Students Perceptions of School-based HIV/AIDS Education Programs in Western Kenya

Kennedy Ongaga*
Department of Counseling, Leadership & Special Education (CLSE)
Missouri State University, 901 S. National Ave. Springfield, Missouri 65897 USA
Email: KennedyOngaga@missouriState.edu

Mary Ombonga,
Department of Educational Leadership, Fayetteville State University
1200 Murchison Road Fayetteville, North Carolina 28301 USA

Abstract
Education on HIV infection, prevention, and treatment has the potential to improve young people's knowledge on sexual health. Utilizing an ethnographic research approach, this study explored students' perceptions of school-based HIV/AIDS education programs in three high schools in Western Kenya. Using a rights-based theoretical framework the authors sought to understand how such programs empower students to understand HIV vulnerability and prevention. This study contributes in two ways: first, it informs education-based policies and guidelines on the design and implementation of HIV/AIDS education programs in K-12 schools. Second, it underscores the influence of social norms, attitudes and behaviors within the broader societal context on the youth and the power of this population in participating in the design, implementation, evaluation, and sustainability of school-based HIV/AIDS prevention programs.
Keywords: HIV/AIDS, School-Based HIV/AIDS Education programs, Students perceptions, Human Rights, Kenya.

1. Introduction
More than three decades since the first HIV/AIDS case was detected in Kenya, HIV education and awareness programs continue to play a central role in prevention, care and support among students and education personnel (UNAIDS, 2017). Young people, both in and out of school, remain a window of hope in stemming the spread of HIV if they are reached early by HIV/AIDS education programs. Kenya's Education sector policy on HIV/AIDS (Government of Kenya, 2013) provides guidelines for young people to understand the nature of the AIDS epidemic and specific actions they can take to prevent infection, especially during their adolescence and young adulthood. However, educating young people about behaviors that expose them to and increase their risk of HIV infection and steps they can take to prevent such infection can be challenging in the face of poverty, stigma, dynamic beliefs, values and meanings, and lack of political will. This study seeks to understand students' perceptions of school-based HIV/AIDS education programs.

2. Review of the literature
Young people aged 15 to 24 account for 40% of all new HIV infections worldwide and around 30% of young men and 19% of young women have basic information about HIV (UNAIDS, 2017). Kenya's Ministry of Health also confirmed that more than half (51%) of all new HIV infections in Kenya in 2015 occurred among adolescents and young people (aged 15-24 years), a rapid rise from 29% in 2013 (MoH, 2017). A number of factors contribute to the increasing rate of HIV infection among young people, including individual behavioral and social factors such as early sexual initiation, unprotected sex, multiple partnerships, sexual concurrency, having sex with older sexual partners, alcohol and drug use, lack of empowerment, engagement in transactional sex, and sexual abuse (UNAIDS, 2013; Mmari & Blum, 2009; Mavedzenge et al., 2011; Maticka- Tyndale, Gallant et al, 2005). Young Kenyan women are three times more likely to be exposed to sexual violence than young Kenyan men. It is estimated that 33% of girls in Kenya have been raped by the time they reach the age of 18, with 22% of girls aged 15-19 describing their first experience of sexual intercourse as forced (NACC, 2014). For youth who are HIV positive, many have inadequate access to health and social support services and face considerable stigma and discrimination.

Research (e.g., Kirby, 2012; Center for Disease Control, 2011; Coombe, 2002; UNFPA, 2011; UNAIDS & UNESCO, 2013) indicate that HIV/AIDS education is critical to prevent HIV infection, but it should begin when children are young, before they get involved in any form of sexual activity. The primary goal of sexuality education is to equip children and young people with the knowledge, skills and values to make responsible choices about their sexual and social relationships in a world affected by HIV (UNESCO, 2009). However, according to UNAIDS and UNESCO (2013), many young people do not receive adequate and comprehensive HIV sexuality education. Even the few who receive such information, social and cultural norms prevent them

from gaining relevant and comprehensive sexuality education, thereby denying them the knowledge, skills and the autonomy to control their own sexuality and reproductive choices.

Schools provide a key opportunity to reach large numbers of young people with HIV/AIDS education, including sex and relationships education in ways that are replicable and sustainable in resource-poor settings (UNESCO, 2007). In their study on the impact of HIV/AIDS on education in Kenya, Ennew et al. (2000) posit that listening to children's voices is important in HIV/AIDS project design, implementation, and evaluation. By so doing, "communities and institutions working with children suffering psychosocial impacts as a result of HIV/AIDS will be sensitized on the needs of these children" (p.130). This makes it imperative to understand how HIV/AIDS education programs empower youth to make informed choices regarding their reproductive health.

2.1 Kenya's Education Sector Policy on HIV/AIDS.
Kenya's education sector policy on HIV/AIDS (GoK, 2013) "formalizes the rights and responsibilities of every person involved, directly or indirectly, in the education sector with regard to HIV/AIDS: the learners, their parents and care givers, educators, managers, administrators, support staff and the whole of civil society" (p.5). The policy is grounded on eight provisions including; access to education for all learners including Orphaned and Vulnerable Children (OVC); access to relevant information; equality of rights to education, responsibilities and opportunities; privacy and confidentiality; access to care, treatment and support; safe workplace and learning institutions and gender responsiveness. Additionally, the policy advocates for a school curriculum that is "sensitive to cultural and religious beliefs and is appropriate to age, gender, language, special needs, and context on HIV/AIDS shall form part of the education for all learners at all levels" (GoK, 2013, p.14). On creating safe, secure and supportive learning environments, the policy requires learning institutions to create health-related school practices that address issues of gender-based violence including rape and sexual harassment. This study sought to understand students' perceptions of school-based HIV/AIDS education programs in Western Kenya. The following two questions guided the study:
1.   What HIV/AIDS education programs exist in schools?
2.   How do these programs help students understand HIV/AIDS vulnerability and prevention?

3. Theoretical framework
Human rights are inextricably linked with the spread and impact of HIV/AIDS on individuals and communities. This study is anchored on a human rights-based approach (HRBA) to HIV prevention, treatment and care (UNAIDS, 2006). This approach is premised on the idea that when individuals and communities realize their rights to education, health services, free association, information, and most importantly, non-discrimination, the personal and societal impacts of HIV/AIDS are reduced. It calls for an open and supportive environment for those infected and affected by HIV (WHO, 2008; UNAIDS 2010; Amnesty International 2012). Human rights-based approaches (OHCHR & UNAIDS 2006) (See Table 1) strongly require that policies and programs for member states/governments intentionally advance human rights by creating enabling environments for successful HIV responses and affirm the dignity of people living with, or vulnerable to HIV infection.
According to UNAIDS (2006), the HRBA to HIV prevention can be integrated into programming in various sectors, including health, education, governance, employment, and social services. There are benefits to implementing and utilizing a HRBA in HIV/AIDS Education programming, including:
- Encouraging participation from all stakeholders,
- Promoting accountability and improving transparency,
- Reducing vulnerabilities or non-discrimination,
- Promoting empowerment through capacity building of human rights (Buse, Patrick, Thomas, & Timberlake, 2013).

Rights-based HIV education programs call for implementation approaches that are cognizant of the local context, and which address specific underlying social, cultural, political and economic issues that increase young people's vulnerability.

4. Methodology
We use an ethnographic approach to explore high school students' perceptions of school-based HIV/AIDS education programs in Southwestern Kenya. Ethnography, as used by cultural anthropologists, denotes both a way of studying people – a process - and a way of presenting the results of the study - a product (Wolcott, 1975). Ethnography is the work of describing a culture and it involves the disciplined study of what the world is like to people who have learned to see, hear, speak, think, and act in ways that are different (Spradley, 1979; LeCompte & Preissle, 1994). This study underscores the fact that HIV/AIDS is still a dreaded disease whose characterization ranges from silence, fear, stigma and discrimination to acceptance, concern, and humanity. Intervention strategies such as HIV/AIDS education programs usually address such sensitive issues as sexuality

and longstanding concerns about human rights, poverty, economic development, gender inequality, stigma, and discrimination (Fisher & Foreit, 2002). Because of the sensitivity associated with HIV/AIDS, it takes a long time for an infected or affected person to trust one to open up to tell his or her story. Ethnographic approach therefore offered us a chance to balance attention to sometimes-nitty gritty everyday detail of students' lives with wider social structures.

4.1 Sampling and Data collection strategies

We purposefully selected the sample (Creswell & Creswell, 2018), which comprised of 25 high school students from three different schools, a boys' school, a girls' school, and a mixed school (See Table 2). Their ages ranged between 15 and 19 years and they were either in grades 10, 11 or 12. We assumed that students in these grade levels had reasonable exposure to and experience with HIV/AIDS education programs and therefore, were information-rich and could talk openly about their experiences, feelings, opinions, and knowledge related to HIV/AIDS education programs in their schools. Utilizing snowball strategy (Miles & Huberman, 1994) we enlisted the assistance of principals of the three schools, and key students who were actively involved in HIV/AIDS clubs in their schools to identity potential participants.

Given that ethnographic interviewing begins with the assumption that the perspective of the other is meaningful, knowable, and able to be made explicit (Patton, 2002), we used an open-ended interview process, which allowed participants to convey their situations from their own perspective and in their own words. We put participants into six focus groups (Morgan & Kreuger, 1993) and conducted interviews outside their instructional time. Each focus group comprised of an average of five participants and interviews lasted for an average of 90 minutes. The interviews covered a wide range of HIV/AIDS topics including; types of HIV/AIDS education programs, sources of HIV/AIDS information, teaching about HIV/AIDS, sex and sexuality, relationships, drugs, parents and culture. We assumed that focus groups offered participants greater openness to voice their shared understanding of HIV/AIDS education programs and ways such programs influenced their construction of HIV/AIDS vulnerability and prevention. Such conversations are inaccessible in ordinary discourse between youth and adults in most school settings in Kenya. With participants' consent, we audiotaped all interviews and transcribed them verbatim. Data collection lasted for a period of three months, between June and August 2017. Besides focus group interviews, we also utilized participant observation, field notes, and analyzed documents to which we had access. We attended Monday morning school assemblies, Friday evening parades, and Parents Day activities in the Mixed school. We reviewed Kenya's Education Sector Policy on HIV/AIDS document as well as HIV/AIDS programs in each of the three schools in the study. Our field notes were composed of not only what we observed, but also what we heard and saw.

4.1.1 Ethical considerations

Prior to interviewing participants, we explained the objectives of our study and sought their written informed consent to participate or withdraw from the study at any time without penalty (Spradley, 1979; Creswell, 1998; Patton, 2002; Greene & Hogan, 2005). During the data collection process, any information that could distinguish individual participants was not collected. To protect their identity and confidentiality, we used pseudonyms or aliases to report the study's findings.

4.1.2. Data analysis

Data analysis started as soon as we entered the research field. Our analysis drew from what we saw, heard, and read in the field with a view to categorizing, synthesizing, searching for patterns, themes, and interpreting the data. We use participants' direct quotes to enrich emerging themes, analysis, and most importantly to capture their experiences and perceptions, reveal the depth of their emotion, and the way they organize their world and thoughts about HIV/AIDS. Given that HIV/AIDS is an emotive disease whose communication assumes the use of tacit language, we embraced metaphors, analogies, euphemistic phrases, and thick descriptions that participants used to make reference to HIV/AIDS. Thick description, according to Denzin 1989b in Patton (2002), "…establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard." (p. 503). In other words, the product of our analysis is the creation that speaks to the heart of what we learned in the field.

5. Findings

5.1 Types of School-based HIV/AIDS education programs

In all the three schools, we found similar HIV/AIDS education programs, which we have summarized in Table 3. These programs had common objectives; to teach the youth how to form healthy relationships, avoid sexually transmitted infections (STIs), including HIV, embrace abstinence, and practice safe sex for those who are sexually active. All participants shared that they had experienced the devastating impact of HIV/AIDS, "we are either infected or affected," said one participant. They also acknowledged knowing someone with HIV/AIDS or had relatives or friends who were HIV positive. While these programs served as participants' primary source of

information about HIV/AIDS in school, much of their HIV/AIDS education information, especially regarding infection and prevention, was acquired from their peers. Additional sources included TV, radio, teachers, parents, the church, billboards and magazines, and related literature. The most popular programs among the students were Chill Club, Let's Talk About AIDS and G-Pange, all which had a strong student participatory approach. One student in the focus group shared their main source of HIV/AIDS information:

> We have programs here in school where we learn about HIV/AIDS and preventions. We also learn about it from our peers, magazines, TV and social media. Our teachers sometimes talk about it. It is also in the streets, on the walls, and billboards. And of course, for me, it is the number of people that are buried in my village that talks louder. When I was home for the holidays five people were buried in my village. Always my father is out to attend a funeral and when he comes home, you hear him say, 'this thing is wiping out the whole village' (Participant, Personal communication, June 18, 2017).

Students further shared that in their community, HIV/AIDS was referred to as the *Radio Disease*. This is because the radio was the common means of receiving information about the debilitating impact of HIV/AIDS in the rural areas. Participants from all three participating schools shared that they watched videos, and one participant remarked, "in some cases we watch scary images of people dying of AIDS. It reminds me of those that have died in my village, including my cousin." Another participant said, "At times we normally go to the hospitals to talk to patients willing to share their experiences. Sometimes, it is young girls like us who are in those beds and it's really scary". These tactics do not necessarily empower students to make healthy decisions. Instead, they scare and traumatize students who had lost loved ones to AIDS related complications.

Participants indicted that "men of the cloak" (clergy) present false impression that HIV/AIDS is curable. A participant from the boys' shared, "these people come here and read the Bible and advance the views of the church and not the reality that HIV/AIDS is a killer disease and is not incurable." Another one from the girls' school shared, "He came to our schools and claimed that he had been healed of HIV/AIDS. Truth is he had no hair, his skin had rushes all over, he was really thin, and he was coughing so hard. I did not believe what he was saying." We underscore that HIV, the virus that causes AIDS, is incurable. However, its progression can be slowed down by antiretroviral therapy.

In addition to sharing their sources of HIV/AIDS information, participants talked about the challenges of communicating about issues related to sex and sexuality that are often regarded as taboo in their culture and their subsequent fears of repulsion from the community. Parents and some religious groups were said to be opposed to the open discussions of sex related issues such as condom use and prevention of HIV/AIDS for fear that they may lead to promiscuity among young people. In our view, students were caught in a dilemma regarding communication, interpretation, and understanding of HIV/AIDS messages that they received from various sources. This made the student's perception of the HIV/AIDS messages, especially those regarding infection and prevention convoluted. We learned that participants were most familiar with one major HIV/AIDS prevention framework, ABC (Abstain, be Faithful and use a Condom).

5.1.1 The ABC Approach

The ABC approach to HIV/AIDS prevention underscores individual responsibility by suggesting that individuals abstain or delay first sex, be faithful to one partner or reduce the number of sexual partners and correct and consistent use of condoms for sexually active young people. The government of Uganda is credited for starting ABC model in the1990s to curb the high HIV/AIDS prevalence rate among her youth. However, US President's Emergency Plan for AIDS Relief (PEPFAR) initiative, which funds most HIV/AIDS education prevention programs in Kenya, including treatment, care and prevention promotes Abstinence and Be faithful and deemphasizes the use of Condoms. This contradicts UNAIDS (2004) stance that "condoms, when distributed with educational materials as part of a comprehensive prevention package, have been shown to significantly lower sexual risk and activity, both among those already sexually active and those who are not" (n.d).

In our study, we discovered that participants had developed a heightened language to describe the ABC model. Female participants referred to abstinence as *chill* and *seal*. One of them stated, *chill* and *seal*:

> Has helped many girls I know to find a language that is not so intruding and culturally embarrassing to say no to sex. It is easier to tell off a boy who is making advances, "*nimechill* and *nimeseal*" [I have chosen to abstain] instead of going to details, it is a common language of saying no to sex and is understood by all teenagers (Participant, personal communication, July 1, 2016).

Participants shared that teachers emphasized "abstinence until marriage" over other forms of prevention. An emphasis on condom use was considered an encouragement for students to engage in sex. A male participant narrated his experience saying:

> Our head teacher and teachers believe that abstinence is the best and only method. Some teachers might mention the use of condoms in class but proceed to tell us that condoms are not meant for us because we are students and students are not supposed to have sex. Like teachers, parents believe that teenage children don't have sex, they don't talk much about the use of that *thing* [condoms] (Participant, personal communication, June 24, 2016).

While participants agreed that abstaining from sex was the best method of preventing HIV infection, they also stated that neither their parents nor schools were talking about other preventative methods, especially the use of condoms. All they heard from their parents and teachers was "take care." A participant observed that parents and teachers "discover that most of us are sexually active when things have gone very wrong. Either when one is infected or, in the case of girls, when they are already pregnant" (participant, personal communication, July 1 2016). They viewed the use of condoms to prevent the spread of STIs, including HIV as a lesser evil than contracting it. A male participant captured the views of others when he shared that teachers always confiscated packets of condoms whenever they conducted impromptu inspections in his school. Such experience [confiscation of condom packets] had left them with "feelings of fear" and "kind of insecure." This was a clear indication that these students were sexually active, and were conscious of having protective sex, but teachers were taking away the very power that meant life or death for them. Religious leaders, who have a big sway in almost all schools in Kenya, were equally opposed to students using condoms as a prophylaxis during sex. Participants wanted the church to see the use of condoms "not as a contraceptive", but as "a guard against STIs and HIV infection". They argued that abstinence might mean delaying sex, but that did not mean waiting until marriage and as one female participant said, "marriage in itself provides no protection to HIV infection". This was a view shared by most participants.

We also gleaned that schools implemented school-based HIV/AIDS programs selectively, to underscore the views of the parents, teachers, and the church. A participant shared:

> I think some of our teachers shy away from telling us the obvious. They stick to the usual facts in the textbooks, its like some of them don't really want us to know anything about sex. So, we feign ignorance. In my view, they should give us details on HIV prevention and not to assume that telling us anything in detail will encourage bad behavior (Participant, personal communication July 2, 2016).

The views of these stakeholders are inconsistent with what research posit about HIV prevention. Comprehensive sexuality education can reduce the spread of HIV by effectively delaying sex debut among young people and providing opportunities for condom use and other methods among sexually active youth (Boonstra, 2007; UNAIDS 2010; UNICEF, 2011; Lacent, 2011; Maticka-Tyndale, 2012). We cannot dispute that abstinence, in and of itself, is the surest method to prevent HIV infection. However, in real life, expecting young people to practice sexual abstinence is like pounding water in a mortar. Condoms are an integral and essential part of comprehensive HIV prevention and care programs and students deserve correct, accurate, and consistent information on the use of male and female condoms.

5.1.2 Cultural norms and gender inequality

Social and cultural norms can greatly influence individual behavior and create an environment that either promotes or mitigates gender inequalities in the treatment, care and support of people affected or infected with HIV. In Kenya, the education sector policy on HIV/AIDS (GOK, 2013) underscores students' right to accurate information on human sexuality and HIV; exploration to values, attitudes and norms regarding sexuality and gender; acquisition of interpersonal and relationship skills; and learners to assume responsibilities for their own sexual behaviors. However, participants in this study captured the social and culturally ingrained gender inequality and power imbalance that disfavors girls. We learned that issues related to gender equality were seldom addressed in school-based HIV/AIDS education programs. This, according to participants, increased their vulnerability to HIV/AIDS infection. Specifically, matters related to sex were taboo and not openly talked about in school. One female participant described the influence of culture on relationships, saying:

> In our culture, I understand that the boy has the overall dominance to initiate matters related to sex. My mother did not tell me, and I did not learn it in class, but I see most things going this way. What a man says is what goes. Our culture does not allow a girl to question some things. If a boy has not asked for sex, a girl is not going to come up and say, John I want us to have sex today. You cannot do that. And of course, you cannot determine when to use a condom if at all one is used. How can a girl even go to buy a condom! Wah! A girl cannot do that. I don't know how to do that. (participant, personal communication, July 3, 2016).

This quote reveals that culture and gender inequality makes girls vulnerable, and they don't have the societal approval to negotiate safer sex. We argue that providing all young people with relevant HIV prevention information and life skills in a safe and supportive environment should be a critical component of HIV/AIDS education programs.

5.1.3 Poverty, drugs and alcohol

Poverty increases the risk of HIV/AIDS when it drives young people especially girls and women to exchange sex for food, and to engage in risky sexual behaviors for survival. Drugs and alcohol abuse on the other hand provide an intoxicating effect that alters judgment and leads young people to engage in impulsive and unsafe behaviors. Participants agreed that drug use had infiltrated their schools and they knew students in their respective schools who were engaged in drug activities. For instance, illicit drugs and alcohol were readily available in schools and surrounding communities. A participant from the girls' school narrated an episode involving three girls:

I know of girls in my school who smoke and drink. They sneak to the bathroom to be high. They make a lot of noise in the dormitories during the night. Almost all girls fear them. We do not have enough courage to report them to the authorities. In fact, if you happen to go to the garbage pit on Saturday mornings, you can find a lot of empty beer bottles. You can never find all the three in school during weekends. If one is out this weekend, the other two remain behind to cover her. Even some teachers know, but I guess they just give them a pass. (Participant, personal communication, June 29, 2016).

Augmenting this view, another participant who had transferred from a city school confessed of being involved in drugs and viewed her transfer as some form of punishment. She stated:

Nowadays, most teens use drugs to fit in. If you engage in drugs, "*umechanuka*" [you are cool] and most teens want to *chanuka* [be cool]. We have a number of local musicians who have come up singing that it is ok to take alcohol, but I believe [that] one can *chanuka* without taking alcohol or engaging in drugs. You can stay sober and still have fun. (participant, personal communication, June 24, 2016).

We also gathered that a nightclub, which had opened for business in the local town had led students to misuse their tuition and fees and even influenced some to drop out of school. A participant confessed:

21st Century nightclub [pseudonym] is really an immoral place. Ok, some of us have been tempted to go there. There is dirty dancing, lights are on and off and you are forced to take alcohol. I think the government should ban totally such places if they cannot regulate who goes there. Anybody can go there. Many students have *chewed* [spent] their school fees and lives in there. (participant, personal communication, June 24, 2016).

These excerpts indicate the extent to which students are involved in drugs abuse and how schools do not have a strong monitoring system to protect students during weekends. The participants' views call for schools and local business communities to partner and create synergy to protect students.

5.1.4 Predatory teachers and Sugar daddies

Predatory teachers and "sugar daddies" (older men who sought sexual favors from young women) preyed on schoolgirls and made them vulnerable to HIV infection and unwanted pregnancies. Participants were aware of teachers who were involved in intimate relationships with their students. They viewed teacher-student relationships as some form of violence. For female participants, aspects of this violence included sexual abuse and harassment by older male students, male teachers, and sugar daddies, who enticed them with money, chicken, cell phones, and other gifts in exchange for sex. Teachers who engaged in such behavior were often transferred to other schools, dismissed, or they silently "squared out with parents not to press charges," said one participant. A female participant shared:

I know some of my friends want nice things and this tempts them to seek older men or teachers who have money to buy them cell phones and nice food and other gifts. Unfortunately, they don't realize the consequences of those gifts because they sleep with them in return for the things [gifts] they receive which can be really risky. One can catch HIV and I know a girl in our school who got pregnant and dropped out of school. (participant, personal communication, July 5, 2016).

The cell phones had become a distraction in school as captured by another participant: "They are a nuisance. Today it is one ring tone, tomorrow it is another and that can really be annoying to others" (participant, personal communication, July 2, 2016). A male participant reflected

The choices girls make about cell phones and cars and money are personal and so they are responsible for putting themselves at risk. I know of a beautiful young girl in my village who got pregnant by a teacher. Her father had sold a piece of land to pay for her school fees. The hopes the old man had in this girl were dashed. To me, it is like her father sold wealth to by poverty. This girl is now taking care of her little child with the help of her frailing mother. What a waste! (participant, personal communication, July 2, 2016).

This excerpt profoundly captures the contexts that make girls vulnerable; the betrayal by teachers who are supposed to nurture them, the diminished power to negotiate for safer sex, and the underlying issue of poverty in the communities of these young people. While Teachers Service Commission has in their Teachers Code of Conduct (Teachers Service Commission, 2014) a guideline that required amorous teachers to be dismissed, this was seldom enforced. These students were violated and their human rights to education in a safer environment were also violated. International Guidelines on HIV/AIDS and Human Rights (UNHCHR & UNAIDS, 2006) call for local organizations such as schools and its community to develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

6. Discussion

Students are information-rich about HIV/AIDS vulnerability and prevention, but they fall short in using such information to change their behavior. This means that the information students receive regarding HIV/AIDS is not empowering and is focused only on individual behavior and not the contexts that regulate the behavior. We

argue that there is need to move away from focusing on the individual behavior on to addressing issues of sex arising from and perpetuated by socio-cultural norms, religious beliefs, gender inequality and a power imbalance. Research (Meier, Brugh & Halima, 2012) has shown that School-based HIV/AIDS education programs need to be intentional in seeking partnerships that create synergy to empower the youth by focusing more on behavioral, structural, and biomedical aspects that make the youth vulnerable (See Table 4). Delivery of HIV/AIDS education programs as students described them seemed to be didactic, non-participatory, inflexible and assessment driven. We underscore that implementation of school-based HIV/AIDS education programs ought to be participatory and responsive, raising questions rather than providing clear-cut answers, and challenging young people and adults to find new ways of relating to one another. Research supports this finding arguing that to have an impact on behavior, the quality of delivery of the curriculum and teaching strategies must be of age appropriate and culturally responsive to the youth (Nzioka & Ramos, 2008). The quality of the implementation is as important as the detailed design of materials or curricula. One thing we didn't hear from participants is voluntary HIV testing. We deciphered that they were afraid to talk or even be HIV tested. We attributed this silence to many barriers to HIV testing, including stigma and discrimination and access to confidential HIV testing and counselling. Many people still only get tested after becoming ill and symptomatic.

Student participation in school-based HIV/AIDS prevention education can help ensure that their specific needs and concerns are met in a culturally and socially appropriate way. Any information about HIV/AIDS prevention should empower them with life skills such as negotiation, conflict resolution, critical thinking, and communication, all which go a long way to improve their self-confidence and decision making (Clarke & Aggleton, 2012 & Luke 2005).

Now more than ever, technology and social media can and does play an effective role in engaging young people in sharing HIV knowledge and skills crucial in the prevention. Through social media, peer educators can serve as mentors, share and disseminate ideas and information geared towards meeting their needs. Therefore, successful HIV/AIDS prevention and intervention programs should infuse the use of technology in ways that is accessible to the young people.

7. Conclusion

Young people still remain to be a window of hope upon which the war against HIV/AIDS pandemic can be won. Successful HIV/AIDS education programs need to focus not only on individuals who are responsible for changing their own behaviors, but also on communities where young people come from. This is where values and attitudes towards sexuality, sexual practices, gendered norms, illness and death are inculcated. Such programs should be integrated in healthy children and healthy schools and should cover issues ranging from reproductive health, sexuality, gender, sex education, STIs, and condoms use. Issues such as discrimination and human rights, respect for women, and life skills should also be part of the prevention strategies.

Appendixes
Table 1
International Guidelines on HIV/AIDS and Human Rights

Guidelines	Rights-based response
1	Establish an effective national framework for their response to HIV which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV policy and programme responsibilities across all branches of government.
2	Ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.
3	Review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.
4	Review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.

Guidelines	Rights-based response
5	Enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.
6	(as revised in 2002): States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price. Take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions. Take such measures at both the domestic and international levels, with attention to vulnerable individuals and populations.
7	Implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.
8	States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.
9	Promote the wide and ongoing distribution of creative education, training and media programs explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.
10	Ensure that Government and the private sector develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.
11	Ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities.
12	Cooperate through all relevant programs and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV at international level.

Note. Adapted from "International Guidelines on HIV/AIDS and Human Rights 2006 Consolidated Version" by Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS. Retrieved from: *https://www.ohchr.org/Documents/Issues/HIV/ConsolidatedGuidelinesHIV.pdf*

Table 2

Participant Sample and Data Collection Methods

Boys School (9 participants)	Girls School (8 participants)	Mixed School (8 participants)
	No. of focus group interviews	
• 4 boys	• 4 girls	• 3 girls and 2 boys
• 5 boys	• 4 girls	• 2 girls and 1 boy

Table 3

Types of School-based HIV/AIDS Education programs

Program Type	Purpose	Target groups
Let Us Talk About AIDS	Designed to teach young people how to form healthy relationships, including avoiding STIs and HIV infection.	8- 19-year old
G-Pange	HIV intervention program sponsored by US President's Emergency Plan for AIDS Relief (PEPFAR) to promote healthy lifestyle choices among youth	10-24-year old
Healthy Choices	Designed to help youth make healthy choices and increase access to HIV Testing and Counseling (HTC), teach abstinence and promote use of condoms and other preventions. Also address behavioral determinants of health to improve interventions.	Youth 9- 24 years Level 1- target 10-14yrs Level 2- 15-24years
Shuga	A multi-media behavioral intervention program aimed at dispelling stereotypes and myths about people infected with HIV	15- 24 years
Chill Club	A club led by peer health educators to promote abstinence, HIV/AIDS awareness, and sexual and reproductive health	Level 1: 10-14years Level 2: 15-24 years

Table 4

Approaches to HIV Prevention intervention

Behavioral Approaches	• Education • Stigma reduction • Delay of sexual debut • Decrease in number of partners • Increased availability and use of condoms • Harm-reduction strategies, including needle exchange programs
Structural Approaches	• Law and policy development • Gender equity • Access to services • Cash transfer programs • Decriminalizing determinants of infection • Targeting programs and services to young people
Biomedical Approaches	• Treating STIs • PMTCT • Male circumcision • Antimicrobials/microbicides • PEP • PrEp • Treatment as prevention

Note. This table is adopted from "Conceptualizing a Human Right to Prevention in Global HIV/AIDS Policy," by B. M. Meier, K. L. Brugh, and Y. Halima, 2012, *Journal of Public Health ethics 5*(3), 263-282. Copyright 2012 by Oxford University Press.

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