions and the resulting behaviours from our cultural experiences” (Noviger 2001: 26-27). This is particularly pertinent to this study that explores the perception of AIDS of the Samburu women.

### **3. 2. 3 Audience segmentation and health communication**

Another observation that is important in health communication is that audiences are not studied as whole groups. Large heterogeneous populations are divided into smaller more homogeneous target audiences, which enable campaign planners to target audiences for whom the campaign goals are most relevant and to design messages that meet those audiences' specific needs. By segmentation or addressing specific audiences the likelihood exists that audience members will pay attention to the messages, be persuaded by the messages and adopt the healthcare actions suggested (Kotler & Roberto 1989: 147). Segmenting of audiences, an idea borrowed from the social marketing approach, may be done in a number of ways; demographic, geographic, psychographic, behavioural, or gender lines, (Maibach 2002: 449; Institute of Medicine 2002: 5). This study singled out the Samburu women as a sub-group to study as opposed to studying the whole Samburu community. Segmentation reduces the risk of unintended consequences such as confusion, unwarranted anxiety, that occur even with the best- intentioned and well-executed health communication interventions (Institute of Medicine 2002: 5). The main aim of segmentation is to identify a subgroup of people who share similar qualities such as views, attitudes and perceptions so that the subgroup be studied in terms of needs, communication barriers and to finally come up with a “product” that would be relevant to that subgroup (Maibach 2002: 449; Kotler & Roberto 1989: 40).

Segmentation of a population group enables the health communicator to focus on understanding the life experiences of communities and individuals within the populations to be reached. There are multiple dimensions to be considered, ranging from economic contexts and community resources such as access to health services to commonly held beliefs and practices pertinent to the health issue in question (Institute of Medicine 2002: 9). The Samburu women have been identified as a segment of the Samburu community whose needs may be different from other members of the community, for example the *morans* (warriors) or the elders.

### **3. 2. 4            Effective health communication**

Ratzan points out that effective health communication is a primary and a most potent weapon in preventing the spread of AIDS. Until a vaccine or a cure for HIV infection is discovered, communication is all we have (1993: 257). This leads us to the exploration of various behavioural and cultural models that have been used in the prevention of HIV/AIDS amongst various communities in a bid to investigate and look for relevant models that can be applicable in the study of the Samburu women.

Markova and Power (1992: 127-128) have made the following observations regarding health communication:

- That the majority of HIV/AIDS campaigns have been information and knowledge based.
- Social and collective representations of HIV/AIDS may have a stronger effect on people's behaviour than scientifically-based knowledge.
- The personal relevance of health communication and socio-cultural factors may strongly affect an audience's response to health communication.
- That information and knowledge are never constructed by consumers as being neutral, rather, information about the disease and knowledge of the disease are always conceived in the context of some relationship to the self and society.
- Health communication concerning HIV/AIDS should address and respond not only to the audience's perceptions, knowledge and attitudes but also to underlying socio-cultural assumptions and social representations on which such perceptions, knowledge and attitudes are based.

Health communication depends on expertise from many other fields to gain an understanding of the health infrastructure. Two main areas that are linked to health communication and relevant to this study are aspects of development communication namely participatory communication and strategic communication, which are discussed respectively.

### **3.3 PARTICIPATORY COMMUNICATION**

Muturi, in her research in Kenya, says that the participatory communication approach in health is a major change from the traditional health communication approach that aimed at reaching mass audiences through health campaigns (2005: 83). Participatory communication is part of a broader area of development communication that promotes development by upgrading education and literacy, family planning, providing information to improve health services, agricultural practices and sustainable industrial production( Sondering 2000: 151). Participatory communication is also described as a social process that communities with common interest seek to improve their lives and advocate for change in unjust social structures that affect them (Mody 1991: 30). Melkote observes that development communication takes into cognizance the fact culture is a central player in development and in the integration of the traditional and modern systems. Indigenous forms of communication which had been discarded by modernisation are now acceptable. Folk media is seen as a product of the local culture and therefore rich in cultural symbolism and highly participatory and can be integrated with modern mass media (Melkote 2001: 252).

Participatory communication in health advocates the involvement of stakeholders in communication related to prevention and care, ensuring that they have access to clear and accurate information to guide them to make informed decisions. Programme planners and researchers have interpreted the goal of the participatory approach as “the involvement of people in the problem definition, data collection, decision making, and implementation” (Muturi 2005: 82). The old communication approach has been the top-down method where receivers are treated as targets for

persuasion and change but the new models of communication call for participatory approaches where the receivers are participants in the communication intervention efforts (Melkote 2001: 242).

Muturi points out that in rural areas, effective communication is more than just disseminating health messages using the mass media or asking people to follow medical regimes. It goes further and deals with issues and interventions that involve participation and empowerment of proper decision making (2005: 78). The participatory communication approach calls for more involvement of the intended audience. This is particularly pertinent for women-centred strategies. Muturi observes from her research on HIV/AIDS in Kenya that client or audience centred communication strategies, especially when targeting rural populations; determine the kind of research methodology to be used to gather information and special attention should be directed towards women (2005: 78). The lack of participation in decision making in sexual and reproductive health matters that is observed in African women due to socio-cultural and economic factors has given rise to several reproductive health challenges such as unwanted pregnancies, STDs, HIV ,sexual and domestic violence (2005: 79).

Participatory communication calls for the integration of multimedia with interpersonal communication and it involves the target audience. This is especially relevant to the Samburu women because if the mass media alone was used they would hardly get any messages because a large number of them are illiterate while other sources of information such as the radio are male dominated.

### **3.4 STRATEGIC COMMUNICATION**

The strategic communication approach in health communication is the new thinking that aims at replacing the one-way doctor-patient approach. This approach has been used extensively to design, implement and evaluate family-planning programmes. This approach advocates the involvement of policy makers, clients, public, and healthcare providers in any health communication interventions. This approach also recognises the fact that to explain behaviour change one needs to

consider factors such as a deeper understanding of community networks, cultural and religious norms and other influences more social than economic, and highly dependent on channels of communication (Piotrow & Kincaid 2001: 251). This approach has been used to design HIV/AIDS prevention programmes and is centred on three principles: 1. Target social norms as well as individual behaviour; 2. Expand beyond ad hoc interventions to a co-ordinated social movement; and 3. Bring community level activities to scale through a linkage with mass media (McKee, Bertrand, Becker-Benton 2003: 31).

Strategic communication is guided by some elements that must feature in the design and implementation of HIV/AIDS programmes: strategic communication follows a systematic approach in the analysis of a problem which should be based on the prevalence rates, segmentation of the population most affected, existing levels of knowledge, psychosocial, and economic barriers to service utilisation and other relevant factors (McKee et al 2004: 31; Piotrow & Kincaid 2001: 252). Health interventions should have an objective and be planned with set results. With HIV/AIDS the specific audience should be identified and the time frame to undertake the research determined. Setting clear objectives determines the design as well as the types of activities that will be executed. Focusing on results means that programmes “cannot stop at the production of catchy, appealing messages or effective outreach activities. Rather, success is judged by the extent to which they actually achieve their objectives” (McKee et al 2004: 34).

The audience should be segmented and the choice of a channel relies on the principles of audience segmentation. Audience segmentation can be determined by identifying the patterns of HIV transmission and targeting those that have relevant behaviours, interests and needs. It also entails identifying subgroups of the population and tailoring communication interventions to most effectively reach those groups (McKee et al 2004: 34).

Audience segmentation is an approved approach in health communication, based on decades of experience and research (Kreuter & McClure 2004: 89), and an important first step in developing health communication programmes. Audience segmentation

strategies can be quite detailed, defining population subgroups by a mix of demographic, behavioural, psychological, geographic, and risk-factor characteristics (91, 96,106). Culture can also be an important audience-segmentation variable.

Strategic communication also recommends that a suitable theory should be identified and incorporated into the communication intervention for a target audience (McKee et al 2004: 31; Piotrow & Kincaid 2001: 251).

Strategic positioning should be used to determine the best approach to motivate an audience to change or adopt a specific behaviour. Piotrow and Kincaid (2001) in (McKee et al 2004: 36) maintain that strategic positioning establishes in the minds of the audience an image of the desired behaviour that helps them remember it, learn about it, and advocate it. Positioning creates a memorable cue for the audience as to why they should adopt a given behaviour. It shapes the development of messages and the selection of channels. In addition, it ensures that messages are consistent and that each communication effort reinforces other activities for a cumulative effect (2004: 36).

Strategic communication advocates the adoption of the entertainment-education approach. This is based on the fact that audiences usually turn to what is entertaining as opposed to other forms of information dissemination (McKee et al 2004: 37; Piotrow & Kincaid 2001: 253).

Communication programmes should be carefully designed implemented and maintain high quality standards. Communication material should be also be pretested for appeal, understanding and cultural acceptability. They should also be developed using participatory techniques and be community owned programmes (McKee et al 2004: 37). Community-based events offer greater opportunities for participation and interaction. It has been established that people learn more when they actively participate as opposed to getting information passively. Programmes no longer operate on a one-way communication system but now use two-way or multidirectional communication (McKee et al 2004: 40).

The use of multiple mutually reinforcing channels is also recommended where various communication channels are usually adopted and are required to send mutually reinforcing messages. This could be the use of mass media, community mobilisation and interpersonal communication and counselling (McKee et al 2004: 38; Kreuter & McClure 2004: 4 41). Client-centred programmes should be designed to cater for the interests of clients and not those who are designing the programmes or the sponsors of those programmes. The communication strategies designed should be based on research and pretested to have increased client participation in allowing the clients to choose their own methods, or treatment or even set priorities for health services (Piotrow & Kincaid 2001: 252; Kreuter & McClure 2004: 441).

The communication interventions should speak directly to the needs and interests of the audience and the gravity of the need to heed to the messages should be established as being beneficial (McKee et al 2004: 38; Piotrow & Kincaid 2001: 252). Strategic communication should also link people to the services they promote and evaluated in terms of their effectiveness in achieving a given impact. (For example, there is a point in advocating the use of condoms without making them available to those who may want to use them. Strategic communication has been used intensively in international family planning and is recommended as a viable option in designing, implementing HIV/AIDS intervention programmes.

### **3.5 HIV/AIDS MODELS AND HEALTH MODELS**

This section discusses and highlights important aspects of behaviour-based theories that can be used with culturally based models used to design programmes and interventions that prevent HIV/AIDS and may be applicable in the study of the Samburu women.

Although the behaviour-based theories spearhead the fight for HIV/AIDS, it is now being observed though that these theories were useful and relevant for certain communities specifically, the western world. It has been observed that HIV interventions should go beyond just providing basic knowledge because basic knowledge does not change behaviour (Bandura 1994: 25).

Behaviour-based theories became popular when information-only approaches seemed to make no headway because the assumption was that greater understanding of the behaviours associated with HIV transmission would more likely result in the adoption of HIV-preventive messages. Despite a marked increase in public awareness of HIV transmission, however, there has not been a corresponding change in high-risk behaviour (DiClemente & Peterson 1994: 3; UNAIDS 2004: 17; Muturi 2005: 78; Singhal & Rogers 2003: 208; Freimuth 1992: 106). Harrison, Smit and Myer concur that most of the theories that focus on individual change and are therefore more individualistic in approach, design and implementation are no longer useful in communities that are collective in nature such as the African communities (2000: 28). It is becoming increasingly doubtful whether the current communication approaches are adequate for health promotion and disease prevention, particularly in HIV/AIDS prevention, care and support (Airhihenbuwa, Makinwa & Obregon 1998: 326; Foster, Philips, Belgrave, Randolph & Braithwaite 1993: 124; Airhihenbuwa & Obregon 2000: 6).

This study recognises the fact that there has been 'a paradigm drift' in the design of health-based interventions so that communities are involved in designing appropriate interventions that enable and support behaviour change. (2006:36). Health interventions designed without the collaboration of/ or participation of the community members are likely to fail (Guttman 1997: 96). This is because they have failed to use the health interventions that are appropriate and in line with those people's culture. Interventions that have not been owned by particular communities have been seen as impositions (Campbell 2003: 9; Airhihenbuwa & Obregon 2000: 6; Foster et al 1993: 125; Bayer 1994: 895).

A consensus has been reached by experts as a result of two global consultative meetings and two regional meetings in Africa and Asia that the existing theories and models commonly used to inform HIV/AIDS communication are not adequate for Africa, Asia, Latin America, and the Caribbean. Some of the reasons that have been identified as impediments for HIV/AIDS prevention are: (a) focus on the individual rather than the context; (b) the assumption that prevention is based on



rational thinking rather than emotion; (c) the assumption that knowledge always leads to behaviour change although behaviour change sometimes precedes knowledge; (d) the assumption that the strategy for a single behaviour change such as immunisation is also adequate for behaviour maintenance such as consistent use of condoms; (e) the assumption that creating awareness in the media leads to behaviour change; (f) the simple approach that assumes that there is a single universal strategy for changing complex human behaviour (Airhihenbuwa, Makinwa & Obregon 1998: 327; Irwin 2003: 65; UNAIDS 1999c: 15; Freimuth 1992: 108). Campbell is in agreement with this view when she posits that: "In the past decade, the practice of HIV prevention has been characterised by a slow but steady paradigm drift". This has involved a move away from highly individual-oriented interventions, informed by narrow psychological theories, towards more participatory approaches" (Campbell 2003: 9).

In this section, some of the behaviour models such as the Health Belief Model (HBM) and the Theory of Reasoned Action (TRA) that were recommended by the Kenyan Ministry of Health (Kenya 1996) are discussed. The reasons why these two theories are not appropriate for the Samburu women of Kenya are also highlighted in this section. The Social Cognitive Theory (SCT), has also been identified as a theory that has some relevance for this study, such as social modelling, the relationship between the environment and the community, the role of opinion leaders, peer involvement, the concept of segmentation, understanding the social structure of a community and identifying the communication structures within it. The health models are discussed in the following section of this chapter.

### **3. 5. 1            The Health Belief Model (HBM)**

The Ministry of Health in Kenya advocated the Health Belief Model (HBM) as a viable model to fight HIV/AIDS in 1990s in Kenya (Nzioka 1996: 565). The Health Belief model developed by social psychologists, Hochbaum, Rosenstock, and Kegeles is an individual-based model that has been in use for five decades and advocates behaviour change through rational decision making (Glanz 2002: 42; Janz, Champion & Strecher 2002: 45). The main goal of the HBM has been to explain behaviour change, maintenance of health-related behaviours and availing a

guiding framework for health behaviour interventions (Janz & Becker 1984: 2; Fishbein & Yzer 2003: 165). The HBM has been widely employed over the past half century and attempts to explain and predict health-related behaviour from certain belief patterns (Green & Kreuter 2000: 162).

The basic components of the HBM are derived from a well-established body of psychological and behavioural theory whose various models hypothesise that behaviour depends mainly on two variables: “(1) The value placed by an individual on a particular goal; (2) The individual’s estimate of the likelihood that a given action will achieve that goal” (Janz 1984: 2). These two variables were conceptualised in terms of health action-related behaviour to correspond to: (i) the desire to avoid illness (or if ill, to get well); (2) the belief that a specific health action prevents (or ameliorates) illness that is, the individual’s estimate of the threat of illness and of the likelihood of being able through personal action, to reduce that threat (Janz & Becker 1984: 2).

Although the HBM has been recommended by the Kenyan Ministry of Health as a model for use, it does have some limitations that would impede its use in the study of the Samburu women. Michal-Johnson points out that many people do not seem to approach the AIDS issue from a logical perspective but seem quite capable of discounting risks and optimistically perceiving themselves as invulnerable to harm (1992: 101). Cochran and Mays assert that this model assumes that people have an in-built impetus to pursue rational courses of action. And, that they have resources to do so and that ‘barriers’ to a rational course of action are trivialised as ‘moderators’ rather than viewed as the defining structure within which people may function (1993: 145).

Nzioka also observes that the HBM fails to account for the “persistence of high-risk behaviour by overlooking the importance of factors such as past sexual behaviour, type of relationships, and self-efficacy and that the approach further ignores emotional and situational frameworks within which sexual activity takes place” (1996: 565).

The HBM assumes that the individual is already aware of HIV/AIDS and its consequences but the truth of the matter is that there is lack of adequate knowledge about HIV/AIDS and this can hinder one from taking any precautions. Rural women have been identified as a group that does not have adequate preventive knowledge (UNAIDS 2004:17).

Irwin, Millen and Fallows observe that there are other major factors such as “economic insecurity, gender, racial inequalities, labour migration, and armed conflict” (2003: 20) that may determine whether an individual will make the right choices regarding high-risk behaviour. This is especially so in the case of women who are disadvantaged because the male partner usually determines sexual matters because they are socially and economically dependent on men, regardless of the fact that they are aware of the seriousness of HIV/AIDS they are unable to control or determine what preventive measures they ought or should undertake (Irwin et al 2003: 32; UNAIDS 2004: 12). Education, empowerment and social change can be factors that can loosen the hold on women and therefore reduce the risk of contracting HIV (Ford, Odallo & Chorlton 2003: 600; Irwin et al 2003: 20; Grown 2005: 542).

### **3. 5. 2            The Theory of Reasoned Action (TRA)**

The Theory of Reasoned Action (TRA) is also an individual-based theory that was recommended by the Kenyan Ministry of Health as a model for use to design HIV/AIDS interventions (Kenya 1996). The Theory of Reasoned Action developed by Martin Fishbein and Ajzen in 1967 as a general theory of human behaviour deals with the relationship of components such as beliefs, attitudes and intention to behaviour (Fishbein, Middlestadt & Hitchcock 1994: 62; Montana & Kasprzyk 2002: 67). TRA is used when one is attempting to develop an intervention that has an informational, educational and/ or communication component (Fishbein et al 1994: 62). The Theory of Reasoned Action has been used to predict and explain why people have or have not engaged in a wide variety of behaviours like smoking, drinking, using contraceptives, dieting, and wearing seatbelts (Fishbein et al 1994: 62). This is a Behaviour Change Theory, which is based on the fact that

“performance of a given behaviour is primarily determined by the strength of a person’s intention to perform that behaviour and the intention to perform that behaviour is based firstly on the person’s attitude towards performing that behaviour and secondly on the person’s subjective norm concerning the behaviour” (Fishbein & Yzer 2003: 165).

The Theory of Reasoned Action also assumes that all individuals are ‘rational actors’ that individual’s process information and are motivated to act on it. This theory points out that there are underlying reasons that determine one’s motivation to perform behaviour. If one has a positive attitude about an issue, there is likelihood that he/she will perform that behaviour. If one has a negative attitude, chances of performing that behaviour may be nil.

To apply the Theory of Reasoned Action, one needs to select and identify the behaviour(s) of interest, which is based on four elements, that is the elements of action, target, context and time. In other words, “every action occurs with respect to some target, in a given context, and at a given point in time...Change in any one of the four elements redefines the behaviour of interest” (Fishbein et al 1994: 64). This theory posits that every action occurs with respect to some target, a given context and at a given time. This theory also suggests that each incidence of behaviour is based on its own unique set of determinants and that each behaviour may require a different intervention strategy and the beliefs that underlie the decision to perform (or not perform) the targeted behaviour may be varied (Fishbein et al 1994: 64). The TRA does provide a “framework for deciphering individuals’ action by identifying, measuring, and combing beliefs that are relevant to individuals or groups, allowing us to understand their own reasons that motivate the behaviour of interest” (Montana & Kasprzyk 2002: 73). This is done by conducting open-ended elicitation interviews to identify the relevant behavioural outcomes and referents for each particular behaviour and the population under investigation. A sample of at least 15 to 20 people from the population of the group under study is identified and divided into two groups, one group have performed or have intentions of performing the behaviour under study while the other group have no intentions of performing that behaviour. The individuals are then asked to describe any positive or negative benefits of

performing the behaviour under investigation. The individuals are also asked to identify people or groups they listen to, in other words who their opinion leaders are who support or are against the behaviour under investigation. The elicitation interviews are then content analysed to identify the relevant attributes and outcomes of their behaviour and the relevant social referents and they form the content of the questionnaire and TRA measures are developed (Montana & Kasprzk 2002: 73). Once the behavioural and normative beliefs affecting the behaviour under study have been identified, interventions can then be designed to target and change these beliefs or the value placed on them, thereby affecting attitude and subjective norm and leading to a change in intention and behaviour (Montana & Kasprzk 2002: 74).

The TRA is criticised on account that it is an individual-based theory and is not appropriate for the Samburu women. Montana and Kaspryk argue that this theory focuses on the theoretical constructs that are concerned with individual motivational factors as determinants of the likelihood of performing a specific behaviour. This theory assumes that environmental, demographical factors do not directly influence the likelihood of a person performing behaviour (2002: 67). Fishbein has referred to these factors as peripheral factors yet it has been observed that these peripheral aspects are very important determinants as to whether an individual will change his or her behaviour.

Cochran and Mays point out that the TRA still presumes that individuals have the freedom to choose a rational course of action – that they possess the necessary skills and resources, and can translate their desires directly without interference into a determinable likelihood of behavioural occurrence (1993: 146). Cochran and Mays emphasise the fact that many groups such as women, commercial sex workers or those using drugs that are at high risk for HIV infection are in an environment where their situation is not under their control. The outcomes of their behaviour are not readily predictable because they are not the determinants of resources such as money, housing, education and mobility that can make it possible for them to make choices that will determine their behaviour (1993: 147). In such cases intention may not always lead to desirable behaviour as assumed by the Theory of Reasoned Action.

Michal-Johnson and Brown describe the TRA as emphasising “a highly rational decision-making process, a presumption that may not be entirely relevant for AIDS-related behaviours that are heavily influenced by emotions” (1992: 153). Singhal and Rogers point out that rational intentions to use condoms can be overcome by a passionate sexual encounter (2003: 212). They also point out that zeroing in on the individual leads to designing individual-based interventions whereby individuals become the units of analysis. But it has been observed that there are unique factors in the case of HIV/AIDS. The social situation in which the infection takes place is very important. The context of HIV /AIDS is thus very important (2003: 208). Susser and Stein observe that each community needs to be studied and assessed in terms of the local situation and the preventive measures advised and facilitated based on the unique needs of that community (2000: 1042).

### **3. 5. 3            The Social Cognitive Theory (SCT)**

This theory was developed by Albert Bandura in 1962. He argues that in order to achieve self-directed change, people need to be given both a reason to alter risky habits and also behavioural means and the resources and social supports to do so (Bandura 1994: 25). To change behaviour one needs what Bandura calls “self-regulative skills and self-guidance” which should be used effectively and consistently under difficult circumstances. That one’s success is based in one’s self-belief in one’s capability or one’s efficacy to exercise personal control (Bandura 1994: 25). The Social Cognitive Theory (SCT) addresses both the psychosocial dynamics influencing health behaviour and methods for promoting behaviour change. Human behaviour is explained in terms of a triadic, dynamic and reciprocal model in which behaviour and personal factors all interact. “Among the crucial personal factors are; the individual capacities to symbolise behaviour, to learn by observing others, to have confidence in performing a behaviour, to self-determine or self-regulate behaviour and to reflect on and analyse experience” (Baranowski, Perry & Parcel 2002: 165). This theory has been used to develop interventions, procedures, techniques that influence these underlying cognitive variables, thereby increasing the likelihood of behavioural change (Baranowski et al 2002: 165). Important

components of the SCT such as modeling, peer education or peer involvement have been singled out as important aspects in designing HIV/AIDS programmes (Peer Educators National Conference 2006).

According to the Social Cognitive Theory, behaviour is dynamic and is determined by two aspects; the environment and the person involved and these two factors influence each other simultaneously. This continued interaction of the two aspects leads to behaviour, which is referred to as reciprocal determinism, which is a major principle in SCT (Baranowski et al 2002: 168; Glanz & Rimer 1997: 23). A change in anyone of these aspects implies a change in the other aspects. The term environment in reciprocal determinism is used to refer to factors that can affect a person's behaviour that are physically external to that person. The social environment includes family members, friends, peers at work or in the classroom. The physical environment may include the size of the room, temperature or the availability of certain foods. Baranowski et al use the term 'situation' to refer to the cognitive or mental representation of the environment that may affect a person's behaviour (2002: 168). The situation refers also to a person's perception of the environment such as time, place, physical features, activity, participants and their role in the situation (Bandura 1994: 25; Glanz & Rimer 1997: 23).

Bandura asserts that in the prevention of HIV/AIDS people or individuals are required to exercise influence over their own behaviour and their social environment (1994: 25).

It is widely assumed that if people are adequately informed about the AIDS threat they will take appropriate self-protective action but this is not the case although heightened awareness and knowledge of HIV/AIDS is an important precondition of self-directed change (Fishbein & Guinan 1996: 5; Bandura 1994: 25). Bandura points out that there is a difference between possessing self-regulating skills and being able to use them effectively and consistently under difficult circumstances and that to successfully change ones behaviour requires strong self-belief in one's efficacy to exercise personal control (Bandura 1994: 26). Perceived self-efficacy is concerned with people's beliefs that they can exert control over their own motivation,

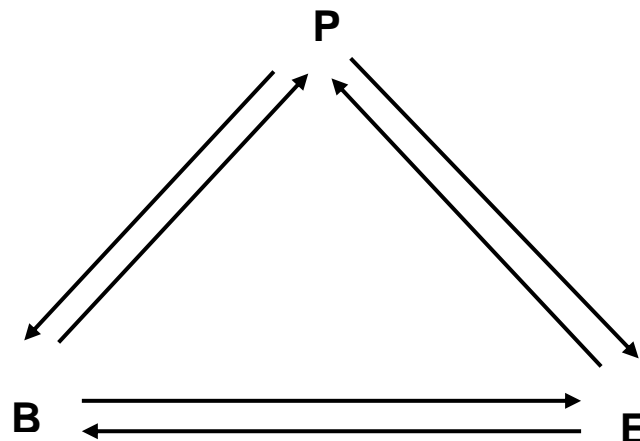
thought processes, emotional states and patterns of behaviour (Bandura 1994: 26). Bandura continues to say that people's beliefs about their capabilities affect what they choose to do, how much effort they mobilize, how long they will persevere in the face of difficulty (Bandura 1994: 26).

The Social Cognitive Theory also asserts that the major problem is not teaching safer sex guidelines which is easily achievable, but equipping people with skills and self-belief that enable them to put the guidelines consistently into practice in the face of social, economic and cultural challenges. This theory suggests that translating health knowledge into effective self-protection action against AIDS infection requires social and self-regulative skills and a sense of personal power to exercise control over sexual and drug activities the two major avenues of the AIDS virus. Safer sex practices often do interfere with self-protection because this conflicts with interpersonal pressures and feelings and sentiments (Bandura 1994: 26).

In the Kenyan situation, beliefs, attitudes, traditions and the socio-economic status are the determinants whether a safe practice will be adopted or not. It has been observed that women have the lowest assurance in their power to exercise control over pressures by a desirable partner to engage in unprotected intercourse and that places them at risk of infection (Bandura 1994: 26). The Social Cognitive Theory states that people's beliefs can motivate and regulate their own behaviour. Belief in one's personal efficacy to exercise control over one's sexual behaviour emerged as the best predictor of sexual risk-taking behaviour (Bandura 1994: 29).

The Social Cognitive Theory explains human functioning in terms of triadic reciprocal causation. That "human functioning is explained in terms of a model of triadic reciprocity in which behaviour, cognitive and other personal actors and environmental events all operate as interacting determinants of each other" (Bandura 1994: 30; Bandura 1986: 24). This is indicated in the diagram below:





**Figure 3.2: Schematization of triadic reciprocal causation.**

"*B* signifies behavior; *P* the cognitive, biological, and other internal events that affect perceptions and action; and *E* the external environment" (Bandura 1994: 32).

This theory points out that an effective programme of widespread change in detrimental health practices has four major components, which are aimed at altering each of the three classes of interacting determinants.

The *informational component* is designed to increase people's awareness and knowledge of health risks. The informational component uses persuasive communication in health campaigns to encourage people to adopt health practices. People need to be given correct and reliable information on how AIDS is transmitted and guided as to how to change their behaviour and they will then rely on their personal ability to adopt preventive behaviour (Bandura 1994: 32). They should also be shown how to have a firm belief in their personal ability to turn concerns into effective preventive actions. This is a shift from scaring people into health behaviour to empowering them with the tools for exercising control over their health habits. Fear appeals bring more stigmatisation instead of changing behaviour and can also lead to fatalism, that is, people may give up the fight of preventing HIV and succumb or resign to the disease (Irwin 2003: 169; Singhal & Rogers 2003: 285).

The informational component also includes two main factors: the informational content of the health communications and the mechanism of social diffusion. Detailed factual information about AIDS should be socially imparted in an understandable, credible and persuasive manner (Bandura 1994: 34). Sensitivity to the context of AIDS is of paramount importance (UNAIDS 2004: 17). Care should also be taken to be sensitive to people when introducing new or different ideas because people are wary of being forcefully introduced to ideas that are not palatable with their own culture and that is why Guttman advocates the participation in intervention creation of the communities concerned (1997: 96). Interventions that have been developed at the grassroots level are more effective than those that have been designed elsewhere (UNAIDS 2004: 17).

Dissemination of information is an important factor that has to be considered or what is referred to, as diffusion vehicles should be used in a public health concern. Existing structural frameworks such as social, religious, educational, recreational organisations can serve as highly effective disseminators of preventive health guidelines.

The second component is concerned with *development of the social and self-regulative skills* needed to translate informed concerns into effective preventive action (Bandura 1994: 30). This implies that a person should be trained to acquire these skills by having sessions with trainers. The only challenge is getting the training and practising what has been learnt. This brings about the aspect of being rational and calculating but the truth of the matter is that it is easier said than done.

The third component is aimed at *skill enhancement and building resilient self-efficacy* by providing opportunity for guided practice and corrective feedback in applying the skills in high-risk situations (Bandura 1994: 30). For the case of women “high-risk” situations could mean violent scenes or life and death situations and these may not be achievable given the unequal status of women both socially and economically.

The fourth component involves *enlisting and creating social support for desired personal changes*. This component involves networking for example with other women or joining women's groups that help empower women in their communities by organising economic activities or projects to empower women economically. Several self-help groups have been established by women leaders for women who may not be economically sound and this is a route that can be used in prevention of HIV/AIDS amongst the Samburu women.

Bandura states that to be most effective, health communications should instil in people the belief that they have the capability to alter their health habits and should instruct them how to do it (1994: 33). Preconditions for changes are created by increasing people's awareness and knowledge of the profound threat of AIDS, its mode of transmission, which constitutes high-risk sexual practices and how to achieve protection from infection that serve as highly effective disseminators of preventive health guidelines and these messages due to a wide cultural diversity, and should be tailored to socio-economic, racial and ethnic differences (Bandura 1994: 35).

The Social Cognitive Theory asserts that the ability to learn by social modeling also referred to as observational learning, and provides a highly effective method of increasing human knowledge and skills. Social learning or observational learning takes place when a person watches the actions of other people and the consequent reinforcement that the person receives. The learner discovers rules that account for the behaviour of others by observing the behaviour and the reinforcements they receive for their behaviour. Many types of behaviour can be learnt through observational learning. (Bandura 1986: 47; Baranowski et al 2002: 170; Glanz & Rimer 1997: 24 Melkote & Steeves 2002: 133). This gels with the idea of peer education or involvement whereby communities are approached instead of the western approach where an individual is approached.

Social modeling is also used as a way of increasing human knowledge and skills (Bandura 1994: 37). When people see other people who are similar to them assuming or adopting safer behaviour in HIV/AIDS prevention, this builds self-

assurance and enhances self-efficacy of the person being communicated to. The model must be similar in age, sex, and status and in a similar type of situation. Modeling also advocates for role-playing and corrective feedback. Modeling as a strategy has been used extensively in the media in many countries in television campaigns to provide knowledge about HIV/AIDS by Population Communication Services (PCS) to reach young adults and adolescents (Melkote & Steeves 2002: 133). The *Tu me Chill* (To Abstain) campaign in the Kenyan media has been encouraging abstinence and postponing sexual intercourse among young people. Prominent people in the music arena have been used as models worth emulating especially in promoting the use of condoms.

Another important concept in SCT is *behavioural capability*; this means that if a person is to perform a particular behaviour he /she must know what the behaviour is and how to perform it (skill). This concept distinguishes between learning and performance in that a task can be learnt and not performed and that performance presumes learning (Baranowski et al 2002: 171; Glanz & Rimer 1997: 24). There have been cases where people have lacked knowledge of some disease and therefore not changed their behaviour. But there are cases where people have knowledge of some disease but they do not want to change their behaviour.

Acquiring knowledge alone about the modes of HIV transmission and effective self-protective methods is not enough as a preventive measure because there are other major factors that do hinder behaviour change such as interpersonal relations, socio-cultural, religious and economic factors (Bandura 1994: 44).

### **3. 5. 3. 1                      *Social cognitive theory and women***

Women face problems with this approach in that even if they are self-determined to protect themselves from HIV/AIDS infection they are not able to control and determine whether their partners will use protective condoms (Ulin 1992: 63). Poor women and those of low status are mostly at risk because of their emotional and economic dependence, the influence of coercive threat and because of sub-cultural

prescription of compliant roles. This is a barrier to women's sense of self-efficacy. Women in unbalanced relationships need to be taught how to negotiate protected sex. This can be a very difficult task because 'sex' is a taboo word in many communities and is usually not discussed. At the broader societal level, attitudes and social norms must be altered to increase men's sense of responsibility for social and health consequences of their sexuality (Bandura 1994: 44). It has been observed by other researchers that changing attitudes and social norms may be almost impossible in societies that are stuck in societal norms like wife inheritance which occurs in some communities in Kenya and also in Zambia (Boahene 1996: 610). It has been observed that interventions that go along with a culture may work better than overhauling a society, a process that would be resisted with a lot of zeal (Ramjee 2000: 280). As pointed out earlier, AIDS prevention programmes if they are to be successful must address the socio-cultural realities that impose constraints on the exercise of self-protective measures (Bandura 1994: 44).

Social influences rooted in indigenous sources generally have greater impact and sustaining power than those applied by outsiders. Campbell recommends that communities should be mobilized to take ownership of a problem such as HIV and look for ways of enhancing, improving sexual health within that community (2003:3). Community-based approaches are more relevant and the use of already existing networks is advocated. Kelly is of the opinion that HIV interventions should not be imposed onto a community but the community should come up with its own home grown solutions that are acceptable and in line with their own culture (1999: 300).

Most behaviour change interventions that have been developed are based on cognitive-behavioural theories, which emphasise the individual as a rational actor in altering behaviour, but recent theoretical contributions emphasise the importance of group norms and collective change and anticipation (Harrison, Smit & Myer 2000: 285; Campbell 2003: 8; Morris 2003: 226).

The Social Cognitive Theory advances the skill enhancement approach to HIV/AIDS, which focuses on individual based strategies of behaviour change that are only acceptable in the western cultures. The social cognitive theory does not rhyme with

non-western cultures whose values and social norms are different (Kalichman & Hospers 1997: S197).

Although the Social Cognitive Theory has been used for sometime, it is becoming clear that the potential for this model for explaining behaviours as complex as sexual behaviour and for directing interventions in real-world settings among people in highly marginalised communities, is limited (Campbell 2003: 8).

### **3. 6 CULTURAL FRAMEWORKS**

Practitioners and researchers in the field have recommended making use of the cultural framework where African, Asian, Latin American and the Caribbean communities are concerned. The cultural framework is used for developing culturally sensitive interventions. During the onset of the HIV/AIDS discovery and the spread of the disease, the behavioural methodologies borrowed heavily from psychology models, which had been designed to prevent other problems. The adoption of western models based on individuals was used yet many communities are more collectivistic and are so even when solving or combating a challenge or a problem in the community (UNAIDS 1999c: 12; McKee, Bertrand, Becker-Benton 2004: 41).

#### **3. 6. 1 The paradigm shift**

This paradigm shift from behavioural theories to cultural models was necessary because of the following reasons:

- The development of HIV prevention, outreach and education programmes should exist concomitantly with cultural realities and include knowledge about a community's cultural belief system regarding issues such as health care, sexuality and death ( 1997b: 260).
- Behavioural variables often fail to provide insight into the influence of pervasive cultural, economic gender-specific, and relational factors that mediate risky sexual relations. When studying women it is important to understand their risk and HIV risk reduction in a gender-specific manner.

Understanding the social influences that shape sexual relationships for example, among the Samburu women, is critical in developing and implementing tailored and more effective programmes (Umeh 1997: 121).

- The social and gender-related constraints are rarely addressed in social psychological theories that guide the design and delivery of many risk-reduction interventions (Umeh 1997: 124). They assume that all individuals make decisions of their own free will, but whether or not a woman is protected from HIV is determined by her male partner and that each individual makes their own preventive health decisions rationally (Singhal & Rogers 2003: 212).
- Psychological models like the Health Belief Model, Theory of Reasoned Action and Social Cognitive Action have been used but they fail to consider the social contextual issues of gender, class and ethnicity (Michal-Johnson & Bowen 1992: 159; Wingood & DiClemente 1997: 124; Mckee et al 2004: 41).
- Reliance on models whose assumption is based on individualistic, rational choices determining behaviour. They assume for example that all individuals are capable of controlling their context. Studies have indicated that many women do not have such rights over themselves (Wingood & DiClemente 1997: 124).
- These models fail to acknowledge socio-economic factors as influencing safer sex practices particularly for women. The issue of economic factors must be given greater consideration (Wingood & DiClemente 1997: 125; Irwin et al 2003: 21). It has been observed that women continue to suffer because they receive low education therefore making them dependent on their male partners and also the fact that they receive poor health attention.
- The other limitation of these models is the failure to acknowledge gender as an independent variable influencing safer sex practices. Wingood &

DiClemente say that 'gender blind models' assume identical sex roles of men and women (1997: 125). Behaviour change researchers assume that all persons are on 'a level playing field' but women and those of lower socio-economic status are vulnerable to HIV/AIDS due to violence, rape and other evils meted to women (Singhal & Rogers 2003: 212; Amaro 1995: 440).

- Individualistic behaviour change models recommend training the women in negotiation skills yet if a woman is in a violent context, the chances of negotiating the use of a condom are nil. There is a need to study a segment of a community and find out when, how and in what circumstances can a woman talk about safer sex or rather which channels can be used. From an individualistic point of view the idea is to go head on and tell the partner to use a condom or else! But that may not be the culturally acceptable way of doing it (Wingood & DiClemente 1997: 125).
- Effective HIV prevention efforts will need to change gender-based relational norms to support women's role in practising safer sex. It is important to recognise the fact that gender roles, cultural values, and partner attitudes are highly influential in affecting the behaviour of women. The nature of heterosexual relationships in which sexual dynamics within a particular community work can help in designing more targeted interventions (Wingood & DiClemente 1997: 126,131).
- There is a need to apply gender-specific theories to construct HIV prevention strategies and health education that address the structure of gender relations and these interventions should address the larger contextual issues that characterise the daily hardships and gender specific risks of the women such as the family dynamics, decision making and economic factors (Wingood & DiClemente 1997: 126; Amaro 1995: 440).



- It is important to note that many rural communities often retain traditional values, beliefs and even modes of communication. This may be because few have formal education and geographical distance and limited resources may result in increased reliance on other community members (McDaniel, Isenberg, Morris & Swift 1997: 170). New ideas in a closed community may be hard to penetrate because they are like a closed circuit. Airhihembuwa points out that many African communities are oral communities. The spoken word is more powerful than the written word. The power of the spoken word has always been recognised by Africans as the hallmark of the varied interpretations and the value of storytelling and interpretations may also be sometimes encoded in songs of a story (1995: 14).
- The bearer of the message is as important as the message itself. Airhihembuwa explains that the language of a community embodies people's culture and that patterns of knowledge production and acquisition in this case oral tradition must be seriously considered in health communication interventions in cultures where orature is the primary basis of communication (1995: 19). Panford, Nyaney, Amoah and Aidoo affirm that in regions where the majority of the people are illiterate or of low literacy levels, modern communication strategies do not work. They recommend the use of folk media (2001: 1560). Walter Ong in Panford et al (2001: 1560) also points out that working with orally based cultures requires a conscious effort "to address the cognitive mindset of audiences who are primarily listeners rather than readers and speakers". Ideas like the use of condoms may not be received automatically because they have to be assessed in the cultural eyes of the users. Studies in various communities have come up with reasons as to why the condom is not acceptable; that sexual relations are viewed as relating not only at the physical level but also at the emotional level as well as the spiritual level. It has also been observed that overhauling even one aspect of a community is not as easy as behavioural theorists would want us to believe. This shows that communities have responded to HIV/AIDS in significantly different ways and therefore prevention interventions must be

sensitive to these differences. A case in point is a study that was done among the Luo of Kenya on AIDS and it was found out that people responded to the AIDS pandemic in their own ways and attempts to have them use condoms were not successful (Singhal & Rogers 2003: 220). Condom use in this community has had to be popularised to make it more attractive and acceptable as a preventive method and it is only young men who have complied to its use (Blair, Ojaka, & Gogi 1997: 56).

This then means that HIV/AIDS interventions and education should be delivered in a manner that respects cultural differences inherent in rural settings; that cultural beliefs of a community influence health attitudes, practices, and responses to the health delivery system (McDaniel 1997: 173-174). More observations from fieldwork in Nyanza in Kenya indicate that in order to improve the effectiveness of HIV prevention programmes it is imperative that better targeted messages, ones that address the fears and beliefs of the population be developed and that reliance on standardised generic messages must be discontinued. These messages should emphasise risk, responsibility and control factors and these messages must be conveyed by credible sources (Blair et al 1997: 56).

- Airhihembuwa and other researchers point out that many health projects in Africa operate on the assumption that information can reach the population through the media (1995: 19). But it has been noted that the media may bring about awareness but not behaviour change. It has also been noted that once a programme prepares billboards, uses radio or television to convey messages that its mission has been accomplished. A case in point is when one enters Maralal town, which is the main town in Samburu district; there is a very big billboard that talks about HIV/AIDS. The message is very clear but who is it meant for? Maybe the school going children and those who are literate, but the Samburu district has been documented as one of the areas with very low literacy levels. It has become quite clear that knowledge about a disease is not synonymous with behaviour change and therefore the media is not enough as a tool for behaviour change.

- It has also been assumed that health information can change negative health practices if the population has the requisite knowledge, therefore health acquisition of the relevant health information. Again it is very clear that this is not the case (Harrison et al 2000: 285). Cultures continue to wrestle with practices such as wife-inheritance, risky practices such as polygamy, multiple partners, circumcision and this is because these practices are intrinsically entwined in the very existence of that community. These practices are said to hold the thread between the forefathers and the present generation therefore removing the thread is tantamount to cutting the umbilical cord of the baby when the baby is still in its mother's womb! This would therefore symbolise the death of the community and that is why there is great resistance in some communities regarding such risky behaviour because it threatens the very existence of that community. Some of these rituals have been able to give certain communities a sense of identity to the extent that if one does not perform that ritual then one is not truly a member of that community.
- To come up with relevant interventions it now becomes very clear that one needs to study and understand the community so as to come up with relevant communication strategies. It is more effective to adapt health programmes and cultural contexts than the reverse. Health promotion programmes that are culturally appropriate seem to be more effective (Airhihembuwa 1995: 26). It is quite clear that beliefs and actions and practices should be examined within the context of culture, history and politics of a given community. It has been noted in studies done on black Americans that whatever strategies and models have been designed for them have not been acceptable because of the credibility aspect and suspicion as a result of their past history and the politics of the day. The same applies to the American Indians as observed by Windal that, messages are usually regarded with a lot of suspicion because of their past history (1997: 16). Kreuter and McClure are of the opinion that people normally identify with sources that are trustworthy, credible, and similar to them in terms of age, race, sex, ethnicity, socio-economic status, employment, educational level, marital status, family structure, and place of residence or other demographic type of variables (2004: 443).

Illich in Airhihenbuwa (1995: 27) cautions that it is necessary to develop cultural sensitive frameworks in the planning, implementation and evaluation of health promotion and behaviour change programmes. This leads us to delve deeper into the subject of cultural sensitivity by defining it.

### **3. 6. 2 Cultural sensitivity**

Resnicow et al define cultural sensitivity as “the extent to which ethnic/cultural characteristics, experiences, norms, behavioural patterns and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs” (1999: 11). There is a need for culturally sensitive health programs because of the diverse and changing demographics of communities, the need to incorporate ethnic specific determinants of behaviour of targeted health promotion programs (Resnicow, Baranwski, Ahluwalia & Braithwaite 1999: 10). The Institute of Medicine acknowledges the fact that communication strategies and decision making are influenced by cultural patterns and factors of a given audience segment which include: the messages that are sent and how they are received based on personal needs and interests, social, cultural and philosophical values; the environment in which communication occurs, the medium that is used to communicate; past experiences as related to the message content ,knowledge level of the subject or basic beliefs or comprehension and how messages are understood (2002: 242)

Resnicow, Braithwaite, Dilorio and Glanz consider cultural sensitivity at two levels: surface structure and the deep structure. Surface structure involves matching intervention materials and messages to observable and social and behavioural characteristics of a target group, it also increases the receptivity, comprehension or acceptance of messages and also undertakes a feasibility study (2002: 494). For audio-visual materials, surface structure may involve using people, places, language, music, food, product brands, locations and clothing similar to and preferred by, the target audience. Surface structure also includes identifying what channels (e.g.

media) and settings (e.g. churches, schools) are most appropriate for delivery of messages and programmes (Resnicow et al 1999: 11; Institute of Medicine 2002: 242).

Surface structure therefore refers to the extent to which interventions meet the target population where they are at, how well they fit within their culture and experience. It is also achieved through expert and community review as well as with involvement of the target population in the intervention development process (Resnicow et al 1999: 12).

The deep structure dimension is not as easily achievable as the surface structure. Deep structure reflects how cultural, social, psychological, environmental, governmental and historical factors influence health behaviours (Resnicow et al 1999: 12). It also tries to understand how members of the target group perceive the cause, course and treatment of illness as well as how they perceive the determinants of a specific health behaviour (Resnicow et al 2002: 494; Institute of Medicine 2002: 242). Surface structure is a prerequisite for feasibility whereas the deep structure establishes the efficacy or impact of a programme (Resnicow et al 1999: 12).

Bayer also looks at cultural sensitivity in three different ways; the semantic, instrumental and the principled aspects. The *semantic* aspect underscores the importance of conveying AIDS preventive messages in a form that makes the content understandable, which uses the linguistic and stylistic characteristic through which the message is addressed (Bayer 1994: 896). Failure to understand the complex ways in which language and culture filter prevention messages is a recipe for failure in HIV/AIDS prevention. The HIV messages should be packaged in a way that is appropriate for diverse target audiences (Bayer 1994: 896; Airhihenbuwa 1999: 267-8). Soola acknowledges the fact that the language component is important and that one need not describe HIV in the scientific jargon otherwise the message will not be received (1991: 37).

The second conception of cultural sensitivity is the *instrumental aspect*. This concept underscores the importance of understanding the cultural context of sexual

and procreative behaviour in order to facilitate the transformation of those behavioural norms that foster the transmission of HIV infection (Bayer 1994: 896). It is important to recognise the fact that emotions are involved in the sexual act and that although the human being is a rational being this is one instance in which rationality is far removed. Bolton in Singhal and Rogers (2003: 213) concurs with this issue by saying that:

Past communication approaches have been mostly anti-sex, anti-pleasure, and fear inducing. While 'sexuality' involves pleasure, as play, as adventure, fun, as fantasy, as giving, as sharing, as spirituality and as a ritual (Bolton, 1995). Behaviour change theorists in their models and frameworks have failed to see how the social construction of 'love'-which requires risk-taking, trusting, and giving - contributes to unsafe sex (213).

The third concept of cultural sensitivity is the *principled aspect* –it prohibits the use of those interventions that violate the cultural norms of those to whom they are directed. This concept emphasises respect for cultural integrity for those to whom public health is directed. This is observed in interventions that are not designed with the members of the communities being involved but by an intervention being designed for them. Other factors could be the use of well-meaning messages that could cause harm to the recipients or the use of sophisticated social marketing techniques that may be engaged in unethical manipulation (Guttman1997: 156). There are also concerns regarding the use of persuasive and social, manipulative approaches that may infringe on individuals rights for autonomy or self-determination. Another important point is the observation that the campaigns have tended to promote predetermined behavioural changes through specially-designed persuasive appeals. This raises concerns regarding paternalism or the notion that certain experts or professionals know what is best for particular members of society or the public as a whole (Guttman1997: 158). There has been for example, the danger of the donor partners controlling all the interventions such that they lack ownership because they are not relevant to those they are meant for. Harlon Dalton in Bayer (1994: 895) refers this to neo-colonialism for those who act without regard to cultural sensitivity who impose their own solutions on others without consulting them and taking into consideration their circumstances, needs and desires. The new

direction is consultations taking place from the government to the regions and finally at the community level.

### **3. 6. 3 Cultural appropriateness and health programmes**

Kreuter and McClure identify four approaches that are said to achieve cultural appropriateness in health promotion and health communication programmes which are referred to as “peripheral, evidential, linguistic and socio-cultural” approaches (2004: 445). Peripheral approaches enhance the effectiveness of health communication in ways that make the target audience comfortable and familiar with health messages that visually reflect the social and cultural world of the target audience through colour, images, fonts or pictures (Keuter & McClure 2004: 445).

Evidential approaches show the impact of a health condition of a specific audience by presenting the epidemiological information or specific data as a form of evidence (Keuter & McClure 2004: 446). Linguistic approaches on the other hand make health communication campaigns, programmes, and materials accessible by providing them in the dominant or native language of a given audience segment. This may call for translating the existing information in different languages or creating programme information in different languages (Keuter & McClure 2004: 446). Socio-cultural approaches recommend that health messages should be presented and find meaning within the social or cultural milieu of the intended audience. This is done by recognising, reinforcing and building upon the target group’s values, beliefs and behaviours (Keuter & McClure 2004: 446).

Michal-Johnson and Bowen view HIV/AIDS prevention and education as a cultural communication process. They also observe that preventive efforts that seem to be effective take cognisance of cultural experiences of those most affected by AIDS and have the chance to offer acceptable messages and messengers to communities of colour (1992: 147). It has also increasingly become apparent that health communicators should carefully assess how cultural beliefs influence individual behaviour and how cultural norms define gender roles, language use, and ways in which intimate partners talk and interact socially and interpersonally (Yep 1997: 220; Singhal & Rogers 2003: 205).

Machlica in addition points out that the epidemiological approaches to prevention have inappropriately focused on the individual (1997b: 249). The focus is usually on the individual as “the locus of a disease and by default, of the intervention” (Singhal & Rogers 2003: 208). HIV/AIDS’s social situation in which the infection occurs is very important. The context of HIV/AIDS demands attention (Singhal and Rogers 2003: 208; Institute of Medicine 2002: 252). Most AIDS interventions are based on epidemiological models that involve either gathering or disseminating information but cannot account for the effects of that information. AIDS programme planners have no method of evaluating the effects of their programmes on the spread of HIV (Philipson et al 1994 in Machlica1997: 249). Preventive approaches that are not culturally sensitive and culturally appropriate will be ineffective “because they will not reach their intended audience, will not be understood by those who are reached and will not be accepted by those who understand” (Bayer 1994: 895).

Pelto and Pelto are concerned that health system policy makers and practitioners appear to have ignored the significance of understanding the cultural beliefs and knowledge systems of the communities they serve (1997: 148).

For HIV/AIDS prevention and education programmes to be successful, they must demonstrate an understanding of the various levels of risk and the human behaviour as well as an awareness of the unique cultural factors of the region where the behaviour change is to be conducted (Machlica1997b: 250; Livingstone1992: 767 ). Machlica singles out two salient aspects of culture that must be considered when designing HIV programmes; the conceptualization held by the target group of the variables that are being studied such as sexual behaviour and the belief system of the target group regarding issues such as disease, sickness, death and how they relate to AIDS (1997b: 250).

Bayer concludes that a failure to consider the history, opinions and the norms of any given community before prescribing solutions to them is interpreted as lack of cultural respect and an imposition “of the values of the dominant and powerful on the subordinate and marginal” (Bayer 1994: 895). Quaidoo cautions that although



African scholars should adapt and replicate research formats learned elsewhere, they should always put into consideration the cultural context in which they operate (1987: 52). Airhihenbuwa also points out that cultural factors have been ignored in the spread and control of HIV, yet cultural variables are salient in understanding the AIDS epidemic and culture to some extent explains why the disease is rampant in some countries and not so serious in others. Culture is seen as either an impediment or a catalyst in the control of HIV/AIDS (1995: 26). If culture is recognised as a contributing factor in public health and in health communication it has a potential of developing new and effective strategies to fight HIV/AIDS (Kreuter & McClure 2004: 450).

### **3. 6. 4            The Pen-3 Model**

This model has been developed by Collins Arhihenbuwa who is a strong proponent of the cultural approach as opposed to the behavioural approaches that have been in use for some time. He suggests that the pen-3 model is suitable for health education in developing countries and that it addresses cultural sensitivity in programme development. The Pen-three model has three dimensions of health belief and behaviour that are dynamically interrelated and interdependent. These three dimensions are health education, educational diagnosis of health behaviour and cultural appropriateness of health behaviour. This model is illustrated in categories according to an acronym for each of the three dimensions (Airhihenbuwa1989: 60; Airhihenbuwa 1995: 28; Airhihenbuwa 2000: 12) discussed below:

The first dimension of Pen-3 model is *health education*

**P**—Person. Health Education is committed to the health of every person.

**E**—Extended Family. Health Education is concerned with both the nuclear and the extended family.

**N**—Neighbourhood. Health education is committed to promoting health and preventing disease in neighbourhoods and communities.

The second dimension of the PEN-3 model is *educational diagnosis of health behaviour* which has been cited from 'the PRECEDE Model' designed by Green, Kreuter, Deeds, & Partridge (1980) which is used to identify which behaviour is most important and most changeable by examining the following factors:

**P**—Predisposing. Knowledge, attitudes, values and perceptions that may facilitate or hinder personal motivation to change.

**E**—Enabling. Societal systematic or structural influences or forces that may enhance or inhibit change, such as availability of resources, accessibility, referrals and skills.

**N**—Nurturing. Reinforcing factors that persons receive from significant others. These are attitudes and behaviour of health and other personnel, peers, feedback from extended family, kinship employers, and government officials.

The third and most critical dimension is the *cultural appropriateness of health behaviour*. This dimension is important for developing culturally sensitive health education programmes for developing countries.

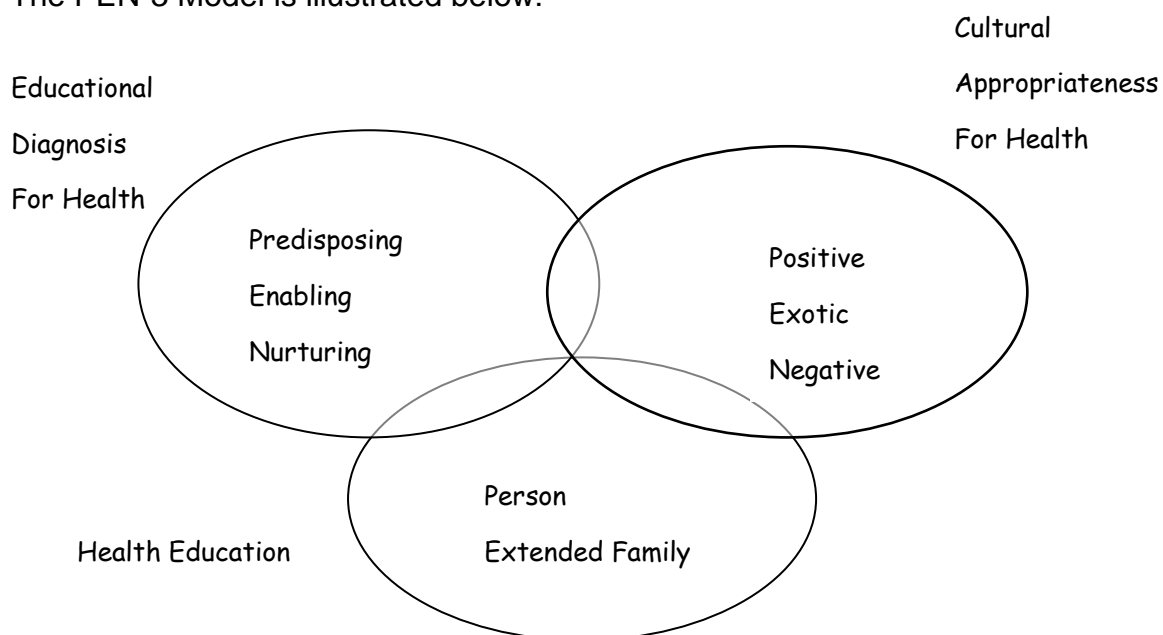
The third dimension has the following aspects:

**P**—Positive behaviour. Behaviours that are known to be beneficial and should be encouraged.

**E**—Exotic behaviour. Unfamiliar behaviours that have no harmful health consequences and therefore need not be changed (Airhihenbuwa 1989: 61).

**N**—Negative behaviour, Behaviours that are harmful to health and which health providers should attempt to help people change.

The PEN-3 Model is illustrated below:



**Figure 3.3: The PEN-3 Model (Airhihenbuwa 1989: 61).**

The PEN- 3 model highlights the following aspects:

- Health educators should focus on both positive and negative behaviours in health programmes. Very often too much attention is paid to the negative behaviours with no regard to the positive behaviours, which should be seen as the starting point to changing behaviour (Airhihenbuwa1989: 62). Singhal and Rogers observe that culture should be seen as an ally and should not be singled out as the explanation for the failure of a health intervention. Culture can also be viewed in terms of its strengths, and attributes that are helpful in HIV/AIDS prevention, care, and support should be identified and harnessed (2003: 217).
- The model advocates for the involvement of communities, women's and men's organisations in health education programmes. These health programmes should begin with (1) assessing individual and community needs for health education; (2) planning effective health education programmes; (3) implementing health education programmes; and (4) evaluating the effectiveness of programmes, ensuring that each phase is completed with community involvement (Airhihenbuwa1989: 64).
- The model also recognises that there is cultural diversity among the peoples of the world and what its impact is on the replicability of programmes. What may be relevant to one community may be repugnant and unsuitable to another community. Community participation is one strategy that acknowledges the impact of culture on a health system. This is realised when individuals, families, and communities for whom a programme is intended, have the opportunity to be part of the team that states the problem and designs the response. This ensures that sensitivity to traditional customs and social norms is ensured by the community members and that the programme is culturally appropriate and that community members should own the programme and be involved as partners (Airhihenbuwa 1989: 64; Singhal & Rogers 2003: 229).

The Pen-3 model concentrates more on culture and does not encompass all the other factors such as the socio-economic status, the gender relations that are very

significant in the HIV/AIDS interventions and is seen as a transition from the behavioural models to the cultural models.

### **3.7 SUMMARY**

Most HIV/AIDS communication strategies in the past have been based on behaviour change theories yet HIV continues to spread relentlessly in some regions such as the sub-Saharan Africa (Ford et al 2003: 600). During the first decade of the HIV/AIDS epidemic, behavioural researchers identified many important factors associated with the individual's ability to use or request condoms. Individual factors regarding HIV prevention that were identified were peer norms regarding safer sex, one's attitude regarding safer sex, and one's perception of vulnerability. Gomez and Movin say although these individual factors are necessary and important components of effective sexual behaviour change, they ignore the cultural and contextual realities of sexual interactions (1996: 355). Markova and Power are of the opinion that information and knowledge are never constructed by consumers as neutral; rather information about the disease is always conceived in the context of some relationship to the self and society (1992: 127). They also add that health communication concerning HIV/AIDS will go deeper and not only address and respond to the audience's perceptions, knowledge, and attitudes, but also the underlying socio-cultural assumptions and social representations on which such perceptions, knowledge and attitudes are based (Markova & Power 1992: 128). Cochran and Mays observe that some scientists are of the opinion that the current models should be discarded because they are incongruent with African world views that stand for unity, co-operation, communality as opposed to western values of individualism, competition and independence (1993: 150).

Kalichman and Hospers also posit that theories of behaviour change have shortcomings by their lack of specificity to sexual relationships, sexuality, and sexual contexts within which HIV transmission risks occur (1997: S197). It is therefore imperative that theories and models that have been used in the past should be re-examined in relation to how adequate and relevant they are regionally as well as contextually (Airhihembuwa et al 1998: 326; Arihihembuwa & Obregon 2000: 6).

It can be argued, however, that behaviour based theories should not be discarded completely because they contain elements that can be applied to cultural models such as the use of opinion leaders, networking, the role of peers and many other elements that may be relevant in the fight against HIV/AIDS.

This chapter recognises the fact that there is a paradigm shift in the way HIV/AIDS interventions are designed and implemented. Factors such as gender relations, socio-economic status, political will, religion and culture determine the success or failure of HIV/AIDS interventions. These are the very factors that most of the behaviour change theories and models ignored or treated as peripheral aspects (Amaro 1995: 439).

This study advocates culturally-based models that have relevant components in the study of the Samburu women such as the PEN-3 Model and the UNAIDS Framework of Communication. The PEN-3 Model advocates cultural sensitivity and community participation and the UNAIDS Framework of Communication advocates interventions that are based on the context within which HIV/AIDS occurs and spreads, interpersonal communication, the role of gender, the use of oral communication and language elasticity. The UNAIDS Framework, as the conceptual framework of this study, is set out in the next chapter.

## **CHAPTER 4**

### **THE CONCEPTUAL FRAMEWORK**

#### **4.1 INTRODUCTION**

It has been argued in several quarters that the biomedical theories and models discussed in chapter 3, though useful and relevant in Europe and America, have had little or no significant relevance to other communities in Africa, Asia, Latin America and the Caribbean as well as the African-American communities (Airhihenbuwa, Makinwa, & Obregon 1998: 327; UNAIDS 1999c: 11; Airhihenbuwa & Obregon 2000: 6). After a decade of battling with the HIV pandemic there are serious questions being raised regarding some of the most commonly used theories/models that guide communication strategies to prevent HIV/AIDS particularly in Africa, Asia, Latin America and the Caribbean (Airhihenbuwa & Obregon 2000: 6).

The risk of HIV is not equally distributed throughout the population, and behavioural research topics and HIV behaviour change messages that are pertinent and necessary for one population segment may be of little value to another population (Kelly & Kalichman 1995: 907). A critical component in the UNAIDS framework of communication is the recognition of culture as central to planning, implementation, and evaluation of health communication and health promotion programmes (Airhihenbuwa & Obregon 2000: 6; Michal-Johnson & Bowen 1992: 167; Airhihenbuwa 1995: 11). The UNAIDS framework of communication asserts that individual responses to HIV are strongly determined by societal norms such as one's gender, socio-economic status, by one's spiritual values and the prevailing government and policy environment related to HIV/AIDS (UNAIDS 2001: 8). The UNAIDS framework of communication also has a broader focus and recognises that there is an inter-regional variation in the context of HIV/AIDS. This study will adapt the UNAIDS framework of communication as its conceptual framework because one of the leading causes of the spread of HIV in Kenya is hinged on cultural practices that make people, particularly women, vulnerable to HIV/AIDS. The Kenya HIV

prevention response and modes of transmission analysis report singles out two factors that are culturally based that are accountable for the spread of HIV in Kenya. These are male circumcision and societal acceptance of concurrent/ multiple partners (National AIDS Control Council 2009: v; Halperin & Epstein 2004: 5).

## **4.2 THE UNAIDS FRAMEWORK OF COMMUNICATION**

The UNAIDS framework of communication was developed as a result of regional and global consultations in Africa, Asia, Latin America, and the Caribbean. It is based on the premise that communication is a planned intervention that combines both media and interpersonal communication to effect changes in the fight against HIV/AIDS with due regard to the environment or context within which communities live. Relevant theories and models that focus on context, which include culture, socio-economics status of women, government law and policy and spirituality, are recommended (Airhihenbuwa, Makinwa & Obregon 1998: 327). Michal-Johnson and Bowen caution that overlooking communication dynamics for a particular group may yield erroneous findings and compromise the academic integrity of the research that may lead to short-sighted findings (1992: 167).

### **4.2.1 The role of culture in the UNAIDS framework of communication**

The UNAIDS framework points out that conscious attention should be paid to cultural aspects instead of ignoring culture as peripheral or assuming that culture is irrelevant. It advocates for a sharper focus on culture as well as a 'meta-theoretical shift' from the simple pursuit of variables to a more encompassing process of research. It may be more fruitful to look at a whole cultural aspect and identify what has made it the way it is or just look at it holistically (Michal-Johnson & Bowen 1992: 167). Buseh, Glass and McElmurry, in a study conducted in Swaziland, also point out that knowledge of traditional and cultural factors should be considered when designing African health promotion programmes because entrenched cultural traditions are major factors in advancing the spread of HIV in rural Africa (2002: 174). Cultural beliefs of a community influence health attitudes, practices, and responses to health delivery (Foster, Philips, Belgrave, Randolph & Braithwaite 1993: 124). Buseh et al observe that the only limitation with this approach is that it is difficult to design appropriate prevention programmes for different sub-populations

because of limited studies on cultural and gender-related issues (2002: 174). Livingston states that the success of any health promotion campaign in Africa relates to how much consideration is given to specific and unique cultural and other factors of the region when the campaign is designed (1992: 767). Culturally competent approaches which include the “willingness and ability to draw on community- based values, traditions, and customs and to listen, learn, and work with members and stakeholders to develop focused interventions and services” are recommended (Scott, Gillian and Braxton 2005: 19).

Many preventive programmes have been “unelaborated admonitions to refrain from sex except in monogamous relationships and the use of condoms under other circumstances” (Kalichman & Kelly 1995: 907). These admonitions could reduce the level of new HIV infections but they not are easily achieved. People, especially women, do have challenges because of other factors such as the “psychological, relationship, culturally affective, arousal and situational influences that surround and form the context for human sexual behaviours” (Kalichman & Kelly 1995: 907). This therefore indicates that the complexities of sexual behaviour must be explored, understood and changed if HIV infections are to be reduced.

This study adapts the UNAIDS framework of communication since its pivotal aspect is based on culture as pivotal in the design of strategies in the prevention and promotion of HIV/AIDS interventions. The UNAIDS framework clearly spells out that target audiences should clearly be identified in the framework, so their specific needs may be addressed appropriately (UNAIDS 1999c: 83). The framework assumes a House-to-Home metaphor where the structure of the house varies from region to region and from community to community. Communities are unique in terms of the different challenges that they face. According to this metaphor every house has a foundation, roof, and the body designed to respond to the conditions in the environment or context. This is illustrated by the Figure 4.1 below;



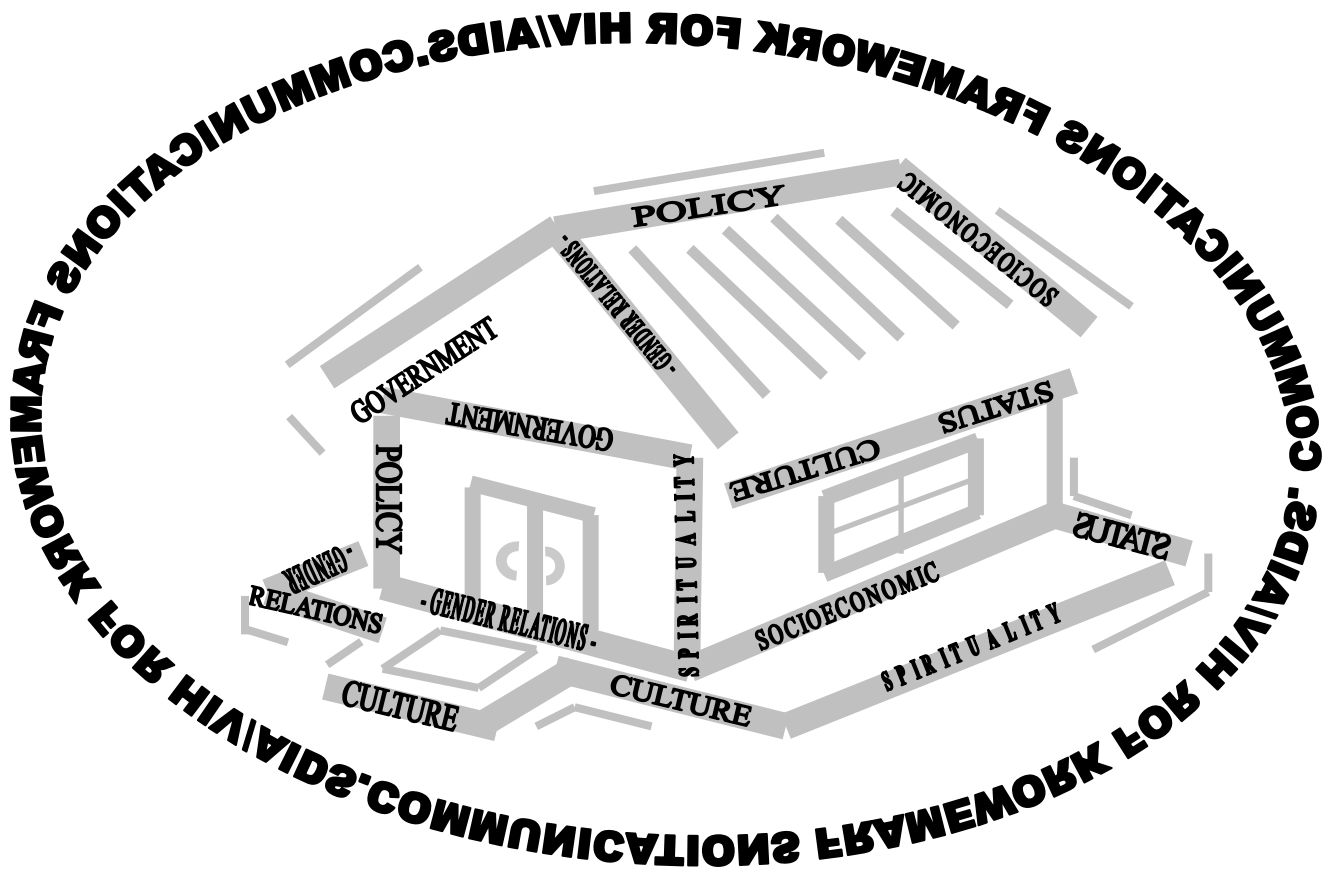


Figure 4.1: House-to-Home Metaphor (UNAIDS 1999c: 86)

The framework as shown in **Figure 4.1** identifies five domains that are considered in the study of any community. These domains are (1) the role of the government in terms of policy and law (2) Cultural factors whether positive, unique or negative that may promote or hinder prevention and care practices. (3) Spiritual factors that may hinder or promote the translation of prevention messages into positive health actions (4) Gender relations that define the status of women in relation to men in society and the community and the influence on sexual negotiation and decision making. (5) Socio- economic status, collective and individual income that may allow or prevent adequate intervention (UNAIDS 1999c: 29-30). These domains are interrelated

although each has a different impact on preventive health behaviours (UNAIDS 1999c: 30). The framework focuses on the context, although the individual as such is not rejected but is viewed rather as a product of the context. For interventions to be meaningful, therefore, they should consider several of these domains. The framework could also draw important and relevant elements from other theories and models (UNAIDS 1999c: 30). The domains mentioned above are discussed below.

#### **4. 2. 1. 1      *Government policy and laws***

Government policy and the laws of a nation play a critical role in programmes aimed at the controlling of HIV/AIDS (Kippax & Race 2003: 8). Governments can either promote or hinder efforts to reach the goals of HIV/AIDS prevention, care and support. Some countries like Senegal have successfully curbed the spread of HIV/AIDS because they acknowledged the existence of HIV among its people from the time the disease first broke out (Diop 2000: 113). Another country that has also been successful in the control of HIV is Uganda. The HIV mortality levels had risen so fast that the country had to do something as a matter of urgency (Diop 2000: 116). There have been cases where government interventions have been prepared according to the rules of the funding organisations and thereby ignoring the social and political fabric of the said community, and finally rendering the interventions irrelevant to those they have been designed for (Airhihenbuwa, Makinwa & Obregon 1998: 326; Guttman 1997: 96).

In Kenya the AIDS pandemic was fuelled by several factors. Lack of political will to develop interventions to stop the spread AIDS was a major social problem in the 80s and 90s; considerable opposition to supplying information to Kenyan adolescents by policy makers in the fear that if information on sexuality and condom use would encourage premarital sexual activity; religious groups also totally ignored AIDS or accused those with AIDS of immoral and deviant behaviour (Black, 1997 in Agha 2003: 750; AIDS Analysis Africa 1997: 2); the Kenyan Parliament shelved discussions to introduce sex education to schools after demonstrations against sex education by anti-abortion groups and the Catholic Church in Nairobi (Kigotho, 1997: 1152).

Agha notes that in the last few years there has been an increase in the political commitment to fight the HIV epidemic. Towards the end of 1999, the Kenyan government declared that HIV/AIDS was a national disaster and established the National AIDS Control Council to co-ordinate the fight against HIV/AIDS (2003: 751). The government policy zeros on the ethical, legal, and financial considerations that must be taken into account when discussing and planning communication interventions.

This domain cautions that successful and sustainable health policies are increasingly determined by the capacities of societies, communities and individuals as they face the realities of their problems. All sectors of society should draw on but not be controlled by external and international expertise and resources (UNAIDS1999: 31). The role of the government according to the UNAIDS framework should be as follows:

- Setting the media agenda so that the media can report without too much censoring in gathering and analysing information.
- Issues of tourism, migration, violence, the rape of women may require the intervention by the government.
- The sharing of information at a regional level in terms of lessons that have been learnt in other countries and facilitating cross-border interventions.
- The government policy can play a vital role in creating an environment that supports positive behaviour change.
- The political will to support HIV/AIDS interventions is important because it makes a difference in the country's response. A case in point is Uganda's Yoweri Museveni who is a leading advocate of HIV prevention. Senegal, Brazil, Thailand are also leading lights in the fight against HIV/AIDS. Political will therefore means that the government is willing to provide funds for prevention interventions.
- A politically friendly environment that acknowledges public opinion should be encouraged so that the public can communicate their perceptions and opinions on the policy-making process.

- The need to focus on risky environments that increase the vulnerability to HIV/AIDS of refugees, displaced persons, commercial sex workers young women and girls should be emphasised (UNAIDS1999: 33-34).

#### **4. 2. 1. 2      *Socio-economic status***

Lower socio-economic status makes a group more susceptible to many ailments including HIV/AIDS. Poverty and illiteracy create a gap in knowledge about HIV. Women of low socio-economic status have been found to be particularly vulnerable to AIDS as a result of their gender and lower class status (UNAIDS 1999c: 35; UNAIDS 2004: 68). The socio-economic context is a crucial domain in the success of HIV/AIDS communication interventions and other key issues that need to be considered are: affordability of medicines, condoms, drug therapies, sustainability of behavioural outcomes; the impact of poverty on individuals, and communities, and safer health practices; allocation and distribution resources to be directed to the pandemic in the light of existing social and development problems (UNAIDS 1999c: 36).

#### **4. 2. 1. 3      *Culture***

The UNAIDS framework defines culture as the collective consciousness of a people which is shaped by a sense of shared history, language and psychology (1999c: 36). Culture is also defined as “a pattern of learned, group-related perceptions - including both verbal and non-verbal language, attitudes, values, belief systems, disbelief systems and behaviours - that are accepted and expected by an identity group” (Singer 1998: 52). Hodge, Struckmann, & Trost 1975 in Lum (2003: 5) define culture as “the sum total of life patterns passed on from generation to generation within a group of people and includes institutions, language, religious ideals, habits of thinking, artistic expressions and patterns of social and interpersonal relationships”.

Beliefs or knowledge of illness and traditional health practice should become the substance of local or culturally appropriate messages and interventions (UNAIDS

1999c: 37). There is also a need to acknowledge the fact that traditional oral communication continues to be strong and contemporary and plays a key role in health communication (UNAIDS 1999c: 38; Airhihenbuwa 1995: 41; Airhihenbuwa & Obregon 2000: 12; Panford et al 1996: 1560). Cultural differences should be recognised and the messages designed should be relevant to the context because if messages are not tailored to suit specific cultures, it is uncertain whether the message has been received.

#### **4.2.1.4 Gender relations**

The UNAIDS framework defines gender as:

The opportunities, roles, responsibilities, relationships, and personal identities a particular society prescribes as proper for women and men. These attributes are socially constructed and learned both individually and collectively. Gender roles are influenced by many other determinants such as race, culture, community, time, ethnicity, occupation, age, and level of education (1999c: 40).

Gender roles and relations play a significant part in the course and impact of the HIV/AIDS pandemic. Gender relations are particularly affected by social, cultural and economic factors. The way in which gender roles are defined influences the ways in which men and women are vulnerable to HIV transmission. The UNAIDS framework advocates for gender-based approaches to HIV/AIDS that are sensitive to the following: “risk as well as societal vulnerability, the experience of living with HIV/AIDS, the impact of individuals’ relationships within the family or community, individual HIV/AIDS-related illness or death within a family or community; and response to the epidemic at the individual, community and national levels” (1999: 41).

A gender-based response approach aims at enabling both sexes to protect themselves against HIV/AIDS infection, to get proper healthcare and manage or cope more effectively with the pandemic. This approach also advocates for a more balanced distribution of resources when designing interventions that involve both men and women. Women have been ignored in the past, yet they are very crucial because they are the ones who suffer more as explicated in chapter two of this

thesis and they are also the care givers. Key issues related to gender that need to be addressed when operationalising the UNAIDS framework are listed as follows:

- That gender refers to both men and women;
- The need to understand gender roles and relations of power and negotiation within a community or group being investigated;
- The relevance of who is communicating in relation to what is being communicated;
- Gender issues should be taken into consideration from the onset of a programme through to implementation and evaluation of the same;
- Closing the gender gap in education, illiteracy rates, school attendance and adult education especially where rural women are concerned (1999: 44).

It is important to note that “gender roles as well as cultural values and norms at least influence, and sometimes define the behaviour of men and women and the interpersonal relationships in which sexual behaviour takes place” (Amaro 1995: 440).

#### **4.2.1.5 Spirituality**

The role of spirituality in African communities is very significant in the fight against HIV/AIDS. According to Relv in UNAIDS (1999c: 450).

Spirituality encompasses hope; faith; self transcendence; a will or desire to live; the identification of meaning, purpose and fulfilment in life; the recognition of mortality; a relationship with a ‘higher power’, higher being or ‘ultimate’; and the maintenance of interpersonal and intra-personal relationships”. Spirituality is grounded in the belief that there is a supernatural being or force that regulates the interaction of living beings with their visible and non-visible environment.

There is a link between the well-being of a person and their religious belief. In some communities HIV/AIDS is seen as a punishment for an 'immoral' lifestyle (Agha 2003: 750). In other communities AIDS is seen as a result of the sins of the forefathers. The position of the church has also been significant. When AIDS debates have been featured in the past, the church in Kenya has fought against the use of condoms to fight against HIV as well as the introduction of sex education in the Kenyan curriculum. The assumption has been that if you teach people about condoms, you are also sanctioning their use (Agha 2003: 750).

Although some religious leaders have been in the forefront in the fight against HIV prevention tools such as the condoms, they play a very powerful role as opinion leaders in their respective communities. They can appeal to the moral code of their followers and also provide a supportive environment for people and families of people living with HIV/AIDS. A relevant example is the significant role of Islam in the fight against HIV in Senegal (Diop 2000: 116). Religion-based programmes should focus on forging alliances with communities and the use of interpersonal communication. There are key issues that need to be addressed according to the UNAIDS framework:

- A non-judgemental attitude should be adopted toward all religions and partnerships should be built with religious leaders.
- That a protective spiritual environment should be built for acceptance and support and the promotion of human rights of persons living with HIV/AIDS.
- That accurate information should be used for discussing sexuality while dispelling myths and fears.
- That HIV/AIDS should be given a human face.
- That health-care providers should work hand-in-hand with spiritual leaders so that the spiritual dimension of care and support is provided (UNAIDS 1999c: 47).

### 4.3 EFFECTIVE COMMUNICATION INTERVENTIONS

The communications framework advocates for the identification of target audiences and addressing their specific needs. Targeting each segment of the community with appropriate messages is critical for reaching a population with diverse modes of knowledge production and acquisition. In the case of this study women have been identified as a segment that will be researched on. In addition, it is important to note that cultures vary in their reliance on new knowledge as a motive for behavioural change. The strength of associations between and among knowledge, attitudes, and practices, also differs from one culture to another. Understanding these cultural variations is essential for communication interventions. The traditional assumption that knowledge automatically leads to behaviour change, is no longer acceptable (UNAIDS 1999c: 71-72).

The communications framework advocates interventions that are based on the context in which HIV/AIDS occurs, spreads, and assails communities, countries, and regions. It also recognises the importance of interpersonal communication and the informational power of the mass media, which should be guided by cultural and gender sensitivity in their application. The use of oral communication and language elasticity is advocated. Language elasticity entails using cultural expressions such as adages, allegories or metaphors that are relevant and suitable for each target group. The uniqueness of each target group is recognised and addressed (UNAIDS 1999c: 69-70, 82).

Community-based interventions should be designed and the role of opinion leaders is also advocated. The community should be involved in the planning, design and the whole process of developing interventions otherwise interventions can be rejected on the basis that they are not owned by the community (UNAIDS 1999c: 84). McKee, Bertrand and Becker-Benton summarise the principle of the UNAIDS communication framework thus:

- Sustainability of social change is more likely if the individuals and communities most affected own the process and content of communication.



- Communication for social change should empower, be horizontal (versus top-down), give a voice to the previously unheard members of the community, and be biased towards local content and ownership.
- Communities should be agents of their own change.
- Emphasis should shift from persuasion and the transmission of information from outside technical experts to dialogue, debate, and negotiation on issues that resonate with members of the community.
- Emphasis on outcomes should be beyond individual behaviour to social norms, policies, culture, and the supporting environment (2004: 43).

#### **4.4 SUMMARY**

The UNAIDS framework which has been adapted for this study of Samburu women in Kenya outlines the major domains that need to be considered in developing communication interventions, which are culture, spirituality, gender relations and socio-economic status. Different communities are guided by different values, beliefs and attitudes that are part of their socialisation. Communication interventions that are planned, designed and implemented should be targeted at different subgroups of a given community because each group is unique in its own way and has different communication needs. Communication interventions should be community owned.

## **CHAPTER 5**

### **RESEARCH METHODOLOGY**

#### **5.1 INTRODUCTION**

This chapter consists of a methodological research design which applies to this study. The chapter discusses qualitative research and then goes on to describe the two research designs, namely qualitative field research and qualitative survey research, which have been employed for this study. The two qualitative data collection methods employed in this study, namely the focus group discussion and the in-depth interview as a form of triangulation are then outlined. The chapter goes on to describe how the study was carried out, giving the rationale for the way the target audience was identified, sampled, and how the interviews were conducted in terms of number and location. The chapter also outlines the advantages and limitations of the two data collection methods, the development of the questioning route, an interview guide and the pretesting of the two data collection methods. The chapter concludes with a description of the procedures that were followed during data collection and how data was analysed.

#### **5.2 RESEARCH DESIGN**

This research lent itself to a qualitative study, which was exploratory in nature. This part of the chapter will therefore highlight some of the salient characteristics of the qualitative paradigm relevant to this study. The research sought to study the

perceptions of rural Samburu women in regard to HIV/AIDS with the aim of designing more effective communication strategies for the Samburu women. This necessitated the researcher to take into consideration the context and the setting of the study situation in order to get a deeper understanding of the respondents' life style based on the UNAIDS framework of communication that guides this study (Marshall & Rossman 1995: 39-40). This aspect of qualitative study compelled the researcher to conduct focus group discussions near *manyattas* (Samburu homes) so as to get an understanding of the context of the Samburu women in which they grappled with the issue of HIV/AIDS. This is in line with the interpretivist view that purports that social phenomena should be understood from the actor's point of view and that an issue is dependent on how it is perceived, and it is based on people's ideas, feelings and motives (Fraenkel & Wallen 2000: 205; Babbie 2001: 53; Denzin & Lincoln 2003: 5). The study took into account the term *Verstehen* which refers to "understanding or establishing meaning from the point of view of the participants in a social environment" (Baker 1999: 242). The interpretivist approach sees "people, and their interpretations, perceptions, meanings and understandings, as the primary data source" (Mason 1996: 56). It was essential in this qualitative study to understand the norms, values, and traditions of the Samburu community that made the women more vulnerable to HIV/AIDS infection (Mason 1996: 7). This gave the researcher an understanding of the framework within which Samburu women expressed their thoughts, feelings, and actions with regard to HIV/AIDS (Marshall & Rossman 1995: 44; Rudertam & Newton 2001: 36).

Qualitative methods permit the evaluator to study selected issues in detail and in depth (Patton 1990: 12). The researcher identified the issue of HIV/AIDS and chose to interact with the Samburu women as opposed to studying the whole Samburu community because as mentioned earlier on HIV affects women and men differently and depth and detail were integral aspects in this study.

Cultural systems frame the perception and the making of a subjective and social reality (Denzin & Lincoln 1994a: 22; Flick 1998: 6; Denzin & Lincoln 2003: 13). This in essence means that the Samburu culture to which the Samburu women belong affected the way they perceived and understood HIV/AIDS and that is why they

could not be studied out of context or without considering the cultural rubric. This meant that cultural sensitivity was taken into consideration and the findings or observations given meaning in the social, historical, and context (Patton 1990: 40).

The researcher adopted a qualitative methodological approach because it is highly effective for research in the field of health communication and in AIDS prevention programmes because it allows for the provision of community-based insights into sensitive cultural issues such as sexuality in their relation to HIV/AIDS (Myrick 1998: 72; Morgan & Krueger 1993: 12; Morrison 1998: 164; Morgan 2004: 264).

It is from these open-ended interviews that dimensions and categories emerged that formed patterns about HIV/AIDS (Patton 1990: 44). The viewpoints of the Samburu women regarding HIV/AIDS were part of the data for this study.

Qualitative research has a number of data collection instruments that can be used to generate detailed information. This study used two instruments that are quite common in qualitative research, namely focus group discussions and in-depth interviews. Through focus group discussions with the Samburu women the researcher was able to have direct contact, get close to the women, observe their situation and the phenomenon under study. The in-depth interviews with the professionals, who work in the hospital, faith based organisations, non-governmental organisations and government departments, gave the researcher more information about the Samburu women regarding their views, attitudes, opinions about HIV/AIDS. The focus group discussions and in-depth interviews also gave the researcher the opportunity to collect qualitative data in the form of depth inquiry, descriptions and direct quotations capturing personal perspectives.

Triangulation is a common feature in qualitative research. It is the use of several data sources in search of common themes to support the validity and reliability of research findings (Leedy & Omrod 2006: 100). Triangulation enables the researcher to corroborate, elaborate and illuminate the research question (Marshall & Rossman 1995: 144) have a deeper and clearer understanding of an issue and its context). Denzin (1989: 236) points out too that the use of multiple methods can reduce

personal biases that accrue from the use of a single methodology. Triangulation enabled the researcher to have a deeper and clearer understanding of the issue and the context of HIV/AIDS among the Samburu women (Taylor & Bogdan 1998: 80).

Triangulation in this study occurred at different levels such as the use of different data sources in this study, Focus group discussions with the Samburu women and in-depth interviews with the professionals who work in organisations that have a HIV/AIDS programmes; the use of multiple methods to study a single problem, the use of focus group discussions and the use of the in-depth interviews; and the use of multiple sampling methods namely the use of convenience sampling with the Samburu women and purposive sampling with the professionals.

### **5. 2.1 Qualitative field research**

Going to the field enables the researcher to develop a deeper and fuller understanding of the phenomenon under study and to have a more comprehensive perspective (Babbie 2007: 286). Babbie describes qualitative field research as “simply going where the action is and observing it” (2007: 293). Qualitative field research typically produces qualitative data as opposed to quantitative field research that is observational in nature and produces statistical or numerical data, which was not the purpose of this study. Field research is deemed appropriate to the study of attitudes and behaviours that are best understood within their natural setting and it is in this setting that the researcher is able to recognise several nuances of attitude and behaviour that might have escaped researchers using other methods (ibid: 287).

Going to the field and interacting with the Samburu women under study gave the researcher an opportunity to personally understand the reality of the respondents’ understanding of an issue from both externally observable behaviours and internal states such as worldview, opinions, values, attitudes, and symbolic constructs (Patton 1990: 47; Lofland & Lofland 1984: 3).

### **5. 2. 1. 1      *Focus group method***

Focus group discussions are categorised under qualitative field research among other research methods such as participatory action research and field observation. The focus group method allows the researcher to question individuals within the group setting to gain a deeper understanding of the issues at hand (Babbie 2007: 308). Focus groups have been used extensively in AIDS research as a tool to use in sensitive subjects in health, sexual behaviour and other social issues (Morgan 1993: 13; Madriz 2003: 366; Kitzinger 1994b: 160; Akwara, Madise & Hinde: 2003: 385). Kitzinger points out that the focus group method is “ideal for exploring social and communications issues and examining the cultural construction of experience” (1994b: 172). Focus group discussions as a research method is also in tune with the current sensibilities in media research, which are redefining media processes and the conception of the audience (Lunt & Livingstone 1996: 90).

Focus group discussions are socially oriented research methods which allowed for the capturing of real life-data in the social environment of the Samburu women. The study used the contemporary approach to focus groups members who knew each other as a naturally occurring group (Lunt & Livingstone 1996: 82; Fern 2001: 165). The members of the focus groups were not strangers because they were recruited from familiar neighbourhoods. The focus group method of data collection was selected for this study because it provided the means through which the researcher was able to explore how and why the Samburu women behaved the way they did regarding HIV/AIDS, locate their sources of information, identify their explanatory frameworks and highlight different forms and levels of ‘knowing’ (Kitsinger 1994: 159).

### **5. 2. 1. 2      *Convenience sampling***

The focus group method (also referred to as group interviewing) is a qualitative method that has a non-probability approach. Stewart and Shamdasani point out that “convenience sampling is the most common method for selecting participants in focus groups” (1990: 53). A convenience sample is a group of individuals who

(conveniently) are available for study (Fraenken & Wallen 2000: 112; Davies 2007: 146; Davies 2007: 55-56). Participants in focus groups do not go through a rigorous selection framework. For the purpose of the study a convenience sampling strategy was utilized for the selection of the participants for focus groups. Convenience sampling does, however, require the researcher to match the sample used with the objectives of the research (Stewart & Shamdasani 1990: 53). Participants were selected on the grounds that they were rural Samburu women from the *manyattas*, aged 15 years and above.

### **5. 2. 1. 3      *Sampling strategy and procedure***

The sampling strategy used by the researcher in this study is referred to as focus group nominations (Krueger & Casey 2000: 76; Krueger 1994: 84). Focus group nominations is an effective strategy in community studies that requires the researcher to ask neutral parties for names (Krueger & Casey 2000: 76; Krueger 1994: 84). The neutral parties are usually those who know the people in the area of interest and are in a position to select the people based on the specifications of the researcher. In this study rural Samburu women living in traditional Samburu homes were the focus of the study.

The researcher visited the Samburu District Commissioner's office and the Maralal Medical Officer (MOH) as well as the District Education Officer in charge to seek permission and to deposit a copy of the research authorisation letter issued by the Ministry of Education, Science and Technology in Nairobi (Appendix iii). It is through the District Education office that a female primary teacher was identified who was fluent in English and Maa language as the contact person.

The researcher worked with the female primary school teacher identified by the education office as the contact person. The primary school teacher then used the teacher network to contact other teachers to recruit women of 15-60 years in the vicinity of the schools where they teach. The teachers were asked to identify rural Samburu women who were based at home *manyattas*. This is meant to achieve homogeneity so as to allow for the free flow of conversation. Homogeneity is

important because “a shared perspective cannot be expected to emerge if the people are not similar” (Calder 2001: 362). The Samburu women also had similar levels of education and economic status (Templeton 1994: 71). Groups that are consistent in composition are easier to conduct because the groups establish group confidence more quickly compared to groups that are of a mixed gender (Lunt & Livingstone 1996: 91; Templeton 1994: 35).

The Samburu community is very sensitive to cultural norms that dictate that you cannot mix men and women in a discussion because the women are not supposed to talk when men are talking. This is what Fontana and Frey refer to when they say that “gender filters knowledge” meaning that the sex of the interviewer and that of the respondent do make a difference (2004: 82).

#### **5. 2. 1. 4     *Sample size and location***

Ten focus groups were identified in the Kirisia and Lorroki divisions of Samburu District (Appendix ii). The main reason these two divisions were chosen was because of insecurity in the region and also the fact that these two divisions were more populated than the other divisions. This is a pastoral community, where families move from one place to the other in search of better pastures for their livestock.

The focus group discussions were conducted soon after recruitment. The researcher was able to carry out ten focus group interviews with between six to eleven women per group, with a total of 85 women. The discussions took between two and two-and-a-half-hours. No new information was forthcoming after the ten focus group discussions. This is referred to as theoretical saturation. The prospective participants gave verbal consent to participate in the focus group discussions since the majority of them did not know how to read and write. There were instances where permission was solicited from the *mzee wa boma* that is, the spouses of the women, as cultural decorum would demand.



All the focus group discussions took place near the participant's homes under trees or in the open fields, near markets, tinsmith's workshop and watering areas. These locations were familiar ground and the participants felt at ease in taking part in the discussions.

#### **5. 2. 1. 5    *Development of the questioning route***

The questioning route (Appendix v) had a standardised or structured format of topics and issues that were used for all the groups for purposes of group comparability, coverage of theoretical concerns and a way of increasing the reliability of the research (Lunt & Livingstone 1996: 85; Fern 2001: 130; Silverman 1993: 106). The standardised format also allowed the researcher to question several individuals systematically and simultaneously (Babbie 2007: 308).

The questioning route was based on the research questions that were guided by the objective of the study: to determine the perceptions of rural Samburu women towards HIV/AIDS. The sub-themes were based on the knowledge, attitudes, beliefs, and opinions and also the channels of communication that were appropriate for the Samburu women. The questioning route was first translated from English to Maa, which is the Samburu language. The questioning route was first pre-tested using Samburu women who worked as herdswomen in Rumuruti Division, Igwamiti Location, Laikipia District, after which the necessary changes were made.

#### **5. 2. 1. 6    *Moderator and note-taker training***

The researcher identified one moderator who was a female primary school teacher of between 30 to 40 years, well versed in the Maa language as well as in English referred to earlier as the contact person. The choice of a female schoolteacher was based on the premise that she was accepted in the community and was able to relate well with the women without them feeling threatened or intimidated. The researcher trained the moderator along with a female note-taker. The researcher also took on the role of assistant note-taker and therefore participated in the ten focus group discussions. The focus group interviews were carried out in Maa since

most of the women are not fluent in any other language. The training took three days during which the researcher introduced the purpose of the study and the focus group method and technique. The researcher went through each question and discussed the aim of each question. The moderator and the note taker were also given time to ask questions when they wanted questions clarified. The moderator was also guided on how to ask probing questions whenever respondents gave answers that needed more elaboration. It was also pointed out to the moderator that she needed to introduce herself as well as the note-takers, introduce the study to the respondents and obtain consent from the respondents to carry out the focus group discussions.

The moderator's role included leading the discussion using the questioning route, leading the group in self-introduction, introducing the subject to the group and explaining the objective of the study, encouraging all the group members to participate, directing the discussions towards the issue at hand in case of digressions, asking probing questions when insufficient information was given or more additional information was required.

The note-takers' role included taking down notes of the discussion, being a silent listener, and working with the moderator, recording the date of the interview, recording the name and location of the interview, recording each participant's biodata using the biodata form (Appendix iv), writing down notes based on the discussants own words.

The assistant note taker's role included following the discussion with a copy of the questioning route, tape recording the discussions, noting down any non-verbal communication and mannerisms such as spitting and any other gestures, and giving the moderator the male and the female condoms for display and discussion at the appropriate time as determined by the questioning route.

### **5. 2. 1. 7     *Pre-testing of the questioning route***

After the training of the moderator and the note-taker, the questioning route (Appendix iv) was pre-tested a second time using the first focus group discussion. Modifications were made such as correcting mistakes, eliminating ambiguous questions and removing questions that appeared to be repetitive or removing some words that meant different things to the target audience. A case in point is the use of the word *biita* to refer to HIV/AIDS. All the respondents saw HIV/AIDS as *biita* although this term refers to a condition that predates HIV/AIDS. Yet, because of symptom similarities, *biita* and HIV/AIDS are synonymous although, in reality, they are two different diseases. Another area that needed to be pretested was the language used in the questioning route to determine whether it was easily understood. A debriefing session with the moderator and note-taker was held after every focus group discussion to highlight the main ideas mooted from the discussion. A summary of the discussions was made as well as an assessment on how the group discussed the issues. Observations made or mannerisms displayed by the focus group were also noted.

### **5. 2. 1. 8     *The focus group discussions***

The focus groups covered five themes namely: (i) the knowledge levels of Samburu women about HIV/AIDS, (ii) the cultural rites and rituals, (iii) the beliefs about HIV/AIDS (iv) the attitudes related to HIV/AIDS (v) the various sources of information that had been instrumental in their knowledge about HIV/AIDS. The researcher was also able to get a range of opinions from the Samburu women regarding HIV/AIDS and the different modes of communication (Vaughn, Schumm & Sinagub 1996: 5). Focus groups exposed the researcher to the Samburu women's own thoughts and means of self-expression regarding HIV/AIDS (Morgan & Spanish 1984: 257; Kitzinger 1994: 166; Madriz 2003: 371).

The ten focus group interviews were conducted with rural Samburu women from the *manyattas* so that the researcher could identify trends in the perceptions and

opinions expressed and revealed through careful systematic analysis (Krueger 1988: 18; Krueger 1994: 3).

The focus groups discussed HIV/AIDS under the direction of a moderator who promoted interaction and ensured that the discussion remained on the topic of interest. The justification for interviewing people in a group setting was based on the premise that an individual's attitudes and beliefs were not formed in a vacuum. In focus group discussions people often needed to listen to other people's opinions and understandings in order to form their own opinion (Marshall & Rossman 1995: 84; Krueger 1994: 19). The focus group interviews allowed the Samburu women to respond to the subject of HIV/AIDS using their own categorisations and perceived associations (Stewart & Shamdasani 1990: 13). The focus group discussions gave the researcher the opportunity to observe the Samburu women engaging in interaction that was concentrated on knowledge, beliefs, attitudes and experiences about HIV/AIDS.

#### **5.2 1.9      *Advantages of using the focus group method***

The study used the focus group discussions because the method uses group interaction to produce data and insights that would be less accessible without the interaction found in a group (Morgan 1988: 12; Kitzinger 1994a: 109). Focus groups allowed the Samburu women to have ample time to reflect, recall experiences especially in response to other group members who triggered recollection and reflection that could have resulted in the modification or amplification of earlier thoughts and commentary (Lofland, Snow, Anderson & Lofland 2006: 20). Focus group interviews allowed the Samburu women to describe HIV/AIDS using their own worldviews and perceived associations, within their own context, within a short time and with different responses from different women as opposed to an individual response (Stewart & Shamdasani 1990: 13).

This study especially found the focus group method relevant to the group under study because the majority of the women were not literate or had low literary levels and the Samburu women are culturally marginalised. This study gave the women a "voice" to air their views, their perceptions, their fears and beliefs, regarding

HIV/AIDS without fear of intimidation from men because the interviewing team consisted of women only and members of the focus group were all women. The fact that the women were able to air their views in the focus group discussions was a perceived major advantage where validity was concerned because rich and believable data was accrued from the women themselves (Reinharz 1992: 19; Frey & Montana 1993: 32; Lunt & Livingstone 1996: 92).

The focus group method gave the researcher the opportunity to observe non-verbal responses such as frowns, gestures, clicks, and spitting particularly when the Samburu women were asked to observe and to make comments about the male and female condoms during the interviews. The moderator also had an opportunity to seek clarification or to give the Samburu women time to recall important aspects that related to the subject of discussion and to prod the women more when they gave a one word answer such as 'yes' or 'no' (Denzin & Lincoln 2003: 72; Stewart & Shamdasani 1990: 16; Frey & Montana 1993: 32; Krueger 1994: 35). The focus group method though having many advantages did give rise to a number of methodological challenges that the researcher encountered while undertaking this study.

#### **5. 2. 1. 10    *Issues arising from the focus group discussion***

A number of issues arose during the focus discussions. It became clear during the discussions that group culture can interfere with individual opinions and the more opinionated individuals tended to dominate the discussions. This intimidated other participants and limited their contributions to the discussions. It was observed that if a group included an elderly woman and she was given the chance to speak, she would be the one to invite the other women to speak. It was also observed that groups that consisted of women of relatively the same age were vibrant and the discussions very fruitful.

The researcher also observed that the dynamics within focus groups varied considerably, with each group having its own personality. Some groups participated

enthusiastically while some discussions were less forthcoming. The moderator had to encourage the women to speak in groups that appeared to be docile.

The focus groups were held under trees, near water points, outside a tinsmith's compound, outside *manyattas* and near the market place where the women felt at ease. This, however, was not always the ideal environment for tape recording and even note taking.

Assembling the women to form focus groups took time and in some *manyattas* the moderator had to seek permission from the spouses. In addition, the *manyattas* were far apart and the roads to the areas were not all-weather roads. The study therefore had to take place during the dry season when the roads were passable. The researcher and her crew had therefore to plan ahead and arrive early at the designated areas so as to capture the women before they left for other chores away from the *manyattas*.

Some of the women in the focus groups thought the research crew were government agents sent to find out if they were involved with FGM and were suspicious. This is because FGM, though illegal in Kenya, is practiced secretly because it is deemed a mandatory rite of passage. The moderator had to make it clear to the women that the researchers were interested in the subject of HIV/AIDS and not FGM.

Lastly, the majority of the women had misgivings about the use of a tape recorder. They had to be reassured that the information from the focus group discussions was not going to be relayed to the radio stations or that the researcher was not going to "carry their voices away with her".

(On a final note: The focus group participants were given monetary incentives as a group after the discussions, although no money had been promised before the interview. They had to divide the money equally among themselves after the focus group discussions. The researcher gave the money as a token of appreciation because its value was immediately appreciated and used by the participants and it

also showed that the focus group meeting was important and that one was not just wasting the participants' time).

The second data collection method used to gather information from government and NGO workers for this study is discussed in the following section of this chapter.

### **5.3 QUALITATIVE SURVEY RESEARCH**

The researcher asked open-ended questions without response options and listened to and tape-recorded the comments of the respondents (Creswell 2002: 402). The fact that respondents were given a chance to express themselves allowed the respondents to create a response within their own cultural and social experiences instead of the researcher's experience (Neuman 2000 in Creswell 2002: 406).

#### **5.3.1 In-depth interviews**

In-depth interviews were conducted with government and NGO workers regarding the Samburu women's knowledge of HIV/AIDS, in terms of origin, prevention, management, care, beliefs, attitudes and culture. Exploring the perceptions and experiences of government and NGO workers allowed for the generation of information that would complement that derived from the focus group interviews.

In-depth interviewing is defined as a conversation with a purpose (Marshall & Rossman 1995: 80; Denzin & Lincoln 2003: 48). The aim of the in-depth interviews with the professionals was to talk about their experiences, feelings, challenges, opinions and to assess their views of the knowledge level of Samburu women regarding HIV/AIDS because they had interacted with the women more extensively and for a longer time than the researcher had (Kvale 1996: 1). In-depth interviews enabled the researcher to hold conversations with the professionals to explore the topic of HIV/AIDS, themes and issues related to the study to help unravel the participants' perceptions in detail and depth (Rubin & Rubin 2005: 54; Mason 1996: 62).

In this study, open-ended questions were used to gather data on assessing the knowledge levels, perceptions and beliefs about HIV/AIDS among Samburu women in order to come up with a communication strategy that was cognisant with their levels of knowledge, understanding and background. The open-ended questions enabled the respondents to describe what was meaningful and salient without being “pigeon-holed” into standardised categories (Patton 1990: 46; Babbie 2007: 246). Through the open-ended questions the researcher was able to get what Lofland, Snow, Anderson and Lofland refer to as “rich, detailed responses that can be used for qualitative analysis (2006: 17).

The in-depth interviews took place between May 2008 and May 2009 in Maralal town. The programme co-ordinators from government departments and faith-based organisations (FBOs) as well as non-governmental organisations (NGOs) consisted of men and women between 20 and 60 years of age with field experience ranging from one year to over thirty years. The process of selecting the respondents for the in-depth interviews is described the next section.

### **5. 3. 2 Selection of NGO personnel and government workers**

The second primary source of data collection for this study was the in-depth interviews of non-governmental organisations and government health workers and co-ordinators who are involved in HIV/AIDS programmes in Samburu District. Most of the organisations that were involved in HIV/AIDS programmes had their main offices in Maralal town. The NGO and government workers were chosen as the subjects for this study because:

- The programme co-ordinators and field officers had interacted more with the Samburu women and therefore could articulate their observations regarding HIV/AIDS.
- Their services were extended to all the divisions in the Samburu District and were therefore in a position to give a wider perspective.



- They had worked with the Samburu women for a longer period as opposed to the researcher who spent a limited time with the Samburu women and could therefore confirm the sentiments that the women had expressed during the focus group discussions as a form of triangulation. The sampling method and procedure are discussed in the next section below.

### **5. 3. 3 Purposive sampling**

Purposive sampling is a non-probability approach that was used in this study to identify the professionals to participate in the in-depth interviews. Purposive sampling also referred to as theoretical sampling involves the selection of groups and categories to study based on their relevance to the research questions. Since the aim of qualitative research is to develop an in-depth exploration of a phenomenon, the researcher purposely selects individuals and sites that are information rich that will lead to a deeper understanding of the phenomenon based on the researcher's objective (Creswell 2002: 193,194; Leedy & Omrod 2006: 206; Silverman 2000: 104). A snowball sampling strategy was used to select participants for in-depth interviews.

Snowball sampling strategy is a "form of purposeful sampling that typically proceeds after a study begins and occurs when the researcher asks the participants to recommend other individuals to study" (Creswell 2002: 196).

#### **5. 3. 3. 1 Selection strategy and recruitment of in-depth interview respondents**

The researcher contacted the District Development Officer of Samburu and was given a list of organisations that have HIV/AIDS programmes in the district. The researcher used the list to contact the first organisation. It was observed that although there is a list of organisations that indicated that they had HIV/AIDS programmes, not all were in operation and that is why the snowball strategy of sampling had to be used. The researcher located one active NGO and then asked them to provide names of other NGOs that had operational HIV/AIDS programmes.

The researcher conducted eleven in-depth interviews with the professionals selected by means of the snowball sampling strategy.

#### **5. 3. 4        Development of the interview guide**

The interview guide (Appendix vi) was prepared according to the objectives of the study and served the purpose of triangulation to confirm and corroborate the views of the Samburu women who had been interviewed earlier. In addition, the interview guide also discusses the communication barriers, cultural barriers and educational challenges that the professionals experienced while undertaking the HIV/AIDS prevention and awareness programmes.

The researcher herself conducted the interviews. Respondents were interviewed in one-on-one meetings held by appointment in offices at the respective organisations. Each session took between two and two-and-a-half hours.

##### **5. 3. 4. 1     *Pre-testing of the interview guide***

Three pilot interviews were carried out with NGO workers involved with HIV/AIDS programmes in Nyahururu town and changes with regard to clarity of the questions were done. The researcher was also able to assess whether the questions asked were commensurate with the objectives of the study.

The researcher first asked the respondents for their consent to be interviewed on behalf of their organisations and the majority of them consented. The researcher interviewed the respondents in English since all the respondents were fluent in English. The first part of the interview guide contained a brief introduction to the study. This was followed by biographical questions to start off the interview (Miller & Crabtree 2004: 191). This was then followed by open-ended questions that introduced the research themes. The open-ended questions forced the respondents to think through their own responses without being led to answer questions in a

prescribed manner. Prompts and probes were used throughout the interview to expand on the rich context (Miller & Crabtree 2004: 191).

### **5. 3. 5 Advantages of in-depth interviews**

In-depth interviews allowed the professionals to articulate what their organisations undertook to prevent and manage HIV/AIDS in the Samburu District. The open nature of the questions enabled the professionals to relate their experiences, ideas, thoughts, encounters, obstacles that they faced and memories regarding HIV/AIDS. This is because in-depth interviewing is said to be flexible, iterative, continuous and “not locked in stone” (Rubin & Rubin 2005: 16). This gives the interviewer, the opportunity to ask for clarification or to probe more on the issues under discussion. The in-depth interviews also have limitations that the researcher encountered in the course of the study.

### **5. 3. 6 Limitations of in-depth interviews**

The researcher found that although the in-depth interviews were fruitful and generated a lot of information, getting and booking an appointment with the respondents took time and some respondents were unwilling or uncomfortable with sharing about such a sensitive issue such as HIV/AIDS.

The danger of digressing in in-depth interviewing is always present and the interviewer had to cautiously guide the respondents back to the questioning guide.

## **5. 4 DATA ANALYSIS**

Data for this study was analysed qualitatively using descriptive and interpretative techniques. Responses from the ten focus group discussions that had been tape recorded were translated from Maa to English and transcribed. Data from the eleven in-depth interviews, which had also been recorded, were also transcribed. Content analysis was the data analysis method adopted for this study for both the focus group discussions and the in-depth interviews with the professionals, with a view to

matching the responses with the themes and categories that had been identified and that were in line with the objectives of this study.

## **5.5 SUMMARY**

The objective of qualitative studies is to study an issue in detail and depth and to take into account the respondent's context, way of interpreting and perceiving an issue holistically. This study uses two qualitative approaches namely, the qualitative field research approach and the qualitative survey approach as a form of triangulation that elicits a more comprehensive perspective, offers validity and allows interaction with the respondents. The qualitative field research approach employs the use of focus group discussions, which gave the Samburu women an opportunity to collectively discuss the issue of HIV/AIDS. The questioning route for the focus group discussions was developed, pretested and refined. A convenience sample was drawn and the nomination strategy for the focus group discussions used. A moderator and research assistant were identified and trained. The qualitative survey research approach gave the researcher an opportunity to get depth information from small samples to understand perceptions, beliefs, feelings and attitudes of Samburu women regarding HIV/AIDS. A purposive sampling method, snowball sampling, is used for the in-depth interviews with the professionals, i.e. NGO workers as well as the government workers. The interview guide, the data collection tool for the in-depth interviews, was also developed and pre-tested and the necessary changes made. In-depth interviews enabled the NGO and government workers to give their perspectives on how Samburu women received information about HIV/AIDS, their beliefs, attitudes and knowledge levels regarding HIV/AIDS. The data was collected, transcribed and analysed using the content analysis method. The findings of the study are discussed in the next chapter.

## **CHAPTER 6**

### **DATA ANALYSIS AND INTERPRETATION OF FINDINGS**

#### **6.1 INTRODUCTION**

In this chapter, the knowledge level, attitudes, beliefs and perceptions of Samburu woman regarding HIV/AIDS are presented. These are based on the analysis of qualitative data derived from ten focus group discussions (FGD) with Samburu women and eleven in-depth interviews with workers from organisations that have HIV/AIDS programmes in the Samburu District. Data from this study was analysed qualitatively using descriptive and interpretive techniques. Description entails collecting “thick description” through the discussions and in-depth interviews (Denzin 1989: 83). The researcher went beyond mere descriptive data and attached significance to what was found, offering explanations and drawing conclusions (Patton 1990: 423). The researcher carried out content analysis after transcribing the tapes and translating into English the focus group discussions that were carried out in the Samburu language. The information from the women and the in-depth interviews was categorised and then matched with the themes previously identified. The major findings of the study may be highlighted as follows:

In sum, the study revealed that Samburu women had inadequate information to protect themselves from HIV/AIDS infection. Cultural rites and rituals play a salient role in the spread of HIV/AIDS in the Samburu community. The women believe that as long as they followed the cultural norms of the community they were safe from HIV/AIDS infection. This was because they believed that HIV/AIDS was a curse, and a result of contravening the cultural norms of the society such as changing one’s faith from the traditional beliefs to Christianity or embracing alien aspects such as education.

The study also revealed that although the women were aware of condoms, the use of condoms contradicted the concept of conception, which is a hallmark of any Samburu family. Condoms, according the women, were meant for the young men

(*morans*). The use of condoms was therefore not accepted as a protective measure from HIV/AIDS infection. Access to condoms is also problematic: Condoms are only available at town centres and female condoms were not available at all. In addition, condoms do not have a long shelf life because of the heat.

Samburu women are marginalised regarding the information they receive because they do not get information directly. A woman either receives information from her husband, her children or other women. This is because the Samburu community is a closed community where there are gatekeepers who may allow or block the flow of information.

The study reveals that a knowledge gap exists regarding areas such as mother-to-child infection, PEP (Post-exposure prophylaxis) therapy, VCT (Voluntary counselling and testing, ART (Anti-retroviral therapy), and care and management of HIV/AIDS. The women's knowledge gap is a result of low literacy levels and the fact that this aspect is not adequately addressed when information is disseminated to the women. The study also reveals that the women's knowledge of the human anatomy is limited and distorted. Samburu women believe, for example, that the human body has one main system, that the stomach that digests food is also the womb that nurtures the foetus. This perception of human anatomy hinders the flow of information regarding the reproductive system and the digestive system.

Other avenues of communication such as the radio are not effective because radios are owned and under the control of the head of the family, making this mode of communication inaccessible to the women. In addition, the radio may not be an effective way of communicating to the women about HIV/AIDS because of the use of either Kiswahili or English by the mass media – languages they are not well versed in.

The use of video and films is more acceptable to the Samburu women than any other mode of communication. However, even this form of communication is impeded because of language issues. There are hardly any films in the Samburu language. The films, though more effective, have also been a source of further

alienation of the Samburu women because they have identified HIV/AIDS with modern educated people, young people or people from other communities.

## 6.2 PROFILE OF FOCUS GROUP MEMBERS

Ten focus groups were conducted with an average of eight women per group. A total of 85 women were involved in the focus group discussions. Of the 85 women involved in the focus group discussions, 72 had not received any formal schooling and none had attended secondary school. The majority of the women interviewed were married and although on the bio-data form there was a slot for widows, none indicated that they were widowed. The estimated ages of the women were evenly distributed between 14 and over 55 years. The groups consisted of women of different age groups and the younger women gave the older women a chance to contribute to the focus group discussions first and they had to be requested to participate as is culturally expected. The interviews took place in two divisions of the Samburu District, which is Kirisia and Lorroki. All the women lived in the manyattas.

The biographical information of the women who participated in the focus group discussion is summarised in the tables below.

### **Marital status**

**Table 6. 1: Marital status of women in the FGDs**

Marital status	Number
Married	78
Widowed	0
Single	7
<b>Total</b>	<b>85</b>

Because most births take place at home and are not recorded (mainly due to illiteracy), the note taker tried to estimate the age of the women. It is easier to estimate the ages of the younger women and older women but more difficult to estimate the ages of the middle-aged women who made up the majority of the

participants in the focus group discussions. The challenges of estimating the age of the women are revealed by one of the informants as follows:

No, by the way, sometimes when we started we used to assess age by looks, but because of what they have gone through, you cannot tell the age. A very young person may look very old because of what they have gone through. You may say for example, this lady is 37, eh...that person could be 26 years. This is because of giving birth, you know how this wears you out? The women do not mention their age because they do not know. They actually don't know even when their babies were born. They also don't know even when they got their last periods. They give birth one after the other, so rarely do they experience their menstrual periods. By the time the menses should start, they are pregnant. You find that a lady of say 15 years has six children, and when you look at that person. I am younger than that person. (NGO worker, age 31-41, female, Maralal).

Table 6. 2 below indicate the estimated age distribution of the women.

**Table 6. 2: Estimated age of women in the FGDs**

<u>Age</u>	Number
15-25 years	14
26-35 years	32
36-45 years	19
46-55 years	12
Over 55 years	8
<b>Total</b>	<b>85</b>

As pointed out earlier the majority of the women interviewed had no formal schooling. (This is also the general profile of the whole Samburu District) (Samburu Report 2008). None of the women in the focus groups had received any secondary or tertiary education. The majority of the girls who enrol in primary school drop out before they reach the secondary school level (Samburu Report 2008). This is also a pointer that verbal messages are more relevant to the Samburu women than written messages. This is indicated in the table below.



**Table 6. 3: Years of schooling of women in the FGDs.**

**Education**

Level of schooling	Number
None	72
Lower primary (Std 1- 4)	8
Upper primary (Std 5- 8)	4
Secondary (F1- 4)	0
Above secondary (college/university)	0
Adult education	1
<b>Total</b>	<b>85</b>

**6. 3 PROFILE OF IN-DEPTH INTERVIEWEES**

Eleven in-depth interviews were conducted with members of NGOs (Non-governmental organisations, FBOs (Faith-based organisations) and Government of Kenya (GOK) workers who are involved in HIV/AIDS programmes in the Samburu District. All the members who were interviewed had received tertiary education. Four of the eleven interviewees were not members of the Samburu community. Out of the eleven interviewees only three were female. Most of the organisations did not have a specific programme for women but they did cover the whole community, and the organisations that were health providers did interact with women more because of the antenatal clinics and other health issues.

A profile of the in-depth interviewees is shown below:

**Table 6. 4: Age groups of in-depth interviewees**

Age group	Number
20-30 years	3
31-41 years	5
42-52 years	1
53-65 years	2
<b>Total</b>	<b>11</b>

Table 6. 4 above shows that the majority of those interviewed were in the 31-41 age group. Age and age sets in the Samburu community are very significant. An elderly person is able to talk or give information to another elderly person much more easily than to a younger person. A younger person may face difficulties in conveying messages to older people and may be more comfortable talking to people their own age. Messages may be rejected based on the bearer's age and sex. This implies that when information about HIV/AIDS is to be disseminated, the age factor determines who will give information to the elderly and who should give information to the young and the women. It is often observed that women cannot give information to men but men can give information to women.

Of the eleven interviews conducted, three respondents were female and seven male. Seven respondents were from the Samburu community while four were from other communities. Ten of the respondents had received tertiary education. The number of women represented here is disproportionately low as a result of the trend observed where very few Samburu women enrol or even complete primary school. It is also noteworthy that only two of the seven members from the Samburu community were women. This is indicative of the low levels of school enrolment of girls and early marriage.

**Table 6. 5 Ethnic affiliation of in-depth interviewees**

Affiliation	Number
Non-Samburu	4
Samburu	7
<b>Total</b>	<b>11</b>

Although the NGOs are foreign-funded they are headed by members of the Samburu community who have a better local understanding of the challenges of the HIV/AIDS pandemic and its far-reaching effect on behaviour change.

Most of the respondents had between one and 30 years work experience. Some of the NGO representatives had interacted with the Samburu women for lengthy periods of time and were, therefore, in a position to articulate the needs of the Samburu women clearly. The table below shows that the professionals came from

various organisations that serve the interests of the donors or the government agencies. HIV/AIDS is seen as a cross cutting issue that is not only confined to health agencies but is also taken up by other agencies. Most of the organisations have their main domains of interest but have also included HIV/AIDS programmes. World Vision, for example, is a faith-based organisation that has agricultural projects in the Samburu District but also has a HIV/AIDS programme.

**Table 6. 6: Designation of in-depth interviewees and years of experience on the job**

<b>Designation</b>	<b>Years of experience</b>
District AIDS/STI Co-ordinator	10
Constituency AIDS Council	10
District Field Facilitator	1
Programme Manager	30
Nursing Officer	2
Field Programme Co-ordinator	4
Church Minister	15
Health Co-ordinator	8
Health, HIV/AIDS Co-ordinator	3
Programme Co-ordinator	6
HIV Project, Arid Lands Resource Management	8

The study juxtaposes the perceptions and views of the Samburu women about AIDS with the views of the workers who have HIV/AIDS programmes in the Samburu District. Both the in-depth interviews and the focus groups dealt with identical themes and the use of the two data collection tools is a form of triangulation. When conducting the FDGs, the term *biita* was used by the Samburu women to refer to AIDS.

The FGD sessions and in-depth interviews dealt with the following themes:

- The knowledge level of Samburu women regarding AIDS
- Cultural aspects that make women vulnerable to AIDS

- Beliefs of Samburu women regarding AIDS
- Attitudes of Samburu women regarding AIDS
- Communication aspects regarding the way in which messages are conveyed to the Samburu women.

In the following section, data deriving from the in-depth interviews and FDGs is presented and interpreted. Patton (1990: 423) states that interpretation goes beyond simple description. He observes that “in qualitative analysis, interpretation means attaching significance to what is found, offering explanations, drawing conclusions, extrapolating lessons, attaching meaning, imposing order, dealing with rival explanations, and confirming cases and data irregularities as part of testing the viability of an interpretation”. This in essence means that the researcher gives descriptions and offers an interpretation and also draws on the experiences of other researchers in the field.

#### **6. 4.           THEME 1: KNOWLEDGE LEVEL OF SAMBURU WOMEN REGARDING AIDS**

This theme has been divided into several sub-themes:

- The origin of AIDS
- Transmission of AIDS
- How the community explains the spread of AIDS
- Prevention of AIDS
- Mother-to-child transmission
- Use of condoms

##### **6. 4. 1           The origin of AIDS**

The Samburu women described AIDS as *biita*. The name *biita* was used to refer to HIV/AIDS even though *biita* existed before HIV/AIDS, it was said to have the same characteristics. AIDS was perceived to be the disease that finished someone slowly (*ikimbiita*). AIDS was also described as the big disease, a bad and dangerous disease for which there was no curative medicine or herbs. AIDS was also described as the disease that ate one up until one died; it was also depicted as a

wild animal. Both the women in the focus groups and the respondents in the in-depth interviews saw *biita* and AIDS as the same disease.

The general feeling of the Samburu women about AIDS was expressed by one participant as:

A disease that came the other day and is finishing everybody, it does not spare an old woman and the young; it is a very bad thing (FGD, elderly woman Lodokejek).

Questions on the origin of AIDS revealed a range of beliefs from the focus groups:

There was once a man by the name '*Imae-openy*' and his name meant 'I will not die alone' He had come from Mombasa and he lurked in the forest waiting for women whom he would rape and consequently infect with HIV/AIDS (FGD, middle-aged woman, Sirata Oirobi)

It is not brought by wind but one goes to look for it (FGD, middle-aged woman, Lodokejek).

The disease was brought by the Europeans but it was the monkeys which are the ones who had the disease but it is man who brought it from the monkeys. (FGD, middle-aged woman, Lekuru)

The disease came from afar (*ng'ampo*) that some people go to, places outside Samburu then bring it to us (FGD, middle-aged woman, Baawa).

It is said that Europeans are the ones who brought it after having sexual intercourse with a monkey. After that they came and met some prostitutes in Nairobi then had sex with them hence spreading it to other parts. The women prostitutes enhanced the spread by having sexual intercourse with both white and black men (FGD, middle-aged woman, Lpartuk (one) Lgoss).

We have also heard that a plant known as the *Itulelei* can also affect one with the disease (FGD, middle-aged woman, Lekuru).

AIDS was not there before, before there was only *kusonono* (gonorrhoea) and *mirika* (syphilis) which both have a cure but are not related to HIV/AIDS, but this *biita* does not have a cure. It only takes one's life (FGD elderly woman, Lower Lpartuk).

It is clear from the above sentiments that the Samburu women have an unclear and distorted understanding about the origins of the disease. Their understandings

range from beliefs that outsiders had infiltrated their community and brought AIDS, to beliefs that AIDS was brought by monkeys. Those who have had relations with outsiders were also blamed for bringing the disease to the community. The women also felt that while they knew how to treat other sexually transmitted diseases but AIDS did not have a cure.

Interviews with NGO and government workers confirmed that while Samburu women were aware that there was a disease known as AIDS, their knowledge level was very low and many misconceptions existed. This was ascribed to various factors such as illiteracy and culture:

In Samburu, due to their culture, they are generally a closed community, that before you reach them, you have to go through the cultural gatekeepers and so they do not know much about HIV/AIDS due to the closed nature of the community (NGO worker, age 20-30, male, Maralal).

It was also observed that where one lived also determined whether one had access to information or not:

It depends on places people who live near towns and generally those who live in settled areas have more access to information than communities living in dry areas and they are very mobile, so among communities that have more access to information, the level is a bit high (NGO worker, age 42-52, male, Maralal).

It was also noted that in some areas people were aware of HIV/AIDS, but were doing very little to prevent it:

I could say some areas have information but they are not putting into practice what they know but in the interior women really need to be empowered to know what their rights are and their rights concerning sexuality (FBO, age 31-41, female, Maralal).

A male researcher who works for a FBO who wanted to find out more about the views of women regarding AIDS tells of his experience:

The majority, the village women give it no attention at all. In fact, in various occasions when I talked to the women, they would brush it off and tell me to go and talk to the men; they are the ones who are bringing it to us. Why are you talking to us? Whether we know it or not it has no effect on us (FBO worker, age 53-65, male, Maralal).

He further emphasises the resistance of women to receiving any information about AIDS:

The levels of knowledge are very low, and besides being low the women are very negative about any information about it even rejecting any information, they do not want to know (FBO worker, age 53-65, male Maralal).

#### **6. 4. 2          Transmission of AIDS**

A number of views emerged regarding the transmission of AIDS. The women in all the FGDs talked about *loloito* which in the Samburu language means adultery or prostitution. The implication being that if one had sexual affairs with other people they were likely to be infected with AIDS. The possibility of getting infected through the sharing of razor blades for shaving with an infected person as a means of transmission was also stated. They also raised the issue of sharing one knife during the circumcision ritual for the boys and female genital mutilation (FGM) for the girls as a means of transmission. Another view expressed was that a woman can be faithful but her husband may have multiple partners, which could result in infection. Other views regarding modes of transmission were expressed:

If a man drinks then misbehaves with young girls, is he not likely to infect me with the disease? There is nothing we can therefore do (FGD, middle-aged woman, Lower Lpartuk).

If a housefly gets on one's wound then goes to another's and maybe that person is infected, then she or he is likely to be infected (FGD, elderly woman, Lower Lpartuk).

In that case there is no way you can escape from getting infected (FGD, middle-aged woman, Lower Lpartuk).

Even if you eat the food of the infected person who has wounds in the mouth, you are likely to get infected (FGD, middle-aged woman, Lower Lpartuk).

Even a chewing gum, if you chew it, then give it to another person and it's got some blood on it and the person might be having the disease then one can definitely get it (FGD, middle-aged woman, Lkurom).

It is evident from the above sentiments that the women have several misconceptions regarding pathways of getting AIDS. It is also clear that even if the women have heard of AIDS they have not understood it fully and myths and erroneous beliefs are rife.

#### **6. 4. 3            How the community explains the spread of HIV/AIDS**

The community was not fully aware of the fact that the HIV/AIDS was primarily spread through sexual intercourse with multiple partners and through infected people. The community believed that prostitutes were the primary vectors of HIV/AIDS. It is also referred to as the 'watchman's disease'. They said that Samburu men are very good watchmen in towns and so, when they go to towns they relate to *wazungu* (European women) and they become infected. When the *morán* (warrior) returns home and become sexually involved with someone in the community, the disease is spread among their age mates.

Soldiers *keya* are also viewed as spreading the disease: once they go to their duty stations and are disconnected from their families they have relationships with other women. They also have a lot of money when they come home and the women in the village want to relate to them. This also results in the spread of AIDS.

The young people (*morans*) who go to Mombasa are also held responsible for the spread of the disease. Often when the *morans* return from Mombasa they come with a European wife. Although they come home with a European wife, he still had his cultural wives and friends so if the Moran was HIV positive he could infect quite a number of people. The wives could get infected and they in turn would infect their secret lovers (*sindani*). Also, since the wives have been left for a protracted period of time they may have had relations with other men which could also have made them vulnerable to HIV.



The spread of HIV/AIDS was blamed on outsiders and the women had difficulty in believing HIV/AIDS could be spread from within the community once it is within the community. Consequently, people from town and those who are not members of the Samburu community are treated with a lot of suspicion and are seen to be the carriers of the disease.

The following observation was made by a church minister who had conducted some research on the spread of HIV/AIDS himself:

The first people, who knew they had the disease, spread the disease like wild fire. You know they became aggressive in spreading the disease. You know they believed that if you got HIV/AIDS, there was no other option, but you die and they believed you died so fast because they did not take care of themselves, they died fast, and they really spread the disease. I know of a village in Kirisia where one man spread the disease to as many as forty women who then infected their husbands with the disease, and they did it deliberately. They would also meet with other positive people and talk among themselves and ask what is the strategy, how do we go about it? They would go to people they presumed were their enemies or rivals in life (FBO worker, age 53-65, male, Maralal).

The view was also expressed by an NGO worker that market centres could be possible routes from where HIV/AIDS could spread to different parts of Samburu:

We have a market place at Wamba - the one I was telling you about, the whole people of Samburu meet there. They meet on Wednesdays because the market day is Thursday, there are no lodgings, there is nothing, people sleep in small shades, under the trees, or some small *kibandas* (tents) with no doors and there is this thing that if you get somebody there and you know this is a cultural thing, somebody who is positive can really infect a lot of people (NGO worker, age 20-30 male, Maralal).

#### **6. 4. 4        Prevention of HIV/AIDS**

A range of views were expressed on the prevention of HIV/AIDS: One woman said that she did not know how HIV/AIDS could be prevented “Only God knows” (FGD, elderly woman, Lkurom). Other observations were that one can help prevent HIV/AIDS infection when helping a woman give birth by “using gloves and if you do

not have gloves you can use polythene bags for protection” (FGD, elderly woman, Sirata Oirobi). Other women advocated the use of one razor blade per person since they have to be clean shaven. Others felt that *loloito* (prostitution) should be stopped. Others felt that condoms should be used to protect themselves from infection. Other views expressed by the women were:

Women should also try to discourage polygamy, whereby if a young woman discovers that a man has two or three wives she should refuse to get married to him (FGD, middle-aged woman, Lodokejek).

Some young people do not listen to their parents when told to abstain; instead they tell their parents that sex to them is like perfume that they have to spray onto themselves (FGD, middle-aged woman Lodokejek).

Woman1: By leaving men!

Woman2: Is leaving men really possible? No, it is not unless for widows, since they can stay without having any relations with a man.

Some widows still go ahead and have affairs with other men (FGD, two young women, Sirata Oirobi).

The husband and the wife should be talked to stay faithful.  
If I am taught alone, then that cannot help unless both of us are taught (FGD, two young women, Sirata Oirobi).

If you move or have multiple partners you will not be lucky, you will get the disease (FGD, elderly woman, Laikipia).

The view was also communicated by some women who felt that educating women alone about HIV/AIDS without educating their partners was futile. However, some felt that having multiple partners through polygamy was risky yet it was culturally acceptable to have multiple partners. The women observed that cultural obligations limited their freedom of choice in decision-making whether to be in a multiple relationship or not.

#### **6. 4. 5 Mother- to- child transmission**

There were diverse responses regarding mother-to-child transmission. Various views on how a child becomes infected were offered:

That if the child is in the stomach then the child can get infected through its mother's blood with which it gets food (FGD, middle-aged woman, Lekuru)

The child can be infected if the father initially had the virus (FGD, elderly woman, Baawa).

When a mother is injected using a needle, which is used on another person, and the other person has the disease, then the unborn child can be infected (FGD, middle-aged woman, Lpartuk (one) Lgoss).

The baby can get infected through *loloito* (prostitution), this is one way in which the unborn child can get the disease through the mother.

The unborn child cannot be infected. We have ever been told that there is no way a child in the womb can be infected (FGD, middle aged-woman, Lkurom).

Yes, when a mother gives birth and breastfeeds the child that is the only time the child can be infected but if you do not breastfeed it then the baby cannot be infected (FGD, middle-aged woman, Lkurom).

The unborn child can also get the disease from having sexual intercourse with a person who is already infected when the mother is already pregnant (FGD, middle-aged woman, Lodokejek).

When a child is born she or he is given herbs to clear any infection. You use the cream of milk and put it in a guard and shake it and you give the herbs to cleanse the blood and this is given the moment the child is born, a herb is administered (FGD, elderly woman, Laikipia).

One focus group member did say that a child could be protected from getting HIV/AIDS if the mother was taken to hospital to give birth there to make sure that the child's blood and that of the mother's did not mix:

It should be ensured that the blood of the mother and the child do not get into contact. You therefore cut the child's umbilical cord and then take it away to avoid contact with the blood (FGD, young woman, Sirata Oirobi)

Woman: The baby should be taken away from its mother for her not to be tempted to breastfeed it.

Moderator: Have you ever heard of a woman who agreed not to breastfeed her child?

Woman: No, we have not heard of one but, we think that is the best thing (FGD, middle- aged woman, Lodokejek).

Some Samburu women are aware that getting medical attention could protect the unborn child if the mother is HIV positive but very few went to hospital and very few would follow a medical regime for fear of being stigmatised. This means that a woman would continue breastfeeding her child even if she is HIV positive for fear of disclosing her status.

It appears that the concept of mother-to-child transmission is not very clear to the women because they believe that the mother and the foetus share the same blood. They have a vague idea that HIV infection can occur but as to how and when it is likely to happen, they do not know. They also suggest that the woman should be taken to hospital to give birth but the truth of the matter is that majority of them give birth at home (Samburu Report 2008: 13). They may attend antenatal clinics and acquire a hospital card as a safe guard in case of an emergency, but they don't consider that giving birth is a medical condition that requires medical attention. Among the reasons cited are that the hospital nurses are very harsh; they recommend a different position in giving birth than that used during home births, the cost, and the distances from their homes to the hospital. They are also ridiculed that they are not women enough to *sukuma* (push) like other women, implying that going to hospital is a sign of cowardice. In addition, Samburu women have always been attended by traditional birth attendants (TBAs) who have been trained by the Ministry of health and other non-governmental organisations (NGOs) but the government has since stopped encouraging home births because of the dangers of HIV infection. This has become a thorny issue in Samburu County because the women are not willing to change, however, given that they still face the same challenges mentioned above. This means the information about mother-to-child transmission is not really understood otherwise they would take precautions to protect their children whom they value highly. The resistance to hospital births is also expressed by Samburu health workers who still think that the TBAs should handle the home births.

They don't see why and even when we go for workshops and the MOH tries to bring this idea of community strategy on safe delivery in hospital, you will see a lot of arguments, they will say, then what is the work of the TBAs? And yet the MOH is trying to tell them that we are trying to go off the TBAs to skilled labour (FBO worker, age 20-30, male, Maralal).

The women are not even aware of the policies and who follows policies unless they are enforced by the law enforcers? (GOK worker, age 31-41, male, Maralal).

The government policy regarding the antenatal clinic and the insistence on the fourth visit when a mother should endeavour to attend antenatal clinic at least four times during her pregnancy, was still facing opposition.

The views expressed by the women show that they are aware that a child may be infected with HIV from its mother but they do not understand the details because of low-literacy levels and their lack of understanding of the basic functions of the human body. Further, very few of them attend ante-natal clinics where information about mother-to-child transmission is available, because they do not think it necessary. This is supported by the observations below that were made by NGO, FBO and government workers during the in-depth interviews.

The idea or the information is not well grasped.... because the majority of them do not go to clinic and those who do go do take the test and even those who take the test , some of them end up giving birth at home( NGO worker, age 31-41, female, Maralal).

It's cultural, as I told you, one councillor once told me that he had five wives and forty-five children and none of his wives have given birth in hospital (FBO worker, age 20-30, Male, Maralal).

The women do not see any link between HIV infection and home births. The TBAs on the other hand say they use gloves to protect themselves and if they do not have gloves they use polythene bags to protect themselves (NGO Worker, age 31-41, male, Maralal).

For this mother to conceptualise how the child can get infected from the mother, it has not penetrated and again the information given by the health provider is not clicking, there are no proper words in Samburu language and unless you use drawings but then you are dealing with people who cannot read and write. It is very hard even for the health community workers to relay that information (NGO worker, age 31-41, female, Maralal).

Mambo ya reproductive health, *ndiyo inatakikana* because *wako na shida ya reproductive health, kujua hali ya maumbile yake yote na namna ya kujitunza anatomy*. Knowing the anatomy *na kuitunza vizuri aweze kuacha kukata, kuchonga*, I've reproductive talks *ndiyo sasa*

*unajua shida.* (The women need to be taught about the reproductive health, this is a problem area. They need to know how to take care of their bodies so that they can stop body mutilations. I've given reproductive talks and that is why I know their problems) (NGO worker, age 53-65, female, Maralal).

Like giving birth, pregnancy was not seen as a medical issue. TBAs are more trusted than the nurses in hospital. The whole of Samburu District has 18 PCTM sites but in those 18 sites, only 20 HIV positive women received a complete course of antiretroviral prophylaxis in 2006/2007 while the number was 46 in 2007/2008 (Samburu Report 2008: 13). It was observed that very few mothers were under medication and that most of them did not adhere to the instructions given on dosage and it was also feared that some were on self-medication (Samburu Report 2008: 13). Samburu women lack access to anti-retroviral medicines that improve their health and well-being because "they do not enjoy programmes that couple prevention of mother-to-child transmission and continuing treatment to help mothers remain alive and in good health to care for their children" (UNAIDS 2008: 14). The study established that because of fear of disclosure of one's status, lack of knowledge, denial of the existence of HIV and a negative attitude towards modern medication, cases of mother-to-child HIV infection are exacerbated. This area is not only of concern to the Samburu community, the UNAIDS 2009 Global Report observes that 91 percent of new infections among children occurred in sub-Saharan Africa (2009: 27). While other country's mother-to-child HIV infections have reduced considerably, sub-Saharan Africa countries continue to increase in the number of children born of HIV positive women also being HIV positive despite this being preventable.

#### **6. 4. 6            The Use of condoms**

Both male and female condoms were displayed during the focus group discussions. This generated a lot of discussion and laughter among the women. The moderator observed their reactions and comments about what the condoms are and their role in the prevention of HIV/AIDS. Some women kept spitting when they saw the condoms. This was an indication that what they were looking at was disgusting. Some women did not even want to touch the condom and those who touched it then

tried to wipe their hands thoroughly. Some women who had attended seminars had seen both male and female condoms. Condoms are referred to as *mpirai* or *kodomi*. When asked if they had been told about condoms, they were too shy to even call the condom by name. The women implied that the condoms are meant for other people not for them.

Woman1: The ones used on hands. (laughter)

Moderator: Not gloves, the other ones,

Woman: Yes, waah!, that is why you were sending children away from this place (laughter) Now I understand, they are called *kodomi*

Woman 2: If one has the virus they can use these things.

Moderator: Which ones?"

Woman 2; *kodomi* (elderly and middle-aged women, Lower Lpartuk)

Those papers (condoms) will finish you people! Even if you use the plastics, what about the sweating that takes place! I hear the plastics also come out, what happens! (FGD, elderly woman, Laikipia).

Woman: Your condoms usually have a hole in the middle and the liquid just slips out and you end up dying. It's true I heard that they make holes using needles to make a hole (FGD, middle-aged woman, Lower Lpartuk).

Moderator: Who is likely to do that?

Woman: The *sindani'* (secret lover) so that he does not die alone (FGD, middle-aged woman, Lower Lpartuk).

Other observations were that the condoms could cause health problems and that is why they would not use condoms:

Woman: It is also said that condoms also have some disease.

Moderator: Who told you that?

Woman: Even the people who taught us told us so.

Moderator: Which disease does it cause?

Woman: It is said it goes until the stomach, and then it has to be removed by an operation (FGD, middle-aged woman, Sirata Oirobi).

The belief that the body had only one system that contained the throat, the stomach and the womb, hinders the understanding of the reproductive system. This was pointed out by Anne Kanai, a nutritionist and an NGO programme manager, who has worked in the Samburu District for about thirty years and who was interviewed for this study. She explained that when a woman gave birth she was given very light

food because if she ate a lot this would affect the womb, which needed to heal. The women were not aware that the reproductive and the digestive systems are separate and function independently of each other and it was not possible for a condom to end up in the stomach or in the throat.

Most women in the focus group discussions expressed fears about the use of female condoms and also the lack of knowledge about how female condoms should be used.

For me, I am afraid the condom might burst (FGD, young woman, Lkurom).

Woman 1: How do we put it on since there is a way in which the male condom is worn, how about ours? (Laughter)

Moderator: (Explains to the women how it is worn). After use you remove it and dispose of it.

Woman 2: Do you remove it yourself?

Woman 3: Yes you do. Who do you think removes it for you? (Laughter) (FGD, middle-aged, women, Sirata Oirobi).

Woman 1: How do you put it on? (Laughter)

Moderator: You press it here for it to be small, then you push it inside then it will open when inside, then you can use it.

Woman 1: In the stomach?

Moderator: Yes, in your body, not stomach since it cannot go inside.

Woman 2: What we fear is if the condom goes into someone's stomach (FGD, a young woman and a middle-aged woman, Lemisigyo).

Woman1: Samburu women do not know how to use those things and so they don't want them.

Moderator: But why? (The moderator returns the condoms back to the packet and wipes her hands).

Woman 1: Can't you see that even her she is wiping her hands? (Laughter) (She looks so disgusted!)

Moderator: But this one was an unused one!

Woman 1: Yes but, I cannot touch it!

Woman 1: I thought they are worn throughout! (Laughter and more laughter!).

Woman2: Now that you say you don't want them, what if you get infected?

Woman1: Fine we just get infected because for me, I cannot use them "*Miyiou taa ntuku*" (I don't want that thing).

(FGD, an elderly woman and middle-aged woman, Lkurom)



Another observation that came out of the focus group discussions was that the condoms are for young people and therefore the older women distanced themselves from the possibility of using the condoms.

Woman 1: We have sons who are old enough who are in secondary schools and others who are old but not in school like the *morani* (warriors), and we hear them talking about 'kondomi'. (Laughter)

Woman 2: But, truly we have never seen nor used those 'kondomi'. We just see the young men carrying them.

Woman 1: You just see them carrying them or you see them in their boxes and when you ask them, they just brush you off or give some naughty answers but can't tell you what they are (FGD, elderly women, Sirata oirobi).

None of the women in the focus groups had used condoms, in fact, one commented that "we have refused to use these things" (FGD, elderly woman, Baawa). An NGO worker who was interviewed and who works with an organization that deals with family planning expressed the fact that they faced a lot of resistance from Samburu women because of the perception that they were given gadgets so as to have fewer children. The sexual act is meant for conception and so the use of condoms would be contrary to their beliefs and culture. The women in the focus groups also stated that their husbands did not use condoms, also an indicator that the sexual act is meant for conception, sharing, trust and intimacy.

The women said that the condoms were available in town chemists where *morans* bought two condoms at a hundred shillings; the condoms were also available in hospitals where they were free. Most women in the focus group discussions associated the condoms with hospitals. This is because the medical personnel from hospitals told them about condoms. As mentioned earlier, hospitals are treated with a lot of suspicion and therefore condoms are treated in the same way. Some mentioned that the condoms were wrapped in papers like medicine *Idawa*. Health workers also pointed out that preserving condoms was problematic because of the heat and they suggested that wooden condom dispensers should be made available (Samburu Report 2008: 13).

#### **6. 4. 6. 1      *Observations of NGOs, FBOs and GOK workers on condom use***

When asked about the preventive measures that Samburu women undertook, the following views were expressed by the NGOs, FBOs and government workers during the in-depth interviews:

They even do not advocate the use of condoms, it is very hard to distribute condoms amongst them (NGO worker, age 20-30 male, Maralal)

Condoms are not welcome, for men they can use but for women, it's not for them to decide. The decision is with the man (GOK worker, age 31-41, male, Maralal).

It's the man who ends up making the decision whether to use condoms or not, in any case it's only the male condoms that are available (NGO worker, age 31-41, male Maralal).

They don't like condoms, even these condoms and are they really available? Can you access them; say you are living 70 kilometres from Maralal. Some of them have not even seen these condoms (GOK worker, age 31-41, male, Maralal).

With prevention, it is the same but we are talking about the behaviour, which is still hard to change. They know how it is spread and how it is prevented but still they are practising. We could be leading in the province in new infections like we did in 2003 and I believe we could be leading again in the Kenya AIDS Indicator 2007 (GOK worker, age 31-41, male, Maralal).

There was a conversation among men and they were saying, "now that the virus is in homesteads, if you don't have sex, you don't reproduce. If you don't reproduce you will wipe yourselves out. The virus wants to wipe us out". They are saying there is a big problem but they don't know how to handle it (NGO worker, age 42-52, Male, Maralal).

It is clear from the comments above that the condom as a preventive measure has not been accepted as one way of protecting one self because it conflicts with the desire for conception. Like the Masaai community, it would appear that the Samburu community "are unwilling to use this technology, as their sperm will then be ejaculated into the condom rather than the woman, returning to the man and entering

his body instead. In that condition he is incapacitated to produce and, as such, is a useless man” (similar to a man without an erection) (Talle 2007: 366). The hallmark of a respected Samburu man is to have many children, many wives and a large herd of cattle. A woman is said to be worth her salt if she has many children although she has no legal claim over them (Talle 1994: 280). This gives her some recognition and acceptance in the community, so telling a woman to use condoms is to curtail her status. In addition, the Samburu woman cannot decide to use the condom because it is not her prerogative to do so. Coast points out that “although human biology is the same everywhere, sexual behaviour in general and condom use in particular are the result of complex socio-cultural values and economic and political conditions, which differ from one society to another and between different groups within a society” (2000: 13).

#### **6. 4. 7           Discordant couples**

Another issue of concern is that of discordant couples as shown by the in-depth interviews:

This is where you find that the husband is positive and the wife is negative but when you ask her how she will prevent herself from being infected. Some of them say, we can divorce or run away because if a man is there he has authority over me, unless I divorce him or run away. The decision to use a condom is entirely on the husband. If he decides not to use a condom, then the wife will not have a choice, so its for the man to decide and it becomes difficult for women to make a decision (FBO worker, age 31-41, female, Maralal).

Interviewer: Even on separation it is difficult?

Yes, it becomes very difficult even going to your family, you will be asked, why did you come? You are married to that man go back! Even if he is sick, *Wanasema ni mzee yako! Utaenda kukaa na yeye mpaka akufe* (that is your husband you will stay with him until he dies). Her responsibility is to take care of the family as well as the ailing husband (FBO worker, age 31-41, female, Maralal).

When a husband is infected the wife will stay with the husband whatever happens but she cannot leave her husband, If the wife is problematic, the husband will marry another girl from a certain manyatta and he takes cows or camels if he is wealthy (GOK worker, age 31-41, male, Maralal).

Interviewer: He will take his infection to his new bride?

Yes! (GOK worker, age 31-41, male, Maralal).

The Samburu woman is at risk of HIV infection because she lacks the power to make an independent decision regarding her own sexuality and her own life. The Samburu woman has a subordinate status in the community. It is evident from the information above that societal factors such as inequality and discrimination of the Samburu woman expose her to risk and vulnerability to HIV/AIDS.

If you tell the women that there is a hyena that eats goats at night, they will struggle and not sleep well because the hyena will come and eat the goats but if you tell them there is a disease that is killing people, as long as that person is not sick, that illness is not an issue to this person because there are many issues that people deal with especially drought, frequent droughts, lack of food and water, lack of pasture for the dying animals and the so called cattle rustling (FBO worker, age 53-65, Maralal).

HIV/AIDS is not seen as an immediate danger or serious threat because the repercussions are not immediate and they are more concerned with more immediate issues such as food and water for the families.

#### **6. 4. 8      The ABC approach**

The ABC approach (discussed in detail in Chapter three) is promoted by the government of Kenya. The researcher argues that this approach is inappropriate for this community for a number of reasons. Firstly, most of the people are polygamous and the community accepts this. Secondly, there are a number of challenges to the issue of abstinence. For example, school children are encouraged to abstain but the challenge was expressed by an in-depth interviewee as follows:

The people you are calling school children are mature people, they are young adults, they are young adults of 15, 17,18,19,20 and they are in primary school. So, they have already undergone initiation and they are sexually active and you cannot tell them to stop because they are in school. Abstinence is not viable because these children have been brought up in a sexual mode. They go to night dancing and the *morans* are there to train them. Girls that are between 10-12 years are

trained on sexual issues so that they are not problematic to their husbands and they are expected to have some experience. When people talk about abstinence it does not occur and when you talk about being faithful, with *sindanism* being rampant in the community, you find that even being faithful to who? I mean being faithful to who? (NGO worker, age 31-41, female, Maralal)

Fidelity does not feature because of the cultural expectations of the members of the community, especially where widows are concerned. An NGO worker observes that:

And the men are always there taking care of other people's women. So, furthermore they say that when you are being faithful, you are being selfish. How do you expect widows to survive and there are so many widows whose husbands died in raids and they are considered heroes, so who will take care of this widow whose husband died as a hero? (NGO worker, age 42-52, male, Maralal).

Condom use is considered a viable option for those who are in towns and are aware of the dangers of relating without protection but once they go into the interior they do not care to use the condoms. The condoms are not even available and those that are available need proper storage because of the high temperatures in the Samburu District and the perception is that those who are in the interior are HIV free and there is no need for using the condoms.

With condom use, condom use they do understand about it because it gives them a wider range of interaction, and it's not limiting them to have sex in a sensible manner (NGO worker, age 31-41, male, Maralal).

Condom use appears to be is confined to town centres and coined to young people. The ABC approach is of limited value to Samburu women and young girls in particular because they lack social and economic power and live in fear of male violence. They have no mandate to negotiate abstinence from neither sex nor can they insist their partners remain faithful or use condoms (UNAIDS 2004: 68; Coast 2000: 15). The cultural expectation is that sexual decisions are male dominated and this brings out the unequal status and vulnerability to HIV of Samburu women.

#### 6. 4. 9 Knowledge level of Samburu women regarding VCT

When the NGO and government workers were asked about VCT (Voluntary counselling and testing) centres, it appeared that fear of stigma and discrimination was the major issue that prevented the community from being tested. There are also very few VCT centres in the Samburu District. The fear of stigma and discrimination is highlighted in the following comments through the in-depth interviews:

People don't like VCTs because of the stigma associated with the disease if you are diagnosed and you are positive, you don't have friends, you have no company. VCT is not something that has been embraced (GOK worker, age 31-41, male, Maralal)

If there is something they reject in totality it is the VCTs. This is because they don't regard HIV as deadly and even if it is a more deadly disease than other diseases. And if it is deadlier than others dying is dying, being sick is being sick, whether malaria or tuberculosis or cancer, it is sickness. For them all diseases lead to death why bother about this one. And so they will reject that for them knowing their status and not knowing is not a bother, it is beyond their ability. In fact, you will be bothering them by telling them to be tested or to visit VCT centres (FBO worker, age 53-65, male, Maralal).

Some are aware of VCT but going there is a problem. For women they are tested when they attend antenatal examinations at the clinics, HIV testing is compulsory but for one to come from home for VCT, even for you, or even men or the educated ones is hard. People go to the VCT if they have been referred there by the community's own resource persons in the village (NGO worker, age 31-41, male, Maralal).

The government has also introduced PITC (Peer/Provider initiated counselling and testing) and DTC (diagnostic testing and counselling). In this case you do not consult, you just test. It's a new government policy, you cannot keep on treating somebody [for] pneumonia all the time and maybe it's HIV and because of his rights he doesn't want to be tested. The new government policy is that you just test even if it is not a recurrent disease or not, even if it is the first visit, yaah, with a cut or wound you just test to avoid the last minute where you try to save the patient's life and it fails (NGO worker, age 20-30, male, Maralal).

The concept of VCT (*kupimwa*) to be tested is often misinterpreted to mean body examination, they think now you are examining, you know body examination, whether you have a chest problem, and they are not used to coming to the District hospital. So, once they know *kuna daktari anapima wanajua kuwa magonjwa yangu yote ile inakaanga kwa damu itapatikana* (So, they say that all the diseases that are in

their blood will be detected by the doctor). And they assume a clean bill of health (NGO worker, age 31-41, female, Maralal).

It is clear from the above sentiments that VCT as a concept is not well understood and is not accepted because of the fear, stigma and discrimination that it creates for the community. Women may be reluctant to be tested because of the stigma, blame, difficulties they would face such as partner rejection, violence and psychological stress as a result of the diagnosis (Esu-Williams 2000: 123). It was evident from the study that the typical Samburu woman had a subordinate position compared to the man; the fact that she could be HIV positive would further socially marginalise her.

The concept of testing was not clear to the women as pointed out by a health worker because they perceive that going for testing means going for a comprehensive medical check up, yet the VCT centres only test for HIV. To de-stigmatize the concept of VCT, integrative testing is preferable where those who are tested are not segregated from other patients, so that they are not identified and consequently alienated from the rest of the community. The health officials reported that in Samburu District as a whole, that the VCT concept had several shortcomings like lack of enough trained counsellors, limited number of VCT sites and acceptability of the VCT concept itself as well as the poor road network (Samburu Report 2008: 8).

#### **6. 4. 10 Knowledge level of Samburu women regarding Anti-Retroviral Therapy (ART), care and management of HIV/AIDS**

The researcher also sought information from the NGO and government workers about what Samburu women knew about Anti-Retroviral Therapy (ART). They observed that the levels of knowledge were very low especially in the interior parts of Samburu District where information seldom reached. The taking of ARVs is also shrouded with a lot of misconceptions. The women as well as the men did not believe that one could take medicine for the rest of their lives. Medicine was only to be taken when one was unwell, if one felt well there was no need for taking any medication. This made the adherence to ARVS problematic because one would only

take medicine if unwell and that is not the regime of ARVs. The in-depth interviewees made the following observations:

You may also find that when women go to clinics and they are known by medical personnel that they are positive. They do not go back for treatment as long as the baby looks fine and if the baby is unwell they take the baby to the traditional women who treat children (GOK worker, age 31-41, male, Maralal).

Drug adherence is very poor, and it is even seen in the records in hospital that some of them could come this month; some will skip the next month and the following month. It will all depend on the problem they have at the moment. Some may not have food and poverty among women is very high so, some stop the treatment all together (GOK worker, age 31-41, male, Maralal).

When one is taking ARVs that person should eat well, but actually the food is not there because you find that one eats whatever comes their way and very little at that. Some people also take *chang'aa* (local brew) and they forget about the ARVs (NGO worker, age 42-52, male, Maralal).

Majority of the Samburu women live in remote areas and they may not be aware that the ART therapy exists because of their pastoral lifestyle and the fact that these services are not available at the divisional level. This implies that the women have been denied their right to health services available to other Kenyan citizens. The problem of distance in accessing services was expressed by an NGO worker as follows:

I'm sure there are clients out there but they cannot access and you cannot tell them to come 100 kilometres to Maralal (NGO worker, age 20-30, male, Maralal).

Women are more disadvantaged than men when it comes to the uptake of ARVs because the women depend on men economically:

One, the decision to get money to use, or get transport, not many women have that ability to get credit from somebody even to get ARVs. Two, women have a lot of work at home; a woman has to fetch water, firewood and to tend to young livestock. Three, it is the woman who shares out food that is in the house to the rest of the family. She has to ensure that the man has eaten; you know it means she eats last. This



means that when the food level is down, she is the one who is to miss and in a situation where someone needs food because they are taking ARVs, that one now becomes difficult to follow or sometimes they forgo the ARVs. I have come across people who say, when I don't have food, I forgo the ARVs because they are very strong (NGO worker, age 42-52, male, Maralal).

For those who are far, we even don't start them with the drugs, because of the distance, we know the person will not take the drugs the way they are supposed to be taken unless we take the drugs to the nearest facility and remember they are mobile. You may take the drugs to the nearest facility only to find that they have moved away in search of good pasture for their livestock and they are nowhere to be seen (FBO worker, age 31-41, Female, Maralal).

Another issue of concern is that the Samburu community as a whole believes in traditional herbal treatment more than modern medicine. People only go to hospital when the herbs have failed and by the time they go to hospital the disease is at an advanced stage and very little can be done. This phenomenon is also common in other communities. The Pharmacy and Poisons Board of Kenya observe that herbalists claim to "have remedies for all manner of illnesses including the ones that have defied modern medicine like HIV/AIDS, cancer, diabetes, and asthma" (Wesangula 2009: 4). When it comes to those who are HIV positive they fear either to go to the hospital or to be seen getting their medicines from the health centres. The main reason that makes them go to the herbalist for medication is:

Because they believe that if you are attacked by a disease that is incurable then it could be because of sin or maybe somebody somewhere is jealous of you or, your success and he must have done that to you (NGO worker, age 42-52, male, Maralal).

They prefer local herbs. They lack confidence in those *dawas* (drugs) and they fear being seen carrying the *dawa* and they are scared of picking the medicine from the health centres (NGO worker, age 31-41, female, Maralal).

They always have their herbs, which they trust more than artificial drugs.

If it is STIs (sexually transmitted infections), they know how to treat. *Matukuti* herbs clear STIs and even if they go to hospital they are given a clean bill of health they say (GOK worker, age 31-41, male, Maralal).

Herbal and other remedies are also used for the treatment of HIV:

They begin with the herbal treatment first. They also go to Lake Turkana and take some water called *mulgo*. This water comes from the underground wells *ya kuharisha* (to cause diarrhoea) to clear the infection. Others are given herbs and then they are put herbs when they are upside down, I don't know how they do it but it washes the stomach (GOK worker, age 31-41, male, Maralal).

The issue of concern that an NGO worker points out is that:

When they are not able to treat they bring the person to hospital, when the person is almost finished and only after the herbs have failed and they take you to hospital and leave you there, there are those who will abandon you. But they can just leave you in hospital. If you die they leave you just like they do in the *manyattas*. If there is death or someone is so sick that death is eminent in the *manyatta*, they move away and leave the dying person there (GOK worker, age 31-41, male, Maralal).

The use of the herbs was seen as one of the coping strategies that the women used. This does not mean that herbs do not play a significant role in combating other diseases, but there is no medically approved herb that can be used to cure HIV/AIDS. Information should be disseminated to clearly indicate that so far it is only the ARVs that have been approved that have been seen to sustain the health of a person and that there is no cure as yet.

#### **6. 4. 11 Views and attitudes on care and management of HIV/AIDS**

The Samburu community appear to have a philosophical view of death, that there was no point of fighting it. This view was succinctly expressed by an in-depth interviewee that:

Why struggle with someone who is dying? Why spend so much on someone who is dying and resources area so limited? (NGO worker, age 31-41, male, Maralal)

The Samburu community lives in a harsh environment where resources are scarce and drought, lack of water and lack of food are prevalent in the community. The adage 'survival of the fittest' prevails. This could explain why the community would rather concentrate on the healthy and discard the unhealthy. The management of HIV/AIDS in terms of uptake is poor because it is apparent that those who are HIV positive are not fully aware of the benefits of taking the drugs. This is because if someone is known to be HIV positive they are considered outcasts and therefore very few people disclose their status because of fear, stigma and discrimination. The other challenge is that the follow-up regimes that are limited or non-existent or impossible. Those who live in the interior do not have an opportunity of using the drugs because they are only found in big towns. The fact that the District also has a limited number of ARV sites and inadequate diagnostic laboratories does not improve this service to the community and that also explains why the ART concept is unknown or unacceptable to them because it is alien to them (Samburu Report 2008: 8).

#### **6. 4. 12 Knowledge level of (Post-Exposure Prophylaxis) PEP Therapy**

The Samburu women are not aware that rape or forced sex can make them vulnerable to HIV/AIDS infection. Access to PEP is further complicated by a complex definition of rape. There did not seem to be a clear demarcation between consensual sex and forced sex unless one crossed age group or clans. Rape in this community is hardly reported. The concept of rape is complicated especially in a culture where:

A man is authorised to have sex with you, I mean if it is a Samburu person, and if this person is in your husband's age group, having sex with the man should not affect you. Even if you are raped or forced to have sex, you better keep it to yourself than exposing yourself. Rape in the Samburu community is not recognized culturally (NGO worker, age 31-41, female, Maralal).

If a case is reported it is solved in the cultural way where one is asked to pay a fine. The majority of the cases are not reported because this is not seen as a shameful

thing. Women themselves are usually blamed for the act and that is why a woman would rather remain silent.

The different concepts of rape for an outsider and the concept of rape for a member of the Samburu community, as pointed out by an NGO worker, further complicates the issue:

According to me I will perceive it as rape but according to them they perceive it as normal. Because *moran anapompata msichana na then anaagusha tu hapo*, (when a Moran gets a girl, once they ask for the name and they know that they are not related, he goes ahead and has sexual relations with the girl without even asking her) you know that is rape. The girl is not ready, and since there is no preparation there will be a lot of bleeding all over. At the end of the day, I will perceive it as rape but they will say that it is normal. When we talk about rape and we say it is taking someone forcibly or unwillingly, they don't understand. (FBO worker, age 20-30, male, Maralal).

A woman who has been raped does not disclose this to anyone even if there is a danger of HIV infection because it is seen as a shameful thing. The other people who are vulnerable to rape are the single mothers, widows and unmarried girls and especially orphaned girls, their cases are not taken seriously by the elders (NGO worker, age 53-65, female, Maralal).

Rape seems to be acceptable in the Samburu community. It is a favour to the girl because it is part of her growth. This therefore means that rape is not linked to HIV/AIDS even where there is forced penetration or physical abuse and this is dangerous because no precautionary measures are taken and the Samburu District hospital does not offer a PEP therapy service.

UNAIDS observes that "although the epidemic is into its third decade, basic AIDS education remains fundamental. Rural women have been observed to be the least informed about transmission of HIV/AIDS" (UNAIDS 2004: 74). Women are denied knowledge and tools to protect themselves from HIV. Low HIV transmission knowledge is observed in many other societies and it denies the women the opportunity to protect themselves (UNFPA 2002: 68).

## **6.5           THEME 2: CULTURAL ASPECTS THAT MAKE SAMBURU WOMEN VULNERABLE TO HIV/AIDS**

The government of Kenya concedes that the HIV epidemic remains strongly associated with cultural patterns. It is also noted that women's vulnerability is compounded by a male dominated society (Kenya 2009: 26). Many cultural aspects of the Samburu community stand out as the main conduits facilitating the spread HIV/AIDS. Readily identifiable cultural aspects that predispose Samburu women to HIV/AIDS are polygamy, early marriages, secret lovers (multiple partners), wife inheritance, the beaded girl and FGM and body piercing. The women gave their views regarding what they knew about the spread of HIV/AIDS through various cultural practices that are discussed below.

### **6.5.1           Polygamy**

Polygamy is accepted in the Samburu community and men are known to have up to ten wives. Polygamy is a cultural indicator of one's economic status. There is a lot of work in the *manyatta* and hence the need to have more children to boost the labour force. The image of a prosperous Samburu man is one of many wives, children and animals. The social standing of a happy Samburu woman is one who has many healthy children. An NGO worker whose organisation deals with reproductive health points out that:

They have the perception that they are very few as a community therefore the norm is to marry three to four wives and get as many children as possible because you do not know how many will survive. You can have a family of fifteen but only five who are alive. Also, with early marriage if one marries at 10 years chances of getting many children are very high and by the time a woman is 30 years old she may have very many children and that is why family planning in the Samburu community is very difficult (NGO worker, Age 31-41, female, Maralal).

The women in the focus group discussions were asked if they saw any connection between HIV/AIDS and polygamy:

It is the worst since the wives are mostly not in terms and so if one gets the virus then it spreads to the rest. If the man is infected it gets to infect the others so easily (FGD, Young woman, Lpartuk (one) Lgoss).

Woman 1: There is no man who is old (cannot have sex). They do not get old unless one is unable to walk on his own and just lies in bed. Men are always active (laughter).

Woman 2: The only man who cannot do that (have sex) is one who is dead! (FGD, Middle aged, women, Lkurom).

The women expressed the fear that their husbands could also infect them with HIV/AIDS, yet they had no control of the situation and the fact that they had other sexual partners apart from their wives. A government officer in the health sector points out that polygamy continues and even if men are aware of the dangers they do not want to change.

The older women felt that it was the younger women who were spreading HIV/AIDS because they had other sexual partners in addition to their husbands:

On the side of the women, Samburu men marry two, three or even four wives and these women are not of the same *ntowo* generation. Some are old and some are young. These young ladies can bring the virus to the man and the man spreads it to the old lady or ladies. Then the homestead gets finished (FGD, elderly woman, Lkurom).

The women do have an idea of how HIV can spread in a polygamous setting especially through the young brides who are married off to older men without their consent by their parents.

### **6. 5. 2 Early marriages**

The age difference between men and women was also pointed out. Many Samburu brides are as young as 10-12 years and their husbands could be as old as 60 years old. These early marriages serve as a form propagation of unity and link people to different clans, a form of friendship, dowry and prestige. If your daughter is married to a good person, you have a good son-in-law and you can build your name from there (Spencer 1965: 212). Young girls who have undergone FGM are usually seen to be ready for marriage to men who are 10-15 years older. Men of the same age group are free to have sexual relations with each other's wives just as they shared

girlfriends when they were *morans*. The community does not see the link between HIV/AIDS and early marriages. Those who live in towns may see the link but those who live in the interior may not see the link, they see this as a normal thing in the community and they cannot use HIV to bring it down or discourage anyone.

The economic aspects of marrying young girls off to older men were alluded to:

The Samburu community's economy revolves around livestock mainly and it is only older men who have wealth in the form of cattle, sheep and camels. A parent would prefer to give out his daughter to that *mzee* (old man) who has wealth than give her to a *moran* (warrior) who in return will pay nothing, the girl is assured of a relatively comfortable life. Many Samburu families have large families and if they continue giving birth and resources are scarce, they will continue selling the seven-year-old girls for one to continue feeding the other boys who are at home (NGO worker, age 31-41, female, Maralal).

Another NGO worker points out that "they do not realise that early marriage can cause or be a link to HIV/AIDS". One of the respondents (who works with a FBO) expresses his sentiments as follows:

I have had differences with the *wazees* (elders) many times because I tell them point blank that those early marriages are legalised prostitution and so it is the men who are entirely to blame because you give your daughter of 11, 12, and even 10 years to somebody aged 60 years. This is child prostitution (FBO worker, 53-65, male, Maralal).

The fact that young girls are married off to older men gives them an impetus to go out and seek younger men and the fact that they have multiple partners increases the risk of getting HIV.

Heise and Elias point out those young girls are especially vulnerable to HIV/AIDS because they are introduced to the world of adult sex when they are prematurely married off as children (1995: 936). One NGO worker who relates a case of how early marriage can ravage the life of an innocent child:

Like now yesterday I took a girl to the dispensary who is married by a HIV positive teacher and the parents were aware that the teacher was sick because everyone knew that he had lost a wife and a child due to

HIV/AIDS. The parents of this 16-year-old girl knew that the teacher was HIV positive but they still gave him their daughter. The girl is now HIV positive and she has already had a miscarriage due to her condition and her husband has full-blown AIDS. This girl did not have a choice, choice; she could not refuse the marriage because it is the father who decides who she will marry. She is now under ARV therapy (NGO worker, age 53-65, female, Maralal).

The family of the girl may not acknowledge that HIV/AIDS exists since the lure of money and the prestige of having a daughter married to a teacher is too strong.

The laws of Kenya state that “Children have a right to education” (The Children’s Act Cap 586 pg.8). Early marriages pose another challenge in that girls’ education is curtailed at such an early stage that they do not complete their basic education (primary education).

One respondent explained:

When children enrol in schools, the number of girls may be higher than that of boys that is classes 1-3. The boys at this age take care of the young livestock, so, it is the girls who are more available to go to school. By class 5 the number of girls drops drastically for example, if a school had 50 girls in class 1,2,3, in class 5 the number drops to 23, in class 6, it declines to 7 girls, and in class 8 you get only 2 girls (FBO worker age 20-30, male, Maralal).

This has created a problem for the empowerment of women. As observed in the focus group discussions, the majority of the women had little or no education because they did not have a chance to go to school because they had been married off by their fathers. The government policy on free universal education is not recognised in the Samburu community. UNAIDS 2008 report on global HIV/AIDS observes that “promoting universal education studies has shown that higher educational levels have lower HIV prevalence” (69). Taking girls to school reduces girls HIV risk and vulnerability. Girls who complete primary education are more than twice as likely to use condoms; while girls who finish secondary school education are between 4 and 7 times less likely to be infected with HIV (Hargreaves & Boler, 2006). Girls may not have many choices regarding their lifestyle as expressed by one respondent in the in-depth interviews that:



The environment is too harsh for these people. In as much as we blame people for being rigid in their culture, the external forces that make some behaviours so stiff, one, that there are no enough schools available, the lifestyle, moving from one place to the other seasonally. The geographical location of these people leaves them vulnerable to practice early marriage because they don't have alternatives (NGO worker, age 31-41, female, Maralal).

Under the Children's Act, which became operational in 2001, and whose purpose is to protect children, the Government of Kenya says:

A child in need of care and protection is one:

- Who is prevented from receiving an education
- A girl who is likely to be forced into female circumcision or early marriage
- Who is forced to practice customs which are harmful to his life, education and health (The Children's Act cap 550: part x pg. 42).

The Children's Act also stipulates what should happen if this law is violated.

If a child is subjected to early marriage, the court should make an order rendering such a marriage null and void and requiring the child to be placed under the care of a fit person or in school (The Children's Act CAP 550: 44).

The community seems to be aware of the laws of Kenya but they simply ignore them or they do not find them relevant to their community. This is because the marriages of these young girls are shrouded in a lot of secrecy so that those who are deemed outsiders to the community are not privy to these activities or information.

### **6. 5. 3 Sindani (Secret lover)**

As pointed out earlier, early marriages lead to a wide age gap between the husbands and wives so that the young wives are forced to have secret lovers referred to as *sindani*. Many young brides usually continue to secretly have affairs with their former lovers. The women choose who their own lovers as opposed to the formal spouse who is chosen for them by their fathers. The relationship between the married woman and the Moran is based on mutual attraction and is a way of countering the authority of the husband and that of the patriarchal system (Talle

2007: 363). This dilemma is pointed out by one government worker who says that this difference in age can be problematic. A female NGO worker who has lived and worked in the District for over thirty years describes the secret lover (*sindani*):

A *sindani* is someone you know and you have a relationship with him. They believe here that *kila mtu lazima awe na hiyo sindani*, its not bad *lazima* (everyone must have a *sindani* it's not bad it's a must).

Because *eeh, sasa mimi nitachukua msichana wangu aende* (I may give my daughter in marriage to someone) I give her away to somebody she doesn't know so behind my mind I know she had a *morani* (Warrior) before as her *sindani*. That is why they do not see it as *loloito* (prostitution) (NGO worker, age 53-65, female, Maralal).

The practice of having two or three permanent lovers in addition to occasional lovers is common among men and women referred to by Halperin and Epstein as concurrent partners (2004:5). A woman or a man may have 7-10 sexual partners, spouses included at any given time. There are also men and women who may have as many as 10-20 lovers (Talle 2007: 353). Women in the focus groups were reluctant to acknowledge the fact that having lovers was risky. They were adamant that they must have the *sindani* no matter what the risk. This large sexual network is a significant risk factor in the spread and control of HIV.

No, we cannot stop (the issue of *sindani*), it has been there since, it is just like a *desturi* (custom). Even you right now do have secret lovers! (Laughter) (FGD, middle- aged, woman, Lekuru).

Secret lovers contribute to spreading AIDS and also put their spouses at risk but then some women have a *sindani* to supplement food for their families (FGD, middle- aged woman, Laikipia).

Parents marry off young girls to elderly men due to wealth from dowry and so the young girls have to look for younger men for sexual satisfaction. The *sindani* is also used to sire children where the husband is either unable to have children or is too old to fulfil his conjugal rights (FGD, elderly woman, Laikipia).

The young married women feel that they are not happy with the old men they get married to, they say they need someone they can talk with, laugh with you because you see culture does not allow women to associate very closely with the husband to discuss, talk or share about issues. The women seem to be on their own and the husband is also on his own (FBO, Age 31-41, female, Maralal).

An NGO worker comments that the women say that “So, there is no problem there because this *mzee* (old man) will come to me to look for two to three children and when we get the children he will leave you and go and marry another wife so, *sindani* is acceptable” ( NGO worker, age 31-41, female, Maralal).

The secret lover (*sindani*) also plays other roles. According to the responses they provide emotional support, financial support and social support. When the women were asked whether there is a danger of the *sindani* infecting one with HIV, they categorically denied that this could happen. They did not want to hear that the secret lover may spread HIV/AIDS because they were emphatic that they must have *sindani*. When asked about the *sindani* causing death, they said they would rather face death than stop having a *sindani*:

We cannot stop *sindani*. Let what is to die, die and what is to live, live.  
(FGD, middle-aged, woman, Lekuru).

The District AIDS co-ordinator observes that the “*sindani* is inbuilt, so to them they are aware of the spread of HIV but changing is a big problem”.

They do not see the link between *sindanism* and HIV/AIDS infection. In the *manyatta*, even the husband has a mistress. It’s true, that is the way it is even if you interviewed the market women, they would confirm that that is how things are. They do not believe the *sindani* can infect you with HIV/AIDS. They don’t believe, they reject (GOK worker, age 31-41, male Maralal).

For them, *sindani* is the right person *ni lazma ukuwe naye* (you must have one).” (NGO worker, age 53-65, female, Maralal).

If you don’t have a *sindani*, you are a lesser person (GOK worker, age 31-41, male, Maralal).

Interviewer: It’s like the old men give a blind eye to *sindani*

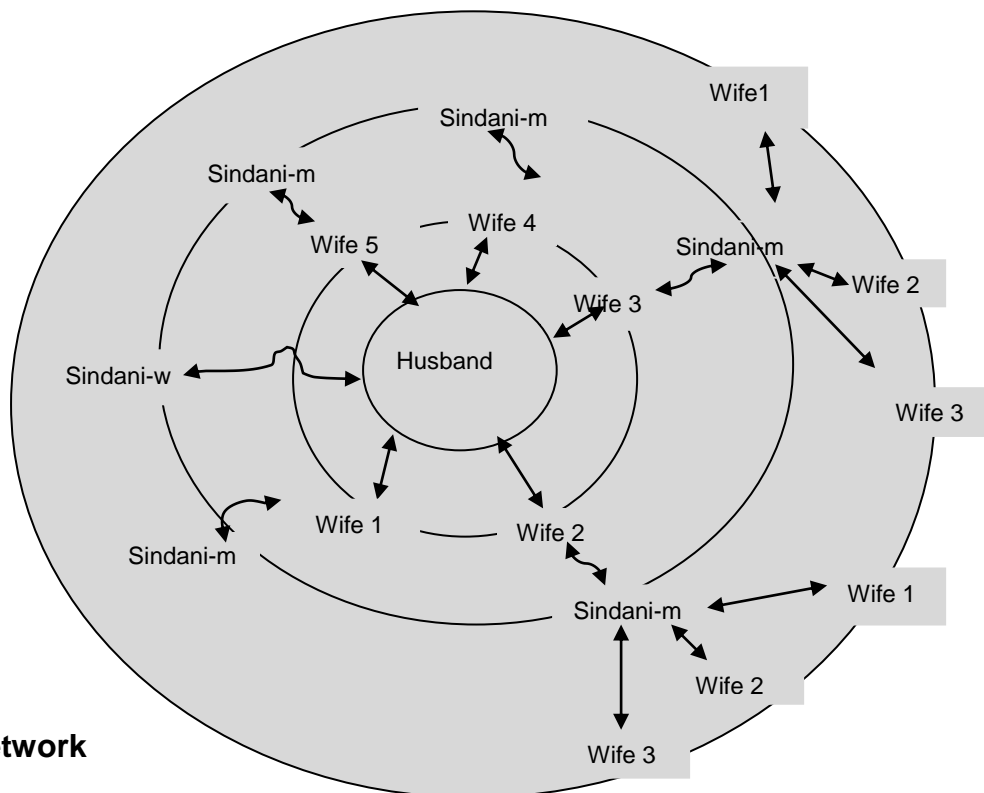
Respondent: Oh yes, they know, they do, of course. You know that you do not satisfy your wife socially and emotionally when you have five wives or more. How do you satisfy all their emotions? They (men) know that, *haja yao ni watoto* (they are only interested in having children) and labour force in his home (FBO worker, age 53-65, male, Maralal).

Spencer, an anthropologist who has done extensive research among the Samburu affirms that the older men are aware that their youngest and most attractive wives are seduced by the *morans* (1965: 144). The older men are unable to stop the younger women from having affairs because of the age difference between them.

Sindanism is so ingrained in the Samburu culture that calls for fidelity do not make sense because this is cultural conditioning; this is how they are socialised. *Sindanism* also has a deeper significance that was not disclosed by the women in the focus groups but one of the NGO workers during the in-depth interviews explained that:

You know '*sindanism*', you have an extra-marital friend outside your marriage, so that all your children you give birth to don't belong to one person in case of any curse going to the family, you still have a baby to rely on who is outside that family. And this is emphasised during weddings to girls by their families. They are told don't be a stupid woman who only keeps one man. Traditionally, it was a positive way of living when people used to go to wars, to raid cattle for almost a year. So, you get the *sindani* man to protect you and be there for you. But now with HIV/AIDS, it now complicates this relationship because you have sex with this person and you are not only having sex with this person alone, this person is also owned by another woman and this other woman has another association. So you find there is a lot of going round and round on sexual matters with different people and there is quite a high possibility of contracting HIV/AIDS (NGO worker, age 31-41, female, Maralal).

The '*sindani*' sexual network is illustrated in the diagram below:



**Figure 6. 1: Sexual network**

The diagram above shows how the spread of HIV/AIDS can be activated and sustained by the *sindani* network and how a whole society can be in danger of being infected with HIV/AIDS. As much as the women insist that they must have a *sindani*, the way in which they describe the *sindani* shows that this is a risky relationship. When they were asked whether the women can use preventive methods with the *sindani* and whether they discuss HIV/AIDS with the *sindani*, they had the following comments:

They also help spread the disease. They are the worst. They move with even nine people at once then go ahead and lie to each one of them (FGD, middle-aged, woman, Lekuru).

The older women accuse the younger women who have the secret lovers of risking the entire family.

Ask the young women because for us we have grown old and so we do not have lovers (FGD, elderly woman, Lemisigiyo).

The *sindani* scenario is not just confined to the people in the *manyatta* only, it traverses the whole community.

The educated ones have more *sindanis* than others, I remember one of the key persons, a high school teacher and her husband was a senior person in the government. *sindanism* is a tradition and you both belong to the same community whether you went to school or not, you belong to this community and this woman is permitted by the community (NGO worker, age 31-41, female, Maralal).

*Sindanism* is so accepted that:

*Na hata ukienda kustaki that your husband ako na sindani utachekelewa na kuchapwa kwa sababu ni lazima. Na hata mzee akicomplain atachekelewa kwa sababu ni lazima.* (Even if you accuse your husband to the elders about him having a secret lover, they will laugh at you and give you a beating. If on the other hand the husband complains, he is laughed at because this is a must) (NGO worker, Age 53-65 female, Maralal).

The *sindani* phenomenon in the Samburu community is one of the most difficult customs to contend with, especially with regard to the fight against HIV/AIDS. The women see the *sindani* phenomenon as the only freedom they enjoy since they have no right to choose their spouses or to decide on anything regarding their lives. This is the only opportunity they have a right to choose and they will fight tooth and nail to retain this right no matter how risky. The sentiment expressed by the young women in the focus group discussions was that they would rather die or be infected by HIV/AIDS than to do away with the *sindani*.

It will not be easy to influence the Samburu community to stop practicing their deep rooted cultural practices that were functional when there was no threat of such diseases such as HIV but a community based intervention must be developed.

#### 6. 5. 4 Loloito (Prostitution)

During the Focus Group Discussions with the Samburu women, when they were asked about the cause of the spread of HIV/AIDS they all stated that HIV/AIDS is caused by *loloito* (prostitution) *loloito* is described as:

When you go (have sexual relations) with everybody, anybody that comes your way, and you know these people also when they hear somebody is weak, they just go to that person whether man or woman (FBO worker, Age 53-65, male, Maralal).

*Loloito* is prostitution, to get money or food (FBO worker, Age 20-30, male, Maralal).

Women in the Focus Group Discussions were also asked whether there was a difference between a *sindani* and *loloito*. They pointed out that *loloito* causes HIV/AIDS infection and *sindani* does not cause the spread of HIV/AIDS. In the minds of the women although this secret lover may not be that trustworthy or may have other lovers, they do not believe that he can infect anyone with HIV/AIDS. The concept of multiple partners causing the spread of HIV is therefore categorised according to the Samburu women. It is believed that if you do the acceptable things within the cultural cocoon then you are safe, but if you do things that are not culturally acceptable then you are susceptible to HIV/AIDS infection. The women felt safe with the *sindani* because this is culturally acceptable but the women were quick to point out, for example, that if people get out of their community and have sexual relations with the outsiders (meaning non-Samburus) then they can be infected with HIV/AIDS. They said that some of the young men who went to Mombasa and came home with rich, old European women were also a source of infection an effect of tourism.

The reason why one has a *sindani* is for sexual satisfaction, pleasure, conception and company and it is based on an ongoing relationship. In *loloito* (prostitution) there is no relationship and it is for monetary gain but the fact remains that both the two relationships expose one to a likelihood of getting HIV/AIDS. The concept of a regular sexual partner in the Samburu sense remains a complex issue because “regular” could mean more than one partner and yet be referred to as “regular”.

### **6. 5. 5      *Child beading***

Child engagement or beading *aishontoyie saen* is a major cultural practice found in the Samburu community that can influence the spread of HIV/AIDS. Girls as young as nine years are engaged to male relatives (sometimes as old as their grandfathers) by use of traditional beads. The young girl is adorned with beads and the mother is also given beads and lavished with food supplies by the male relative. Sometimes the mother of the beaded girl builds a *manyatta* outside the other *manyattas* where the male relative visits the beaded girl to engage in sexual activity. The ‘couple’ is allowed to have sexual intercourse but pregnancy is forbidden. In case pregnancy occurs, it has to be terminated by use of herbs or massaging the stomach. If a baby is born it is abandoned in the forest as “it would be mystically dangerous to allow the child to live” (Spencer 1965: 112).

This traditional practice of beading has the potential of spreading HIV in the community. In sub-Saharan Africa young women aged 15-24 have the highest HIV rate (Coast 2000: 7). Girls who are initiated into sexual intercourse at a tender age have immature genital organs which are normally inflicted with cuts and ruptures in the process of intercourse with older men who are experienced and who may have sexual relations with other partners thereby creating pathways for HIV transmission and increasing their vulnerability. There is also a potential of young girls being exposed to sexually transmitted diseases at an early age that predisposes them to HIV/AIDS infection. The beading of young girls still continued in the Samburu community and a NGO worker observed that “ this issue of beading will only go away when we encourage our people to be educated” (Ndirangu 2010: 3).

### **6. 5. 6      *Yimbo***

The “yimbo” (dance) tradition allows uncircumcised girls to participate in songs and dances in the moran’s *manyattas* and although sexual contact is not acceptable, it is often overlooked. The *moran* and the uncircumcised girl are allowed to be lovers although they cannot marry because they belong to the same clan and marriage is



prohibited and this relationship ceases once the girl gets married. A NGO worker explains that:

You see, a mother cannot stop her daughter from going to '*yimbo*' or songs, if she attains the age of being given beads this going out entails being able and having sexual relations with the *morans* (Age 53-65, female, Maralal).

Attending the songs and dances gives a girl the opportunity to gradually acquire her "right" to fertility- fertility has to be mediated and constituted culturally to prepare the girl for her future role as a wife and mother (Talle 1994: 280). Pre-pubescent girls are the sexual partners of the *morans* and several girls can be attached to one Moran but they also share them among themselves.

The *morans* are young men who have undergone circumcision and have to stay without marrying for a period of 15 years as dictated by tradition. Although the *morans* are single they are sexually active. These are the young men the young married women were referring to as *sindani* because they continue this relationship even when the girls are married by older men whom they cannot associate with but who their parents choose for them. The *morans* are also known to have casual sex with married and widowed women and this can greatly increase the risk of HIV infection since both the women and the men often have multiple partners. Talle observes that the relationship between the *morans* and the young girls has its own significance "The Moran's "work" on the immature girls, despite the occasional use of violence and brutal force, are acts of regenerating a moral and an ordered world" (2007: 358).

#### **6. 5. 7      Wife inheritance**

Wife inheritance is a cultural aspect that is a possible conduit for the spread of HIV/AIDS:

Somebody can be inherited when the husband had all the signs of the disease but still they will follow the culture. The community still

believes in the culture. They can give the woman (widow) to somebody else even when the status is known. They bless you with the widow (GOK worker, age 31-41, male Maralal).

Widow inheritance in the Samburu community may not be as elaborate as it is in Nyanza province among the Luo of Kenya but it is practised fastidiously (Shisaya 2003). A woman who has been traditionally married in the Samburu community by the killing of the marriage ox cannot remarry (Spencer 1965: 46).

You cannot be married twice; there is a bull, which is killed and once it is killed, it cannot be killed twice. Once it has been killed you are regarded that you belong to this man (NGO worker, age 20-30, male, Maralal)

A widow has to remain in the late husband's family and she has to be "blessed", (meaning to be given a husband by the elders), with a relative of the husband who could be a brother or a relative of the husband. If the woman is young, she should bear more children.

A respondent explains that: "When an old man of over 60 years lives for 10 years and then dies and then leaves a wife aged 20 years. She actually becomes free for all and chances of infection are high". (GOK worker, age 31-41, male, Maralal).

If a woman is not "blessed" with a husband then she relates to anyone who visits her and she can be at risk of being infected and also infecting other people and she does this until the elders "bless" her with someone who will take care of her.

There are a few observations regarding the life of a widow: The widow cannot decide who will inherit her, it is the elders who bless her with someone from her husband's clan regardless of her HIV status. The widow cannot transact any business regarding the sale of cows and goats even if her husband had many cows and goats. The inheritor is the one to sell on her behalf and get a commission out of the transaction. The inheritor does have sexual relations with the widow even if she or he is HIV positive, and she is expected to continue having children. She cannot get married to someone outside the husband's clan, marriage to the husbands' clan is permanent and this is symbolised by the ceremonial bull that is killed at dawn on the

wedding day. The wealth of the deceased man can be taken by his brothers if the lady is not strict, or she does not have mature sons who can take care of the family property. If the widow has a young son (10 years), they may not harass the widow, but if the widow has girls only, all the livestock is taken away from her because she is just a woman.

The issues raised above reveal that a widow's privileges are taken away from her with the demise of her husband to the extent that she cannot be a functional member of the community unless she gets a male companion from the clan. She does not own any livestock, which is the economic strength of this community. The widow becomes vulnerable to HIV infection either through inheritance or through sexual relations with other men in the community to support herself. It is clear that the socioeconomic strength of a widow in the Samburu community is curtailed and controlled. The Samburu community does not recognise laws that allow women to own and inherit property. This institutionalised discrimination is often compounded by cultural norms that require widows to marry a male relative of the deceased and as pointed out earlier, the widow has no freedom to marry outside her husband's clan.

The possible sexual network of a widow is also a danger to the widow herself, if she is HIV negative, but the inheritor could also be HIV positive. The widow could also be HIV positive and wreck havoc in the inheritor's family, by infecting the inheritor and also his wives as well as their secret lovers.

A government worker observes that wife inheritance continues in the Samburu community because:

They still deny the *wazees* (elders). Most people still deny the presence of this disease because they still marry even widows. (NGO worker, age 31-41, male, Maralal).

### 6. 5. 8      **Body piercing**

The Samburu community has a long history of tattooing the body for beautification purposes and also piercing the ears to adorn themselves. This applies to both men and women. Medicine men and herbalists also make cuts on the body to apply medication. When the Samburu women were asked whether they saw any link between body piercing and HIV/AIDS, the only link they saw was the use of razor blades where they said they should not share razor blades because of the risk of infection. A church worker who is involved in a HIV programme pointed out that:

They are responding positively even if they cannot stop piercing their bodies. We are encouraging them to use a single knife for single person so that if you want to have that decoration you go with your instruments and then after that you dispose of them. So the issue of sharing knives like what was there before is changing a bit not 100% but learning is taking place (FBO worker, age 31-41, female, Maralal).

A Ministry of Health official expressed his concern with the practice:

The community is aware that body piercing can spread the virus but they are still going on with the practice” (GOK worker, age 31-41, male, Maralal).

Some forms of traditional surgery can expose one to infection. An example is where the herbalist punctures the skin to suck out the infected blood.

If you have swollen legs and you go to the herbalist, he will puncture your legs by making small incisions using a razor blade and he sucks out the bad blood that is causing the swelling of the legs and he administers herbs on the cuts that have been inflicted. The herbalist can infect himself, if he has a wound in his mouth or infect the patient. The danger is that the herbalist does this blood sucking to quite a number of people and therefore chances of infection are high. If someone has been unwell for sometime like if they have stomach-ache or one has been unwell for some time, you will find they have the cuts indicating they have been unwell and that they have consulted a herbalist (NGO worker, age 53-65, female, Maralal).

The cutting of the epiglottis *n’gejeb* is mandatory in the Samburu community and can be a possible risk to the spread of HIV/AIDS to the community. The fear is that if

the epiglottis is not trimmed, they believe that it may grow long and block the airways as well as cause persistent coughing. This proves that cultural beliefs over shadow scientific knowledge and as a result lead to risky practices. It is the herbalist who does the cutting and he does that using his own instruments and if precautionary measures are not taken this can also be an avenue for HIV infection.

#### **6. 5. 9 Female genital mutilation (FGM)**

Female genital mutilation (FGM) in the Samburu community is mandatory. Cutting or excision of young girl's genitals is seen as a cultural rite of passage. Coast observed the same trend with the Maasai community where FGM is considered essential for correct sexual behaviour and fertility. "Female genital mutilation represents the acquisition of social adulthood and sanctions child bearing" (Coast 2000: 7). Talle reiterates that according to the Maasai community "the reproductive capacity of a woman is activated by cutting her clitoris" (1998: 96). A Samburu girl usually undergoes FGM at the time of the onset of puberty. FGM is an indicator that the girl has ceased to be a child, her social status has changed, and she is ready for marriage and childbearing.

FGM is a significant ritual that demarcates childhood from womanhood and is a cultural practice that is resistant to change. The Samburu women advocated FGM as a way of controlling the female sexual libido in women and this was one way of preventing HIV and prostitution.

The old women believe that the girls will be promiscuous, they will be (*wataenda kama vile mbuzi zinaenda zikifuatana* (that the girls will behave like goats on heat). There is a lot of misconception (NGO worker, age 31-41, female, Maralal).

FGM for girls under 18 was outlawed in Kenya in 2001 but the practice is still widespread. The side effects of FGM include bleeding, shock and sometimes death due to infection or heavy bleeding. Long term effects range from cysts to leaking urine and increased child mortality (Vukets & Mwaniki 2009: 4).

When the women in the focus groups were asked if there was a link between HIV/AIDS and FGM, they said that there was no connection between the two and therefore precautionary measures are hardly ensured. The women were not willing to discuss FGM because they thought that the researcher had been sent by the government agencies to dissuade them from practising this ritual.

When it comes to that cultural practice that they hold dear, they throw away everything else out even HIV/AIDS and they fall into the cultural trap (NGO worker, age 42-52 male, Maralal).

FGM is regarded as one of the highest-ranking cultural rituals.

Moderator: And can't you stop the circumcision of girls?  
*haij !* (Exclamation of dismay) *mepalai-* It cannot be stopped (FGD, elderly woman, Lkurom)  
All in a chorus: *meidimai !* –It is not possible! (FGD, women, Lkurom).

If they do not undergo FGM, the children we give birth to will be cursed. It is a bad omen. If I do not undergo FGM, I will not get a man to marry me. So there is stigma surrounding those who have not undergone FGM. That means that all the girls have to undergo FGM (NGO worker, age 31-41, female, Maralal).

Most learned girls do not want to be circumcised but they are forced to since it is a culture of the Samburu. In the Samburu culture, if you are not circumcised, you are not a person (FGD, elderly woman, Lemisigyo).

It is believed that if a boy or girl bleeds to death as it often happens, that girl or boy is cursed (NGO worker, age 31-41, female, Maralal).

The issue of FGM was sensitive because even the elite in the community still appear to support it and do not want to show that they were against it.

They are not stopping it soon, it is a big problem. We had a seminar with the Kenya leaders, with the District prevention officer and when we discuss FGM, everyone becomes quiet, they don't respond, that will to show that we want to come out of it is not there. When we ask suggestions on how to stop it, no one is willing to stop it, it is a very big issue (FBO worker, age 20-30, male, Maralal).

The fact that FGM is illegal and is, therefore, practised clandestinely is also problematic:

No one knows when it happens. It is done in hiding, so it's hard to know when it will be done or know the people who are doing it to tell them to take precautions is very difficult. That illegality that is associated with it makes it hard for anyone to intervene (NGO worker, age 31-41 female, Maralal).

The community has been sensitised about FGM but they still practise it. The women and the girls themselves accept FGM although the Government of Kenya deems it a violation of children's rights. It has been observed that the practice of using one blade for the initiates could spread HIV. The chances of children being infected with AIDS during circumcision by one knife is high because the blades are not sterilised (Adanje 2010: 32).

There are other communities that have had the ritual in the past but their elders have guided the community out of it as they have become informed about the violations of this practice. The Ameru of Kenya have done this through their council of elders called the '*Njuri Ncheke*'. The '*Njuri Ncheke*' has been very decisive about FGM since its 1956 declaration when it banned the rite of passage and any member who participates in this rite is fined heavily (Daily Nation 2009: 5).

Efforts to devise an alternative rite of passage have been made but the community is not prepared to accept any alternative. It was pointed out that some learned people within the community were not taking their daughters for FGM, thereby cutting the link with the community because the girls end up marrying non-Samburu men.

There have been attempts to have a less severe form of FGM but the women in the focus group related that young brides were being sent home by their new husbands to have the traditional form of FGM. The fact that the community is unwavering about FGM means that young girls will always have the risk of HIV infection as well as other infections associated with FGM.

The Samburu women interpret the danger or risk of infection in terms of whether the ritual or practice is sanctioned by the community or not. It seems that if a practice is sanctioned or is acceptable in the community then it is not harmful. In the absence of HIV/AIDS most of these rituals can be acceptable but with the threat of HIV creeping into the society precautionary measures are mandatory. Some of the men and women who go out of the community and get infected normally come back to the community and continue with their previous sexual networks. The fact that they may be oblivious of their status poses a great danger to the community. The spread of HIV will proliferate unless precautionary measures are adhered to urgently and with the gravity and seriousness it deserves. The elders who hold the sceptre of life and death should address this issue and make informed decisions on the course of action that should be taken. The Samburu community needs to address the issue of HIV/AIDS and come up with solutions that will not violate their cultural expectations but that will help them protect them from the scourge of HIV/AIDS. *Manyattas* are already being left empty or with orphans only because all the wives and the husband are infected and all the children being born are dead.

## **6.6            THEME 3: BELIEFS ABOUT AIDS**

When asked what they believed AIDS-to be the women in the focus groups said that it was just a disease that they did not understand. Some women thought that \*HIV was brought by God as a form of punishment. All the women in the focus group did not associate AIDS with witchcraft. The main observation is that majority of the members of the Samburu community consult medicine men to give them herbs for all types of ailments. Many Samburu people are suspicious about modern medicine and even campaigns such as polio or trachoma are treated with a lot of suspicion and there are claims that the medicines are laced with poison or that the medicine has doses of birth control medicine. The medicine men and their herbal medicine are more trusted than hospital staff and modern medicine respectively.

Most of the respondents interviewed in the in-depth interviews indicated that the community believe that AIDS is a curse. This then means that one can only go to the herbalist or medicine man who treats physical as well as the spiritual ailments. It



is only the herbalists who are believed to remove curses. The Samburu women in the focus groups discussions explained that the influx of modernity and Christianity were seen as the causes of the strange new infections that were not there before.

Since Christianity coming into the community, they have stopped offering sacrifices to their gods on Mt. Nyiro and that is why some of these incurable diseases are coming over to the people and those who get infected are those who go to the *mzungu dini* (white man's religion). The gods are unhappy and they are punishing these people because they are following *mzungu* (Whiteman's) gods (NGO worker, age 31-4, female, Maralal).

The community also believes that it is the non-Samburus who bring the disease to the community. They believe it is the other people from other communities who get infected and who spread the disease to them and not the other way round. This was pointed out by an NGO worker that:

Now that their culture has been eroded by the Western culture, people have left their normal way of living. It's like we are adopting the Western culture, there is no respect between the old and the young. On the issue of sexuality, they said they could stay without promiscuity in the society, so the change in lifestyle and their way of association has changed and that is why they are being punished (FBO worker, age 53-65, male, Maralal).

There is a belief that death must be caused by something that was done by one's family and there must be retribution. This is the cultural way of explaining death or the occurrences of strange happenings such as new diseases.

Even if they know it is HIV/AIDS, somebody will have done something to have contracted the HIV/AIDS virus. In Samburu, even if you are knocked down by a vehicle or bitten by a snake, or hit by a buffalo there must be something bad that you did. That you must have done a socially unacceptable act somewhere sometime like when he was travelling, he refused to give an old man a little water that he was carrying. It could be anything! (NGO worker, age 42-53, male, Maralal)

A church minister observed that even when a whole family has been wiped out by HIV/AIDS, they say that "These people are cursed, that is the sin of their fathers, probably this family had done something wrong and now they are paying for it." (FBO worker, age 53-65, male, Maralal)

### 6. 6. 1      **Tourism and AIDS**

Tourism was perceived to be one of the main causes of HIV in the Samburu community. Some opinions were:

Tourists, they are the worst since they get married to our children and end up infecting them hence its spread across the whole community (FGD, elderly woman, Lekuru)

The children who went to Mombasa and other big towns brought the disease to other people (FGD, middle-aged women, Lkurom).

Some women were taken from here to Mombasa by tourists to sing for them and they ended up having affairs with the European men so that is where AIDS came from (FGD, middle aged women, Lodokejek)

This experience is true, all those who have gone to Mombasa, when they come back to the villages, they come to infect others and at the end they die. They still call this disease the *Mzungu* disease and they still ask *Kama ni ugonjwa imetoka wapi?* (If this is a disease where has it come from?) Because they often ask me, what it is, where has it come from, why it is there, why it was not there before (FBO worker, age 31-41, female, Maralal).

Marriages between Samburu men and older European women are negatively viewed:

If they married and kept faithful to each other and live together as husband and wife, the lady should be as young as the man, not in a case where the man is young but the wife is just too old, that cannot be a family (FGD, elderly woman, Lemisigiyo).

If our son comes with an old European woman and tells you she is his wife, you fear to tell him to leave the European lady because she gives you a lot of money and the man is old enough not to be told to leave the lady. *Tamaa e silinki* (It is the lust for money) (FGD, elderly woman Lemisigiyo).

### 6. 6. 2      **Education and HIV/AIDS**

The Samburu women feel that education plays a significant role in the spread of HIV in the community.

The women have the following sentiments about educated people.

They pretend to behave like Europeans yet end up bringing the disease. They go to towns and various places then bring it to other people in the villages. (FGD, young woman, Lpartuk (one) Lgoss).

They are the ones who brought AIDS to our community. The doctors said that the people in the urban areas who are educated are the majority regarding the issue of being infected much more so than the rural people (FGD, middle-aged woman, Lpartuk (one) Lgoss).

Our school children are also to blame since they are the ones who bring (the disease) from other places (FGD, middle-aged woman, Lodokejek).

The women interviewed did not see themselves playing any part in the spread of the disease. They believe it is others who infect them but not vice versa. They do not take cognisance of the fact that they too could get the disease from Samburu men and women who had had no direct link with either the European men or women but through the sexual networks that were already operational. They drew from the general Kenyan culture where people hardly want to take responsibility for their actions:

As long as they look out, and say that these diseases are in “Kenya” Kenya meaning the developed towns such as Nyahururu, Nakuru, Nairobi meaning then the disease will continue spreading because no precaution will be taken as long as it is seen as a disease from outsiders; and a disease that is remotely far way from them; nothing much will be done as far as prevention of the disease is concerned. The outsiders may be blamed for the spread initially but now one does not need to go to Mombasa or out of Samburu land to get infected. (NGO worker, age 42-52, male, Maralal).

The threat of HIV/AIDS is mitigated by a sense of fatalism. The church minister explained that:

There is also a belief that one only contracts HIV/AIDS when their time for dying has come. A young man of 20 years will say ‘when time reaches for you to die by *bunduki* (gun) or you die by AIDS then the time for you to die has reached so, for them there is no need for them to take precaution (FBO worker, age 53-65, male, Maralal).

Death is seen as inevitable and there is therefore one need to do anything about it.

## 6.7            **THEME 4: ATTITUDES TOWARDS HIV/AIDS**

An NGO worker observes that women are seen as the carriers of HIV even if it was the husband who probably infected her.

Usually anybody who is positive is regarded socially displaced but in most cases it is the woman who is responsible for the spread and they say that she is moving or not taking care of herself or she is reckless. When they know it is the mzee (husband) who is responsible for the spread, they don't talk so much about it, where it came from or any of that but in cases it is known. If it is the lady they say *alipata kile alikuwa akitafuta* (she got what she was looking for (NGO worker, age 31-41, Female, Maralal).

The social status of the Samburu woman is very low under normal circumstances so, when she is known to be HIV positive, her circumstances are grave as observed by an NGO worker:

Women are considered just like children, the position of a woman is low, she does not have bargaining power. So you can imagine a woman is a nobody in the community, what about when she is sick, sick, she is like an outcast, she can be left you know, they keep moving. According to the Samburu, a woman who is infected is said to be a prostitute. They judge her very harshly. It is more acceptable when a man is sick (NGO worker, age 20-30, male, Maralal).

When a woman is infected, they regard this woman as getting the infection from different men who are not of their community. 'You must have had a Kikuyu boyfriend or you must have been given money to have sex in whichever context. So, they regard you as an unfaithful woman, a cursed person because their community cannot have that. If you moved around in your community, you would not get HIV (NGO worker, age 31-41, female, Maralal).

The Samburu community believes that HIV does not emanate from them. It is only the non- Samburus who can infect one with HIV and this is devastating to say the least because of the danger that looms in the future because infection and re-infection will take place as long as they believe that one cannot get infected with HIV. They believe that as long as they relate within the community no matter how many partners one has, one has immunity. This is not the case because the community is interacting with people from different parts of the country and the educated people

work away from home and they have sexual networks even where they work. They also have their sexual networks at home when they either come or leave to see their families. The men who go to the shopping centres to sell livestock also have sexual relations with commercial sex workers and this is a major HIV/AIDS transmission pathway.

A church AIDS co-ordinator says that the Samburu people strongly feel that HIV/AIDS is contracted through promiscuity. They also think that this is one of the major avenues of HIV transmission. Although this is true to some extent, the concept of promiscuity needs to be re-defined because the way it is held it will still promote more HIV infection. In the respondent's view having sexual networks within the community is not seen as promiscuity, promiscuity is defined rather as having relations with non-Samburus.

An AIDS co-ordinator from the Ministry of Health in the Samburu District referred to the isolation and abandonment in hospitals of those patients who had full blown AIDS:

Before they could not even touch, or even come near those who were sick. If it is the lady who is sick, the husband marries another wife who will take care of the children (GOK, age 31-41, Male. Maralal).

In the Samburu community AIDS may not be perceived as a reality or a challenge because even a HIV positive person will marry a HIV negative person because they either do not believe they can be infected or they do not fully understand the pathways of infection. It is all encapsulated in the belief that it is only a cursed person who can get infected. A husband may believe that it is his wife who is cursed, that is why the husband goes out to look for a new wife who is free from the curse.

Women are known to be the caregivers, so when the caregiver is ill the chances are that she has no one to take care of her. Men are given better treatment than women. When a man realises he is infected, he can go to hospital and leave his wife at home. He is also the financial controller so he can buy herbal medicine for

himself as opposed to the woman who has no access or control of resources. He can even slaughter a goat for himself to eat the mutton together with his medication. But in the case of the woman, a church worker observes: “unless it is the dying stages - that’s when you see them a bit concerned.” The woman is also in a precarious position because she is the one who knows her status first if she attends antenatal clinics:

When a woman knows she is positive, if she tells the husband, the husband denies it, he is always in denial. The men deny and they also reject the child who is HIV positive. They claim that the woman must have gone out with someone who is sick. The woman is blamed for the infection. It’s a big issue, most of the people we know who are HIV positive are women, like now in Suguta, I have 45 women living with HIV, they are all women, and there is no single man. Stigma is directed at the woman. At the end of the day the woman is at the centre of stigma (FBO worker, age 20-30, male, Maralal).

The implication is that efforts to curb any stigma and to empower the woman economically should take centre stage. However, the most disconcerting thing is that:

It is only the HIV women whose identities are known but the men who are HIV positive are unknown and they will continue to spread the disease in the community because they think they are safe and the disease is mostly referred to as “*ile ugonjwa ya wanawake*” (the women’s disease) (FBO worker, age 20-30, Male, Maralal)

## **6.8           THEME 5: COMMUNICATION**

This study also explored the communication channels that have been used to convey messages about AIDS and how receptive the Samburu women have been to these messages. Communication plays a salient role in the prevention of HIV/AIDS and the first level of this exploration is to find out whether the messages are received as intended with the desired results in terms of behaviour change. This section has two sub-themes:

- Modes of communication that the organisations use to convey HIV/AIDS messages.

- Reactions of the women to the messages on video, TV and film.

The section on communication started off by asking basic questions about communication within the community regarding HIV/AIDS. The women were asked to identify who had told them about HIV/AIDS. Some women had been told about HIV/AIDS by medical staff that held some seminars, some teachers, priests, the Catholic Church, school children, campaigns, non-governmental organisations and seminars organised for the women. The women therefore received HIV/AIDS information from varied sources. The majority of the information was through verbal communication, i.e. word of mouth.

#### **6.8.1 Modes of communication that organisations use to convey information about AIDS**

The organisations had a number of ways in which they passed on information about HIV/AIDS. A FBO indicated that they use the church platform and that after sermons, health messages are given. Brochures and posters are also given to those who know how to read. Churches also use cell groups in the villages where people pray, and discuss issues. Health information is also integrated. They also organise workshops and seminars for the women. Videos and/or films are also watched at night in the villages. One film that has been shown extensively is *Silent Epidemic*.

There was one (film) on STI and when we showed it, some people requested, actually 45, for medication because they realised as a result of seeing the film that they had the disease and required treatment immediately. The video shows work better than the talks (NGO worker, age 31-41, female, Maralal).

Other health based NGOs indicated that they mainly use audio-visual communication. They also use opinion leaders, chiefs, health workers and FBOs. Most of the information is verbal because of the high level of illiteracy and the use of community members to communicate HIV/AIDS messages. Peer educators live in the *manyattas* and teach the members of the community from within. Youth peer educators use drama, plays and role-play to communicate messages about HIV and other health related challenges. They also use participatory training where members

of the community participate in discussions and come to a consensus regarding matters that affect them as a community. What is remarkable, however, is that the issue of HIV/AIDS has not been considered a serious enough aspect to warrant a discussion.

The Ministry of Health supervises and provides expertise to NGOs in terms of ensuring that government policy is followed. The HIV/AIDS department has no funds set aside to produce any information or to carry out workshops. It is the other NGOs that provide funding. The department has books, pamphlets and radio cassettes on HIV. The District AIDS Co-ordinator is used as a resource person to train health workers from NGOs and to supervise and maintain the health standards stipulated by the government.

The researcher also wanted to know in what ways the AIDS messages are real to the women. Most women in the focus group discussions who attended the seminars responded that the messages became real to them when they watched the videos about the disease.

I understood best the information through seeing pictures shown on the TV (FGD, young woman, Lodokejek).

I understood better through the explanation of the educators (FGD, middle-aged woman, Lkurom).

I believed it best when I saw it in the videos (FGD, middle-aged woman, Lkurom).

For me I can say that I believed the information after seeing people who were infected by the disease who are my neighbours (FGD, middle-aged woman, Lkurom).

We have seen many who have died even in homes and so we believe. (FGD, middle-aged, woman, Lkurom).

Women understood messages better when they watched videos which depicted people who were HIV positive in real life situations. The videos were, however, subject to their own interpretations that may not have been the intended message. Therefore videos alone may not be adequate modes of communication regarding AIDS. This calls for a multiplicity of communication approaches. The women felt



removed from the disease because the videos depicted modern men and women wearing modern dress (and presumably educated). The women in the focus group discussions were dressed in the traditional regalia (*shuka*) and did not identify with the people they saw on the video, hence the perception that HIV/AIDS is a disease of those who have gone to school. In the Samburu community it is common practice that those who are educated do not wear the traditional regalia (*Shuka*) anymore. The women needed more discussions after watching the videos, so that if there were any queries or clarification needed, or if they misinterpreted the messages these misconceptions could be cleared immediately after the discussion

### **6. 8. 2 Reactions to HIV/AIDS messages on video, TV and film**

The women in the focus groups were asked about their reactions after viewing the videos or receiving the HIV/AIDS messages. They gave the following responses:

I felt so horrified and so bad and thought that everyone saw what I saw, they would have stopped these bad behaviours they practice. I have attended the seminars and we were told to use polythene bags when bathing the infected persons in case we do not have gloves (FGD, young woman, Lpartuk (one) Lgoss).

If people knew where this disease came from, then it could be chased away to wherever it came from since no one wants anything to do with it (FGD, old woman, Lemisigyo).

It was something I wished I never got associated with. It really horrified me and I just asked God to help my children not to get it. Even when I was asleep, I saw the pictures all through (laughter) (FGD, middle-aged woman, Sirata Oirobi).

We learnt that anyone can get the disease and so we should talk to the children if they will listen to us. Even at home we keep thinking of the pictures we saw (FGD, middle-aged woman, Sirata Oirobi).

Even at night, I still see those pictures and I hate them much since it eats up all the people; men, women and even small children born with the disease which enters into the eyes. Pus gets out of the eyes (FGD, middle-aged woman, Lemisigyo).

It is evident from the above responses that the videos that the women watched had some impact on them. Fear of AIDS was instilled in them further stigmatising

HIV/AIDS. The women felt very helpless because they could not control the HIV since they had no say where sexuality was concerned. The women also expressed the notion that HIV is spread through promiscuity here referred to as “bad behaviour” which is a myth.

When the women were asked about the change in behaviour after watching the video a number had the following sentiments:

One really feels scared and says she is not going to continue with '*loloito*' (prostitution) (FGD, middle-aged woman, Lekuru).

Moderator: Do you stop it completely?  
People only stop it after seeing it like for two days and then they continue with it again (FGD, middle-aged woman, Lekuru).

This observation indicates that after watching the videos the women felt that they needed to change their behaviour but after two to three days they continued with life as usual. It is also important to note that the older women thought that it is their young men who were at risk of HIV infection, but these women did not perceive that they were in danger of also getting infected too. The impression they got was that it is the young people who were in danger. It is not clear whether the videos depicted young people only or where this impression emanated from. It is important to mention that in almost all the focus group discussions the issue of the young men emerged during the discussion of the videos. The women did not identify themselves as being at risk of acquiring HIV after watching the videos. They felt that it was the others meaning young men and the educated ones who were at risk but not themselves. This is the notion of positive self representation and negative othering where there is a tendency to see ourselves positively and others negatively. The information did not have a lasting impact on them and the question is if they had been convinced by the video that it had a message why did the message not have a lasting value? There is a need to find out why the messages in the video did not have a lasting effect on the women or change any behaviour and why they felt that they were immune to HIV.

### **6. 8. 2. 1      *Descriptions of what the women had seen on the videos and films***

The women in the focus groups were also asked to describe the pictures they had seen about AIDS:

The person looked like any other normal person but then he shrinks, starts having boils and wounds all over, the hair starts dropping off. The body skin starts peeling off. The person looks anaemic; later on at a later stage the person has diarrhoea and vomits (FGD, middle-aged woman, Lpartuk (one) Lgoss).

In the first picture, I saw a woman who has been eaten by the disease in the womb. In the next picture it shows how one gets eaten up by the disease until she/he gets finished (FGD, middle-aged woman, Sirata Oirobi).

I saw a woman also with bones only. The disease had finished all the flesh and left only the bones. The private parts were finished. She had a wound that ends up finishing the private parts of that person (FGD, Middle-aged woman, Lkurom).

It is said that AIDS comes out from the body in form of worms (FGD, middle aged woman, Lower Lpartuk).

For us, we have seen one who removed a big worm which was the size of a snake and after removing it, she died on the spot! (FGD, middle-aged woman, Lower Lpartuk).

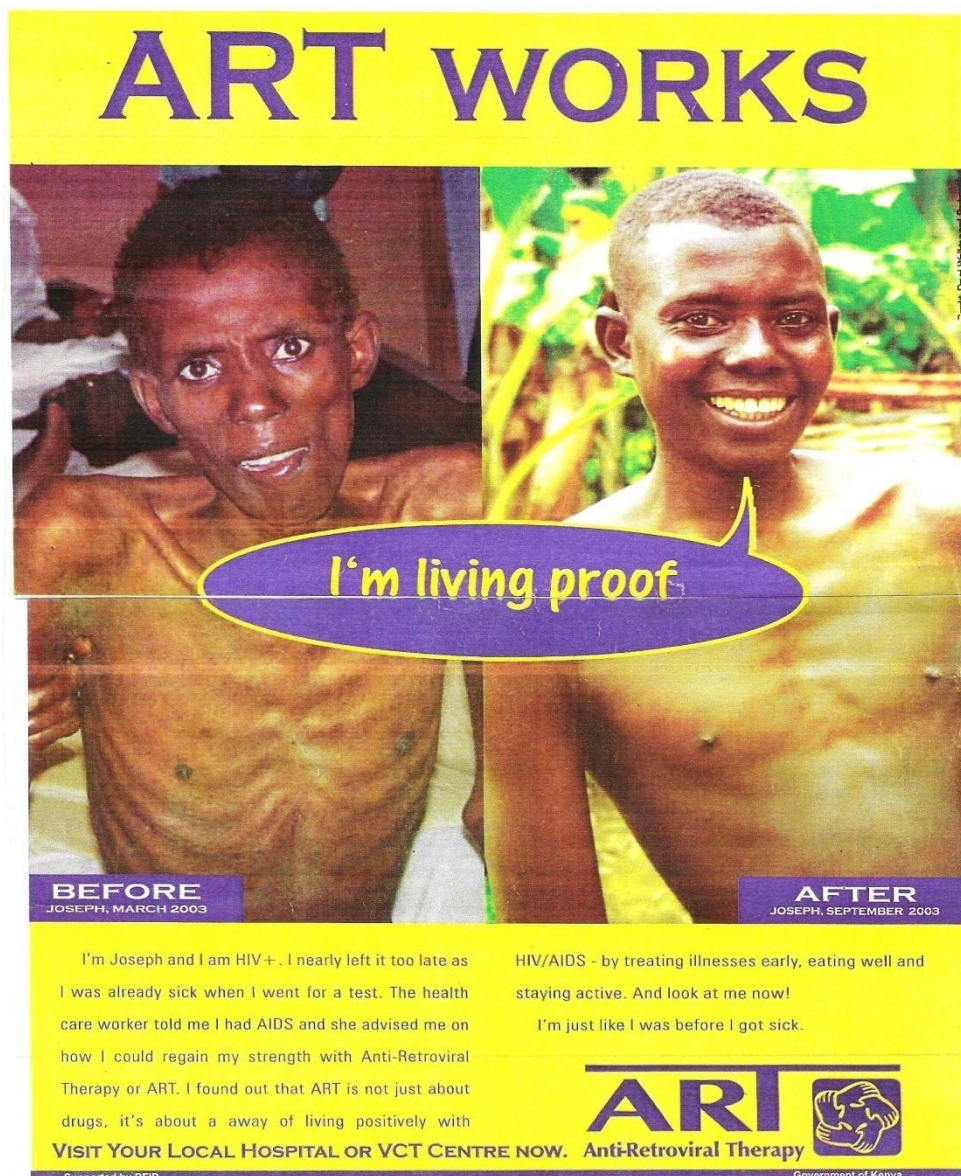
From these descriptions it was obvious that the women did not have an accurate understanding of HIV/AIDS. The women perceived HIV/AIDS in their own world view. There were bound to be some inconsistencies with perceptions because when people are given some information they see it through the screens of their experiences, culture, sex, knowledge, attitudes, background and feelings as expounded by Verderber (1990) in his transactional model of communication. This was reinforced by the women's descriptions in that the pictures were of foreigners or people who were not members of the Samburu community.

The women conceded that HIV/AIDS was a very serious illness and this was seen by the verbal descriptions that talk about death and they know that once one gets the disease they are bound to die. The descriptions showed that they actually saw the videos and they knew that the disease existed. It was very clear that the women

who saw the videos knew that HIV existed but we also see the misconceptions in the interpretation of the messages thereby reinforcing the idea that videos alone are not enough because they will be subjected to unintended messages like “HIV comes in form of a worm”. The videos although meant to educate them, further alienated the women leading them to have the perception that they were in a safe haven and it was only those who left the community and went outside who were in danger. This could have been as a result of the film showing people in towns only. The context of the film could have also have given the impression that HIV infection took place exclusively in towns.

### **6. 8. 3        HIV/AIDS messages**

Workers from the NGOs, FBOs, as well as the government organisations (GOK) indicated that they used the same posters and videos to pass their messages to both the men and the women about HIV/AIDS. The main observation here is the issue of contextualisation of messages. The Ministry of Health distributes identical posters that are produced for the whole country without considering the unique characteristics of the audiences. A case in point is the poster on ART (Anti-Retroviral Therapy) where there is a picture of an emaciated HIV positive man and underneath the picture there is a comment that this was the state the man was in before he started using ART. The next picture is of the same man looking healthy and there is a comment that after ART, his condition improved considerably. Some women had seen the poster but their interpretation was that the man was healthy then his health deteriorated. This means that the women missed the message altogether that there was a drug that could restore the health of one who was severely ravaged by HIV. This was because they could not read the comments below the poster to fully understand the message, so posters and pictures could be misinterpreted and mislead people who are illiterate. Unless the picture was shown and there was a verbal explanation of what the picture was, it was subject to various interpretations that may not have been the intended message. The picture shown below was produced by the Ministry of Health and was the picture that the women saw.



**Figure 6. 2: A poster on the use of anti-retroviral therapy.**

Most posters found in hospital notice boards are either written in English or Kiswahili as shown above. The posters that are found on hospital notice boards for patients to read as they wait to be attended to by the doctors may be clear to someone who is literate but they would mean a myriad of things to a Samburu woman who is illiterate, who will only look at the picture and make her own interpretation based on her knowledge and her experience. The fact that the posters are only found in the health centers would also mean that majority of the Samburu women may not have seen these posters because very few of them visit the health facilities.

Another observation was that there were no teaching materials from the Ministry of Health prepared in the local languages. Most of the materials available were written in English and a few were written in Kiswahili and generally the majority of the women did not know how to read and write so a reliable translator had to be sought. It was also observed that some teaching materials were not relevant to the current situation. Some of the cassettes were very old and lacked relevance but are still in use because there are no alternatives. The cassettes from the Ministry of Health were said to be outdated and current ones were needed. An NGO worker explained that some teaching materials were not clear:

But we still show them, they translate and interpret them differently and it becomes irrelevant to the set-up. Sometimes they do not get the intended message but they interpret it differently. These materials need to be prepared in relation to the current situation in relevance to the group you are handling. You see most of the people who prepare these messages in *watu kutoka town* (people from town). At least they could prepare them with local people because *Wakiona mama wa shanga* (if they see a woman with beads). *Wata sema hata mama wa ushanga kweli anaweza kupata* (so even a woman in beads can get this disease?) or *hata wakiona moran atauuliza ataweza kuuliza hata warani wanaweza pata* (if they see a warrior, they will ask, even the warriors can get this disease? If they see town folk, they will say *sisi awezi kuwa wagonjwa ni watu ya town*. (If they only see town people they will say that this disease is only for town people (FBO worker, age 31-41, female, Maralal).

Creating pictures that were acceptable within the communities was also a challenge. An NGO programme co-ordinator comments on a poster designed in the USA:

I remember one of our partners from California sent a poster for condom use, even me; I would not look at it twice. These *wazungus!* (Americans) they came up with a protruding penis and the condom and the lady lying down. I just wrote an e-mail and told them to delete that because if you went with that to the community no one would look at you. If I cannot look at it personally it would be impossible to show it to anyone else. Messages, pictorials and posters have to be acceptable. We try to make the message more local, more basic without using a lot of imported methods from other areas (NGO worker, age 31-41, Maralal).

The use of symbols and posters could be politically manipulated, as was the observation of an NGO worker:

When people were campaigning for elective posts, there was someone who had a good idea, but the way the message was put, the way the pictorials were put made him fail. He got a picture of a Samburu girl with beads and a graduation hat, it was fantastic, and this was promoting education in Samburu. He then took a Turkana girl, carrying water because there is no water in the Turkana area. The Turkana Girl was carrying a pot of water, she was bare footed. The message written was 'bring education and water close to the people'. But the interpretation was that this Samburu person only wants to educate the Samburu girls only and '*sisi tukae tukibebanga maji tu na miguu tupu, wacha akapewe kura na wasamburu basi* (why remain just carrying water barefooted? Then let the Samburu people vote for him!). He failed because he did not think seriously about his message (NGO worker, Age 31-41, female, Maralal).

As pointed out earlier the Samburu community was referred to as a closed community where outside interference was looked at suspiciously. A church minister explained that:

They are suspicious that they are being used for their traditional opinions. It's like being polluted, so they will hardly be open and also they don't want to be identified as the ones who are leaking information of their tribe or group to other people. These people are reserved even when you want to get information. Even for us, even for me, they will look at me as a foreigner. I am a priest, I am a Christian. He is one of us because he is born here but not traditionally (FBO worker, age 53-65, male, Maralal).

You find them very protective, the translator or the elite may tend to distort a message before it reaches the consumer. Some opinion leaders also act as gate keepers, they censure messages such that they give a different message, from the one being sent as a ploy to preserve their culture at all costs (NGO worker, age 31-41, Female, Maralal).

Health workers trained as community workers had problems disseminating the information within the community for fear of being reprimanded or going against the cultural norms. They also found out that the messages were not relevant at all or that they went against salient aspects of the community's culture. The community workers in their own perception may not have seen the need of changing or

adjusting cultural norms such as FGM, ABC approach and early marriages and they may have ended up paying lip service to the NGOs or even the government departments. A health worker who worked for an NGO observed that the community members “tend to trust the illiterate peer educators more than those who are literate. They feel that is the person who they know most, they associate with or even spend time together and he is part of the community”. The community workers, Samburu health workers and the political ruling class and church leaders need to be convinced about the harmful cultural practices that are observed by the community. They should spearhead the changes because true change can only come from within the community. The community elders who are very powerful should also be enlightened by the ruling class and those members of the community who are opinion leaders.

The translator will tell you what he/she wants to tell you, but not the reality coming from the women. You may go to a village and find that all of them are illiterate and you have to translate everything into the language they understand, and some of the workers we have do not understand the local language and therefore a translator has to be used and sometimes the translator leaves the most important points or messages out (NGO, worker, age 31-41, female, Maralal).

It was observed that messages could also be very complex and there was a need to have them simplified. For example, the concept of the term ‘HIV virus’ is not easy to explain to women who have no basic education.

Despite government policies regarding issues such as FGM, homebirths, compulsory education for children of school-going age and early marriages, the messages have not been accepted by the community. Is it just a cultural issue or is it that these messages have not been interpreted in the light of how they can be beneficial to the community or is it that the community understands these issues and has chosen to ignore them deliberately. This is a crucial question especially as far as HIV is concerned. HIV has had far reaching repercussions that have taken place in communities such as Luo Nyanza, which has been grappling with the issue of HIV. The Luo community is now coming to terms with the ravages of HIV and one of the things they have done is to accept male circumcision that is a major player in the



spread of HIV. The Luo community has adopted a cultural rite of passage that does not belong to them so that they can control the spread of HIV.

#### **6. 8. 4 Information flow**

It was observed that very little information trickles down to the women because of the illiteracy levels and this is worsened by the cultural decorum that hinders information flow. It was observed that cultural or social norms restricted women's access to basic information about sexual and reproductive health (UNAIDS 2008: 67).

Information on anything is not reaching them. The information flow from the policy makers to pastoral communities and especially to the pastoral women is not the best. For example, the women's fund, very few are aware of it. (NGO worker, age 53-65, female, Maralal).

The normal environmental problems, the lifestyle is an impediment to reaching many people. There are social kinds of variants. That people who get the information are not able to pass on information because there is very limited space for people to share information. You only tell your age mate and a close age mate at that. It is only an age mate with whom you can share this information. So information moves very slowly because somebody in a household, probably the father or child may have information but cannot pass it to the mother because of that barrier (NGO worker, age 42-52, male, Maralal).

Environmental challenges such as drought also hamper the flow and continuity of information as observed by an NGO worker:

We also get problems when we get drought. The Samburu District is normally hit with drought from time to time. So people migrate and there is no trace of where they have gone. So, you give messages to them this time and when you want them to implement what you have taught them, the other time you come, you find it is a new group that has never even heard such information (FBO worker, age 31-41, female, Maralal).

Lack of continuity and follow up may be detrimental to the internalisation of messages. This means that messages are heard but do not necessarily lead to behaviour change. For people to change behaviour they need consistent and

continuous messages regarding what needs to be changed as observed by the in-depth interviewees:

If information is separated from different people and age-sets, it is always easier to disseminate information to other tribes where everything is mixed up (NGO worker, age 31-41, female, Maralal).

The culture, the women also play a major part. When we try to involve them, it is hard to involve them because of culture. When you call meetings, the women are not available but if you involve them with men, they can attend the meetings. If you want to meet them either they come late and leave early because of the involvement at home. They come at around 10 and by 3 they want to go home, because of the duties at home, the cattle coming home and preparations for milking (GOK worker, age 31-41, Male, Maralal).

In Samburu culture people find it hard or difficult to mix and the issue of time is also a constraint...in Samburu culture you have to talk to *wazee* (men) alone, the women alone, and the young people. If you mix the young women and the old women, the young women will not be free to talk (GOK worker, age 31-41, Female, Maralal).

The other important aspect that was noted is that a Samburu woman is usually censored in terms of how much information she may disclose. An example was given of a woman who went to hospital and she could not disclose the name of her husband. She had to look over her shoulders to find someone who was in the age bracket of her husband who could disclose his name. If she does not get someone to disclose her husband's name then information cannot be accurately recorded. A woman is supposed to get information from her husband. The husband can only pass information to the woman that is of interest or importance to him. Any useful and relevant information from the woman can be ignored. Health information is also not spontaneous; a woman is usually accompanied to hospital by the husband. The husband talks on her behalf because he is ultimately in charge of everything and he can go on to describe the problems of the woman. The difficulties of obtaining information directly from a woman were expressed by a NGO worker:

If the woman is being attended to by a male nurse the husband stays put, but if it is a female nurse he may be comfortable but you have to tell him candidly to move aside '*sasa mzee wacha tuongee siri ya wanawake*' (please allow us to have some women talk). Once you

have the woman alone, the woman will tell you everything—that has been a challenge so we say, don't get the history from the man, but just pretend that you are doing it but wait until you capture this woman alone. *Unaenda unapata* the lady *ako na* STI (you find that the lady has an STI). It is the man who has given her the STI and the man is hiding and talking of malaria, *sijui* discharge, *sijui* pregnancy *inatoka* (the man may say that the woman has malaria or having a discharge or having a miscarriage). So if the husband is not available then the mother-in-law is available (NGO worker, age 31-41, Female, Maralal).

Women will not disclose information of a personal nature easily, (for example the number of sexual partners she has), and she will certainly not disclose personal information in the presence of her husband.

Again the women will discuss '*kando peke yao* (aside) for a while before they tell you anything. But if they have come as a couple, they will not say (anything) and the man will make sure that when the woman comes, he is also there, so that that information is not disclosed (NGO worker, age 31-41, Maralal).

It was also observed during the focus group discussions that whenever a question was asked they would hold a *tete-a-tete* in low tones and then give a response. This may be explained that since the women are so censored they may fear to disclose information that may let out community secrets. This fear of letting out information came from past experience where people would come to the *manyatta* to find out where the owner of the *manyatta* was. If they told them where the man was, the man would be arrested or disappear altogether. This is because the men were usually involved in cattle rustling so the community learnt not to disclose information about anyone just in case you endangered his life, because cattle rustling is part and parcel of their culture and one way of acquiring wealth in the form of cattle. It was also for the same reason that they did not disclose that they could speak the Kiswahili language so that they were not interrogated. The respondents were afraid to speak out and give out secrets about their community.

There are some researchers who have gone to the community under dubious circumstances to even collect sperm from the *morans* by coaxing them with money, so the community is aware that it can be abused and nobody wants to be accused of being party to such deeds (NGO worker, age 31-41, female, Maralal).

This excerpt shows why the Samburu people may be described as a closed community as they wish to preserve their culture and they do not want it to be diluted. That is why everyone seems apprehensive about giving out information because they are under the watchful eyes of the community elders who could invoke curses. An NGO worker conceded that the community was weary of strangers.

Sometimes, some strangers or organisations who want to give them food if they give information and there is a drought. They have been misused in the past and their trust with newcomers has gone down unless you have a very strong community connected person who assures them, but it has to take time for them to accept you. Like us now, they have accepted us now by seeing us in the field for the last three years, going to the *Manyatta*, identifying ourselves with them, sleeping in the *manyatta*, taking their milk and then treating their children and maybe someone was almost dying and you helped them, they will say *aai daktari huyu ni wetu* (this is our doctor), you know you have to build their trust, for them to open up (NGO worker, age 31-41, female, Maralal).

The other challenge with the information flow was that the opinion leaders also censored information:

Opinion leaders who may be semi-illiterate are in the vicinity. They would always say that if you want such and such information you have to bribe them in a way, they are like gatekeepers. You have to be on their side. It's like to you have to use them every time you want to penetrate the community. When you stay longer you find that these people are not even trusted by the community, so they will always give fake information. The community look at you, they don't interfere, by the time they see that you are still there for them, they will always come and tell you themselves, delink yourself from this person because we don't respect that person (NGO worker, age 31-41, female, Maralal).

This aspect of censorship did inhibit the information flow and the women were therefore exposed to dangers they did not understand. The fact that the Samburu community was weary of strangers or non-Samburus could also contribute to rejection of information because that information could not come from a credible or a trustworthy source as far as they are concerned. It has been recorded elsewhere in the thesis that even important health campaigns such as polio or trachoma were treated with suspicion and chances of rejection were high.

The other challenge in the information flow is that information about HIV/AIDS and other dangerous diseases does not sufficiently reach the elders who were the government and security of the Samburu community.

The current level of education in the current constitution of elders is low. Maybe after some time when these ones have died, and they have a new brand of elders, then things will change. You see, traditionally the elders are our government, they are the security. So what we are trying to do here is to demystify their authority and leadership. So, you are bound to have some resentment. In one way it's like they are closing their ears to those changes, because those changes are degenerating their status (NGO worker, age 42-52 male, Maralal).

The elders are the custodians of the Samburu culture and they try to preserve it as much as possible. However, the emergence of diseases like HIV that demand that certain traditions be revised or discarded altogether becomes an uphill task because it defeats their purpose and role. This could therefore explain the apathy that was seen in the lack of decisive action that could be undertaken to stop the scourge. The elders are powerful and whatever they decide wins the day.

If for example, the elders say we the Samburu people have blessed that girls get married without being circumcised, it becomes, it just becomes. Whatever the elders decide carries the day (NGO worker, age 42-52, Maralal).

The elders hold tremendous power and strategies of reaching them and giving them information that would help direct the community to safe behaviour should be explored.

#### **6. 8. 5      Language**

Most of the AIDS messages were in Samburu (Maa) and Kiswahili. Although the Samburu women did speak some Kiswahili they did not easily agree to use it. The women said that they preferred the Samburu language. The NGO and the government workers expressed some challenges that were related to language.

There are certain terminologies that would be difficult to interpret and give the actual or real meaning of what you want to say (GOK worker, age 31-41, male Maralal).

There are some scientific words you know, you may find easy to translate but there are others which, when used end up distorting one's message and also the written word may not be translated to mean what you intended (FBO worker, age 20-30, Male, Maralal).

Sometimes you have an English word that cannot be translated in the mother tongue. A word like 'virus', so you need to use a lot of words to explain and you cannot judge the understanding from there (NGO, age 20-30, Male, Maralal).

When talking about the virus, we give an example of *askaris* (soldiers) fighting others, those are the type of systems we use because of illiteracy. *Tunawaita Askapa, Askari la ni jeshi" wakienda, wakienda kwa askari wengine*, you just show something like that; you show some falling in the battle field. *Na unafanya virus askari mkubwa eeh, inaangusha angusha wale wengine.* (The virus is depicted like a strong soldier who is fighting and vanquishing the foe) (NGO worker, age 52-62, female, Maralal).

Someone may have something to share and they can do it better in Kiswahili which are the languages that these people do not know especially deep in the interior. Most of the facilitators have gone to school and are fluent in the local language. Another thing, I can speak about sex in English and Kiswahili so well, but when it comes to Kisamburu, I start having another different perception about it and I become a little shy, so there is that aspect of taboo communication(NGO worker, age 42-52, male, Maralal).

We use videos whose context is not very compatible, you see people living in modern houses, wearing modern clothes, with talking mannerisms. They see the messages as belonging to town people and therefore are not fully embraced (NGO worker, age 42-52, male, Maralal).

The language, the African way is that we don't talk specifically about issues about private parts and that this disease attacks, the symptoms, sex. That is why they say this man lacks respect *yeye tu ni kusema!* (He discloses everything!) (FBO worker, age 53-65, Maralal).

When I say cultural barrier, when you talk about HIV/AIDS, you talk about HIV/AIDS you talk alot about private parts and in culture *wanaona ni aibu* (shameful). It's like you are having no manners and again sex is not talked about by women. Women are not allowed to talk about it and the other thing is you could talk to them about how to prevent, but the problem is men because there is no negotiation about

sex among Samburu women. A woman cannot talk or discuss sex with the husband. Even for women who attend seminars, they know the condom and if she decides to take the condom home. It will end up being a fight in the house, how did you know that this is a condom? He knows you were doing something outside, how did you know that it is a condom, hii ni ukora (this is mischief) (NGO worker, age 53-65, female, Maralal).

Some messages are very technical so unless you find someone who is very innovative. Some of these strategies that the government wants used are supposed to be translated to the local communities. Language can pose a problem because of the illiteracy levels but innovative ways of communication new terms and concepts to the Samburu women is necessary to communicate the dangers of HIV/AIDS, prevention and the possible pathways that can lead to infection (NGO worker, age 20-30, male Maralal).

The language that was used to communicate HIV/AIDS messages could also be a barrier in itself especially if the language was not contextualised and if the communicators were not aware that the language they used could be misinterpreted in the light of the cultural background of the women. The fact that majority of the women were illiterate complicated the issue of how to pass on messages that would be significant in sending and receiving the messages as intended. The issue of translation also posed a challenge because most of the NGO and government workers were non-Samburu and they had to use translators who were in thus themselves gatekeepers. Messages that were translated could be misinterpreted and mistranslated depending on the translator's understanding, attitude, and knowledge of the message.

#### **6. 8. 6        Radio**

A radio in the Manyatta belongs either to the husband or the Moran (warrior) and it is the husband or the Moran only who switches it on. The radios used Kiswahili language and many of the women said they did not fully understand the language. For those who understood Kiswahili, the radio did talk about HIV/AIDS:

We just hear some few words since we do not fully understand the Kiswahili language (FGD, middle-aged, woman, Sirata Oirobi).

The radio then is not a viable avenue that can be used to communicate messages about HIV/AIDS to the Samburu women unless it is in the Samburu language (Maa). Radio belongs to the men so it is not accessible to the women. An NGO worker observed that one could go to a village and only find one radio or none at all. So the radio was not a viable option because it was also not readily available and even if it was available then the use of other languages would be an impediment to the women. What also needed to be explored was whether they would believe the messages that were on radio to effect behaviour change.

### **6. 8. 7        The use of songs**

The women had heard songs about HIV/AIDS in the Samburu Language and Kiswahili. The songs were sung by women's groups during public functions, school children in school or at public functions, on the radio and by choirs during public functions. The songs do seem to be a viable mode of reaching the women because they are a form of edu-entertainment, where people are educated as well as entertained. The songs are geared to awareness because whenever there is something new in the community; songs are used to make people aware of what is happening. The songs are general in nature since they have to reach everyone. A woman in the focus group discussions commented that:

The messages from the songs are scary, so one really fears listening to the songs. You imagine if your child was among the ones dying. You then decide to advise your children to try and avoid it. When you listen to them singing, it is a song that shows much pain and trouble. It is not a song that makes one happy. It helps people try to stop the disease since one learns how bad it is through the songs sung. (FGD, Middle-aged woman, Lekuru).

Songs in the Samburu community can be significant because they are part and parcel of the community and have been used in the community. Spencer points out that the young women have in the past sung songs to motivate the *morans* to go for cattle raids and therefore this is one avenue that can be explored (Spencer 1965: 125). The *morans* and the young women are also known to go for *yimbo* (Song and dance). This could also be a viable means where HIV/AIDS messages can be



disseminated at the venue and especially if these messages can be passed on by their peers.

#### **6. 8. 8        The role of women groups in preventing HIV/AIDS**

The women had a mixed reaction towards the role of women's groups as a conduit for passing on information about HIV. One group indicated that some women's groups did talk about HIV/AIDS.

We do talk about it and since everyone has her own life, then a disease like this one is something I do not want to hear about. For these people in towns, they say that it is nothing and so they term it as a disease like any other, just a cold. They say it is like Malaria. These are the people who are just after money (FGD, elderly woman, Lemisigiyo).

We do go to women's meetings but we do not talk about it (FGD, elderly woman, Lkurom).

We do not have women's groups here; these people are dead and like people locked in somewhere. They are like locked in a box and the keys to the padlock locking the box are lost! (FGD, elderly woman, Lower Lpartuk).

Yes we do, we talk to our children and ask our fellow women to talk to their children. We also talk about it even in church meetings (FGD, elderly woman, Lpartuk (one) Lgoss).

Yes, we at times talk about it and talk of how we can protect ourselves now that the disease is here and is finishing our people (FGD, young woman, Sirata Oirobi).

It is very clear from the above statements that women's groups have been partially used but they have not been fully utilised. The women's groups may not have been utilised because of lack of sufficient information to share about HIV because they only get information about the disease by word of mouth. Women's groups can be a potential vehicle to pass on information if they are explored and developed.

### **6. 8. 9 Other people and the role they play in passing on information about HIV/AIDS**

The researcher also wanted to explore the possibility of whether other people had been instrumental in passing messages about HIV. The other people in women's lives included the husband, the co-wife and the friend (interpreted as the *sindani*) who was described-elsewhere in this chapter.

#### **6. 8. 9. 1 Husband**

The women expressed it very vehemently in the focus groups that they did not have free and open communication with their spouses. Husbands were not a viable means of passing information on about HIV to the women. They had this to say about the communication they had with their husbands:

No they do not, when you talk to them at night that is the end of it, tomorrow they still do the same thing (FGD, middle aged woman, Sirata Oirobi).

Our husbands do not discuss with us but they just warn us to make sure we do not bring the disease while they themselves continue to *loloito*- practise adultery (FGD, middle aged woman, Lekuru).

They do talk about it. They tell someone or rather their wives not to get them infected where they themselves go around infecting them. Especially when one is drunk, it is easy to infect or get the disease (FGD, elderly woman, Lower Lpartuk).

From these excerpts, the husband may not be the ideal communicator about contracting HIV/AIDS because it appears the husbands give warnings but they themselves don't seem to take the necessary precautions. It is apparent that the woman is seen as the one who is a possible carrier hence the warnings and admonitions and the wife may not say much because culturally a woman cannot speak or warn the husband because that would be disrespectful and it may result in violence in the home. The comments above also show that the men can have multiple partners but it is only the woman who is supposed to be careful about contracting HIV.

### **6. 8. 9. 2      Co- wives**

Co-wives do not communicate with one another regarding HIV/AIDS because of the kind of relationship they have. The majority of the women do not have a cordial relationship with their co-wives that would enable them to talk about such a sensitive issue such as HIV/AIDS due to the conflict of interests and the blame game where no one wants to be the originator of the message.

For those who are in good terms, they talk but they do not talk about the disease since the younger one thinks the other is jealous (FGD, middle aged woman, Lodokejek).

In case one talks they can even quarrel, since one thinks the other one is trying to annoy or show that she suspects her of having it (FGD, elderly woman, Lpartuk (one) Lgoss).

Co-wives do not talk as a rule especially if they are both young and so are not on terms with each other due to jealousy but if one is young and the other is old, they do talk (FGD, middle-aged woman, Lekuru).

The above comments indicate that there is a lot of tension between co-wives. They do not discuss HIV/AIDS issues because this is a sensitive issue. This implies that since they do not talk about the spread of HIV, silence fuels the transmission of HIV and there is the risk that entire homesteads can be wiped out by HIV/AIDS.

## **6. 10            DISCUSSION**

The field data reveals that the Samburu women lack sufficient information to protect themselves from HIV/AIDS infection. The women had gaps in the knowledge regarding how HIV/AIDS is spread. Most of the women mentioned prostitution as the main avenue of infection. Another avenue that was mentioned was the sharing of razor blades but as to how that happened was vague. Other avenues such as blood contact were not clearly understood.

The fact that majority of Samburu women are illiterate hampers them from understanding the human body and how it functions. The general belief was that the body has just one system and there is no distinction between the digestive and reproductive systems. This affects the way the Samburu community takes care of lactating mothers and also the suggestion that they cannot use condoms because they will block the respiratory system or that the condom can go inside the stomach and block the flow of food and cause death.

The study also established that condoms are hardly used. Many women from the focus groups had seen condoms during seminars but the majority of them had not used them. The use of condoms is also viewed as an obstruction to conception, which is highly valued in the Samburu community. The women in the focus groups did not trust condoms. The view is that condoms are for young people. A Samburu woman cannot decide about or control the use of condoms; this is entirely a male domain. A woman who purports to know about condoms is suspected of prostitution and can be subject of abuse by her husband. Female condoms are not accessible and are very expensive and therefore not a viable option in the prevention of HIV/AIDS. Even if the female condom was available, the Samburu woman is not at liberty to choose which protection methods she can use.

The Samburu women are not sufficiently aware of mother-to-child infection to undertake protective measures. Pockets of women in the focus groups were aware that a child could be infected by HIV/AIDS but could not explain how that happened. The women did not see going to antenatal clinics as an important safe guard to HIV/AIDS infection. What is of grave concern is that the women did not see going to clinics as one way of preventing infection or protecting themselves or the unborn children. Samburu women hardly attend regular antenatal clinics. They attend once and get a medical card for use in case there is an emergency, they do not see the need for regular attendance because pregnancy is not considered a sickness. Hospitals are associated with sickness and the idea of check- ups or monitoring was neither evident nor prioritised.

It was also observed that majority of Samburu women give birth at home and efforts to convince them to attend a clinic and give birth in hospital have been met with a lot of resistance from the women themselves and even the professional Samburu community. The women prefer to be assisted by the Traditional Birth Attendants (TBAs) who were sanctioned and trained previously. This practice has been discontinued by the government of Kenya but it still goes on unabated. The TBAs are in danger themselves of getting infected and so are the women because they do not know the status of the TBAs, and chances of a baby getting infected from a HIV/AIDS positive mother are high.

It was noted that the VCT concept has not been embraced by the Samburu community and this derives from the fact that HIV/AIDS as a disease is feared and no one wants to be associated with it. Although the women are tested during the antenatal clinics, even if they are found positive they do not go for any follow up treatment because of the perception that if you are not in pain why you should be on medication or go for clinics. This is an indication that HIV/AIDS information is clearly not understood. Women lack the opportunity to be tested because they do not see the need for one to go to the VCT centre and they have many chores at home.

The idea of being tested has also been misinterpreted to mean that if medics go to the community to test people, once they have been tested they assume that they have been tested for all the other ailments, so if one is told that they are HIV negative they also assume that they are also free of other diseases such as tuberculosis or typhoid. There should be a distinct message that they are being tested for HIV only.

PEP therapy is alien to most of the women because rape is hardly mentioned when it takes place and therefore PEP therapy is not known. The traditional view of sexual coercion in the Samburu community is that it is expected and accepted because it is beneficial to the "victim". Rape is hardly talked about because if a woman says she has been raped she is blamed for it. What is of major concern is that since rape is forceful penetration to the sexual organs it can cause abrasions and tears that can be effective pathways for the spread of HIV. The fact that PEP is unknown implies

that those women who may have been raped could also be infected with HIV as well as have other STIs without their knowledge. Having untreated STIs will further exacerbate the chances of acquiring HIV through sexual relations with other partners.

The data collected also reveals that the Samburu community prefers to use herbal treatment as opposed to modern medicine. This is more so because this community has a rich heritage of herbal medicine. Even those who have tested HIV positive prefer herbal medicine. The ARV concept is not clear to the women especially regarding the fact that one has to take ARVs for life. The perception is that one cannot take medicine all the time and therefore when one feels well they may not use the ARVS. Reinforcing this regime has been met with challenges where it has been observed that it is only those who live in towns who can easily access and follow strict regimes. What is of grave concern are those who live in the interior because the ARVS are only found in urban centres and because of the Samburu nomadic lifestyle, follow up is an uphill task, so medical officers do not even attempt to put anyone on ARVS if they know he or she will not be accessible. The Samburu women have other challenges that may not allow them to access ARVS, they may not have the money nor be allowed to go and get ARVS and they may also be stigmatised if they are known to be using ARVS that further leads to marginalisation and alienation from the community.

The data reveals that the Samburu women lack access to antiretroviral medicines that improve their health and well being because they do not enjoy programmes that couple prevention of mother-to-child transmission and continuing treatment to help mothers remain alive and in good health to care for their children. The fact that many women do not go to antenatal clinics also means that many women do not know their HIV status and are not in a position to decide whether to take medication or to be medically monitored if they are tested HIV positive.

Data in this study shed light on the fact that since women have scant information regarding how HIV/AIDS is transmitted, they are also not aware of preventive measures that need to be taken to protect themselves from infection because they

are the care givers. Their role as caregivers exposes them to infection as they take care of an HIV husband without knowing what he is ailing from and even if he is ailing from HIV/AIDS, it is the moral duty of a wife to look after an ailing husband.

The study also established that Samburu women are at the epicentre of the spread of HIV/AIDS because most of the cultural practices that expose one to HIV/AIDS are controlled and sanctioned by women. FGM is a ritual that involves women but the women did not see the link between this ritual and HIV/AIDS and therefore neither the initiator nor the initiated take any precautions. Even though FGM is illegal in Kenya, it is very important to the Samburu women because it gives the women identity and allows them to marry. The women and the entire Samburu community support FGM regardless of the danger that it poses in the spread of HIV/AIDS and of other health complications.

The data also revealed that the young Samburu girls are in danger of getting infected by HIV because they have sexual relations with *morans* when they are as young as nine years old. This makes the girls vulnerable because their sexual organs are not mature and are susceptible to tears and abrasions that are effective pathways to HIV/AIDS and other Sexually Transmitted Infections (STIs). What is of great concern is that the *morans* have multiple partners including married women. The same young girls are also beaded by older men who also have multiple partners thus extending the sexual networks without putting in place any preventive measures. Even the fact that they marry when they are young (12-15) exacerbates the chances of infection because their husbands have other wives and other lovers on the side and the wives have their lovers also. Chances are that if one person is infected in this sexual network, the chances of infection to the others become very high. This in essence means that young girls are at high risk of HIV/AIDS infection because as the UNAIDS 2008 report puts it, "Certain behaviours create, increase, and perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown, multiple sexual partnerships involving unprotected sex" (65).

The ABC approach that has been recommended by the government of Kenya is not relevant to the Samburu women. Abstinence does not make sense to the Samburu

women because sexual activity begins at puberty and therefore is a way of life. Young men of 15-20 years who are usually sexually active are the ones who are enrolled in schools. Being faithful is also irrelevant in a community where polygamy is highly valued as a symbol of wealth and where *sindanism* (multiple partners) is sanctioned by the community. The one partner slogan is not relevant to the Samburu community in view of the cultural norms. This is worrying because the Samburu community is rated as having one of the highest prevalence rates in the country (Dofa, 2009). If this trend continues, we are just at the threshold and the worst case scenario is about to happen.

There is apathy towards prevention especially due to the fatalistic view that one cannot avoid death and that when the time for death comes you cannot escape from it. This paralyses all efforts to come up with preventive measures to curb or control the spread of HIV/ADS.

The study also shows that the women had the impression that they were safe from HIV/AIDS infection as long as they operated within the cultural norms. Since having multiple partners within the community was sanctioned, they felt safe. The problem of infection came about if one had sexual relations with an outsider or one did not follow the cultural norms and one got infected as a punishment. This is reinforced by the fact that the community believes that HIV/AIDS is a curse and a result of sin. It was indicated that those who had left the ways of the community and had gone to the Christian religion had sinned and that is why unknown diseases were affecting the community. The members of the community who were HIV positive said that they had annoyed the elders or there was something that they had failed to fulfil and hence the curse and that is why the traditional medicine men are consulted because HIV is not just a disease. It has other implications in the spiritual realm and this has resulted in very few people going to hospital for treatment and that is why stigma and discrimination against the infected are very high in the community.

The data collected indicates that the Samburu community is a closed community in which information about HIV/AIDS has not penetrated fully. This is because new information especially from outside the community is treated suspiciously. The



women are the last people to receive any information and their spouses hardly share any information, due to the dictates of culture. Majority of Samburu women are illiterate and therefore cannot access information directly necessitating a mediator to deliver the information and the chances of that information being misinterpreted or mistranslated are high.

The study also noted that information presented in the form of posters is usually misinterpreted by the Samburu women because they are not able to read the captions that normally appear below a poster. The pictures also depict town folk and therefore the women got the impression that it is only those who live in towns who get HIV/AIDS. The modern clothes worn in the posters relegates the message to those who go to school or are educated. This gives the impression that those who are dressed in the traditional regalia are safe.

It was observed that the educational health materials that are distributed by the government are usually uniform and one can go to any District hospital and find identical posters. This trend does not consider that different audiences need different messages and posters. The same applies to the videos and films that are shown; chances of misinterpretation of the messages are high. The women do not identify themselves with the characters they see and it gives them the impression that HIV/AIDS is remote and is only acquired by certain kinds of people such as prostitutes, those who are educated and chances of getting the disease within the community are slim.

The study also revealed that there is only one organisation that deals with women's issues and the rest of the organisations address the needs of all members of the community. It was realised that the needs of women have not been considered unique because of the peculiar challenges the women face especially in a community where the status of women is very low. Most of the NGOs in this community are headed by men and therefore women's issues may not be well articulated. The government agencies on the other hand also do not have any specific programmes for women and this could account for the lack of adequate information that was evident when the women were interviewed. The little effort

that the government of Kenya has made is to provide the posters and the films but as mentioned earlier they are not relevant and effective enough to pass HIV/AIDS messages that would result in behaviour change. It can therefore be said that the Samburu women are not able to access information and services they need to make informed reproductive decisions.

It was also evident that very limited research has taken place on HIV/AIDS information, education and communication on Samburu women, although information is disseminated in the community, it is not research based and little or no evaluation has been done to address these needs.

## **6. 11            SUMMARY**

Field data reveal that the Samburu woman is greatly disadvantaged due to cultural practices that expose her to high chances of contracting HIV/AIDS. The practices that make the Samburu woman susceptible to HIV/AIDS infection range from being a beaded girl, undergoing FGM, early marriage, multiple partners in marriage in terms of polygamy, relating with the husbands age mates, and the *sindani* or the secret lover.

The information disseminated about HIV/AIDS regarding its transmission, spread and protection against infection is not well understood by the Samburu women. The messages that the women have received have not led to behaviour change due to impediments such as the low status of women, low literacy levels, mediated information flow, cultural barriers regarding information flow from the men and to the women.

Films and videos that have been shown by the NGOs and the government agencies are commendable but they need to be contextualised so that the women can identify themselves with the characters depicted. Samburu women are under the impression that it is only those who are educated and non-Samburus who can be infected with HIV/AIDS. Relevant information, communication and education materials need to be developed that women can relate to.

Posters that are developed by the Ministry of Health are identical in all the communities in Kenya. It is clear from this study that posters and brochures that are distributed are not useful to the Samburu women because the majority of them are illiterate. Since the women see only the pictures, they are not able to read the print that goes with the pictures and therefore most of the messages are misinterpreted.

The concept of preventive measures such as condom use is ignored because it also hinders conception, which is the epitome of fulfilment of a Samburu woman as well as her security in the community.

The Samburu women believe that HIV/AIDS is a curse and therefore hospitals or medical care are not a relevant solution to the care and management of HIV/AIDS. Herbal medication takes precedence over any other form of treatment or therapy.

The Samburu elders wield tremendous power and control over the community and solutions should come from them. This is because they must sanction any decision or activities in the community. They need to address the issue of HIV just like other heads of communities such as the *Njuri Njeke* of Meru or the elders of the Luo community are doing in order to salvage their communities from the spread of HIV, because of their cultural rites and rituals that make their communities vulnerable to HIV. Preservation at any cost of cultural rites and rituals that expose the community to HIV is like signing a death warrant for the annihilation of the same community that you are seeking to protect. It is now a question of protecting the lives of people versus preserving rites and rituals that will kill the same people.

The next chapter provides general conclusions of the study and recommendations for policies and programmes.

## **CHAPTER SEVEN**

### **CONCLUSION AND RECOMMENDATIONS**

#### **7.1 INTRODUCTION**

The main objective of the study was to uncover the perceptions of rural Samburu women of Kenya of HIV/AIDS with a view to determining; firstly, their knowledge of HIV/AIDS, secondly, their beliefs about HIV/AIDS, and thirdly, their communication needs regarding HIV/AIDS. The major conclusions of this qualitative study are summarised as follows: The Samburu culture is at the heart of promoting, sustaining and fanning the spread of HIV/AIDS. Samburu women are vulnerable to HIV/AIDS because of the challenges that they face that are beyond their control. They have low knowledge levels about HIV, its transmission and prevention. The limited knowledge they have is distorted and mediated by cultural beliefs and understandings. The subservient position of Samburu women renders them powerless to make any decisions regarding their sexuality. The community elders and Samburu men are the gatekeepers as all decisions are made by them and they censor all the information coming to the samburu community. Lack of education further disadvantages the women socio-economically. The women themselves are resistant to change with regard to cultural practices which put their health at risk. The failure of the government to implement policies and crack down on illegal cultural practices which render women and girls susceptible to HIV/AIDS further exacerbates the situation.

These conclusions and recommendations are based on the findings of this study and are discussed more fully in terms of the five domains of the UNAIDS Framework of Communication as outlined in Chapter four, namely the role of the government in the in terms of policy, culture, spirituality, socio-economic factors and gender relations.

## **7.2 THE ROLE OF THE GOVERNMENT IN TERMS OF POLICY AND LAW**

The Government of Kenya has enacted several laws and policies regarding health and education. These laws cover health issues, educational issues that seek to protect the human rights of women and young girls. Although the laws are written down and are part of the constitution they have yet to be enacted in the lives of Samburu women and young girls. Lack of access to basic health care leads to greater susceptibility to HIV/AIDS as outlined below.

### **7.2.1 Health**

The government of Kenya provides free health services so as to encourage mothers to attend antenatal clinics to safeguard their lives and that of the unborn children by stipulating that mothers should at least make four visits to the ante-natal clinics. It is through the antenatal clinics that pregnant mothers know their HIV status and are given guidance on how to handle their pregnancies in case they are HIV positive. The Samburu women do not see the need to attend clinic even with the dangers of HIV, yet it is documented that the second most predominant mode of HIV transmission in Kenya is perinatal transmission in which a mother passes the virus to the child during pregnancy, delivery or through breastfeeding (KDHS 2010: 198). The UNAIDS 2009 report also adds that 91 percent of the world's prenatal HIV infections took place in 2008 in sub-Saharan Africa (UNAIDS 2009: 21).

The majority of Samburu women give birth at home and prefer the services of TBAs rather than medical staff. The women do not fully understand that the TBA could also infect the mother during childbirth because the TBA herself could be infected or because she may not take the necessary precautions to protect herself or the mother. The Samburu women are not cognisant with the fact that a HIV mother can give birth to a HIV negative baby if she follows a medical regime observed by HIV positive mothers.

Antiretroviral therapy uptake and adherence is poor because those who are known to be on medication are stigmatized and discriminated upon. ARV therapy has not

been well understood and accepted. NGOs do provide health services but the concern is that if they do not get funding then the services are withdrawn. Another important factor is that the NGOs do not cover the entire Samburu District but only cover certain areas depending on their funding as well as their interests.

The VCT concept is not sufficiently understood and VCT centres are not acceptable in the Samburu community. Those who go to the VCT centres are associated with HIV and are stigmatised and discriminated upon.

### **7. 2. 2 HIV prevention**

Government strategies and prevention policies are in contradiction with the cultural practices of the Samburu where the prescriptions of one faithful partner and abstinence are not relevant to the Samburu women who are permitted multiple partners. This practice puts them at risk because their sexual partners may also have other sexual networks. Misconceptions and lack of comprehensive knowledge about the use of the condoms as a protective tool as advocated by the ABC approach was evident in this study. Condom use was seen to be in contradiction with the concept of conception which is sacrosanct in the Samburu community. The majority of the Samburu women interviewed indicated that condom use was for young men or the *morans* and they found it difficult to advocate condom use with their steady partners due to their lack of power to make any decisions as women. The distorted view of the human anatomy also mitigated against the use of condoms.

### **7. 2. 3 Education**

The Government of Kenya provides free and compulsory primary school education to all school going children but not all the children in Samburu District go to school. Due to the pastoral lifestyle school enrolment is low generally for both boys and girls but it is much lower for the girls and even those who enrol later drop off to get married, and this accounts for the high school dropout rates of girls of 10-13 years. Although early marriage is banned by the government of Kenya it is common practice in the Samburu community. The vulnerability of the young girls is

exacerbated by the immaturity of their bodies and the fact that their spouses may have other wives and partners. Lack of education also leads to knowledge gaps and lower levels of HIV/AIDS prevention methods that can fuel the spread of HIV/AIDS. Current studies concur that education is an important factor in the spread of HIV/AIDS and has a strong effect on health behaviour and attitudes (KDHS 2010: 40).

### **7. 3            SAMBURU CULTURAL PRACTICES AND HIV/AIDS**

Cultural practices such as female genital mutilation (FGM), child beading, and multiple partners make the Samburu women vulnerable to HIV/AIDS. The Samburu women do not have the power to decide or make any decisions regarding their sexuality. Although practices such as FGM and early marriages have been banned since 2001, the community holds these practices very dear and are not willing to let them go. The reluctance of the women to abandon FGM is due to its significance as a rite of passage. A woman lacks recognition, identity and membership of the community if she does not undergo FGM. Although community leaders themselves were involved in developing legislation banning FMG, in reality they turn a blind eye to the practice. There is a lot of secrecy surrounding FGM and hardly any preventive measures are undertaken. Information on the risks related to FGM should be articulated clearly. Also, an alternative ritual to replace FMG must be developed by the women themselves which is acceptable to them and to the community at large.

The *sindani* (secret lover) phenomenon of having multiple and concurrent sexual partners is another cultural practice which is sanctioned by the community and makes the Samburu women vulnerable to HIV infection, yet the women refuse to acknowledge the dangers of this practice. The one partner option is contrary to the norms of their culture. Changing established cultural practices and beliefs must be approached with a lot of caution and sensitivity.

Samburu women regard HIV/AIDS as a curse, that someone must have done something that is not socially acceptable for him/her to get the disease. Because of this belief many people do not seek medical assistance but prefer to go to the herbalist who can treat both the physical and the spiritual aspects of the disease. As is the case with other Kenyan communities, Samburu women and the Samburu community at large have more faith in herbal treatment than medical treatment. The Samburu people believe that when the time comes for one to die, there are many vehicles through which death comes, and HIV/AIDS is one of those vehicles. This fatalistic view of death means that the view exists that there is no need to take any preventive measures. This also, explains the apathy exhibited when prevention is recommended. The apathy towards prevention, especially due to the fatalistic view that one cannot avoid death, impedes all efforts to come up with preventive measures to curb or control the spread of HIV/ADS.

The community elders have little knowledge and understanding of HIV/AIDS. The adherence of the elders toward practices that make people susceptible to HIV/AIDS is a key factor that hinders any meaningful strategies as these have to be sanctioned by the elders who cling to traditional beliefs and practices. The continuity of harmful cultural practices and the fact that there is no guarantee that the new crop of elders will change anything for fear of the curse is a challenge. The community at large must devise solutions that will halt the devastating consequences of HIV/AIDS on the community in general and particularly on women and girls who bear the brunt of the epidemic.

Cultural norms and values have a strong hold on the Samburu community. The belief that if one practices what is sanctioned by the community, then one is safe, but if one practices what is frowned upon by the community then one gets infected needs to be addressed.



## **7.5 THE SOCIO-ECONOMIC STATUS OF SAMBURU WOMEN**

Samburu women do not control resources be it money or livestock. This renders them powerless to reject risky behaviour or to negotiate any precautions against HIV/AIDS. The fact that very few Samburu women get any education means that they cannot access formal employment, credit and support. Poverty has been identified as one of the main drivers of HIV/AIDS and Samburu district is ranked the second poorest in the country (Kenya 2008: 25). The low socio-economic status of Samburu women has particularly affected widows and those who are separated or divorced.

Even the perks like the women enterprise funds that the government gives to women do not benefit them because they are not informed about them and they lack the capacity to make use of them. The National HIV/AIDS Council has been approving and funding HIV/AIDS related projects but very few projects have been approved because very few are presented to the council yet there is money set aside to fund these projects.

## **7.6 GENDER RELATIONS**

Although gender relationships differ from one community to the other, power imbalances, harmful gender norms, gender-based violence and marginalisation increase the vulnerability of women to HIV infection. Gender inequality is evident in the Samburu community and impacts severely on their circumstances. Samburu women have a very low status within their community. The consequences are lower educational levels, lower literary levels and inadequate access to information. Women do not inherit land or own property. It remains to be seen how the Samburu community will translate the new constitution where women now have a right to inherit land and to own property.

## **7.7 COMMUNICATION**

The third objective of the study was to discover what AIDS awareness channels of

communication have been used by the government and non-governmental organisations. It would appear that the government is doing very little in terms of awareness, largely because of a lack of funds. The government has, however, had a supervisory and regulatory role in the policies that have been spelt out by the Ministry of Health. The government has supplied some video tapes like the “Silent Epidemic” and posters and pamphlets dealing with HIV/AIDS. The videos have been used extensively by the NGOs. While the women felt that the videos were more helpful than health talks only, NGO workers expressed the concern that the videos and posters were not adapted to the specific needs and understandings of the community. These generic messages simply result in the creation of misunderstandings and mistaken impressions, for example, that HIV/AIDS only affects educated, town dwellers because the videos depict urban people (who by implication are educated). Rural folk, on the other hand, who wear traditional regalia (shukas), are safe because they are not depicted in those videos.

Another problem with these videos and posters is that they have to be translated and explained since the majority of the Samburu women are illiterate. The chances of the translator imposing his/her own views are high thereby contributing to the possibility of the information being distorted and misinterpreted. In addition, most of the programmes and interventions that are prepared by the government focus on both men and women as a combined audience. There are no programmes that target men or women separately. With the exception of one organisation that focused on women, most NGOs do not have a specific programme for women. There is a dire need for specific programmes that deal with the particular problems and cultural understandings of a targeted audience such as the Samburu women

Word of mouth or verbal messages are the main channel of communication since most of the Samburu women are of low literacy levels. Contextualized messages should be designed that are easily understood and relevant to the community. Language can be a barrier to good communication in that health terms may be difficult to translate and explain.

Although the radio has been identified as the most effective channel to use to the Kenyan general population, the Samburu women have no access to the radio because it belongs to the men and the language used is a communication barrier. It has also been documented that urban women have more access to mass media compared to rural women and that access to mass media increases with educational attainment and financial status which the Samburu women lack (KDHS 2010: 60) .

The Samburu community is a closed community. Gaining access to the women needs the sanction of men, who are the main gatekeepers and opinion leaders in the community. This means that not all information reaches the women because it is censored information and the chances of accurate and relevant information being conveyed is also slim. Information flow from the men to the women is minimal because of cultural decorum.

## **7. 8           LIMITATIONS OF THE STUDY**

This study was a qualitative study that focused on a sub- population of Samburu women through focus group interviews and in-depth interviews. The findings of this study cannot therefore be applied to the general population of the Samburu community or any other Kenyan community. The findings of the study, however, are similar to studies which have been conducted among the Maasai regarding HIV/AIDS and serve to confirm that certain cultural practices can make women vulnerable to HIV/AIDS. Kenya government studies such as the Kenya 2007 AIDS Indicator Survey confirm that the major drivers of the HIV/AIDS epidemic are culturally based and therefore the recommendations of this study would be generally valid.

## **7. 9           RECOMMENDATIONS FOR POLICY AND PRACTICE**

From the above conclusions the study makes the following recommendations and further areas of research.

- HIV/AIDS as a disease should be taken seriously by the government. Awareness campaigns must be targeted at specific audiences, and must take

the circumstances and cultural context of the audience into account. More awareness messages using the Samburu language in form of group communication and the use of traditional forms of communication such as song and dance that are acceptable to the community should be used. Giving accurate information about HIV/AIDS is critical if the Samburu women will adopt behaviour that will reduce their risk of HIV infection (UNAIDS 2010: 224).

- The government should reinforce its policies and work with the community leaders and elders to put an end to early marriages and to reduce the high school dropout rate of girls in the Samburu District. The fact that the government turns a blind eye to early marriages has encouraged the community to continue to expose the girl child and women to harmful practices that make them susceptible to HIV/AIDS. Allowing girls to get an education, and keeping girls in school longer, ideally until they are eighteen, is one way of keeping them out of early marriages. In this way they could receive primary and secondary education which would give them more economic opportunities and prevent early marriages. This can be done by supporting and funding mobile schools that are in line with the cultural lifestyle of the people. Having education or lack of education is a significant factor in the spread of HIV/AIDS.
- There is a need to create more awareness about the risk of wife inheritance as a pathway of the spread of HIV/AIDS and to encourage HIV testing before those unions. The elders should also be educated about the dangers of wife inheritance and encourage HIV testing to ascertain the status of both the inheritor and the widow as a way of controlling the spread of HIV/AIDS. The use of the women funds to start self-help groups can support women financially who are widowed instead of being in unions that expose them to HIV Infection.
- The dangers of FGM must be emphasised in the community. While attempts to devise alternative rites of passage have failed in this community, continued

efforts should be made by all stakeholders to devise an alternative to FMG that would imbue women with the same privileges and status.

- A participatory approach to the fight of HIV/AIDS is recommended instead of a top down approach that is not sensitive to people's cultures. Cultural sensitivity is paramount. Ways within the cultures should be explored so as to stop the spread of HIV/AIDS. It is important to engage respected and accepted people in the community such as pastors and religious leaders, traditional healers, and the political leaders as well as the elders in effecting behaviour change within the community. As a community that is very sensitive to external influences, it is necessary for its own leadership to provide solutions that are acceptable to the community.
- Traditional herbalists play a significant role in the health of the Samburu community and should be trained in order for them to provide relevant information about HIV/AIDS to those who consult them and to take precautions and use safety measures when administering traditional medicine.
- There is a need for greater awareness regarding mother- to- child HIV transmission, both for those women who attend the clinics and those who do not. Outreaches are required for women who do not attend clinics in order to explain the dangers of not attending clinics and the necessary follow up for pregnant mothers. These outreaches must also be directed at men, political leaders and decision makers to acknowledge the importance of safe motherhood. The government must also look for ways of providing healthcare to those who live in remote areas. Having the communities own health workers is one possibility, but they should be supported by the government instead of the NGOs that rely on outside funding which can be erratic at times.
- The use of condoms as a protective tool could be a viable option but it is the sole decision of the man whether to use condoms or not. The men should be sensitized to first accept the condom as a way of protecting their families.

More awareness campaigns using the community health workers and involving men as well as the elders should be encouraged so that the community is sensitised to the dangers that are eminent if condom use is not encouraged. Condoms have not been acceptable to the women because they contradict conception which is highly valued in the Samburu community where even family planning has long been resisted. Ways of selling the idea of the use condoms among women must also be devised.

- Women should be involved in the dissemination of information to Samburu women because currently the majority of people disseminating messages are men and their messages can be ignored. The fact that it is the men giving the women information may in itself curtail freedoms that the women would have in terms of interaction. The women may not feel free to ask any questions as expected in the community. Women must be enabled to access information directly without intermediaries who may misinterpret information or withhold vital information because it goes against the Samburu culture. This can be done by training women who have attained some level of education in the community who will then give the women information in a more culturally acceptable way.
- Women have to be economically empowered so that they can provide for themselves and also have bargaining power. This can be done through women's projects and small enterprises where they are able to generate their own money which will give them a degree of independence.
- The need to involve men and women in the fight against HIV/AIDS. If women are involved alone they will not make headway because this is a patriarchal community.
- The need for the health services to be nearer to the people taking into consideration their mobile lifestyle and creating a positive image about medical services and medical facilities. Mobile medical services are necessary to reach the Samburu women who have no resources at their

disposal to go to the health centers or who are in remote locations. There are mobile camel services that are being provided by some NGOs, but in order to ensure continuity and a wider coverage, the government should also have mobile services because NGOs rely on funding from other agencies, so if the funding is late or even absent this means that the services cease.

- Most of the NGOs are based in Maralal town; they should extend their services into the interior where their services are needed more because this is where most of the Samburu community is concentrated.

## **7. 10            RECOMMENDATIONS FOR FURTHER RESEARCH**

- a) Further research should be done to find out what can bring about behaviour change in men and women regarding HIV/AIDS in the Samburu community.
- b) Further research should be done in designing effective HIV messages for Samburu women that will take into consideration their low levels of literacy and fill the knowledge gaps that were identified in this study such as Mother-to-child HIV transmission, human anatomy, ARV therapy, PEP therapy and the VCT concept.
- c) Further research should be done to find out the perceptions of Samburu men regarding HIV/AIDS.

## **7. 11            CONCLUSION**

The data collected from this study indicates that the use of verbal messages is very significant because the majority of the Samburu women have low literacy levels. The use of the traditional modes of communication to communicate HIV messages such as the use of song and dance, proverbs, adages, riddles, folklore and story telling should be used. The language of communication should be the Samburu language. The use of videos that depict the local people should be used so that they can identify with them and find relevance in them. Rural Samburu women who are acceptable and credible in the community should be trained to communicate HIV messages to the other women.

It is hoped that the information and the suggestions, which are contained in this thesis, will assist government health workers, non-governmental organizations and faith based organizations to tailor their communication strategies to suit the Samburu women as well as to the general Samburu community. The data in this study will also serve to strengthen the position of communication theory which posits that culturally sensitive communication interventions are crucial and that communities should spearhead the behaviour change interventions which they themselves have developed and accepted as a community. This is therefore an example of the recommended studies that identify and address unique needs of specific most at risk populations to come up with targeted messages and communication approaches. This study cautions that when prevention interventions, programmes and policies are designed for communities, they should be research and evidence based and context specific failure to which a lot of resources will go to waste because they may not reach their intended target audiences. This study is an example of studies that can be undertaken especially in sub-Saharan Africa where most HIV infections occur among women to actually assess the prevention strategies that are in use and to find out why these strategies are not working and to come up with focused prevention programmes that are tailored to local needs. This study is also an example of evidence-based research to policy makers, donor partners, non-governmental organisations and government agencies in designing HIV communication interventions. This study in addition exposed the researcher to the experience of going to the field and getting information first hand from the Samburu women and giving them a pen to express their fears, their views, their challenges and their perceptions about HIV/AIDS.



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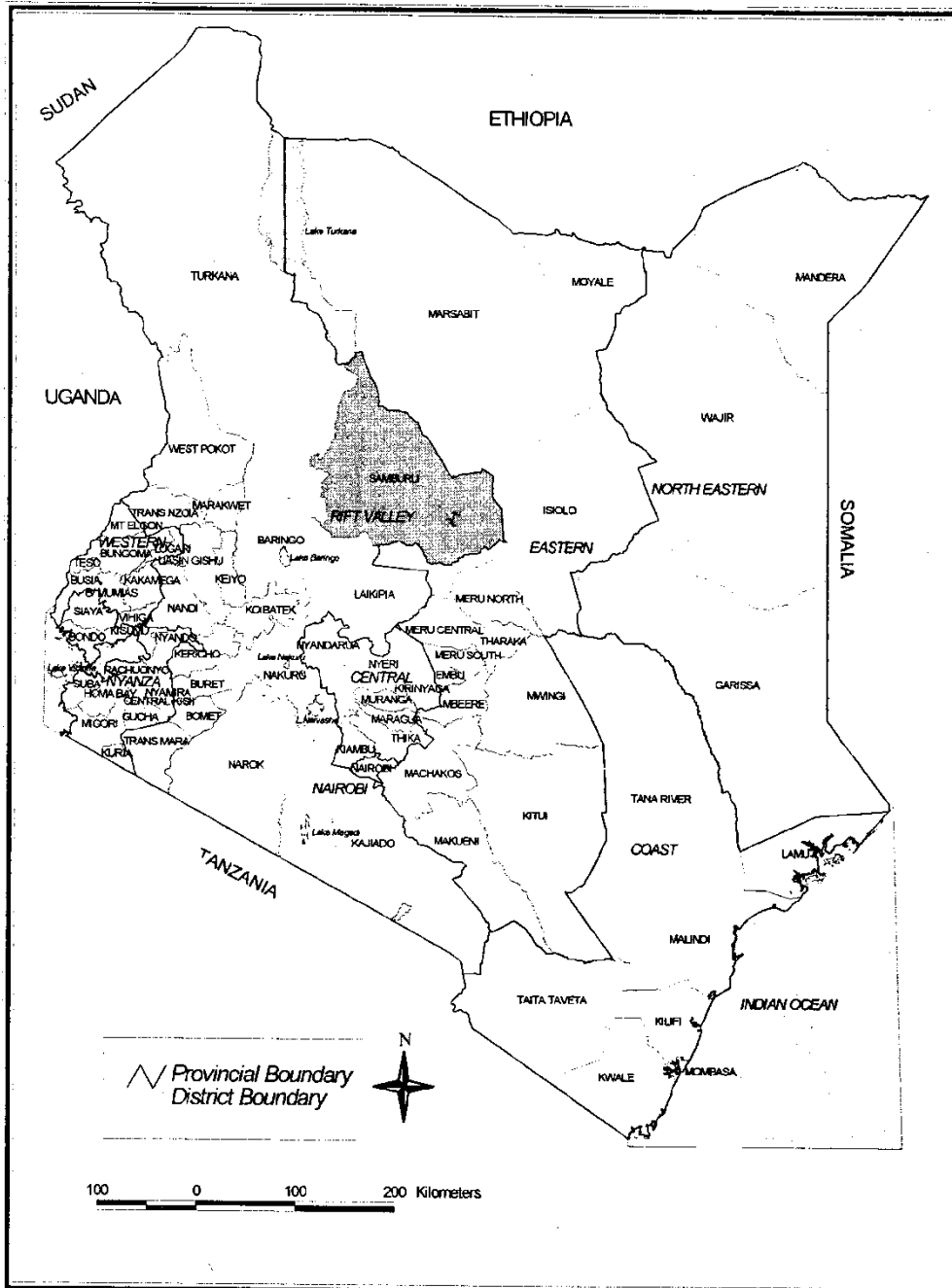


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# APPENDICES

## Appendix i: Location of Samburu in Kenya

LOCATION OF SAMBURU IN KENYA

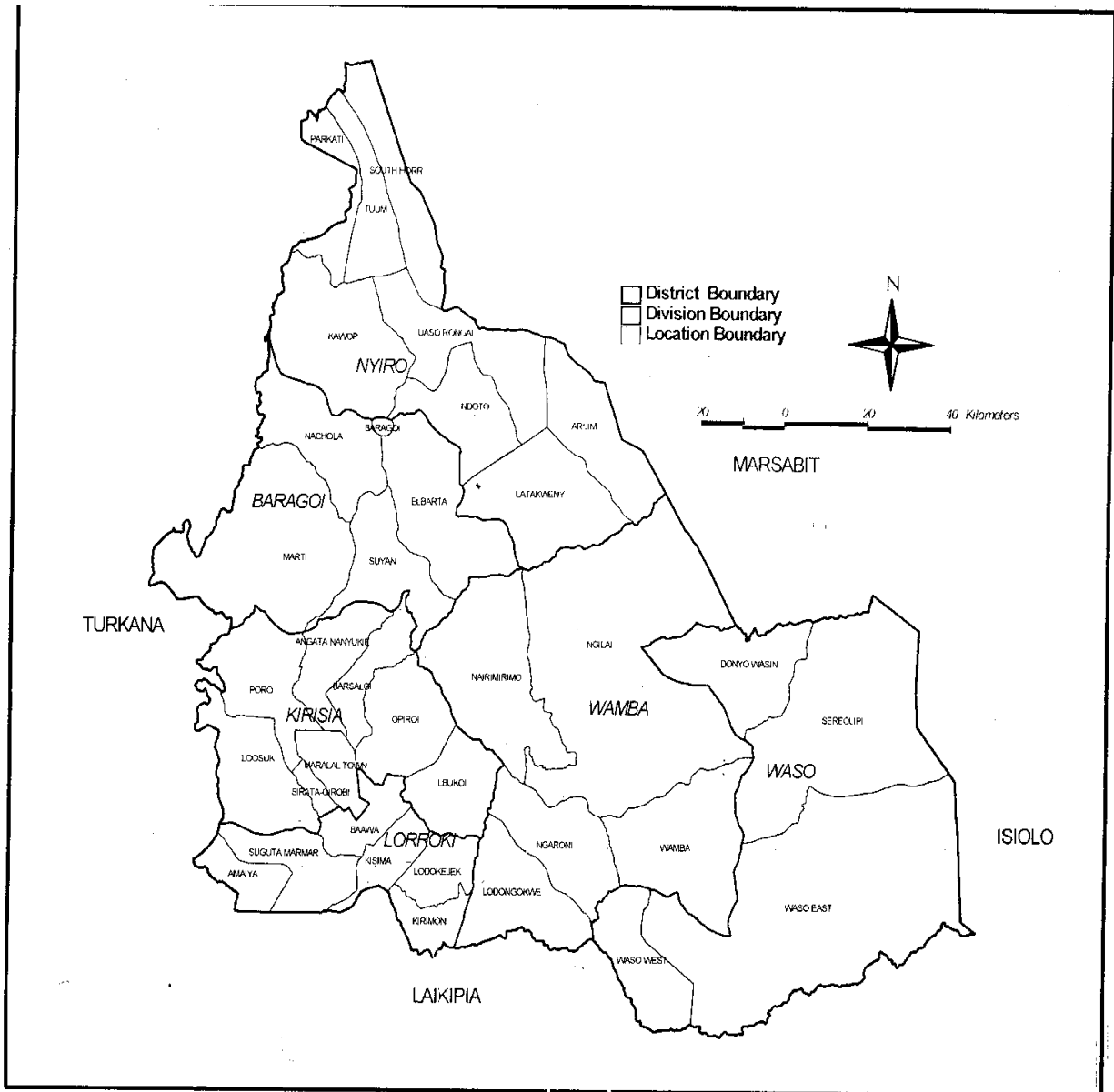


Prepared by CBS, 1999 Pop. Census

This map is not an authority over administrative boundaries

Source: Samburu District Development Plan (2002-2008)

**Appendix ii: Samburu District Administrative Boundaries**



**Source: Samburu District Development Plan (1997-2001)**

## Appendix iii: Research Authorisation Letter



REPUBLIC OF KENYA

### MINISTRY OF SCIENCE & TECHNOLOGY

Telegrams: "SCIENCE TEC", Nairobi  
Telephone: 02-318581  
E-Mail: ps@scienceandtechnology.go.ke

JOGOO HOUSE "B"  
HARAMBEE AVENUE,  
P.O. Box 9583-00200  
NAIROBI

When Replying please quote  
Ref. NO most/13/001/38C 74/2

18<sup>th</sup> March, 2008

Pauline N. Wanyoike  
University of South Africa  
**NAIROBI.**

Dear Madam

#### **RE: RESEARCH AUTHORISATION**

Following your application for authority to conduct research on: "***The Perceptions of Rural Samburu women in Kenya with Regard to Aids: Towards developing a Communication Strategy***", this is to inform you that you have been authorized to conduct research in Samburu District for a period ending 30<sup>th</sup> March, 2010.

You are advised to report to the District Commissioner, the District Education Officer and the Medical Officer of Health Samburu District before embarking on your research project.

On completion, you are expected to submit two copies of your research report to this office.

Yours faithfully,

  
**A. O. TULI**  
**FOR: PERMANENT SECRETARY**

CC: The District Commissioner  
Samburu District

The District Education Officer  
Samburu District

The Medical Officer of Health  
Samburu District

## **Appendix iv : Bio-data Form**

### **FOCUS GROUP REGISTRATION FORM**

Focus Group Number \_\_\_\_\_

#### **BIOGRAPHICAL INFORMATION**

Name \_\_\_\_\_

#### **1. Marital status:**

- (a) **married**
- (b) **widowed**
- (c) **single**

#### **2. Age Distribution**

- (a) **15-25**
- (b) **26-35**
- (c) **36-45**
- (d) **46-55**
- (e) **Over 56**

#### **3. Years of schooling**

- (a) **None**
- (b) **Lower primary (STD 1- 4)**
- (c) **Upper primary (STD 5-8)**
- (d) **Secondary (Form 1- 4)**
- (e) **Above secondary (College/University)**

**APPENDIX V: FOCUS GROUP QUESTIONING ROUTE**

**FOCUS GROUP QUESTIONING ROUTE**

**Focus Group No.** \_\_\_\_\_

**Date of Focus Group** \_\_\_\_\_

**Time of Focus Group** \_\_\_\_\_

**Tape No.** \_\_\_\_\_

**Location of Focus Group** \_\_\_\_\_

**Name and Description of Participants** \_\_\_\_\_

**Moderator's Name** \_\_\_\_\_

**Moderator's Phone Number** \_\_\_\_\_

**Assistant Moderator's Name** \_\_\_\_\_

**Assistant Moderator's Phone Number** \_\_\_\_\_

**INTRODUCTION:**

Welcome to this meeting of women where we will talk about HIV/AIDS. HIV/AIDS is a health problem that is affecting women in various ways. I am a researcher from Egerton University where I work and we want to find out how we can effectively communicate to Samburu women about the dangers of HIV/AIDS. We have invited you as Samburu women to help us come up with ways of communicating how we can prevent the spread of HIV/AIDS. We will talk about HIV/AIDS in a question and answer format about what you know about HIV/AIDS and we will record what you will say so that we can write a report.

**Opening Question**

Tell us who you are and where you come from and what work you do \_\_\_\_\_.

**THEME 1: Knowledge level of the Samburu Women about AIDS.**

**1. What comes to your mind when the word *biita* is mentioned?**

Brief Summary/Key points	Notable Quotes

**2. What is the difference between *biita* and AIDS?**

Brief Summary/Key points	Notable Quotes



### 3. How is AIDS transmitted?

Brief Summary/Key points	Notable Quotes

**4. What is the cure for AIDS?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**5. How is AIDS prevented?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**6. What causes AIDS?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**7. In what ways can you be in danger of being infected with AIDS?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**8. How does a mother transmit AIDS to her unborn child?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**9. How can a child be protected from getting AIDS from its mother?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**10. What are condoms?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>
<p data-bbox="188 275 632 309"><b>(A) What do condoms prevent?</b></p>          <p data-bbox="188 680 679 748"><b>(B) Are there condoms for men and women?</b></p>          <p data-bbox="188 1193 647 1261"><b>(C) Do women see the need to use condoms?</b></p>          <p data-bbox="188 1632 620 1666"><b>(D) Are the condoms available?</b></p>	



DISPLAY MALE AND FEMALE CONDOMS AND RECORD THE COMMENTS.

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**THEME 2: Communication based on source, message and channel about HIV/AIDS.**

**11. Who told you about AIDS?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**12. In what ways was the message about AIDS real to you?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**13. In what ways is the information you get about AIDS useful to you?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**14. Could you identify behaviours that you have since practiced from the information you have got about AIDS?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>



**16. In which language did the AIDS message come to you?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>
<b>(A) Was the language clear to you?</b>	





**18. Can you identify songs that you have heard about HIV/AIDS?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>
<p data-bbox="188 342 778 383"><b>(A) In which language where those songs?</b></p> <p data-bbox="188 636 740 676"><b>(B) Who are the singers of those songs?</b></p> <p data-bbox="188 1003 724 1075"><b>(C) What messages did the songs have that are relevant to women?</b></p> <p data-bbox="188 1554 695 1626"><b>(D) In what ways were the messages useful to you?</b></p>	

**19. What is the role of women groups in preventing HIV/AIDS in women?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**20. What have the following people told you about HIV/AIDS?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>
<p>(A) your husband</p>          <p>(B) your co-wife</p>          <p>(C) your friends</p>          <p>(D) Others</p>	

**THEME 3: Cultural aspects of HIV/AIDS and women**

**21. How can AIDS be passed through circumcision?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**22. What is the connection between body piercing and tattooing and HIV/AIDS?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**23. What is the connection between AIDS and polygamy?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**THEME 4: Beliefs and Perceptions about HIV/AIDS**

**24. What do people believe HIV/AIDS to be?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**25. What is the connection of HIV/AIDS and witchcraft?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>



**26. What is the connection of HIV/AIDS and tourism in the community?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**27. What is the connection of HIV/AIDS and those who have gone to school?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**28. What is the role of men in the spread of AIDS to women?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**29. What is the role of the secret lover and in the spread AIDS?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**THEME 5: Attitudes of women towards HIV/AIDS**

**30. Describe some of the symptoms you have seen in a woman who is suffering from AIDS?**

Brief Summary/Key points	Notable Quotes
<p data-bbox="188 371 687 450"><b>(A) Where do you think she got the disease?</b></p>          <p data-bbox="188 920 683 958"><b>(B) How does her family treat her?</b></p>          <p data-bbox="188 1323 735 1435"><b>(C) Are men and women treated in the same way if they are suffering from AIDS?</b></p>	



**32. Who is to blame for the spread of HIV/AIDS in the Samburu community?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>

**33. How should the spread of AIDS be prevented among Samburu women?**

<b>Brief Summary/Key points</b>	<b>Notable Quotes</b>



## APPENDIX VI: IN-DEPTH INTERVIEW GUIDE

### **IN-DEPTH INTERVIEW GUIDE FOR ORGANIZATIONS THAT HAVE A HIV/AIDS PREVENTION AND CARE PROGRAMME IN SAMBURU DISTRICT.**

#### **INTRODUCTION:**

My name is \_\_\_\_\_. I am a researcher from Egerton University. We are undertaking a study on assessing the knowledge level, perceptions and beliefs about HIV/AIDS among Samburu women in order to come up with a communication strategy that is best suited for them.

Would you spare an hour or so, to answer questions in which we will discuss the experiences that your organization has in regard to the prevention of HIV/AIDS among Samburu women.

#### **SECTION A: BIOGRAPHICAL INFORMATION**

1. What is your name? \_\_\_\_\_
2. To which of the following age groups do you belong?
  - (a) 20-30
  - (b) 31-41
  - (c) 42-52
  - (d) 53-65
3. To which of the following Educational levels do you belong?
  - (a) Primary Education
  - (b) Secondary Education
  - (c) Tertiary Education
4. Which organization do you work for? \_\_\_\_\_
5. What is your designation in this organization? \_\_\_\_\_
6. How long have you worked in Samburu district? \_\_\_\_\_

7. What objectives does your organization have in regard to HIV/AIDS prevention amongst Samburu women?

Summary/Brief Notes	Quotable Quotes



**SECTION B: KNOWLEDGE LEVEL**

1. What is the knowledge level of Samburu women regarding how HIV/AIDS is transmitted?

Summary/Brief Notes	Quotable Quotes

2. What are the possible knowledge gaps that the Samburu women have regarding prevention of HIV/AIDS?

Summary/Brief Notes	Quotable Quotes

3. Could you identify some of the problems you have encountered in relaying information about HIV/AIDS to Samburu women.

Summary/Brief Notes	Quotable Quotes

4. How do Samburu women regard VCT (Voluntary Counseling and Testing) Centers?

Summary/Brief Notes	Quotable Quotes

5. What level of knowledge do Samburu women have regarding ARV (Antiretroviral) therapy?

Summary/Brief Notes	Quotable Quotes



6. What level of knowledge do Samburu women have regarding PEP (Post Exposure Prophylaxis) therapy?

Summary/Brief Notes	Quotable Quotes

7. What level of knowledge do Samburu women have regarding mother-to-child HIV transmission?

Summary/Brief Notes	Quotable Quotes

**C: ATTITUDES, PERCEPTIONS AND BELIEFS ABOUT HIV/AIDS**

1. How does the community regard a woman who is HIV positive? Is she treated in the same manner as a man who is HIV positive?

Summary/Brief Notes	Quotable Quotes

2. What do the Samburu women say is the cause of infection?

Summary/Brief Notes	Quotable Quotes

3. Could you mention some of the beliefs the community has regarding HIV/AIDS?

Summary/Brief Notes	Quotable Quotes

4. How does the community explain how HIV/AIDS is spread?

Summary/Brief Notes	Quotable Quotes

5. What do Samburu women identify as ways of preventing HIV/AIDS among themselves?

Summary/Brief Notes	Quotable Quotes





**SECTION D: COMMUNICAION**

1. What mode of communication does your organization use to pass on information about HIV/AIDS?

Summary/Brief Notes	Quotable Quotes



3. What identifiable barriers to communication have you come across in the dissemination of information about HIV/AIDS to Samburu women?

Summary/Brief Notes	Quotable Quotes

## SECTION E: CULTURE

1. What do the Samburu women see as a possible link between the following cultural practices with the spread of HIV /AIDS?

Summary/Brief Notes	Quotable Quotes
<p>(a) Body piercing</p>          <p>(b) Multiple partners</p>          <p>(c) Early marriages</p>          <p>(d) FGM</p>	

2. What is the role of women groups in the fight against AIDS amongst Samburu women?

Summary/Brief Notes	Quotable Quotes

3. What are some of the special needs in so far as prevention of HIV/AIDS amongst Samburu women is concerned?

Summary/Brief Notes	Quotable Quotes

4. What in your view is the most effective way of having behaviour change in regard to risky sexual behaviour in the Samburu community?

Summary/Brief Notes	Quotable Quotes

