

IMPACT OF GUIDANCE PROGRAMME ON ENHANCING RISK BEHAVIOUR
CHANGE AMONG YOUTH LIVING WITH HIV/AIDS IN
NAKURU COUNTY, KENYA

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A Thesis Report Presented to the Institute of Post Graduate Studies of Kabarak University in
Partial Fulfillment of the Requirements for the Award of the Doctor of Philosophy in
Education (Guidance and Counselling)

KABARAK UNIVERSITY

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DECLARATION

The research thesis is my own work and to the best of my Knowledge it has not been presented for the award of a degree in any University or college.

Signed:.....Date:.....

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GDE/M/0828/09/14

RECOMMENDATION

To the Institute of Postgraduate Studies:

The research thesis entitled “**Impact of Guidance Programme on enhancing risk behaviour change among youth living with HIV/AIDS in Nakuru County, Kenya**” and Written by **Reuben Gathii Kariuki** is presented to the institute of postgraduate studies of Kabarak University. We have reviewed the research thesis and recommend it be accepted in partial fulfillment of the requirement for award of the degree of Doctor of Philosophy in Guidance and Counselling.

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DEDICATION

This thesis is dedicated to the Almighty God, who by His grace gave me the strength to undertake and accomplish this work in the prescribed period of time.

ABSTRACT

According to Kenya National Bureau of Statistics projections (2015), Nakuru County has a population of 1,959,880 comprising of 982,505 males (50%) and 977,375 females (50%). Children below 15 years constitute 39% of the population, while youth aged 15-24 years constitute 21% of the population. By the end of 2015, a total of 41, 217 people were living with HIV in the County, with 15% being young people aged 15-24 years. Nakuru county HIV and AIDS strategic plan (2015/2016) reported that, the number of adolescents living with HIV in Nakuru County was 16,153. Adolescents who have low self-efficacy may be swayed into risky behavior experimentation. Such risky behavior involves alcohol and substance abuse and unsafe sex. This risky behaviour among youth living with HIV may lead to re-infection and the development of AIDS and hence premature death. Social cognitive theory by Bandura was used in this study. The core objective of the study was to assess the impact of guidance programme in enhancing risky behavior change among Youth Living with HIV/AIDS, in Nakuru County. The study used an experimental research design with 38 participants in control group and 38 in experimental group. The experimental group was given the guidance programme as an intervention. Quantitative and qualitative data were collected through a questionnaire and an interview schedule. T-test for independent means was used to determine the difference between means of the two groups, the experimental and the control group, while percentile was used to test the level of professionalism of the VCT counselors. Both the tests were calculated at 0.05 level of significance. The findings were that; the guidance programme raised the level of self-efficacy, self-esteem, attitude towards safe sex and hence lowered the level of risky behaviour among youth living with HIV/AIDS. Recommendations were that the Guidance programme be incorporated in the intervention programmes for YLWHA.

Key words: Guidance programme, Behaviour change, Self-efficacy, Self-esteem, Safe sex

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ABBREVIATIONS AND ACRONYMS

AIDS	-	Acquired Immuno-deficiency Syndrome
ANC	-	Antenatal Clinic
HIV	-	Human Immunodeficiency Virus
NYP	-	National Youth Policy
PITC	-	Provided Initiated Testing and Counseling
PLHIV	-	Persons living with Human Immunodeficiency Virus
PLWHA	-	Persons Living with HIV/AIDS
PWAS	-	Persons with Aids
SDA	-	Seventh Day Adventist
VCT	-	Voluntary Counseling and Testing
VMMC	-	Voluntary Medical Male Circumcision
WHO	-	World Health Organization
YLWHA	-	Youth Living with HIV/AIDS

OPERATIONAL DEFINATION OF TERMS

The following terms are operationally defined as follows:

Adjustment - Adaptation, especially behavioural adaptation to a particular environment or set of circumstances.

Effective risky reduction behavior programmes-This refers to educational programmes that focus on perceptions of vulnerability to disease and peer norms, beliefs about the value of prevention behaviour, recognition of high risky behavior, behavioral intention and self-efficacy.

Guidance - Helping a person to find and select opportunities and activities that will yield maximum satisfaction and profit.

Guidance programme - In this study, the Guidance programme is defined as a systematic organized programme of activities that focuses on specific HIV/AIDS information, self-esteem and Effective risky behavior reduction.

Impact - To have an effect or influence on someone or something. For research purpose, someone refers to the youth living with HIV/AIDS whereas something is the risky behaviour itself.

Informed consent - The requirement that a potential participant in a study be told what he or she will be asked to do and possible risks and benefits of the study before agreeing to take part.

Prevention, intervention programmes - This refers to programmes offered to the Youth as Comprehensive Clinical Care, which include, drug adherence, Health and Nutrition awareness.

Risky behaviour –This refers to multiple behaviours that collectively enhance risky. These mainly include, unprotected sexual activities (vaginal, oral or anal sex), that place others at risk for infection and places the self at risk for contracting secondary infections that may accelerate HIV disease. It also refers to multiple sex partners, lack of public disclosure of one's HIV status; and alcohol and drug abuse.

Risky Behaviour change - This refers to the individual practice of risky reduction behavior. For the purpose of this study, this refers to, (increased access to condom and condom use, decreasing number of sex partners, and self-disclosure of HIV sero-status and building of positive self-esteem and self-efficacy).

Schema - a collection of concepts that specify necessary and optional aspects of a particular situation. A mental structure that organizes perceptual input and connects it with appropriate responses.

Sex Behavior orientation – is defined as an episode of (*hetero sex*-inserting of the penis in the vagina, *oral sex* –inserting of the penis in the mouth of a partner or inserting the tongue in the vagina of a partner and *anal sex* – inserting the penis in the anus of a partner.

Self-esteem - The evaluative and affective dimension of self-concept. Self-esteem is also referred to as self-worth.

Self-efficacy - is the belief that one can master a situation and produce positive outcomes. In this study, self–efficacy is defined as a belief that one can disclose his or her HIV serostatus to a sex partner; master the idea of engaging in safe sex and refuse to engage in unprotected sex.

Serostatus disclosure -The medical definition of serostatus is status with respect to being seropositive or seronegative for a particular antibody. In this study, the serostatus disclosure refers to revealing openly of one’s HIV status, whether one is HIV positive or HIV negative.

Unprotected sexual behavior - is defined as engaging in a sex event without a condom and hence placing others at risk for infection and the self at risk for contracting secondary infections that may accelerate HIV disease.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

UNAIDS Fact sheet (2015) shows that there were 36.9 million people living with HIV globally by the end of 2014. Since 2000, around 38.1 million people have become infected with HIV and 25.3 million people have died of AIDS-related illnesses. Regional statistics show that in the year 2014 there were 25.8 million people living with HIV in Sub-Saharan Africa. In the same year, there were estimated 1.4 million new infections in the region. Although the new infections declined by 41% between 2000 and 2014, Sub-Saharan Africa accounts for 66% of global total new infections; with a total number of 790,000 people who died of AIDS related causes in the year 2014 itself.

According to Kenya AIDS Response Progress Report (2014), the HIV epidemic in Kenya has evolved, since the first case was diagnosed in 1984, to become one of the major causes of mortality and has placed tremendous demands on the health system and the economy. The epidemic has affected all sections of society; children, youths, adults, women and men. The country's response to this epidemic has also evolved over the years from a health sector led response to a multi-sectoral one coordinated by one national authority, one strategic framework and one monitoring and evaluation framework. The response to the epidemic has been improving in tandem with increase in availability of reliable and comprehensive data, which has enabled the country to sharpen its focus on the key HIV transmission areas and populations in order to reduce new infections (Kenya AIDS Response Progress Report, 2014).

Kenya is one of the six HIV 'high burden' countries in Africa. About 1.6 million people were living with HIV infection at the end of 2013. Women in Kenya are more vulnerable to HIV infection compared to Kenyan men, with the national HIV prevalence at 7.6 per cent for

women and 5.6 per cent for men (Kenya HIV Estimates Report, 2014). The epidemic is geographically diverse, ranging from a high prevalence of 25.7 per cent in Homa Bay County in Nyanza region to a low of approximately 0.2 per cent in Wajir County in North Eastern region. The high burden of HIV and AIDS in Kenya accounts for an estimated 29 per cent of annual adult deaths, 20 per cent of maternal mortality, and 15 per cent of deaths of children under the age of five (UNAIDS, 2013). The epidemic has also negatively affected the country's economy by lowering per capita output by 4.1 per cent (National AIDS Control 2011).

Prevalence estimates by county shows the geographical variability of the HIV burden across the country. It is estimated that HIV prevalence ranges from a high 27.1% in Homa Bay County to below 0.2% in Wajir County. Ten counties have an estimated prevalence higher than the national average, while 7 counties have prevalence of less than 2%. This variability shows the need to design programmes that address the specific underlying issues in the counties (Kenya AIDS Response Progress Report 2014). The report further states that the number of Persons Living with HIV (PLHIV) is estimated to have increased from about 1.4 million in 2009 to 1.6 million in 2013. Women constitute about 57% of the PLHIV, while men account for 43%. About 80% to 90% of the PLHIV are adults. The percentage of women and men having multiple sexual partners has increased over the last 10 years. The increase has been higher among men than women. Having multiple sexual partners puts one at a high risk of HIV infection especially if the partners are not using a condom consistently and accurately. According to the report, Kenya initiated Voluntary Medical Male Circumcision (VMMC) in 2008. Since then, the programme has been scaled up from about 8,000 VMMCs performed annually in 2008 to 190,000 in 2013. Over this five year period, about 670,000 VMMCs were performed against a target of 860,000; which means 77% achievement of the target. About 50% of the males circumcised were aged 15-19 years and about 80% of the

VMMC's were conducted in Nyanza region. The overall coverage of circumcision among men aged 15-49 in the country is estimated at 91%. Despite the VMMC programme the number of Persons Living with HIV (PLHIV) is estimated to have increased from about 1.4 million in 2009 to 1.6 million in 2013.

The country also continues to serve as a pivotal host for some of the most important HIV-related research studies in the world, expanding the evidence base to support more effective interventions here and in other countries. Through these and other concrete achievements, Kenya is accelerating progress towards national and global HIV goals and targets. Along with other countries, Kenya has embraced the goal of ensuring universal access to HIV prevention, treatment, care and support. Attaining this goal is essential to usher in the vision of a world with zero new HIV infections, zero AIDS deaths, and zero AIDS discrimination (Kenya AIDS epidemic update, 2012). According to the Ministry of Health, Kenya HIV county profiles (2014) Nakuru county had a total population of 1,825,229 by the year 2013. The County's HIV adult prevalence overall stands at 5.3% with a total number of 53,700 adults and 7,898 children living with HIV.

With a significant proportion of the national population already infected, the risks of encountering HIV during any single episode of risky behaviour are considerable, meaning that relatively low levels of risky behaviour may nevertheless carry a substantial likelihood of transmission. In much of sub-Saharan Africa, the term "youth" is associated with young men from 15 to 30 or even 35 years of age. Youth in Nigeria includes all members of the Federal Republic of Nigeria aged 18–35. Many African girls experience youth as a brief interlude between the onset of puberty and marriage and motherhood. But in urban settings, poor women are often considered youth much longer, even if they bear children outside of marriage (*Nigeria 2009 National Youth Policy*). According to Kenya National Policy (2006), Youth is defined as people aged between 15 to 30 years (GoK, 2006: 3).

The HIV/AIDS scourge has broadly affected youth, with 33% of all the AIDS cases in Kenya being associated with people aged 15 to 34 years. 75% of all new HIV/AIDS infections are among people aged 20 to 45 years. This situation presents youth as needy, helpless and unprepared to make any contribution to national developmental affairs. In her situational analysis on HIV/AIDS in Kenya, Department of Adult Education, Kawewa (2015), states that, the majority of the infected people are aged between 15-39 years. This is a correct reflection of a population, which has over 50% people less than 16 years of age. This means that the majority of the basic education clients and the productive groups are within Aids vulnerable category and therefore very susceptible to infection: if the labour force (15 years-49years) is infected by HIV/AIDS, the production in country will decline and a vicious circle of poverty will persist (UNAIDS 2015).

1.2 Statement of the Problem

Nakuru county HIV and AIDS strategic plan (2015/2016) reported that, the number of adolescents living with HIV in Nakuru County was 16,153. The report called for concerted efforts to address the needs of this population Fan and Williams (2010) assert that, adolescents who have low self-efficacy may be swayed into risky behavior experimentation. Such risky behavior involves alcohol and substance abuse and unsafe sex. This risky behaviour among youth living with HIV may lead to re-infection and the development of AIDS and hence premature death. Kawewa (2015) argues that if the labour force (15years-49year) is infected by HIV/AIDS, the production in the country will decline and a vicious circle of poverty will persist.

While other approaches have been used to solve the HIV pandemic problem Nationwide, Nakuru county included; for example; biomedical HIV prevention interventions, male circumcision, increased use of condoms, ensuring that all donated blood for transfusion is screened for HIV and training of health workers in adherence to recommended infection

control procedures to prevent HIV transmission, the pandemic still persists. Whereas the support group's programmes give information on HIV/AIDS and safe sex; Information on building self-esteem and self-efficacy is lacking. This study therefore sought to test the Impact of guidance programme in enhancing Risky behavior change among the Youth Living with HIV/AIDS in Nakuru County since there was need to carry out research in this specific area of study. In this study, Guidance programme is defined as a systematic organized programme of activities that focuses on specific HIV/AIDS information, self-efficacy and serostatus disclosure, and self-esteem. The programme was specifically offered for research purpose. The details of the programme are shown in appendix "C".

1.3 Purpose of the Study

The purpose of this study was to assess the Impact of guidance programme in enhancing risky behavior change among the Youth Living with HIV/AIDS in Nakuru County, Kenya.

1.4 Objectives of the Study

The following objectives will guide the study:

- i. To establish whether there is a statistically significant difference in the level of self-efficacy and serostatus disclosure between the YLWHA who undergo guidance programme compared to those who do not.
- ii. To find out whether there is a statistically significant difference in the level of attitude towards safe sex between the YLWHA who undergo guidance programme compared to those who do not.
- iii. To examine whether there is a statistically significant difference in the level of self-esteem between the YLWHA who undergo guidance programme compared to those who do not.
- iv. To establish whether there is a statistically significant relationship between guidance programme attitude and respondents gender.

- v. To investigate the professional qualification of personnel working in VCT centres in Nakuru County.

1.5 Research Hypotheses

The following research hypotheses were tested at 5% level of significance.

- i. **H₀₁**: There is no statistically significant difference in the level of self-efficacy and serostatus disclosure between the YLWHA who undergo guidance programme compared to those who do not
- ii. **H₀₂**: There is no statistically significant difference in the level of attitude towards safe sex between the YLWHA who undergo guidance programme compared to those who do not
- iii. **H₀₃**: There is no statistically significant difference in the level of self-esteem between the YLWHA who undergo guidance programme compared to those who do not.
- iv. **H₀₄**: There is no statistically significant relationship between Guidance programme attitude and respondents gender.

1.6 Significance of the Study

The recommendations of the study may be of significance in helping policy makers in all institutions that deal with YLWHA, in making and evaluating guidelines for establishment and sustenance of risky reduction behavior programmes. It is also anticipated that the findings may provide useful information to professionals such as Social workers, Counselors working in VCT centers and other related centers. Health Center workers, Psychological Counselors, Doctors, Nurses, and Full Time Counselors (including Psychiatrists, Psychologists, and family Therapists. All YLWHA Care givers and Relatives may also gain awareness so as to create environments that will enhance risky behavior change. The YLWHA themselves may benefit from the training and adopt a positive lifestyle. Study

findings should provide useful information to all trainers and especially in creating awareness on the importance of the support groups' programmes that are geared toward risky behavior change. This will thus help in fighting the HIV scourge, and achieve the national major goal that is essential to usher in the vision of a world with zero new HIV infections, zero AIDS deaths, and zero AIDS discrimination by the year 2030.

1.7 Scope of the Study

The study assessed the effectiveness of guidance programme in enhancing risky behaviours change among YLWHA, in Nakuru County Kenya. The guidance programme focused on specific HIV/AIDS information, coping with HIV/AIDS, Safe sex behavior, Self- disclosure of HIV serostatus and strategies for risky behaviour change. The guidance training programme took three months of four weeks each, with three hours, session of training in each week. The whole programme of training thus covered a total of thirty six contact hours. That is, 24 contact hours and 12 hours in total for home assignments of the participants.

1.8 Limitations of the Study

The following were limitations of this study.

- i. Not all YLWHA in the targeted population sample volunteered to participate in the study. Eighty participants were targeted initially, but only seventy six volunteered. The researcher did not coerce those who did not volunteer. The sample was not much affected and therefore the researcher worked with the seventy six.
- ii. Some respondents seemed to have been exposed to some guidance and counseling in the VCT and the support group and this was a major limitation to the study. The researcher investigated to find out the professional level of qualification of personnel working in the VCT caters and the findings are indicated in the results of the analysis.

- iii. It was only 14% of all the participants who were assisted to fill in the questionnaires while 86% were able to fill the questionnaires independently without much difficulty. The researcher and his assistant therefore assisted the few who were not able to do it independently.

1.9 Assumptions of the Study

This study was conducted under the following assumptions:

- i. Those subjects in the target population sample would all volunteer to participate in the study. This did not happen but the number of those who did not volunteer was quite minimal, that is, four out of a total of eighty expected to volunteer and thus it did not affect the study much. The researcher applied the principal of informed consent at the onset of the study meaning that those who did not volunteer had a right to make the decision
- ii. That all the subjects in the study would open up and respond to the questionnaires and interview schedules freely. All the respondents worked on and returned the questionnaires dully filled and therefore the researcher assumed that they had all opened up and given correct information.
- iii. That the attrition rate would not be as high as to adversely affect the study. The attrition rate that took place at the onset of the study was insignificant and thus did not affect the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a literature review on the historical background of HIV/AIDS epidemic, prevalence of HIV globally, in sub-Saharan Africa, in Kenyan counties, and in Nakuru County. It also reviews the psychosocial effects of HIV, Self-efficacy and serostatus disclosure, attitude towards safe sex, and Self-esteem. The chapter further reviews various studies that verify importance of risky behaviours change, the theoretical framework, the relevance of Social Cognitive Theory to the study and conceptual framework of the study.

2.2 Background of HIV/AIDS

The first recognized cases of the Acquired Immune Deficiency Syndrome occurred in America in the summer of 1981 when a very rare form of pneumonia, caused by the micro-organism *Pneumocystis Carinii*, and Kaposi Sarcoma (a rare form of skin cancer), suddenly appeared simultaneously in several patients (Belin, 2012). These patients had a number of characteristics in common; they were all young homosexual men with compromised (damaged) immune systems (Cherie, 2012). Soon afterwards, a new disease, which undermined the immune system and caused diarrhea and weight loss, was identified in Central Africa in heterosexual people (Berhan & Berha 2015).

Initially, scientists and doctors were baffled because the causes and modes of transmission of this new disease (called 'slimming disease' in Africa) could not immediately be identified (Boaco, Dagbanu, & Opong, 2014). It was only in 1983 that it was discovered that the disease was caused by a virus which at that stage was known as LAV (Lymphadenopathy-associated Virus) and HTLV-III (Human T cell lymphotropic virus Type III). In May 1986, the virus causing this condition was named HIV (Human Immunodeficiency Virus) (Madise, Zulu, & Ciera, 2017). At present there are two viruses associated with AIDS, namely HIV-1

and HIV-2. HIV-1 is associated with infections in Central, East and South Africa, North and South America, Europe and the rest of the world. HIV-2 was discovered in West Africa (Cape Verde Islands, Guinea-Bissau and Senegal) in 1986 and is mostly restricted to West Africa (Savaş, Bozgeyik, & Eser, 2014)). All indications are that while HIV-2 is as dangerous a virus as HIV-1, it acts more slowly. This means that it takes longer for the symptoms of infection to develop in an HIV-2 infected person (Dahal, Pokharel & Yadav, 2013).

2.2.1 Prevalence of HIV/AIDS across the Globe

According to the latest estimates from (UNAIDS, 2015). There were 36.9 million people living with HIV in 2014, up from 29.8 million in 2001, the result of continuing new infections, people living longer with HIV, and general population growth (Mazhnaya *et al.*, 2014). The global prevalence rate (the percent of people ages 15-49 who are infected) has leveled since 2001 and was 0.8% in 2014. The report continues to state that 1.2 million people died of AIDS in 2014, a 42% decrease since 2004. Deaths have declined due in part to antiretroviral treatment (ART) scale-up. HIV is a leading cause of death worldwide and the number one cause of death in Africa (WHO, 2012).

The UNAID report shows that, new HIV infections globally have declined by 35% since 2000. In 61 countries, new HIV infections have decreased by more than 20%. Still, there were about 2.0 million new infections in 2015 or about 5,600 new infections per day (Madise, Zulu, & Ciera, 2017). Most new infections are transmitted heterosexually, although risky factors vary. In some countries, men who have sex with men, injecting drug users, and sex workers are disproportionately affected by HIV. Over the years, testing capacity for HIV has increased and this has helped people learn their HIV status. However, nearly half of all people with HIV are still unaware they are infected (Hall, Holtgrave, & Maulsby, 2012).

In sub-Saharan Africa, young women account for 63% of young people living with HIV. Globally, there were 2.6 million children living with HIV in 2014, 220,000 new infections among children, and 150,000 AIDS deaths (Madise et al., 2017). The report further shows that whereas the global total is 39.9 million people living with HIV, 2.0 million newly infected and an adult prevalence rate of 0.8%; sub-Saharan Africa has 25.8 million people living with HIV an adult prevalence rate of 4.8% and 1.4 million newly infected. Sub-Saharan Africa is thus the region with the highest prevalence and incidence rate globally.

HIV prevalence in Kenya is estimated based on the Demographic and Health Survey (2003 and 2008/9), AIDS Indicator Surveys (KAIS 2007 and 2012) and Antenatal Clinic (ANC) sentinel surveillance. A trend analysis starting from 1990 shows that prevalence in the general population reached a peak of 10.5% in 1995-96, after which it declined by about 40% to reach approximately 6.7% in 2003. Since then, the prevalence has remained relatively stable. The decline of the prevalence from 1995 to 2003 is partly attributed to high AIDS related mortality while the stabilization of the epidemic in the last 10 years is largely due to the rapid scale up of anti-retroviral therapy (ART) and reduction in the number of new infections that occurred during this period (Ministry of Health., 2017)). Population based surveys undertaken in the last 10 years show that HIV prevalence among women and men aged 15-49 years ranged from 6.7% in 2003 to 5.6% in 2012. Although the prevalence has taken a downward trend, women are disproportionately affected than men (Ministry of Health., 2017). HIV prevalence is higher among the general population in urban areas than those in rural areas. However, men in rural areas are more likely to be infected by HIV than men in urban areas (4.5% compared to 3.7%). Over time, the HIV prevalence in urban and rural areas has converged with only a modest different between the two (Ministry of Health., 2017).

Prevalence estimates by county shows the geographical variability of the HIV burden across the country. It is estimated that HIV prevalence ranges from a high 27.1% in Homa Bay County to below 0.2% in Wajir County. Ten counties have an estimated prevalence higher than the national average, while 7 counties have prevalence of less than 2%. This variability shows the need to design programmes that address the specific underlying issues in the counties (Ministry of Health., 2017). The counties with an estimated prevalence higher than the National average include, Homabay 27.1%, Kisumu 18.7%, Siaya 17.8%, Migori 13.4%, Mombasa 11.1%, Turkana 9.9%, Kisii 8.9% Nairobi 8.6% Transoia 7.2% and Busia 7.1%. The counties with low percentage are; Garissa 2.6%, West Pokot 2.4%, Tana River 2%, Mandera 1.3%, Lamu 1.3%, Marsabit 1% and Wajir 0.2% (Ministry of Health., 2017).

According to the Ministry of Health, Kenya HIV County profiles (2014) Nakuru county had a total population of 1,825,229 by the year 2013. The County's HIV adult prevalence overall stands at 5.3% with a total number of 53,700 adults and 7,898 children living with HIV. Nakuru town has been identified as the hardest hit by HIV/Aids in Nakuru County according to the latest statistics from the County Aids and STI group. Current figures indicate that the county's average HIV prevalence rate stands at 5.6% (Ministry of Health., 2017).

Kenya National Bureau of statistics projections (2015) show that, Nakuru County had a population of 1,959,880 comprising of 982,505 males (50%) and 977,375 females (50%). Children below 15 years constitute 39% of the population, while youth aged 15-24 years constitute 21% of the population. HIV prevalence in Nakuru was lower than the national prevalence at 4.1% (Kenya HIV Estimates 2015). The estimates further showed that the county contributed to 2.7% of the total number of people living with HIV in Kenya, and is ranked the ninth of the forty seven counties nationally. By the end of 2015, a total of 41, 217 people were living with HIV in the County, with 15% being young people aged 15-24 years.

2.2.2 Psychosocial Effects of HIV

There is a tendency for HIV-infected individuals to become engrossed with their health to the extent of becoming obsessed and even exhibit signs of hypochondria. Although this is a temporary condition that is common immediately after diagnosis, the condition may persevere in individuals who find it hard to adjust or to accept the disease. This may be temporary and limited to the time immediately after diagnosis, or it may persist in people who find it difficult to adjust to or accept the disease (Dyk, 2012).

Many authors have described the psychosocial effects of HIV disease. The principal psychological symptoms associated with HIV are *anxiety*, *depression*, and *prolonged adjustment reaction* (Schadé *et al.*, 2013). Anxiety is a state of uneasiness, accompanied by dysphonia and somatic signs and symptoms of tension, focused on apprehension of possible failure, misfortune, or danger (Colman, 2015). According to Dyk (2012), there is an uncertainty that comes along with the progress of HIV infection. This uncertainty only serves to propel the feelings of anxiety. Anxiety is as a result of the illness diagnosis, the risk of infection with other diseases and infecting loved ones with HIV, as well as social, occupational, domestic and sexual hostility. Rejection, abandonment, isolation and physical pain; fear of dying in pain or without dignity, inability to alter circumstances and consequences of HIV infection are an inevitable feeling. They are worried about loss of physical and financial independence. There is uncertainty and fear about being able to keep as healthy as possible in future and how their loved and family will cope. There is also worry about access, availability of appropriate medical treatment-or lack of it. HIV-infected people also fear that they will lose their privacy. This brings about concerns about their confidentiality, future social and sexual unacceptability. They are also worried about the inefficiency to function efficiently as they did before the infection.

According to Berhan and Berhan (2015), HIV infected people often have psychosocial experiences and needs such as, fear, loss, grief, guilt, denial, anger, suicidal behaviour or thinking and obsessive conditions and hypochondria. HIV-infected people have fears about being isolated, stigmatized and rejected. They fear the uncertainty of the future; they know and fear what awaits them. Fear may also be caused by not knowing enough about what is involved in HIV infections and how the problems can be handled (Savas *et al.*, 2014). HIV-infected people often feel that they have lost everything that is most important and beautiful to them. They experience loss of control, loss of autonomy, loss of their ambitions, their physical attractiveness, sexual relationships, status and respect in the community, financial stability and independence (Boafo et al., 2014). They fear the loss of their ability to care for themselves and their families and they fear the loss of their jobs, their friends and family. They mourn the loss of life itself. Perhaps the most commonly experienced loss is the loss of confidence and self-worth occasioned by the rejection of people who are important to them, people who were once friends but who now reject them because of the physical impact of HIV-related diseases that cause, for example, facial disfigurement, physical wasting and loss of strength or bodily control (Tura, Alemseged, & Dejene, 2012).

Alemu, Shegaze, Gobena, Abraha, and Temesgen, (2015) say that, people with HIV infection have profound feelings of grief about the losses they have experienced or are anticipating. They grieve for their friends who die from AIDS, and they grieve with and for their loved ones-those who must stay behind and try to cope with life without them. HIV infected people also feel guilt and self-reproach for having contracted HIV and for having also possibly infected others (Belin, 2012). They often feel guilty about the behaviour that may have caused the infection. Feelings of guilt may be associated with a person's unresolved conflicts about homosexuality or about sexuality in general (Chilisa, Tlhabano, & Vista, 2012). There is also guilt about the sadness that the illness will inflict on loved ones and families-

especially children. Doku (2012) asserts that, previous events that may have caused others pain or sadness but which still remain unresolved will often now be remembered and be the cause of even greater feelings of guilt and anguish for persons living with HIV/AIDS. Most HIV infected people go through a phase of denial as well. Denial is an important and protective defense mechanism because it temporarily reduces emotional stress.

In his study, Mwanga, (2017) reveals that, HIV-infected people are often very angry with themselves and others, and this anger is sometimes directed at the people who are closest to them. They are angry because there is no cure for AIDS and because of the uncertainty of their future. They are often also angry with those who infected them and with society's reaction of hostility and indifference. Inwardly directed anger may manifest as self-blame, self-destructive behaviour or (in its most intense form) suicidal impulses or intention. Suicide may be construed as a way of avoiding pain and discomfort, of lessening the shame and grief of loved ones, and of trying to obtain a measure of control over one's illness. Certain core characteristics are often seen among people with depression. These characteristics may be organized within the four psychological domains, used to describe anxiety; the *affective domain*, the *cognitive domain*, the *behavioral domain* and the *physiological domain* (Sue et al., 2012). An individual who has a depressed mood, dejected, sad and excessively mourns exhibits an outstanding indication of depression. The individual is not joyous and weeps wildly at no specific situation but as a general reaction to frustration or anger. According to Becker and Kleinman, (2013), there is a correlation between anxiety and depression that tap in to the aspects of the negative affective or trait. The negative affect is exhibited by not only a depressed mood but also poor concentration and irritability.

2.2.3 HIV Information and Behaviour change

In a study carried out amongst young women in Mbale eastern Uganda, Nicholas (2010) found out that; though women were informed and motivated to prevent HIV, poverty and

inequality were significant barriers, limiting their power to protect themselves. Gender inequality within sexual relationships put women at risk of HIV/ AIDS, highlighting problems arising from lack of control within sexual encounters. Rape cases and coercion were reported to contribute to unsafe sex behaviour.

In her study, Nicholas (2010) citing a report from the WHO (2006) stated that there had been too much emphasis on health promotion targeting individual knowledge and related behaviour and not sufficient emphasis on protective factors. She argues that Findings in her study support this position suggesting that accurate knowledge of HIV and awareness of personal risky does not necessarily result in protective behaviour.

Mosha, (2012), conducted a study amongst university students in Tanzania, where she focused on HIV/AIDS information, safe sexual behaviour and practices including fidelity, correct and consistent use of condoms and being faithful to one partner. Respondents reported that information concerning HIV status could empower individuals to take precautions to prevent him/her against either acquiring or transmitting the disease. Respondents also reported that prevention information must be coupled with skills that enable individuals to translate their knowledge into actions. It was also reported that even though information is necessary to bring about behaviour change, it is not sufficient on its own, it is also necessary to take into consideration other determinants such as experiences, emotions and the socio-cultural environment. Information will provide the basic facts about the means of HIV transmission and how to protect one's self. The study further noted that Young people need to develop self-esteem, self-confidence and self-efficacy. More importantly, they need practical skills to cope with peer pressure, solve problems, be assertive, negotiate safer sex practices, and develop life plans. Although awareness about the HIV/AIDS pandemic was high among the undergraduate students in this study, the proportion of those using HIV/AIDS information was low.

Amo-Adjei *et al.* (2014) conducted a study on transactional sex among Young female University students in Ghana. The study in particular explored the implications for HIV education in institutions of higher learning. This study is said to have been carried out in a society in which parents, older people and men are given unquestioning respect, and this reduced the young girls ability to negotiate safe sex practices despite the information they had on HIV. It was reported in the study that the young girls practiced safe sex to avoid pregnancy rather than disease, believing that they would be able to tell from physical signs if their partner was infected. Materialism, sexual gratification, perception of trust and the father-daughter nature of the relationships hampered negotiations for safe sex practices.

With heterosexual sex as the main driver of HIV transmission in sub-Saharan Africa, correct and consistent condom use is recognized as one of the important safety measures for preventing infection apart from faithfulness and abstinence. Previous research (Amo-Adjei, 2012) had shown that education improves safe sex practices. Horrocks and Johnson (2014) cite that health promotion has increased over the years. New ways and approaches have been utilized so as to bring about and improve health and wellbeing of individuals. However, the health promotion does not always bring about a change in the health behavior of individuals. In other words, health promotion initiatives do not always result in protective behavior.

2.3 Guidance Programme and Risky Sexual Behaviour Change

Collins dictionary defines guidance as counseling or advice on educational, vocational, or psychological matters (Collins Dictionary, 2014). Risky behavior change is a psychological matter. In her article Guidance services, Ramirez (2014) defines guidance as systematic and organized procedures, tools and facilities to assist an individual in securing knowledge and skills needed in making plans and services, and in interpreting life. These services provide comprehensive information about opportunities, personality development, effective studying

and learning. Collins dictionary defines learning psychologically as, relatively permanent change of behaviour that occurs as a direct result of experience (Collins Dictionary, 2014).

Similarities and differences are seen among people who display risky behavior for HIV transmission. There is need for further investigation as to why a rebound occurs for individuals who had initially decreased their risky behavior following a diagnosis. This investigation would shed light on the risky behavior change over the course of HIV infection. In doing so, there would be an improvement on targeting of groups that are in need of interventions and approaches for managing HIV transmission-related behaviors (Kalichman, 2014a). Even though immediate decreases in risky behaviors are clearly reassuring from a prevention viewpoint, it is obvious that for some heterosexual men and women, and men who have sex with men (MSM), high risky behavior remains after HIV diagnosis (Phillips *et al.*, 2013).

In this study, Guidance programme is defined as a systematic organized programme of activities that focuses on specific HIV/AIDS information, self-esteem and Effective risky behavior reduction. The programme is specifically offered for research purpose. Chersich, Luchters, Ntaganira, Gerbase, *et al.* (2013) reviewed group interventions and revealed that peer interventions, condom promotion and STI screening help to reduce HIV exposure and transmission efficiency. Chersich *et al.* (2013) maintained that information served to mobilize the community and empower individuals.

Fonner, Armstrong, Kennedy, O'Reilly, *et al.* (2014) postulate that school-based education is fundamental in the provision of HIV/AIDS information. School-based education increases knowledge and changes young people's risky behavior. Availability of information promotes and shapes safe sex behaviors in order to prevent new infections. Change of risky behavior is

a preventive and control measure for restricting the spread of the HIV/AIDS pandemic (Crepaz, Tungol, Higa, Vosburgh, *et al.*, 2014). Mosha & Manda (2012).

Mosha and Manda (2012) states, “The transfer of HIV/AIDS information is important in creating awareness but what is critical is the extent to which information is followed by action in the form of new or modified behaviour”. According to Julien and Fourie (2015) HIV/AIDS information needs to be focused on raising awareness about the virus, on avoidance of risky sexual behaviour, and on providing strategies for people living with HIV/AIDS. Information changes the behavior of individuals and is seen to have a positive effect which modifies HIV risky behaviors.

In their study, “Online information seeking behaviour among people living with HIV in selected public hospitals of Tanzania”, Lwoga, Nagu and Sife (2017) says that information is important in the creation of awareness and to prevention of the spread of HIV/AIDS. Access to information assists in managing difficulties that supplement the infection and protract the lives of people living with HIV/AIDS.

As for HIV/AIDS information and dissemination Lwoga *et al.*, (2017) indicated that information dissemination helps people to locate information that is relevant to their needs; HIV/AIDS information has the potential to positively affect behaviour change. There is therefore need to disseminate relevant, reliable and accurate HIV/AIDS information in order for users to understand the benefit for behavioural change. In order to fight against HIV/AIDS, information should be readily available, relevant and reliable so as to change risky sexual behavior (Paula, Shapira, & Todd, 2014).

Mhalu, Leyna and Mmbaga (2013) elucidate that lack of information on HIV and its transmission mode bring about a bias among those who are infected. Understanding the predictors of risky behavior would help to inform efforts on prevention as well as routinely

pass positive messages. There is need for information so that also the HIV positive individuals can have sufficient information about HIV/AIDS (Gong, 2015). It is important for people living with HIV/AIDS to identify coping strategies as they are linked to self-esteem. In their study schema on coping strategies, Arrey, Bilsen, Lacor, and Deschepper, (2015) present two types of coping mechanisms. Active coping includes adhering to the treatment, seeking support, faith based acceptance and resilience and positive reinterpretation. On the other hand, passive coping include denial, social isolation and distancing, and excess alcohol drinking. People with active coping strategies have a higher self-esteem as compared to those with passive coping strategies. Those in the active coping strategies have access to information and reinforced messages which bring about proper self-management; thus, self-esteem.

Namir, Wolcott, Fawzy, and Alumbaugh, (2013) made several recommendations for interventions based on the findings of their study on coping strategies for PWAs. They recommended the use of interventions that would increase Self-esteem and feelings of control in PWAs. These interventions would encourage the use of problem-solving techniques, participation in treatment decisions, and the usage of active as opposed to avoidant coping strategies. Interventions should help PWAs in their efforts to change risky behaviors and to become more involved in beneficial social activities. It is important to teach assertion and ways to enhance Self-concept.

There have been substantial changes over the years, concerning the diagnosis of HIV. At first, HIV positive people were only given palliative and supportive care. As medical advancements were made, AIDS defining conditions that existed declined. This is owed to antiretroviral therapies and prophylaxis which fought against opportunistic illnesses. Without a doubt, this helped to increase and lengthen the lifespan of people living with HIV/AIDS (Insight Start Study Group, 2015). Although, the antiretroviral treatment has side effects, the

benefits are generally considered to be more as the HIV related symptoms are greatly decreased.

Langebeek, Sprenger, Gisolf, Reiss, *et al.* (2014) showed that antiretroviral therapy can result in the quality of life for individuals who are HIV positive. The study shows the individuals who were constant in their treatment had higher levels of role functioning as compared to those who were not constant in their treatment. The antiretroviral treatment was associated to satisfaction in the day to day life. Role functioning includes physical, mental and social functioning. Gong (2015), reviewed that risky behavior is affected by a number of factors such as age, substance use, financial status and social norms. High rates of HIV have led to increasing HIV infections and even a rapid spread of HIV as a result of acute infection. Reductions in risky behavior are often seen immediately following an HIV diagnosis. To say the least, these behavior changes are not universal. There is a 'don't care attitude' that is often experienced after diagnosis of HIV (Gong, 2015).

A review by Arseniou *et al.* (2014) reveals that there is a relationship between depression and engagement in risky behaviors in persons living with HIV and AIDS. Depression negatively affects the development of HIV infection. This affects the immune response of an individual who has HIV infection. This is because depressive symptoms influence the CD4 T lymphocytes, CD8 T lymphocytes and natural killer cells. Body cells infected by the virus are destroyed by CD4 T lymphocytes, CD8 T lymphocytes and natural killer cells. Moreover, the CD4 T cells and CD8 T lymphocytes inhibit virus replication through secretion of cytokines.

2.4 Self-Efficacy and HIV Serostatus Disclosure

Herek (2014), cites that HIV-related stigma undermines its prevention and treatment efforts. HIV-related stigma inhibits open discussion of the epidemic, and fear of discrimination or disapproval may also deter individuals from seeking the services they need. In some

instances, individuals may actually avoid taking steps to protect against HIV transmission out of fear that they may be considered potentially infectious or thought to belong to a marginalized group that has been heavily affected by the epidemic.

Research suggests that as many as one in three people living with HIV-AIDS engage in unprotected intercourse subsequent to knowing that they have HIV, and that continued risky behavior often occurs with uninfected partners Kalichman, (2014a). For people living with HIV-AIDS, sexual decisions are closely linked to knowledge of a sex partner's HIV status and disclosure of their own HIV status to sex partners (Altschuler & Rhee, 2015).

In their study on transactional sex among university female students in Ghana, Amo-Adjei, Kumi-Kyereme, and AnamaaleTuoyire (2014) found out that, all the respondents concealed their relationships from "other" friends and families for fear of reprimand and stigmatization, discrimination and name calling. It is therefore often the case that people who have HIV infection do not disclose their HIV status to their sex partners (Gong, 2015). Jasseron, Mandelbrot, Dollfus, Trocmé, *et al.* (2013), for example revealed that 15% of women did not disclose their HIV status to their partner. In a study on factors associated with HIV status disclosure, Loukid, Abadie, Henry, Hilali, *et al.*, (2014) found out that many people living with HIV had not disclosed their serostatus to their steady sexual partner.

Social cognitive theory defines self-efficacy as the self-evaluative belief held by an individual that he or she can effectively perform a specific behavior under specified conditions (Bandura, 1986, 1994). In both the HIV prevention and HIV-AIDS coping literatures, self-efficacy has emerged as a fundamental construct for predicting behavior and, perhaps more importantly, behavior change. Self-efficacy is the belief that one can master a situation and produce positive outcomes. Self-efficacy perceptions help determine what individuals do with the knowledge and skills they have (D'Amico *et al.*, 2013). Effective HIV disclosure

decision-making is therefore a difficult challenge facing most people living with HIV-AIDS, particularly within the context of their sexual relationships. Among the many factors that influence decisions to disclose one's HIV status to sex partners, self-efficacy for making effective disclosure decisions may be of particular importance.

Social cognitive theory defines self-efficacy as the self-evaluative belief held by an individual that he or she can effectively perform a specific behavior under specified conditions (Bandura, 1986, 1994). In both the HIV prevention and HIV-AIDS coping literatures, self-efficacy has emerged as a fundamental construct for predicting behavior and, perhaps more importantly, behavior changes (Kalichman, 2014a). Closely related to self-efficacy beliefs, are the decisions to disclose HIV status to sexual partners, and negotiating safer sex practices for safer sex practices among people living with HIV (Rodkjaer, Chesney, Lomborg, Ostergaard, *et al.*, 2014).

Although of theoretical and practical importance, self-efficacy is often considered a difficult construct to measure. In a review of 65 published studies that assessed self-efficacy in relation to HIV risky and preventive behaviors, Forsyth and Carey (1998) determined that self-efficacy scales are often methodologically flawed and lack construct validity. They found that 45% of studies used measures that appeared to assess constructs other than self-efficacy and that Self-Efficacy for disclosing many of the scales that actually measured self-efficacy were not behaviorally specific. Fortunately, Bandura (1997) has offered several practical guidelines for assessing self-efficacy. For example, Bandura (1997) stated that "Efficacy beliefs should be measured in terms of particularized judgments of capability that may vary across realms of activity, under different levels of task demands within a given activity domain and under different situational circumstances" (p. 42). According to Bandura (1997) self-efficacy scales should be limited to beliefs about personal abilities to enact behaviors under specified conditions. Elaborating on Bandura's (1997) suggestions, Forsyth and Carey

(1998) stated that measures of self-efficacy should specify beliefs, behaviors, and circumstances within a particular domain of functioning and in situations that present graduated task demands. Self-efficacy should, therefore, be assessed in relation to specific behaviors and across situations that vary in terms of performance difficulty.

To assess self-efficacy within functional domains and situations requires construction of realistic and relevant scenarios within which target behaviors may be performed and self-efficacy can be assessed. The challenge in assessing self-efficacy therefore lies in identifying situations that are personally relevant to a majority of persons in a population. Situations that are too generic can jeopardize the specificity of a self-efficacy scale and, on the other hand, situations that are too idiosyncratic can be irrelevant to a majority of the target population. Formative elicitation research with members of the target population should therefore be first undertaken to derive personally relevant and meaningful scenarios in which self-efficacy can be assessed. In their paper, Kalichman *et al.* (2014)., report four studies conducted to develop and evaluate the psychometric properties of four self-efficacy scales to assess self-efficacy for two behaviors (a) decisions to disclose HIV status to sex partners and (b) negotiating safer sex.

2.5 Attitude towards Safe Sex

In India, a study on prevalence and contexts of inconsistent condom use among heterosexual men and women living with HIV showed that one third of men and one fourth of women reported inconsistent condom use with regular sexual partners. The reported prevalence of inconsistent condom use was attributed to: the beliefs that condoms were unnecessary in HIV-positive sero-concordant relationships; lack of sexual satisfaction with condoms; the desire to have children; husbands using alcohol; depression and anxiety; fear that disclosure of HIV status would bring marital discord and family shame and inadequate counseling by health care providers (Chakrapani, Velayudham, Shunmugam, Newman, & Dubrow, 2014).

Sarna, Luchters, Musenge, Okal, *et al.*, (2013) reported that risky sexual behaviors decreased with ART and a substantial proportion of PLHIV on ART continued to have unsafe sex, even with partners known to be HIV negative Sarna *et al.* (2013). A Côte d'Ivoire study reported a short-term increase in unsafe sexual behaviors after ART initiation (Diabate, Alary & Koffi 2007) in (Musinguzi *et al.*, 2014a).

The increased incidence of HIV/AIDS and other sexually transmitted infections is widespread in an environment such as the Niger Delta region, where women are often exposed to abuse if they do not consent to sex, and are deprived of their basic rights to negotiate the use of preventive measures during sexual intercourse (Abasiubong, Udoh, Idung, & Umoiyoho, 2012).

With increased access to treatment for PLHIV, there has been a consequent decrease in mortality among PLHIV in care, improved wellbeing and subsequent increase in normal functioning including sexual activity (Musinguzi *et al.*, 2014a). Therefore PLHIV in care continue to be at risk of acquiring new strains of HIV and transmitting HIV to others. Indeed, high-risky sexual behaviors continue to be reported in Uganda (Musinguzi *et al.*, 2014a).

In their study, among University students in Ghana, (Amo-Adjei *et al.*, 2014) found out that, despite the fairly privileged position of the respondents, sexual risky taking still clearly existed. Even among those who did practice safe sex, the motive was not for protection against STIs including HIV but to avoid pregnancy. This means that, whenever they felt secure against pregnancy, the chances of condom use was still extremely minimal.

Studies show that there is a relationship between certain social demands such as the desire to have children and risky sexual behavior. There is an expectation of people living with HIV to be aware of negative consequences of unprotected sex, especially after they receive counseling on risky reduction (Ngure, Baeten, Mugo, Curran, *et al.*, 2014). However, some

PLHIV desire to have children (Musinguzi *et al.*, 2014b) and the decision to have children appears to be a driving force for risky sexual behavior (Sofolahan-Oladeinde & Airhihenbuwa, 2014). It is not surprising that risky sexual behavior was strongly associated with the married. Uganda and most parts of Sub-Saharan Africa, social and cultural contexts put pressure on couples to produce children places a demand that married couples have to fulfill (Musinguzi *et al.*, 2014b). Being HIV positive and childlessness cause double stigma, as with childlessness comes even stronger stigma especially among married couples in most of sub-Saharan Africa. They further state that, when PLHIV are living quality lives, they oblige to societal demands to produce children. As a result, they succumb to unprotected sex but also overcome the stigma due to childlessness.

Studies conducted on HIV prevalence rate and gender show that the effects of HIV/AIDS disproportionately affect young women more than young men. A study on young people in Northern Uganda revealed that the HIV prevalence was 15.6% among women and 9.9% among males (Patel, Schechter, Sewankambo, Atim, Lakor, *et al.*, 2014). Iwelunmor, Ezeanolue, Airhihenbuwa, and Obiefune, *et al.*, (2014) states that socio-cultural norms reinforce gender inequalities, leaving young women more vulnerable to HIV than their male peers and this is often compounded by poverty.

In her research, Nicholas (2010) found out that the young women who participated in her study from Mbale region of Uganda were well informed of HIV and considered it to be a serious problem since there was no way one could heal it and it always killed. However the young women frequently cited as having difficulties with the practicalities of avoiding high risky sexual behaviour. They repeatedly spoke about poverty and lack of money as being a direct barrier to HIV prevention leading to risky sexual practices despite knowledge of the risks. Young girls exchanged sex for money in order to meet their basic needs. Furthermore, participants described how gender inequality within sexual relationships put them at the risk

of HIV/AIDS, highlighting problems arising from lack of control within sexual encounters (Bell & Aggleton, 2014).

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Young girls exchanged sex for money in order to meet their basic needs. Furthermore, participants described how gender inequality within sexual relationships put them at the risk of HIV/AIDS, highlighting problems arising from lack of control within sexual encounters (Nicholas, 2010). Even within marriage commitments, young women explained that it was socially acceptable for men to continue having multiple sexual partners (Nicholas, 2010).

In sex-related behavior, HIV is transmitted through unprotected vaginal intercourse in which factors that contribute to this include; the large surface area of the mucosal tissue in the

vagina lining, uncircumcised males who are HIV positive and partners that have an STI (Auerbach, Parkhurst, & Cáceres, 2011). Oral sex is also found to be a high risky sex-related behavior as body fluids are exchanged and in case the partners have sores or open cuts, there is bound to be a risky of HIV transmission. In their report, Duby, Colvin, and Kitungulu (2011) observed that anal sex is also another factor that contributes to transmission of HIV and it is not only practiced among the MSM but it is also high in heterosexual relationships. The report further stated that heterosexuals practice anal sex for pleasure, to avoid unwanted pregnancies and to preserve female virginity especially in the East African society where some communities still hold female virginity in high regard.

In drug related behavior, frequent use of drugs places individuals at high risk of HIV infections. Frequent use of drugs hampers the way of thinking of an individual. When this occurs, the individual will have multiple sex partners in which they will be engaged in casual sex. There is also a high chance of involvement in intergenerational relationships which are mainly transactional. There is also a likely-hood of involvement in commercial sex as a way of feeding the frequent drug use. With inhibited thinking due to frequent drug use, the individual addiction is imminent which can lead to sharing of unsterilized needles (Kimanga *et al.*, 2014).

HIV risky behaviors are deeply rooted and embedded on interpersonal relationships. According to Kalichman (2014, p.17), close attention has to be paid on interpersonal relationships in a bid to understand HIV risky. In dyadic relationships, safe sex practices are not comprehended in the same manner. For instance, a sexual partner can deem use of condoms to mean mistrust while the other partner sees it as a contraceptive and a means of protection. Incorrect use or lack of use thereof, of condoms is a determinant of HIV and STI infections. As asserted by Goodman *et al.* (2016), there are perceptions that condoms can only be used in casual as opposed to stable sex relationships. This is a reason attributed to the

rationale that in stable relationships there is more trust. The risky of the consequences of disclosures halts sexual partners from discussing about their past sexual relationships (Kalichman, 2014). Therefore, the sexual partners do not know each other's HIV status. This is quite a high HIV risky behavior.

Community is a larger group level and community norms that stem from cultures can increase HIV risky behaviors. Dynes, Stephenson, and Bartel, (2012) observed that in Kenya, men and women are greatly influenced by their community norms. Community norms are tied to the customs and traditions of that community. There are those community norms that are positive however, there are those that can present high risk for HIV. For instance, Dynes *et al.* (2012) noted that the community norms dictate use of contraceptives among men and women. Cultural traditions such as wife inheritance also placed both men and women at a high risk of HIV infection. During circumcision, as an initiation rite, there is frequent use of unsterilized equipment which can increase the spread of HIV/AIDS. In communities where power imbalances are prevalent, the control over sexual decision-making is affected particularly among the women.

In sex-related behavior, HIV is transmitted through unprotected vaginal intercourse in which factors that contribute to this include; the large surface area of the mucosal tissue in the vagina lining, uncircumcised males who are HIV positive and partners that have an STI (Auerbach, Parkhurst, & Cáceres, 2011). Oral sex is also found to be a high risky sex-related behavior as body fluids are exchanged and in case the partners have sores or open cuts, there is bound to be a risky of HIV transmission. Although

Smith, Muhaari, Agwanda, Kowuoret *et al.*, (2015) reported that the rate of HIV transmission through oral sex is relatively low in Kenya. That however does not negate the fact that it is a mode of HIV transmission. In their report, Duby, Colvin, and Kitungulu (2011) observed that

anal sex is also another factor that contributes to transmission of HIV and it is not only practiced among the MSM but it is also high in heterosexual relationships. The report further stated that heterosexuals practice anal sex for pleasure, to avoid unwanted pregnancies and to preserve female virginity especially in the East African society where some communities still hold female virginity in high regard. Kang'ethe and Xabendlini (2014) note that there are also some traditional myths, such as sex with a virgin can prevent the risk of HIV transmission, tend to be misleading. On the contrary, these are behaviors that place one at high risk of contracting HIV/AIDS. Highest risk for HIV can be observed on young people who are between the ages of fifteen to thirty-five (Dyk, 2012). This age bracket is involved in very high risky behavior. This can be attributed to poverty, low employment levels, curiosity and peer pressure, and lack of awareness of the dangers that they put themselves into when they engage in unprotected sex and having multiple sex partners. According to Dellar, Dlamini, and Karim, (2015), girls are at a higher risky because of being initiated in to sexual activities at a very early age. Some girls are also forced into early marriages and this puts them at high risk for HIV. Girls are also more vulnerable and some have low self-efficacy and self-esteem which leads to them feeling that they are powerless in the choices that they make relating to risky behavior for HIV.

In drug related behavior, frequent use of drugs places individuals at high risk of HIV infections. Frequent use of drugs hampers the way of thinking of an individual. When this occurs, the individual will have multiple sex partners in which they will be engaged in casual sex. There is also a high chance of involvement in intergenerational relationships which are mainly transactional. There is also a likely-hood of involvement in commercial sex as a way of feeding the frequent drug use. Azim, Bontell and Strathdee (2015) point out that many women are driven to selling sex so as to support their own and at times their partner's drug use. This puts the woman at a dual risky for HIV infection. With inhibited thinking due to

frequent drug use, the individual addiction is imminent which can lead to sharing of unsterilized needles (Kimanga *et al.*, 2014).

HIV risky behaviors are deeply rooted and embedded on interpersonal relationships. According to Kalichman (2014, p.17) close attention has to be paid on interpersonal relationships in a bid to understand HIV risky. In dyadic relationships, safe sex practices are not comprehended in the same manner. For instance, a sexual partner can deem use of condoms to mean mistrust while the other partner sees it as a contraceptive and a means of protection. Incorrect use or lack of use thereof, of condoms is a determinant of HIV and STI infections. As asserted by Goodman *et al.* (2016) there are perceptions that condoms can only be used in casual as opposed to stable sex relationships. This is a reason attributed to the rationale that in stable relationships there is more trust. Moreover, El-Bassel, Shaw, Dasgupta, & Strathdee, (2014) note that it is this perceived trust that will also lead intimate partners to share unsterilized needles when using injectable drugs and other injection paraphernalia. The risky of the consequences of disclosures halts sexual partners from discussing about their past sexual relationships (Kalichman, 2014b). Therefore, the sexual partners do not know each other's HIV status. This is quite a high HIV risky behavior.

Community is a larger group level and community norms that stem from cultures can increase HIV risky behaviors. Dynes *et al.* (2012) observed that in Kenya, men and women are greatly influenced by their community norms. Community norms are tied to the customs and traditions of that community. There are those community norms that are positive however, there are those that can present high risk for HIV. For instance, Dynes *et al.* (2012) noted that the community norms dictate use of contraceptives among men and women. Cultural traditions such as wife inheritance also placed both men and women at a high risk of HIV infection. During circumcision, as an initiation rite, there is frequent use of unsterilized equipment which can increase the spread of HIV/AIDS. In communities where power

imbalances are prevalent, the control over sexual decision-making is affected particularly among the women.

Institutional risky factors do play a role in the increase of HIV risky behavior. The major factor here is credited to health care (Wachira, Naanyu, Genberg, Ndege, *et al.*, 2014). Impediments to access to health care such as transportation challenges, long distances and lack of proper health care facilities and equipment are a contributing factor to HIV risky behavior. For instance, Kitui, Lewis, and Davey (2013) observed that many women in the rural areas of Kenya have to deliver at home due to long distances to the health facilities and lack of transport. Pregnant women are unable to access antenatal HIV testing which could be consequential also to the unborn baby. Home delivery is done by midwives who put the child at high risk in terms of mother-to-child-transmission of HIV. Wachira *et al.* (2014) also observed that unequipped health care facilities and poor payment of staff that are unmotivated leads to the increase of HIV transmission through poor prevention care such as HIV testing. There is also the stigma that is associated with health facilities especially in receiving health care related to HIV.

Structural risky factors are mainly macro level including political, socio-cultural and economic barriers that place vulnerability on individuals and they become at high risk for HIV. The behavior of an individual is affected by his environment which may be a great contributing factor to high risky behavior. Platt, Jolley, Rhodes, Hope, *et al.* (2013) cite that structural risky factors are an object for a society to suffer great inequalities. These inequalities can lead to marginalization of individuals and view of one gender as lesser to the other. In African societies, women, youth and the physically challenged are in the most cases the marginalized group. This is regarded especially in the access to health services, experiences of violence and migration. Naidoo, Chirinda, Mchunu, Swartz, *et al.* (2015), aver that poverty is one structural risky factor that has been associated with the highest levels of

HIV infections in Sub-Saharan Africa. The global economic crunch has had an effect on many individuals and in Africa, there have been low employment opportunities that has seen the poverty levels rise. The economic insecurity has led to labor migrations. McGrath *et al.* (2015) affirm that labor migrations have catapulted high risky HIV behaviors as individuals move from one place to another, from rural to urban areas, and even from nation to nation in search of employment opportunities. Husbands, in patriarchal societies are seen as providers. Thus, they are the ones who migrate while the wives are left at home as the homemakers.

McGrath, Eaton, Newell, and Hosegood, (2015) further asserts that, the mobility of labor migrants is at times long distance or international with infrequent return visits back home. This condition leaves room for the individuals to engage in deviant sexual behaviors and inconsistent condom use. Lack of access to financial institutions is also a contributing factor to poverty. Poverty is also related with low education levels (Auerbach *et al.*, 2011). Low literacy levels increases vulnerability to HIV transmission may impact the prospect of individuals in accessing health care services and access to information especially that related to HIV transmission.

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2.6 Self- Esteem and Risky Sexual Behavior Engagement

Self-esteem has been defined in a number of ways. (Baumeister, 2013) regard self-esteem as a self-reflexive attitude that emerges when an individual views the self as an object of evaluation. Thus self-esteem is related to self-concept. Self-concept emerges for self-constructs. People with low self-esteem have poorly articulated self-concept of themselves. This then pushes them to be more dependent and susceptible to their external environmental prompts. Individuals with a low self-esteem tend to be exhibit tendencies of affective reactions which emanate from negative self-construct. Self-esteem is perceived as a cognitive-behavioral aspect that helps individuals to cope with their environment as well as solve problems. Stereotypes that are brought about by HIV/AIDS affect the People Living with HIV/AIDS in a very negative way. The society tends to stigmatize these individuals which may affect the self-esteem of the HIV-positive people. In many cases, when an individual has been tested positive for HIV, they may be afraid to share the results with family members and close friends this means they lack the social support that they ought to have. Social support promotes relational self-esteem and when it lacks, an individual is taken down a spiral of loneliness (Du, Li, Chi, and Zhao, *et al.*, 2015).

Dyk (2012) adds that low self-esteem is further heightened by the rejection either from loved ones, friends and colleagues. Stress is intensified by the lack of social support from loved ones. Society has a way of reacting to HIV/AIDS which is often negative. Du *et al.*, (2015) assert that the fear of being a social pariah which is shown through marginalization and stigmatization is a fact that HIV infected persons does not want to live with. The assumption with HIV infection is that the infected person is deviant or immoral. Such is the thinking of the society. Social discrimination anticipation can damage the self-esteem of an individual as they are unable to cope with the situation. Low esteem can impact the adaptation of an individual to their HIV status. Eller, Rivero-Mendez, Voss, Chen, *et al.* (2014) advances that,

this can hinder the ability of an individual to socialize and they go in to a cocoon. The ripple effect here is that their self-confidence is affected, which in-turn affects their jobs and their relationships.

Exposure to HIV can lead to a low self-esteem in an individual. Ramiro, Teva, Bermúdez, and Buela-Casal (2013) note that in cases of self-condemnation, self-loathe, guilt, and self-blame, there is bound to be low self-esteem. This can be a common case scenario in the case of stigma. HIV infection has it consequences such as physical body changes that can lead to a poor body image. Ramiro *et al.* (2013) allude that this may lead to some negative psychological tendencies such as suicide and other depressive symptoms. The loss of one's self-identity can be mirrored in their self-worth. This leads to very high risky sexual behavior by individuals who have been exposed to or have been infected to HIV (Dyk, 2012). As a reflection of passive suicidal tendencies, a person with low self-esteem may refuse to practice safe sex. Jacoby (2016) asserts that an individual develops false esteem as a coping mechanism but in false tendencies. False esteem causes individuals to repress their thought and their feelings. The individuals make choices based on fear. According to Fennel (2015) self-esteem affects individuals' choices and the decisions that they make.

False self-esteem therefore causes individuals not to want to face reality. In Person's Living with HIV/AIDS, the initial shock of their HIV-positive status leads to a false esteem in which they do not want to deal with reality. Many may turn to numb repressors such alcohol abuse. Additionally, low self-esteem leads to abuse of substances and self-medication. Use of drugs and alcohol tend to mask the individuals worry about HIV and here, caution safe sex practices is thrown to the wind. Shelby, Aronstein, and Thompson (2014) point out that there have been claims by some people that use of alcohol or drugs makes sex to feel better. This can be a cause factor to reinfections (Abler, Sikkema, Watt, Eaton, *et al.*,2014).

With a low self-esteem, people devalue the resources that they have at hand. Jewkes, Fulu, Naved, Chirwa, *et al.*, (2017) explicates that a connection exists between HIV/AIDS and self-esteem in which HIV-positive men and women at first believe that they do not have a choice. This stems from the beliefs, feelings, and attitudes that are negative (Eller *et al.*, 2014). In African communities, the social context perceives the woman in line with the gender roles she is expected to carry out. In cases in which the woman is unable to carry out these roles, the woman is looked down upon and this affects her self-esteem (Naidoo *et al.*, 2015).

In many instances, an HIV-infected woman is unable to perform some roles because of associated poor health that may be associated with HIV/AIDS. The woman is perceived by the society as an unfit mother if she cannot take care of her children or her inability to safely bear more children. This threatens the position of the woman in the society, affects her self-esteem and hinders her from seeking and receiving health care and services, and also disclosing her HIV status to close family and friends (Dyk, 2012) A woman that is HIV-positive will likely have a low self-esteem and will be less confident and tends to be dependent on others in her maternal roles (Fordham, 2014). Regrettably, this can lead to lowered values. Lowered values as explained by Dyk (2012) can lead an individual to engage in high risky sexual behavior such as having unprotected sex or even having multiple partners. Interestingly, Moskowitz and Seal (2012) observe that men with a low self-esteem have a higher inclination to high risky behaviors than women.

Low self-esteem can also lead to an individual seeking outside validation. The HIV-positive person is seeking approval from people who do not judge him or her. This can be a dangerous affair as there are those people that can take advantage of the situation. For instance Wamoyi, Stobeanau, Bobrova, Abramsky, *et al.* (2016) view that women seek assurance from men so that they can feel wanted and search for emotional intimacy. Dellar *et al.* (2015)

also note that young girls who want to feel appreciated will look for validation from older men.

High risky sexual behavior that is as a result of low self-esteem can lead to anxiety, doubt and confusion. This leads to a sense of powerlessness in an individual (Sahu, 2015). An HIV-positive individual feels that the power to live a fruitful life has been taken away from them by the HIV/AIDS disease. This undoubtedly leads to anger and depression. The infected individual becomes cynical about everything, everyone and life in general. Guilt can lead to self-stigmatization as a result of repressed anger (Arrey *et al.*, 2015). The stereotypes of HIV also result to self-stigmatization. Baumeister (2013) notes that there is need for the society to support an individual. Social support vital in stopping an individual from embarking on a self-destructive path that marred by low self-esteem. A lack of sense of belonging is propagated by societal stigma and this has repercussions on an individual's identity and wellbeing. Low self-esteemed individuals do not have regard for their protection and as such, will be averse to the use of a condom (Gong, 2015). They not only put themselves at a health risky, but also their partners.

Colman (2015), defines self-esteem as one's attitude towards oneself or one's opinion or evaluation of oneself, which may be favorable or high, neutral, or negative, unfavorable or low. The self-esteem of HIV-infected people is often severely threatened. Rejection by colleagues, friends and loved ones can cause one to lose confidence and a sense of one's social identity and thus to experience reduced feelings of self-worth. The inability to continue in a career to participate in social, sexual and loving relationships also diminishes the client's self-esteem. The physical consequences of HIV infection such as physical wasting and the loss of strength and bodily control contribute even more to a lowering of self-esteem (Dyk, 2012).

2.7 Theoretical Framework

This study was be guided by the Social Cognitive Theory developed by Albert Bandura. Social Cognitive Theory states that behavior, environment and the person/cognitive factors are important in understanding personality (Bandura, 1986). The theory stresses that, behavior is determined not only by its controlling environmental conditions, but also by how thoughts modify the impact of the environment on behavior. Bandura's conception of reciprocal determinism is the view that, personal factors in the form of cognition, affect biological events, behavior, and environmental influences, create interactions that result in a triad reciprocity.

Bandura states that individuals possess various capabilities that underlie their functioning in the context of the interaction between person, situation and behavior. The Self-reflecting capability is the uniquely human ability to have self-image, to be able to reflect on oneself, and to evaluate oneself. For Bandura, the central component of this capability is people's self-efficacy perception, in other words, their beliefs about their capabilities to function effectively in a given situation. Self-efficacy is the belief that one can master a situation and produce positive outcomes. Self-efficacy perceptions help determine what individuals do with the knowledge and skills they have (Bandura, 1997).

Karpram, Wolfe and Vargo (1986).stated that, individuals are likely to be overwhelmed by their inability to interpret their experiences adequately, leading to symptoms such as depression. However, as more information about the new environment is gathered and integrated, new schemas can be developed. Consequently, a more realistic stance towards life can be adopted, together with a brighter outlook on the future and fresh involvement in the community.

According to Van Dyk (2001), HIV infected people often experience fear about being isolated, stigmatized and rejected. They experience loss of control, loss of autonomy, loss of ambitions, loss of physical attractiveness and loss of respect in the community. They also experience guilt, denial, anger (especially anger with themselves and others close to them) and have suicidal behavior or thinking. They have obsessive conditions and hypochondria. The principal psychological symptoms associated with HIV are *anxiety*, *depression*, and *prolonged adjustment reaction* (King, 1990). Social cognitive theory is rooted in a view of human agency in which individuals are agents proactively engaged in their own development and can make things happen by their actions. Key to this sense of agency is the fact that, among other personal factors, individuals possess self-beliefs that enable them to exercise a measure of control over their thoughts, feelings, and actions, that, “what people think, believe, and feel affects how they behave” (Bandura, 1986, p. 25). This study is based on the assumption that if YLWHA were given guidance training that will create more awareness on dealing with Self Efficacy, information on Self-esteem, information on HIV/AIDS, and how to develop positive attitude towards safe sex ; will change their way of thinking, their beliefs, their feelings and hence their behavior. The new formed schemas in their cognition will hence enhance Risky Behavior Change.

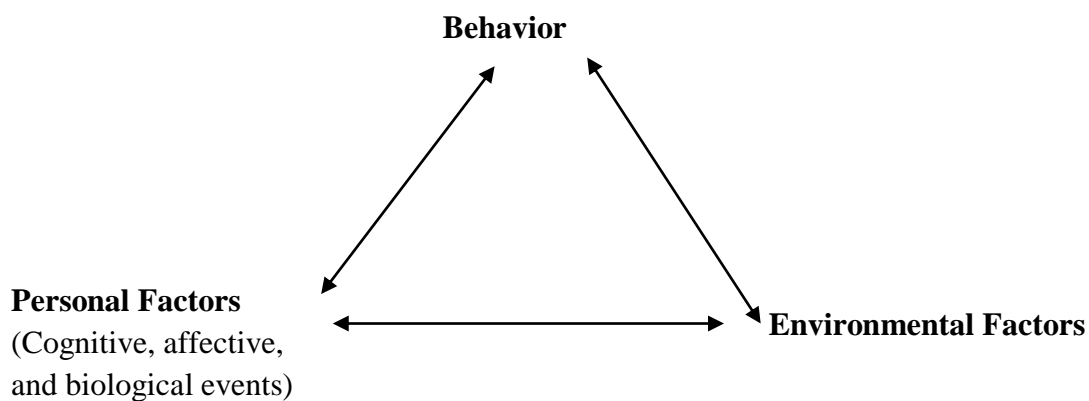


Figure 1: Illustration of the reciprocal nature of determinants of human functioning in social cognitive theory.

Source: Bandura's Social Cognitive Factors. From, Pajares (2002). *Overview of social cognitive theory and self-efficacy* (pg.1)

According to Bandura, (1986), the reciprocal nature of determinants of human functioning in social cognitive theory makes it possible for therapeutic and counseling efforts to be directed at personal, environmental, or behavioral factors. Strategies for increasing well-being can be aimed at improving emotional, cognitive, or motivational processes, increasing behavioral competencies, or altering the social conditions under which people live and work. Social cognitive theory is rooted in a view of human agency in which individuals are agents proactively engaged in their own development and can make things happen by their actions (Benzon, Denler, & Wolters, 2014).

2.8 Conceptual Framework

A model showing how guidance programme can enhance Behavior Change for Youth Living with HIV/AIDS (YLWHA) is shown in Figure 2. The principal psychological symptoms associated with HIV are Low self-esteem, low self-efficacy hence lacks of self-disclosure of HIV serostatus and negative attitude towards safe sex. This leads to a state of being psychologically unstable and maladjusted. A Psychosocially adjusted person is one who has a behavioral adaptation to one's psychological development in and interaction with a social environment. Bandura (2012) states that ,Strategies for increasing well-being can be aimed at improving emotional, cognitive, or motivational processes, increasing behavioral competencies, or altering the social conditions under which people live and work.

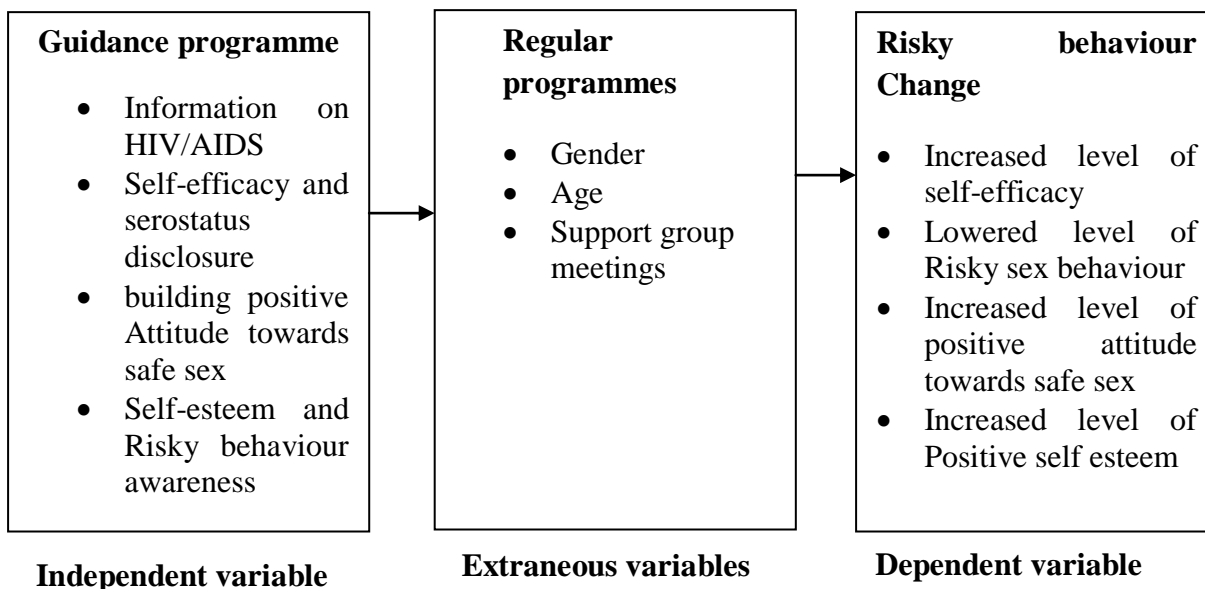


Figure 2: Factors that Influence Risky Behavior Change for YLWHA.

The study assumed that the Guidance programme (Independent variable) that would focus on Information on HIV/AIDS, self-esteem, and Effective risky behavior reduction programmes, would lead to Risky behavior Change (Dependent variable). The YLWHA would have a lowered level of Risky Sex Behavior, an increased level of Self efficacy and Self-esteem, an increased level of positive attitude towards safe sex and hence have a positive behavior change. The extraneous variables were to be controlled by exposing the two groups (the treatment and control groups) to, Support group meetings and stratification of gender and age in the sampling. The independent variable had two levels, namely “those who underwent the Guidance programme” and “those who did not”. These two levels implied two populations (the treatment and the control groups), which were to be compared with regard to their scores on the dependent variable. Since the two groups were exposed to the extraneous variables, any difference in the dependent variable would be attributed to the independent variable.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter outlines the methodology that was used in data collection and analysis. The discussion here includes the research design, the location of the study, the population of the study, the sample size and the sampling procedure, instrumentation, validity and reliability of the instruments, data collection procedures and data analysis.

3.2 Research Design

The study adopted a pure experimental research design (separate groups design). An experiment usually involves two groups of subjects, an experimental group and a control or a comparison group (Fraenkel & Wallen, 2007). The experimental group received the treatment while the control group received no treatment. Both the groups were tested before and after the guidance programme. In this study, the experimental group was taken through a guidance programme that focused on Information on HIV/AIDS, self-esteem, and Effective risky reduction behavior programmes, building a positive attitude towards safe sex and disclosure of HIV status; while the control group was not. The guidance programme took twelve weeks with two hours of training in each week and one hour of practicum in every week. At the end of the experiment, the control group was taken through the programme for ethical reasons. The two groups continued with the regular programmes on drug adherence, nutrition awareness, and support group meetings, to ensure that these extraneous variables were kept under control. The researcher also ensured that other variables such as gender, age and HIV status were held constant through random assignment of subjects to the two groups. Internal validity was controlled through standardization of the conditions under which the study occurred. In this study, the Independent variable is the Guidance programme while Risky behavior change is the dependent variable.

3.3 Location of the Study

The study was conducted among the 76 YLWHA in the Support Group in Nakuru Town of Nakuru County Kenya. The Group was purposefully selected because it was situated in a town said to have a slow behavior change, High incidence of STDs and HIV/AIDS, and one that is cosmopolitan hence has diverse cultural representation and thus facilitating the control of culture as an intervening variable.

3.4 Population of the Study

In this study, the target population was all Persons Living with HIV/AIDS in Nakuru County Kenya. The County is said to have a population of 57,800 living with HIV/ AIDs with 3,770 new infections in the year 2011.

3.5 Sampling Procedure and Sample size

Purposive and Stratified random sampling was used in this study. Purposive sampling was used because those selected met the selection criteria, which was; they were all YLWHA and were in the support group. Since the subjects were unequal on the variables gender and age, stratified sampling was used to ensure that, the strata (gender and age) in the population were fairly represented in the sample. There were 11 female and 27 males in every stratum. The researcher purposively selected the 76 YLWHA in the support group to participate in the study. The 76 YLWHA were divided into two equal groups that had similar representations of characteristics, which are gender and age stratification. Subjects were randomly assigned into an experimental group (N=38) and a control group (N=38). A total of 27 personnel working in the VCT centres were also selected. The level of their qualification in Guidance and counseling was tested through answering of a questionnaire that captured their type and level of training in the counseling profession.

3.6 Instrumentation

The study used a questionnaire for quantitative data collection and an interview schedule for qualitative data collection. For self-efficacy and safer sex measurement, the Self-efficacy scale by Kalichman, *et al.* (2001).was adopted and slightly modified. In order to score in the two scales, the Sum of self-efficacy ratings across behavioral situations was configured. The specific behavioral items were:

- i. How confident are you that you could make an effective decision of whether to tell this person you are HIV positive in this situation?
- ii. How confident are you that you could know whether it was safe to tell this person in this situation that you are HIV positive?
- iii. How confident are you that you could bring up the need to practice safer sex in this situation?
- iv. How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe?

Thus, the respondent obtained 4 self-efficacy scores: Disclosure Decision Making A, Disclosure Decision Making B, Safer Sex Initiation, and Unsafe Sex Refusal.

Disclosure scores are summed across the 6 stories. Self-efficacy beliefs were assessed using an ascending scale of perceived ability to perform the actions, with Responses on an 11-point scale, 0 = cannot do, 5 = moderately certain I can do, and 10 = certain I can do. Thus, summing the items for each of the 2 disclosure behaviors (Effective decision, know whether it is safe) across 6 scenes relevant to disclosure allowed the researcher to compute mean rating scores for 2 disclosure decision self-efficacy scales and ratings for each of the 2 safer sex behaviors (bringing up condoms, refusing unsafe sex) which was summed across all 6 scenes to compute mean scores for the 2 safer sex self-efficacy scales.

The safe sex questionnaire was adopted from HIVNET Statistical and Clinical Coordinating Centre and modified for the purpose of data collection in this study. The initial questionnaire had 27 items testing safe sex behavior, of which 7 were dropped and the 20 adopted had minor changes in the wording with some questions testing frequencies in the type of sex behavior (hetero, anal and oral sex). The final questionnaire was in two parts. Part one assessed the mode of sex behavior (hetero sex, anal sex or oral sex) the respondent engaged in, and the number of times he/she had engaged in the act in the last two months. The scale ranges from 0 to over 5 times across the four types of sex orientations, meaning that the highest possible score was 20 points. 0 to 10 points indicated a higher level of safe sex attitude whereas 10 to 20 scores indicated a low level of safe sex Attitude.

Part two consists of 20 items measuring an individual level of attitude towards safe sex. It uses a four point response format. Strongly Agree (SA), Agree (A), Disagree (D) and, Strongly Disagree = (SD). For items 3, 4, 8, 9, 11, 13, 14, 17 and 20, Strongly Agree = 4, Agree=3, Disagree=2, and Strongly Disagree=1. For items 1, 2, 5, 6, 7, 10, 12, 15, 16, 18 and 19, which are reversed in valence: Strongly Agree=1, Agree=2, Disagree=3 and Strongly Disagree=4. The scale ranges from 0-80 indicating the highest score possible. Scores between 0 and 30 suggest a low level of safe sex attitude; scores between 31 and 80 indicate a high level of safe sex attitude.

The self-esteem scale developed by Rosenberg (1965) was used to measure the level of self-esteem in the respondents. The scale consists of ten items measuring an individual evaluation of Self-esteem. It uses a four point response format. For items 1, 2, 4, 6, 7: Strongly Agree = 3, Agree=2, Disagree=2, and Strongly Disagree=0. For items 3, 5, 8, 9, 10 which are reversed in valence: Strongly Agree=0, Agree=1, Disagree=2 and Strongly Disagree=3. The scale ranges from 0-30 indicating the highest score possible. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem. In order to establish whether there is

a statistically significant relationship between coping training and respondent's gender, the correlation coefficient was calculated using statistics drawn from the demographic scale and the interview schedule.

The interview schedule was administered to the experimental group only since it was devised to explore the participant's evaluation of the guidance programme. The questionnaire contained two main parts. Part 1 consisted of the introduction and three open ended questions asking participants to indicate what they learned, their preferred topic and areas of training that may need improvement in future. This section that is part one of the questionnaires was administered at the end of the Guidance programme and the responses were in form of statements by the respondents. Part 2 comprised of eight statements asking the participants to respond on a four-point Likert scale (strongly agree, agree, disagree and strongly disagree), on their willingness and confidence in applying skills in risky behavior, whether they know how to deal with self-efficacy, their perceptions on Self-esteem and hence attitude towards Safe sex. The Likert scale was administered before and after the guidance programme.

As for the professional qualifications of personnel working in the VCT centres, questionnaire was used to determine, gender, age, academic level and experience in guidance and counseling. Anyone with seven years and above in the profession was termed as long served. As for the professionalism, any person who holds a degree and above was termed as professionally qualified. Others with other qualifications were termed Para-professionals.

3.7 Validity of the Instruments

Validity is the quality of a test doing what it is designed to do. In order to ensure validity of the instruments in this study, the researcher adapted the existing instruments on self-efficacy, attitude towards safe sex, self-esteem and formulated items in the modified instruments. The interview schedule was structured in such a manner that it captured the intended constructs,

by considering the set of objectives in order to ensure that they contained all information that enabled answer the research question. The researcher also consulted experts from the Department of Education, Kabarak University and more so, the two supervisors guiding in the study from both Machakos University and Kabarak University for opinion and on the instruments. The researcher also did a piloting (trying out the tests) to a similar population with similar characteristics and hence modified the questionnaire and the interview schedule where they needed be. Piloting was done among 38 YLWHA from Love and Hope Centre, Nakuru which is in a different locality within Nakuru town. The pilot group was purposively selected so that it was homogeneous. This ensured control of any intervening variable.

3.8 Reliability of the Instruments

Reliability is the degree to which scores obtained with an instrument are consistent measures of whatever the instrument measures (Fraenkel & Wallen, 2007). In order to determine the internal consistency of the instrument in this study, Cronbach's alpha was used with a reliability level set at 0.7. Cronbach's alpha measures how well a set of items (or variables) measure a single unidimensional latent construct. The following formula for the standardized Cronbach's alpha was used in this study:

$$\alpha = \frac{N \cdot \bar{C}}{V + (\bar{N}-1) \bar{C}}$$

Where N is equal to the number of items, C-bar is the average inter-item covariance among the items and V-bar equals the average variance. If the average inter-item correlations are high, then there is evidence that the items are measuring the same underlying construct. The scale had a Cronbach's alpha of 0.905 for pre-test and 0.886 for post-test of self-efficacy. Corrected item-total correlation for pre-test and post-test for safe sex behaviours and attitude, had a Cronbach's alpha of 0.904 and 0.926 respectively. The corrected item total correlation

for pre-test and post-test for self-esteem had a Cronbach's alpha of 0.804 and 0.786. All these values are well above the threshold for a scale which is 0.7.

3.9 Data Collection Procedures

After the approval of the proposal by the Board of Postgraduate Studies, at Kabarak University, and the receiving of the permit to carry out the research granted by the National Council for Science and Technology, The researcher sought authority from the County offices. An authority was issued from the Office of the president: the county commissioner's office Nakuru County, and another from the Ministry of Education, The county Director of Education's office Nakuru. It is then that the researcher proceeded to the field for data collection. The researcher contacted officer in charge of the YLWHA support group, from SDA church Nakuru, and appointments on how and when to meet the participants. On meeting the YLWHA group participants who were purposefully selected, the researcher explained to them the purpose and importance of the research, and on the informed consent.

The researcher also purposefully selected a sample of 76 participants from all the YLWHA in the support group who volunteered for the research. Random assignment was done in order to divide the subjects into two groups, an experimental group (N=38) and a control group (N=38). Participants of the treatment group were informed of the guidance programme, and where and when it was to take place. The group met for one session each week for a period of Twelve weeks. Each session took 120 minutes (two hours). The learners as well spent one hour per week in the duration of the training where each one practiced some of the skills learned (as a practicum) and kept a record. There was therefore a total of thirty six hours of training. The Experimental group was taken through the guidance programme that focused on; Information on HIV/AIDS, Self-esteem, Self-efficacy and Effective risky reduction behavior; while the control group was not taken through the programme. The control group

was taken through the programme at the end of the study for ethical reasons. Both the groups continued with the regular programmes on health and nutrition awareness, drug adherence and support group meetings.

The instruments were all administered in a group format. The Self Efficacy, Attitude towards safe sex, and self-esteem scale, was administered to both the experimental and control groups at pre-test (slightly before the training programme) and post-test (Immediately after the training programme). All the participants from the experimental group were interviewed individually after the completion of the guidance training programme. The researcher did the interviewing using a face-to-face interview and had notes recorded on the interview schedule. Views on the programme and its effectiveness and the respondent's intentions about their Risky behaviour after the Guidance programme training; was explored during the interviews. The researcher assisted those who were not able to read the questionnaires by interpreting the same to them, and assisting them to fill in the questionnaire. Data from 27 personnel working in VCT/PITC institutions within Nakuru west Sub County (purposely selected) was collected using a questionnaire prepared by the researcher.

3.10 Data Analysis

The quantitative data collected from the questionnaires was analyzed by use of descriptive and inferential statistics. T-test for independent means was used to determine whether there was a statistically significant difference between the means of the two independent samples. Percentile was used to check the level of professionalism of the VCT counselors. The results were used by the researcher to determine whether to accept or reject the study hypotheses at 0.05 alpha. Statistical Package for Social Sciences (SPSS) windows version 22.0 was employed to analyze the data after organizing it. The results were used for the interpretation thereof. Any differences observed at the end of the experiment were explained as being due to treatment since all other explanations were accounted for.

3.11 Ethical Considerations

The National Commission for the protection of Human Subjects of Biomedical and Behavioral Research (1979) issued “The Belmont Report: Ethical Principles and guidelines for the protection of Human Subjects of Research.” The Belmont Report established three basic principles that underlie the ethical conduct of all research conducted with human participants. These are: Respect of persons, Beneficence and justice. This study observed the three principles.

In respect of persons, the researcher obtained a voluntary informed consent of the potential human subjects in that at the onset of this study, the targeted population sample was informed of the study and requested to volunteer to participate. The researcher did not coerce those who were not willing to volunteer whatsoever. Respondents were as well reassured of the confidentiality thereof. Those respondents who wanted to withdraw from the study for whatever reason were allowed to do so. As for the juniors, that is, children under eighteen years, a form of consent to be filled by Parent/Guardian was provided for: see APPENDIX “D” attached.

During the study there were only four participants who opted not to participate and there was no one who was less than eighteen years who participated. The youngest in the age span were eighteen years and above. However, the 76 participants who volunteered out of a total 80 that was initially expected continued with the study to the end. The withdrawal did not affect the study much.

As for the Beneficence, there was no harm or risky to the subjects since there were no harmful activities that participants were involved in. The treatment involved the administering of the Guidance programme to the Experimental group while the Control group was not given the treatment. Until after the experimental group went through.

In order to observe justice the researcher used random sampling to assign the participants to either of the two groups. In this study, which was an experimental one, the subjects were purposefully selected on the basis of being Youth Living with HIV. As for placement in the control or the experiment group, random sampling was applied. This means that all participants stood an equal chance of falling into either the experimental or the control group.

Another aspect of the principle of justice according to the Belmont Report is how research participants are treated, or not treated. In order that the principle of justice is observed in this study, the researcher ensured that participants in the control group were also taken through the programme for them to benefit as well. The results were positive and hence beneficial especially on the issue of self-esteem.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND DISCUSSION

4.1 Introduction

This study sought to find the impact of the guidance programme in enhancing risky behaviours change amongst Youth Living with HIV/AIDS in Nakuru County, Kenya. In order to achieve this objective, five objectives were conceptualized that is; an examination of differences amongst youths that have undergone guidance programme and those who have not in relations to self-efficacy and serostatus disclosures, attitudes towards safe sex, and self-esteem levels. The other objectives included; to establish whether there was significant relationship between guidance programme attitude and respondents' gender as well as to investigate the professional qualification of personnel working in VCT centers in Nakuru County. The study utilized the cross tabulation, frequency distributions, Chi-square, means and t- tests for the purposes of analyzing the study. The study results were presented in tables for ease of data analysis.

4.2 General and demographic Information

4.2.1 General information

The study was carried out in Nakuru County in the Rift-valley Provenance Kenya. The total number of youth living with HIV/AIDS is 16,153 of whom 76 were purposively sampled for the study. The response rate was 100%.

4.2.2 Demographic Data

Nakuru County is one of the 47 counties in the country. It has a population of 1,959,880 of whom 982,505 are males; 977,375 females while 39% of the total population are children less than 15 years. The county has 16,153 Adolescents living with HIV/AIDS.

4.3 Findings for Objectives

Data Transformations

Prior to data analysis, various transformations were carried out to make the data amenable to statistical analysis. The following sub-sections present the main data a transformation that was carried out.

4.3.1 Changing the Direction of Variables

Given that the study sought to analyse the positive changes that were realized as a result of the intervention, items that were in reverse of the expected outcome were recorded so that all the variables in the data set had the same direction. More specifically, responses to statement that were in the positive (e.g. I am able to avoid behaviour that may put me at risky) were recorded so that responses took a reverse direction from that in which the data was collected hence: Strongly disagree took new value 1; disagree took new value 2; agree took new value 3; and strongly agree took new value 4. This transformation ensured that positive statement like the one above had the same direction as negative statements (e.g. I have trouble letting a partner know that I want to have safer sex) which has the following response categories: Strongly agree value 1; agree value 2; disagree value 3; and strongly disagree value 4.

This transformation was essential too because it made it possible to meaningfully construct various scales used in this report. For instance, using only the two variables mentioned above, a person who is least efficacious scores a maximum of two points (since he or she said *strongly disagree* in the first statement - I am able to avoid behaviour that may put me at risky – and *Strongly agree* in the second statement - I have trouble letting a partner know that I want to have safer sex).

4.3.2 Construction of Various Scales

Three sets of scales were adopted and modified: self-efficacy scale; safe sex attitude scale; and self-esteem scale. The first requirement in scale construction is a test of the level to which the items in the scale contribute to the overall scale, that is, measure the underlying construct. Cronbach's alpha was used to test the reliability of the self-efficacy scale at pre-test and the results of the test are presented in Table 4.1. It can be seen in the table that all the individual items were strongly correlated with the final scale (value of at least 0.3) hence none of the items was removed from the scale. In addition, the scale had a Cronbach's alpha of 0.905 for pre-test and 0.886 for post-test. These values are well above the threshold for a scale which is 0.7. In other words, the individual items indeed measured the construct which is self-efficacy.

Table 4.1: Reliability analysis of the 24 items that capture self-efficacy for Pre-test and post-test

Item	Corrected Item-Total Correlation for Post-test	Corrected Item-Total Correlation for Post-test
How confident are you that you can make an effective decision of whether to tell this person you are HIV positive	0.3	0.6
How confident are you that you can know whether it was safe to tell this person in this situation that you are HIV positive	0.3	0.4
How confident are you that you could bring up the need to practice safer sex in this situation	0.3	0.5
How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe	0.3	0.5
How confident are you that you can make an effective decision of whether to tell this person you are HIV positive	0.6	0.6
How confident are you that you can know whether it was safe to tell this person in this situation that you are HIV	0.5	0.5

positive		
How confident are you that you could bring up the need to practice safer sex in this situation	0.4	0.3
How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe	0.5	0.5
How confident are you that you can make an effective decision of whether to tell this person you are HIV positive	0.6	0.5
How confident are you that you can know whether it was safe to tell this person in this situation that you are HIV positive	0.7	0.5
How confident are you that you could bring up the need to practice safer sex in this situation	0.5	0.4
How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe	0.3	0.3
How confident are you that you can make an effective decision of whether to tell this person you are HIV positive	0.6	0.4
How confident are you that you can know whether it was safe to tell this person in this situation that you are HIV positive	0.7	0.6
How confident are you that you could bring up the need to practice safer sex in this situation	0.5	0.3
How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe	0.5	0.3
How confident are you that you can make an effective decision of whether to tell this person you are HIV positive	0.6	0.7
How confident are you that you can know whether it was safe to tell this person in this situation that you are HIV positive	0.6	0.5
How confident are you that you could bring up the need to practice safer sex in this situation	0.5	0.4
How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe	0.5	0.4
How confident are you that you can make an effective decision of whether to tell this person you are HIV positive	0.7	0.6
How confident are you that you can know whether it was	0.6	0.5

safe to tell this person in this situation that you are HIV positive		
How confident are you that you could bring up the need to practice safer sex in this situation	0.5	0.4
How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe	0.5	0.5
Cronbach's alpha	0.905	0.886

Given the above findings, the scale of self-efficacy was computed by adding up the scores for each respondent for all the 24 statements that captured the underlying construct. Thus, the lowest score a person could have was 24 and the highest was 72 since each individual item has a scale of 1 to 3. This was done for pre-test and post-test separately to enable comparison before and after the intervention.

The second scale was safe-sex attitude scale which was computed from the 20 individual items that collectively captured that construct. Since individual items had a score of 1 to 4, and the total number of items or statements was 20, the minimum possible score was 20 and the maximum possible score was 80. However, 2 items had corrected item-total correlation (the extent of correlation between the item and the overall scale) that is less than the recommended 0.3 at both pre-test and post-test, hence they were removed from the two scales. A low score implies that, that particular item is measuring something other than what the overall scale is measuring and it is recommended that such an item is removed from the scale (Pallant, 2011). The final scale was therefore computed by adding the scores for the 18 items which had a corrected item-total correlation of at least 0.3.

Table 4.2: Corrected item-total correlation for pre-test and post-test for safe sex scale

Item	Corrected Item- Total Correlation pre-test	Corrected Item- total Correlation post test
I have trouble letting a partner know that I want to have safer sex	0.4	0.6
I am able to avoid behaviour that may put me at risky	0.6	0.3
can choose safer sex with man/woman I have sex with regularly	0.4	0.4
I find it difficult to have safer sex with a man /woman i have very strong sexual feelings for	0.7	0.6
I find it difficult to have safer sex when I am under the influence of drug/alcohol	0.4	0.4
I am less concerned about having anal sex without a condom now that new anti HIV drug combination treatments are available	0.7	0.7
I never lose sight of what I consider safer sex no matter what I'm feeling	0.5	0.6
I feel confident that I will never slip from safer sex	0.6	0.7
Someone can talk me out of safer sex by persuading me that they are HIV negative	0.6	0.7
If i ever did something risky , I am confident that I would go back to having safer sex right away	0.6	0.7
I find it difficult telling a sex partner not to do something i think is risky	0.4	0.8
I can avoid situations that i consider sexually risky	0.7	0.7
I am confident that i can have safer sex even if my partner really doesn't want to	0.6	0.6
I find it difficult telling a sex partner i won't have anal intercourse without a condom	0.4	0.8
I find it difficult telling a sex partner i won't have oral sex without a condom	0.4	0.7
I can choose safer sex with a man/woman I have never has sex before	0.6	0.6
By taking the new drug combination , an HIV positive man decreases the chances that he will infect his partner with HIV	0.5	0.6
By taking new drug combinations , an HIV positive woman decreases the chances that she will infect her partner with HIV	0.6	0.7
Cronbach's alpha	0.904	0.926

The final scale was self-esteem scale which had a total of ten items. As shown in Table 4.3, all the items had a corrected item-total score of at least 0.3 hence all the items were used in computing the scale.

Table 4.3: Corrected item-total correlation for pre-test and post-test for self-esteem scale

Item	Corrected Item-Total Correlation for pre-test	Corrected Item-Total Correlation for post-test
I feel that I'm a person of worth, at least on an equal plane with others	0.769	0.525
I feel that I have a number of good qualities	0.412	0.548
All in all, I'm inclined to feel that am a failure	0.418	0.419
I am able to do things as well as most other people	0.5	0.529
I feel I do not have much to be proud of	0.445	0.497
I take positive attitude toward myself	0.391	0.301
On the whole I'm satisfied with myself	0.535	0.376
I wish I could have more respect for myself	0.288	0.25
I certainly feel useless at times	0.435	0.541
At times I think am no good at all	0.576	0.656
Cronbach's alpha	0.804	0.786

Table 4.4: Descriptive statistics for each of the three scales for all the respondents

	Self- efficacy pre-test scale	Self- efficacy post-test scale	Safe sex attitude pre- test scale	Safe sex attitude post-test scale	Self- esteem pre-test scale	Self-esteem post-test scale
Mean	50.7368	54.4868	44.6974	52.8816	25.4342	30.1316
Minimum	30	30	28	19	15	15
Maximum	71	72	64	74	36	40
N	76	76	76	76	76	76
Cronbach's alpha	0.905	0.886	0.904	0.926	0.804	0.786

4.4 Response Rate

The target population of this study was youth living with HIV/AIDS within Nakuru County. The study purposively selected 76 YLWHA from Nakuru that were divided into two equal groups that is an experimental group (N=38) and a control group (N=38). The response rate was therefore 100% as all the targeted YLWHA participated in the study.

4.4 Background Characteristics of Study Respondents

The demographic characteristics of the study were examined based on the gender distribution, marital status distribution, and age distribution.

Table 4.5: Percent distribution of respondents according to background characteristics

Variables	Categories	Percentage	Number
Gender	Male	28.9%	22
	Female	71.1%	54
Marital status	Married	30.3%	23
	Single	57.9%	44
	Divorced	1.3%	1
	Separated	5.3%	4
	Widow	5.3%	4
	Widower	0.0%	0
Age of respondent	15 - 18 years	14.5%	11
	19 - 34 years	63.2%	48
	35 -45 years	22.4%	17

Source: Researcher (2017)

The gender distribution of the study was examined and is reported in table 4.1. The respondents involved in this study were made up of 28.9% male respondents and 71.1% female respondents. The results show that, majority (71.1 %) of the youth living with HIV/AIDS are female. The findings of the study concurred with previous findings in other parts of the globe that termed girls and women as quite vulnerable.

In Sub-Saharan Africa women account for more than 60% of the estimated infections (WHO & UNAIDS, 2009). There have always been disparities in the HIV/AIDS mechanisms of infection. These disparities have been believed to stem from constructed gender differences between men and women. Magad (2011) points out that these differences are an exacerbation of the role of women in the society as well as their biological vulnerability. Economically, socially, culturally, and biologically, women are more vulnerable to HIV infection. The number of infections among the women has continued to be on the rise as much as the HIV prevalence in Sub-Saharan Africa has been on the decline (WHO & UNAIDS, 2009). In the scholarly discourse, it has emerged that, the biological makeup of a woman makes her susceptible to infection that her male counterparts. Transmission of HIV is efficiently done by the men while the women are found to be more susceptible.

Kang'ethe and Chikono (2014) contend that the spread of HIV/AIDS has been boosted significantly by poverty. As a result of poverty, there are economic constraints on the women and also girls. In order to fend for her family, the woman will engage in selling sex. Many sub-Saharan countries hold their traditional and cultural practices to heart. Maleche and Day (2011) confer that although some of these practices are slowly dissipating, there are those that are entwined with religion; making them hard to let go. In many patriarchal societies such as those found in Sub-Saharan Africa, women hold subordinate positions. The man is also the sole decision-maker and controller of family resources. The dominant patriarchal dogma secludes the woman from access to education and independence to make decisions that are for the benefit of her family. According to Kirtley and Chien (2013) both men and women are subject to cultural expectations. However, in these cultural expectations men are superior to women. Therefore, women should respect the men and not to question their conduct such as extra-marital relationships.

This heightens the spread of HIV/AIDS. During the bride price ceremony, the brides are given a physical test to examine whether they are virgins. The price is placed higher if the girl is a virgin (Maleche & Day, 2011). Some African cultural practices also encourage 'dry sex' as a way of making the act of sex more enjoyable for the man (Maleche & Day, 2011). In this practice, plants and herbs are used to dry and contract the vagina. This is a very dangerous practice as it usually causes friction and the vaginal mucosal lining, which is very delicate, can tear.

In other cases (Maleche & Day, 2011) opiate that cleansing rituals in some communities in Kenya make women more vulnerable to HIV infection and reinfection. In the cleansing rituals, sexual acts are committed so as to 'purify the recipient through the semen entering the woman's body' (pg. 6). In most cases, it is the wife that is involved in the ritual after the death of her husband. The ritual is meant to purify the widow and a community elder appoints the cleanser from the community. No condoms are used during the cleansing ritual. Gender based violence is not a problem that is faced in Africa only, it is a global problem. A common definition of gender based violence is hard to come by. However, there are similar terms connected to gender based violence such as physical abuse, sexual abuse, rape, or emotional abuse. According to (WHO, 2014) the United Nations definition of gender based violence is any suffering or mental harm that may come to a women when they feel threatened through coercion or arbitrary self-deprivation of freedom.

This may be physical, sexual or mental. Hwenha (2014) views gender based violence is a human rights violation that is committed against any person; be it a man, woman, boy, or girl. Women and girls, according to Chitiga-Mabugu *et al.* (2014), continue to be primary victims of gender based violence; whereas, the men continue to be primary perpetrators. KNBS and ICF (2010) presents that in Kenya, women aged 15-49 have experienced some form of gender based violence in their lifetime. Otsola (2012) posits that Kenyan women have been

increasingly socialized to accept and tolerate gender based violence. As such, they choose to stay quiet about it. This can be attributed to the patriarchal nature of many communities in Kenya. Sexual violence can lead to adoption of risky behaviors. Even though, there have been significant changes in the gender realm in Kenya, gender violence still persists as a show for power and male entitled perceptions that they are superior to women (Otsola 2012). In other words, the women have to be chastised for the wrongs that they commit and they cannot challenge this school of thought for fear of being attacked or even raped. This is an indication that gender inequality has fuelled HIV/AIDS epidemic. This has many implications on the women and girls whose autonomy, ability to protect themselves, and ability to exercise reproductive rights is greatly abridged. All these contribute to risky behaviour and hence HIV infection or reinfection.

Female genital mutilation predisposes women to sexually transmitted diseases. In males, Kaul *et al.* (2011) state that rejection of male circumcision in some communities such as those in the South-Western part of Kenya, has led to a high prevalence of HIV. This is because during circumcision, there is direct removal of the foreskin which contains HIV target cells and not removing the foreskin leaves individuals more susceptible to HIV/AIDS.

As for the variable marital status: given the above distribution (with very few cases in the divorced and widowed categories), in (Table 4.1) the variable, marital status, was recoded into only two categories namely ever married (which combined Married, Divorced, Separated, Widow and Widower) and single, meaning never married. The new variable is the one that was used in all subsequent analysis. This new distribution is shown in Table 4.3.

Table 4.6: Marital status distribution

Marital status	Percent	Number
Married	42.1	32
Single	57.9	44
Total	100.0	76

The results show that amongst the youth, those who were single were the majority (57.9%) compared to the married (42.1%). The study therefore showed that, there were more youth who were single living with HIV compared to the married.

The age distribution results showed that the majority of the youth fell in the bracket of between 19-34 years with a majority of (63.2%). This is not very far from the Kenya National Policy (2006), definition of Youth, as people aged between 15 to 30 years (GoK, 2006: 3). The findings are in agreement with Abbink (2005) who asserts that the HIV/AIDS scourge has broadly affected youth, with 33% of all the AIDS cases in Kenya being associated with people aged 15 to 34 years; and that 75% of all new HIV/AIDS infections are among people aged 20 to 45 years. This situation presents youth as needy, helpless and unprepared to make any contribution to national developmental affairs. Consequently, they are marginalized in national state policies and have a weak legal position.

In her situational analysis on HIV/AIDS in Kenya, Department of Adult Education, Kawewa states that, the majority of the infected people are aged between 15-39 years. This is a correct reflection of a population, which has over 50% people less than 16 years of age. This means that the majority of the basic education clients and the productive groups are within Aids vulnerable category and therefore very susceptible to infection: if the labour force (15-49) is infected by HIV/AIDS, the production in country will decline and a vicious circle of poverty will persist.

4.4.1 Comparison of Control and Experimental Groups before Intervention

The main purpose of comparing the experimental with the control group before the intervention was that, we need to see if the two groups were similar in all the parameters of interest before intervention. The researcher assumed that since the two groups were formed out of one homogeneous group then they were similar in all parameters of interest before the intervention. In the onset of the study the two groups were randomly assigned into experimental and control groups respectively. Both gender and age were also considered to ensure that there was balance in the variables. After the participants were assigned to both the control and the experimental groups, a questionnaire having three scales testing the different variables, that is, self-efficacy, safe sex, and self-esteem was administered to the two groups. This was done in order to see if the groups were at the same level with respect to each of the variables. Since this was done at pre-test, then, it means that any significant difference in change of the attributes at post- test for the two groups could then be attributed to the intervention, that is, the guidance program's effect. Marczyk, *et al.* (2005), state that, the main purpose of the randomized two-group design is to demonstrate causality, that is, to determine whether a specific intervention (the independent variable) causes an effect (as opposed to being merely correlated with an effect). In this study, the distribution is as shown in Table 4.7.

Table 4.7 Comparison of control and experimental groups according to background characteristics

Gender	Control Group		Experimental group	
	Percentage	Number	Percentage	Number
Male	28.9	11	28.9	11
Female	71.1	27	71.1	27
Total	100	38	100	38

Chi-square 0.000; df 1; significance 1.000

The findings from Table 4.7 show that, $p=1.00$ this is greater than the significant level set, that is $p>0.05$ and therefore there was no statistically significant difference between the experimental and the control group in terms of gender distribution. The results show that, there was an equal distribution of gender in both the control and experimental groups with 28.9% male and 71.1% female in each group.

Table 4.8 Marital status for control and experimental groups

Marital status	Control Group		Experimental Group	
	Percentage	Number	Percentage	Number
Married	36.8	14	23.7%	9
Single	55.3	21	60.5%	23
Divorced	2.6	1	0.0%	0
Separated	2.6	1	7.9%	3
Widow	2.6	1	7.9%	3
Widower	0.0	0	0.0%	0

Given the above distribution (with very few cases in the Divorced and widowed categories), the variable was recorded into only two categories namely ever married (which combined Married, Divorced, Separated, Widow and Widower) and single, meaning never married. The new variable is the one that was used in all subsequent analysis. This new distribution is shown in Table 4.9.

Table 4.9: Marital status (two categories) for control and experimental groups

Marital status	Control Group		Experimental Group	
	Percentage	Number	Percentage	Number
married	44.7	17	39.5	15
single	55.3	21	60.5	23

Chi-square 0.216; df 1; significance 0.642

Table 4.9 shows $p=0.642$ and that means that p -value is greater than 0.05 ($p>0.05$). These results therefore indicate that there was no statistically significant difference between the control and the experimental group in terms of marital status.

As for the percentage, comparison of the two groups in the variable marital status showed that the difference thereof was quite minimal, that is 44.7% married for the control group compared with 39.5% married in the experimental group. Under the category of the single, that is those who had never been married there was 55.3% in the control group compared to 60.5% in the experimental group. The variable; “marital status” therefore would thus not affect the study.

Table 4.10: Age distribution for control and experimental groups

Age	Control group		Experimental group	
	Percentage	Number	Percentage	Number
Age bracket				
15 - 18 years	18.4%	7	10.5%	4
19 - 34 years	57.9%	22	68.4%	26
35 -45 years	23.7%	9	21.1%	8

Chi-square value 1.210; df 2; significance 0.546

Table 4.10 shows $p=0.546$ and that means that p -value is greater than 0.05 ($p>0.05$). These results therefore indicate that there was no statistically significant difference between the control and the experimental group in terms of age distribution.

As for the percentage, comparison of the two groups in the variable age distribution showed that the difference thereof was quite minimal, that is; in the age bracket of 15-18 years there was 18.4% in the control group compared to 10.5% in the experimental group, whereas in the age bracket of 19-34years, the experimental group had 68.4% compared to the control group that had 57.9%. The age bracket of 35-40 years was not quite far apart since the control group

had 23.7% compared to 21.1% in the experimental group. The age distribution variable could not negatively affect the study.

4.4.2 Comparison of Control and Experimental Group Scores on Self- efficacy, Safe sex, and Self- esteem Scales at pre-test

At the onset of the study and considering that the two groups were randomly assigned into the experimental and the control groups, the researcher felt that it was of paramount importance to compare the two groups at pre-test in terms of the three variables self-efficacy, safe-sex and self-esteem for homogeneity. Since the study sought to find the impact of the guidance programme in enhancing risky behaviours change amongst Youth Living with HIV/AIDS in Nakuru County, Kenya, it was important to check the difference in the levels of the three variables so as to establish whether the two would have any statistically significant difference at post- test in the same variables, whose difference could be attributed to the intervention; that is the guidance programme. In order to achieve this objective, three of the five objectives were conceptualized that is; an examination of differences amongst youths who underwent guidance programme and those who did not, in relations to self-efficacy and serostatus disclosures, attitudes towards safe sex, and self-esteem levels.

The objectives in the study were (i) To establish the impact of the guidance programme on self-efficacy of YLWHA, (ii) To investigate the impact of the guidance programme on the level of attitude of YLWHA towards safe sex and (iii) To examine the impact of the guidance programme on the self-esteem of YLWHA. The other two objectives were meant for the experimental group only at post- test, since it is the one that received the treatment. The Findings thereof are reported both in inferential and descriptive statistics.

Table 4.10 shows results of independent sample t test comparing the control group and the experimental group on the self- efficacy scale at pre-test.

4.5 Independent Samples t-Test for Self-efficacy

An independent t-test for self-efficacy was done in order to compare the control group with the experimental group after the intervention. Table 4:11 shows the results

Table 4.11: Independent Samples Test for Self-efficacy at pre-test

Variances	Levene's Test for Equality of Variances		t-test for Equality of Means		
	F	Sig.	T	df	Sig. (2-tailed)
Equal variances assumed	0.046	0.83	-0.706	74	0.482
Equal variances not assumed			-0.706	73.014	0.482

The Results of Table 4.11 show that the p-value which is 0.482 is greater than 0.05 ($p > 0.05$). This means that the two groups did not have any statistically significant difference in self-efficacy at the onset of the study and thus were homogeneous.

4.6 Comparison of Control and Experimental Group Scores on Safe sex Attitude at pre-test

In order to test the equality of variances, Levene's test was used. According to Levene (1960) Levene's test is an inferential statistic used to assess the equality of variances for a variable calculated for two or more groups. In this study, there were two groups and these were the control and experimental group. Some common statistical procedures assume that variances of the populations from which different samples are drawn are equal. In this study the assumption was that; the two groups were equal in terms of safe sex attitude. Levene's test assessed this assumption.

According to Levene, equal variances across samples are called homogeneity of variance. It tests the null hypothesis that the population variances are equal (called homogeneity of

variance or homoscedasticity). If the resulting p -value of Levene's test is less than some significance level (typically 0.05), the obtained differences in sample variances are unlikely to have occurred based on random sampling from a population with equal variances. Thus, the null hypothesis of equal variances is rejected and it is concluded that there is a difference between the variances in the population. The findings of this study are shown in Table 4.12.

Table 4.12: Comparison of control and experimental group scores on safe sex attitude-pre-test

Variances	Levene's Test for Equality of Variances		t-test for Equality of Means		
	F	Significance	t	df	Significance (2-tailed)
Equal variances assumed	1.819	0.181	-0.359	74	0.72
Equal variances not assumed			-0.359	72.508	0.72

The results of the test show that p -value which is 0.72 is greater than the significant level of 0.05, that is ($p > 0.05$). These results therefore indicate that, there was no statistically significance difference in the level of safe sex attitude between control and the experimental group before the treatment of the experimental group.

4.7 Comparison of control and experimental group scores on self-esteem at pre-test

In order to test the equality of variances, Levene's test was used to determine whether there was a statistically significance between the control and the experimental group in respect to self-esteem before the intervention. Table 4.13 shows the results.

Table 4.13 Comparison of Control and Experimental Group Scores on Self-esteem at pre-test

Variances	Levene's Test for Equality of Variances		t-test for Equality of Means		
	F	Significance	t	df	Significance
Equal variances assumed	0.437	0.511	0.348	74	0.729
Equal variances not assumed			0.348	73.302	0.729

The results show that the p-value which is 0.729 is greater than the significant level of 0.05, that is ($p > 0.05$). These results indicate that there was no statistically significant difference in the level of self-esteem between the control and the experimental group at the pre-test.

The findings of the study are in agreement with the argument of Marczyk, *et al.* (2005), who state that, the main purpose of the randomized two-group design is to demonstrate causality, that is, to determine whether a specific intervention (the independent variable) causes an effect (as opposed to being merely correlated with an effect). The study sought therefore to find out if there was any impact on the variables; self-efficacy, safe sex attitude and self-esteem after the experimental group was taken through the guidance programme.

4.7 Testing of the Hypotheses: Testing the importance of the intervention; bivariate comparisons of the control group with the experimental group

A hypothesis test is a statistical test that is used to determine whether there is enough evidence in a sample of data to infer that a certain condition is true for the entire population.

The hypotheses that were tested for this study include:-

H_{01} : There is no statistically significant difference in the level of self-efficacy and serostatus disclosure between the YLWHA who undergo guidance programme compared to those who do not.

H₀₂: There is no statistically significant difference in the level of attitude towards safe sex between the YLWHA who undergo guidance programme compared to those who do not.

H₀₃: There is no statistically significant difference in the level of self-esteem between the YLWHA who undergo guidance programme compared to those who do not.

H₀₄: There is no statistically significant relationship between Guidance programme attitude and respondents gender.

In order to undertake the hypothesis testing, the sample size of 76 respondents that had been split into two groups that is Pre Control Test Group and Pre Experimental Test Group composed of 38 members each was to be compared at both the pre-test and post- test. Since the subjects were initially from the same group, they needed to be similar on the variables gender and age. Stratified sampling was used to ensure that, the strata (gender and age) in the population were fairly represented in the sample. The researcher purposively selected the 76 YLWHA in the support group to participate in the study. The 76 YLWHA were divided into two equal groups that had similar representations of characteristics, which are gender and age stratification. The two strata were then randomly assigned into an experimental group (N=38) and a control group (N=38). As earlier on indicated, this study adopted a pure experimental research design (separate groups design). An experiment usually involves two groups of subjects, an experimental group and a control or a comparison group (Fraenkel & Wallen, 2007). Random assignment involves assigning participants to groups within a research study in such a way that each participant has an equal probability of being assigned to any of the groups within the study (Kazdin, 1992). The Experimental Group represents the group that underwent through the guidance programme training sessions in relations to self-efficacy, safe sex attitude and self- esteem. Whereas, the Control Group was not taken through the

guidance programme. After the Experimental Group had undergone the guidance programme sessions post testing was done.

The hypotheses testing which was done before the experimental group was exposed to the guidance programme, was carried using the t statistics through four steps (i) checking whether there was significant difference between pre experimental and pre- control test groups in terms of the level of self-efficacy and serostatus disclosure; (ii) checking whether there was significant difference between pre experimental and Pre Control test groups in terms of the level of attitude towards safe sex; (iii) checking whether there was significant difference between pre experimental and pre control groups in terms of the level of self-esteem, and (iv) finally checking whether there was significant relationship between Guidance programme attitude and respondents gender at post- test. The fourth step was administered to the post experimental group only after the guidance programme sessions.

There are diverse reasons for the four steps. The first step that involves the checking on whether there was significant difference between pre experimental and pre control test group in the three variables; the self-efficacy and the sero status disclosure, the self-esteem and safe sex attitude was critical in that, it was to ensure that the randomization process was effective. Through steps (ii) and (iii), the researcher was able to figure out and to see how the pre control and pre experiment test groups changed from pretest to post- test so as to evaluate on whether one, both or neither improved over time. It was also of importance to establish whether the difference was statistically significant to be attributed to the independent variable, that is, the guidance programme. If the control group also shows a significant improvement, then the researcher must attempt to uncover the reasons behind this. The final step in the testing of the hypothesis was to establish whether there was a relationship between the attitude towards the guidance programme and the gender respondents.

In his study, “interventions to reduce sexual risky for the HIV in adolescents”, Johnson (2003), argues that HIV/AIDS information has been found to be very important in interventions that have been successful in modifying behaviour of young people who are at risk from HIV infection. Given that one of the major modes of transmitting HIV/AIDS is hetero sex, it stimulates a strong belief that change of risky behaviour is a preventive and control measure for restricting the spread of the HIV/AIDS pandemic.

The overriding hypothesis is that training on the impact of HIV/AIDS and intervention measures needed, various skills on how to negotiate for safe sex and serostatus self-disclosure. Identifying common Causes of Risky behaviour; identifying sources of self-efficacy and strategies for improving self-efficacy; as well as identifying causes of low Self-esteem and how to build positive self-esteem; can increase self-efficacy to choose safe sex, change safe sex attitudes and increase self-esteem among youth people living with HIV.

For people living with HIV-AIDS, sexual decisions are closely linked to knowledge of a sex partner’s HIV status and disclosure of their own HIV status to sex partners (Wenger, Kusseling, Beck, & Shapiro, 1994). In their study on transactional sex among university female students in Ghana, Adjei *et al.* (2014) found out that, all the respondents concealed their relationships from “other” friends and families for fear of reprimand and stigmatization, discrimination and name calling. It is therefore often the case that people who have HIV infection do not disclose their HIV status to their sex partners (Bayer, 1996). Schnell *et al.* (1992), for example, reported that 11% of HIV infected men do not disclose their HIV status to primary sex partners. In a study of mostly low-income Hispanic men, Marks *et al.* (1991) found that 52% had not disclosed their HIV serostatus to at least one of their sex partners. In a similar study, 24% of HIV seropositive women had not disclosed to sex partners and 13% had not disclosed being HIV infected to anyone (Simoni *et al.*, 1995). Effective HIV

disclosure decision-making is therefore a difficult challenge facing most people living with HIV-AIDS, particularly within the context of their sexual relationships. Among the many factors that influence decisions to disclose one's HIV status to sex partners, self-efficacy for making effective disclosure decisions may be of particular importance.

It was earlier on mentioned that, Social cognitive theory defines self-efficacy as the self-evaluative belief held by an individual that he or she can effectively perform a specific behavior under specified conditions (Bandura, 1986, 1994). In both the HIV prevention and HIV-AIDS coping literatures, self-efficacy has emerged as a fundamental construct for predicting behavior and, perhaps more importantly, behaviors change (Forsyth & Carey, 1998). Self-efficacy is also an important construct in the development and evaluation of behavioral interventions, including those targeting HIV status disclosure decisions and negotiating safer sex practices. Kalichman and Nachimson (1999) reported that self-efficacy beliefs were closely associated with decisions to disclose HIV status to sex partners as well as negotiating safer sex practices among people living with HIV-AIDS. Kalichman and Nachimson's (1999) study was among the first to show that lower self-efficacy is related to withholding information about one's HIV status to sex partners, suggesting that persons who fail to disclose their HIV status may do so because of a lack of confidence in their ability to make effective disclosure decisions. The importance of self-efficacy as a theoretical construct, its predictive value in behavioral research, and its potential as an outcome from behavioral interventions demonstrates a need for reliable and valid measures of self-efficacy for decisions to disclose HIV status to sex partners.

This section presents results of various analyses that were carried out to statistically test for differences between the two experimental and control groups after the experimental group was exposed to the intervention discussed above. For each of the three scales, a paired sample

t-test and a chi-square test were carried out to test out differences in the two groups so as to confirm or else refute the hypothesized importance of the training. The tests involved the checking on whether there was statistically significant difference between post experimental and post control group in the three variables; the self-efficacy and the sero status disclosure, safe sex attitude and self-esteem.

4.7.1 Comparison of control group with experimental group after the intervention on self-efficacy

H₀₁: Stated that, there is no statistically significant difference in the level of self-efficacy and serostatus disclosure between the YLWHA who undergo guidance programme compared to those who do not.

According to Eaton and Kalichman (2009), self-efficacy refers to the self -evaluative belief held by an individual that he or she can effectively perform a specific behavior under specified conditions. The self-efficacy beliefs are critical in this study as the self-efficacy beliefs are closely associated with decisions to disclose HIV status to sex partners as well as negotiating safer sex practices amongst people living with HIV/AIDS (Tadesse & Yakob, 2015). Various scholars have indicated that the measurement of self-efficacy has been problematic in practices. According to Eaton and Kalichman (2009), the self-efficacy should specify beliefs, behaviors, and circumstances within a particular domain of functioning and in situations that present graduated task demands.

Self-efficacy should, therefore, be assessed in relation to specific behaviors and across situations that vary in terms of performance difficulty. To assess self-efficacy within functional domains and situations requires construction of realistic and relevant scenarios within which target behaviors may be performed and self-efficacy can be assessed. In this context, the following scenarios were constructed.

Story 1 Version A

This week has been difficult for you and you want to forget all of your problems for a while. You go out walking and meet up with some people you know. You go off with them and have a drink to relax. Even though you haven't had much to drink you feel it affecting you. One of your friends introduces you to someone you have seen before and felt attracted to in the past. This person seems to be making it clear that they want to have sex with you. You feel interested.

Story 1 Version B

Just like in the previous story, imagine that this week has been difficult for you and you want to forget all of your problems. You go out walking and meet up with some people you know. You go off with them and have a few drinks. You get to feeling pretty buzzed when one of your friends introduces you to someone you have been attracted to in the past. This person seems to be making it clear that they want to have sex with you. You feel like you are a little drunk. You also feel interested in being with them.

Story 2 Version A

As in the previous story, imagine that you have had a difficult week. You have been feeling lonely and you realize that it has been some time since you had sex with anyone. You decide to go out and meet some friends to get something to eat. While out, you meet a person that you have seen around and think is attractive. They seem interested in you and seem to be flirting with you. Soon it becomes clear that they want to have sex with you.

Story 2 Version B

As in the previous story, imagine that you have been feeling lonely and depressed. You realize that it has been a long time since you were intimate with someone. While

you are out you meet a person that you have seen around and think is attractive. They seem interested in you and you want to be with this person.

Story 3 Version A

While out with some friends and having fun, you unexpectedly run into an ex-partner from your past. You had sex with this person many times long before you became HIV positive. They start telling you how much they missed being with you and that they think of you often. Then they say that they are not currently partnered. You are feeling good and the mood seems right for the two of you to get together. Because you still like this person and have feelings for them you want to be with this person.

Story 3 Version B

Imagine that you had been in a relationship with someone who just left you and ended it. You unexpectedly run into an ex-partner from your past who is visiting in town. You had sex with this person many times long before you became HIV positive. After telling you how much they missed being with you and that they think of you often, this person asks you to come to their hotel room. You are feeling really good, the mood seems right, and you want to have sex with this person.

Score on items per story were used to construct the self-efficacy scale which was subjected to a paired sample t-test. According to Bandura many of the scales that actually measured self-efficacy were not behaviourally specific. Fortunately, Bandura (1997) has offered several practical guidelines for assessing self-efficacy. For example, Bandura (1997) stated that “Efficacy beliefs should be measured in terms of particularized judgments of capability that may vary across realms of activity, under different levels of task demands within a given activity domain and under different situational circumstances” (p. 42). According to Bandura (1997) self-efficacy scales should be limited to beliefs about personal abilities to enact behaviors under specified conditions. Elaborating on Bandura’s (1997) suggestions by

Forsyth and Carey (1998) stated that, measures of self-efficacy should specify beliefs, behaviors, and circumstances within a particular domain of functioning and in situations that present graduated task demands.

According to Forsyth and Carey (1998) then, Self-efficacy should, therefore, be assessed in relation to specific behaviors and across situations that vary in terms of performance difficulty. To assess self-efficacy within functional domains and situations requires construction of realistic and relevant scenarios within which target behaviors may be performed and self-efficacy can be assessed. The challenge in assessing self-efficacy therefore lies in identifying situations that are personally relevant to a majority of persons in a population. Situations that are too generic can jeopardize the specificity of a self-efficacy scale and, on the other hand, situations that are too idiosyncratic can be irrelevant to a majority of the target population. Formative elicitation research with members of the target population should therefore be first undertaken to derive personally relevant and meaningful scenarios in which self-efficacy can be assessed. In this study, the question as to the effectiveness of the decision to disclose the HIV Positive status within the given situation was examined in respect to each of the six scenarios. These scenarios were quite relevant to this study. The respondents were also asked on their confidence levels in bringing up the need to practice safe sex in the given situation; thus, when confronted with Story 1 Version A then Version B, Story 2 Version A, Story 2 Version B, Story 3 Version A, and Story 3 Version B respectively.

The first test that was carried out was a paired sample t-test to see if the experimental group's scores at pre-test were statistically different from its scores at post-test. In other words, the idea was to find out if after the intervention, their scores had improved in a statistically significant way. Results of this analysis are presented in Table 4.14.

Table: 4.14 Comparison of self-efficacy pre-test scores with post test scores for the experimental group

Self-efficacy tests	Paired Differences			t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean			
Self-efficacy pre-test scale vs Self- efficacy post-test scale	-3.75	8.31244	0.9535	-3.933	75	0.000

These results show that the scores between pre- and post-test are significantly different at 95 Percent confidence in the experimental group (t value -3.933 and p-value of 0.000).

The results show that p-value is less than the set significant level that is $p < 0.05$, and therefore there was a statistically difference in the level of self-efficacy between pre-test and post-test of the same group.

To confirm that these differences were not caused by some other factors during the intervention period, the control group was subjected to the same test. As hypothesised, differences in the pre-test and post-test scores for the control group are not statistically significant (t value of 1.047; p-value of 0.302). This p-value is greater than 0.05 showing that there was no statically significant difference in self-efficacy between the pre-test and post-test for the control group. These differences in the two groups can be attributed to other factors other than the time span, since the two groups were exposed to the same test at the same time after the intervention.

Table 4.15: Comparison of self-efficacy pre-test scores with post test scores for the control group

Variables	Paired Differences			t	Df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean			
Self-efficacy pre-test scale – vs Self-efficacy post-test scale	0.42105	2.47836	0.40204	1.047	37	0.302

p>0.05

As noted earlier, a second test, the chi-square test, was carried to check if indeed the experimental group was significantly different from the control group after the intervention. To enable this test, the self-efficacy scale was transformed from a continuous variable to a categorical variable with two categories Low Self-Efficacy for those who scored lower than the mean score (which was 54.4868) and High Self-Efficacy for those who scored higher than the mean score on the self-efficacy scale. Changing the structure of the scale enabled a more direct and visually appealing comparison of the two groups. Table 4.16 shows the Percent distribution of control group member and experimental group members according to self-efficacy.

Table 4.16: Percent distribution of respondents according to self- efficacy at post-test

Groups	Low self-efficacy	High self-efficacy	N	
Control	71.10%	28.9%	38	100.0%
Experimental	23.70%	76.3%	38	100.0%
	47.40%	52.6%	76	100.0%

(Chi-square value 17.100 p-value 0.000)

Findings of this test show that 71.10% of the control group had low self-efficacy compared to the 28.9% of the experimental group. The experimental group had a high self-efficacy score

of 76.3% compared to 28.9% of the control group. Finally, an independent samples t-test was finally carried out to see if the control group was statistically different from the experimental group after the treatment and the results are presented in Table: 4.17.

Table 4.17: The Levene Test for the Equality of Variances

Variances	Levene's Test for Equality of Variances		t-test for Equality of Means			
	F	Sig.	t	df	Sig. (2-tailed)	
Equal variances assumed	6.979	0.01	-4.114	74	0.000	
Equal variances not assumed			-4.114	63.32	0.000	

P value < 0.05

In order to test the equality of variances, Levene's test was used. According to Levene (1960) Levene's test is an inferential statistic used to assess the equality of variances for a variable calculated for two or more groups. In this study, there were two groups and these are the control and experimental group. Some common statistical procedures assume that variances of the populations from which different samples are drawn are equal. In this study the assumption is that; the two groups are equal in terms of Self-efficacy at pre-test. Levene's test assesses this assumption. It tests the null hypothesis that the population variances are equal (called homogeneity of variance or homoscedasticity). If the resulting *p*-value of Levene's test is less than some significance level (typically 0.05), the obtained differences in sample variances are unlikely to have occurred based on random sampling from a population with equal variances. Thus, the null hypothesis of equal variances is rejected and it is concluded that there is a difference between the variances in the population. The findings of this study are shown in Table 4.17. The *p*-value is less than 0.05 and therefore the null hypothesis is therefore rejected.

This difference can be attributed to the intervention that is, exposure to the guidance programme. These findings are in agreement with a study by Johnson (2003), who argues that HIV/AIDS information has been found to be very important in interventions that have been successful in modifying behaviour of young people who are at risky from HIV infection. Given that one of the major modes of transmitting HIV/AIDS is hetero sex, it stimulates a strong belief that change of risky behaviour is a preventive and control measure for restricting the spread of the HIV/AIDS pandemic.

In his Social cognitive theory Bandura (1986,1994), defines self-efficacy as the self-evaluative belief held by an individual that he or she can effectively perform a specific behavior under specified conditions. Research conducted earlier on by (Forsyth & Carey, 1998) state that, in both the HIV prevention and HIV-AIDS coping literatures, self-efficacy has emerged as a fundamental construct for predicting behavior and, perhaps more importantly, behavior change. Self-efficacy is also an important construct in the development and evaluation of behavioral interventions, including those targeting HIV status disclosure decisions and negotiating safer sex practices. The findings of this study are also in agreement with the study conducted by Kalichman and Nachimson (1999), who reported that, self-efficacy beliefs were closely associated with decisions to disclose HIV status to sex partners as well as negotiating safer sex practices among people living with HIV-AIDS. Kalichman and Nachimson's (1999) study was among the first to show that lower self-efficacy is related to withholding information about one's HIV status to sex partners, suggesting that persons who fail to disclose their HIV status may do so because of a lack of confidence in their ability to make effective disclosure decisions. The findings of this study also affirms Kalichman and Nachimson's (1999) argument that the importance of self-efficacy as a theoretical construct, its predictive value in behavioral research, and its potential as an outcome from behavioral

interventions demonstrates a need for reliable and valid measures of self-efficacy for decisions to disclose HIV status to sex partners.

The findings of this study concur with Bandura's (1997) concept of self-efficacy. Self-efficacy as presented by Bandura (1977) is the belief in oneself to be able to perform a certain task. Self-efficacy is geared towards behavioral changes as it determines how people think, feel and behave. In this concept of Self-efficacy, Bandura presented self-efficacy as an operative construct that determined the consequent behavior of an individual. In his observation, Bandura (2006) demonstrated that a person can have a high or a low self-efficacy based the tasks that the person has to perform. The task that an individual is to perform has three dimensions: generality, magnitude and strength.

The magnitude of a task is its level of difficulty. The harder a task is, the higher the individual's self-efficacy (Schwarzer, 2014). For instance, an individual may find it hard to purchase a condom but the moment that they do, their self-efficacy increases. Generality involves being able to generalize tasks that are similar to one another. In this, a task can bring about a specific or a general self-efficacy (Noah, 2003). Practicing safe sex always is a show of generality in self-efficacy. Strength is the level of confidence that an individual has in performing a task. Being able to purchase a condom in itself is a show of strength especially when there is a possibility of an individual being negatively judged.

On the high self-efficacy, a person sees an opportunity to master tasks that are presented in challenging situations, develop an interest in activities in which the person is performing, and be able to develop a sense of commitment to the activities. On the reverse, an individual whose self-efficacy is low tends to avoid any challenges presented as they believe that they are not capable of performing the task.

Further, Bandura's model indicates that self-efficacy can be developed through: (i) mastery experience where by an individual persistently puts on the effort so as to overcome any obstacles that they may have; (ii) vicarious experience whereby an individual observes other people who have similar challenges employ sustained efforts and succeed; (iii) social persuasions whereby an individual is given verbal persuasions so that they can overcome any self-doubt they may be experiencing. In the case of negative persuasion, the self-efficacy of an individual is lowered; and (iv) somatic and emotional states in which an individual's perception of their physical response in situations and environments that are threatening influences the self-efficacy of that individual. This is in agreement with the findings of the study and thus, affirming the impact of the intervention.

Other studies that attest to the findings of this study include the findings by Sheer (2014) who observes that self-efficacy can be used to explain health-related behaviors and is central in its linkage to behavior, beliefs and attitudes. Through self-efficacy, people are able to make decisions so that they can embrace healthy behaviors. This is because self-efficacy influences the way humans function. According to Bandura (2012), the cognitive processes of an individual are influenced by the choices that the individual will make for instance, the choice to attain a certain goal. Self-efficacy also affects the motivational processes of an individual and this is reflected in the effort the individual puts in achieving a set goal. Affective processes, such as the way an individual responds in times of stress or anxiety are also affected by self-efficacy. Finally, selection processes such as the choices that people make in their interactions with their environment are also affected by self-efficacy.

People are modeled to behave in one way or the other through their interactions with the environment. For children, parental influences model the self-efficacy of children. As the children grow and develop in to adolescents, Fan and Williams (2010) assert that the adolescent's self-efficacy is modeled by his or her peers. In this stage of development,

children with low self-efficacy may be swayed into risky behavior experimentation. Such risky behavior involves alcohol and substance abuse and unsafe sex.

Noah (2003) observes that since self-efficacy levels affect human functioning, they also affect the sexual functioning of individuals. Goodman *et al.* (2016) posit that in Sub-Saharan Africa, the aspect of power imbalance reduces condom use in many relationships. Women and young girls find themselves in situations whereby they are unable to exert control over efforts that would prevent HIV infections and reinfection. Moreover, Falola and Heaton (2007) add that even though risky-taking behavior is regarded purely as an individual matter, women's experiences are modeled by socio-cultural, political and economic contexts that may be very complex to fathom. Risky-behaviors that are undertaken by individuals may be out of coercion; which is as a result of low self-efficacy. The women are not allowed to speak out of issues pertaining condom use lest their male partners react negatively to them (Dyk, 2010). Physical and emotional consequences are observed in such a scenario. Physically, the woman is at risk of HIV infections and sexually transmitted diseases. Emotionally, the self-esteem of the woman is affected as they feel that they have no control over their decisions.

Power imbalances also hinder the communication in a relationship. Self-efficacy builds a sexual partner's ability to communicate Goodman *et al.* (2016). One should be able to communicate to their partner about their sexuality and also be able to negotiate about safe sex. Consistency in condom use has the ability to build the self-efficacy of individuals because they feel in control of their relationship and sexual functioning. Even though much attention has been focused on negotiation for condom use, traditional communities still do not give the woman the opportunity to talk. Kartikeyan *et al.* (2007) allude that communication allows sexual partners to express their physical and emotional needs. This however does not mean that it in traditional societies it is desirable. With low self-efficacy among many women

as pertains to communication with their sexual partner, women find it hard to say no to unwanted sex. Falola and Heaton (2007) agreeably note that communicating with a sexual partner is deemed a difficult task. The magnitude of the task influences self-efficacy. This is observed in sexual gender based violence when a woman is coerced and forced in to sex by their intimate partner.

A high self-efficacy can help to prevent HIV infection (Bandura, 2012). Individuals with a high self-efficacy have the confidence in their ability to be able to avert risky situation and be able to look at positive behaviors that will lead to positive outcome. As self-efficacy can be modeled, individuals who are at a high risk of HIV infection, such as women, young girls and orphans can be empowered. However, Falola and Heaton (2007) notes that many-a-times empowerment is not viewed in a positive light. Even though self-efficacy that results from empowerment is a conjecturer of safe sex, Lack of empowerment leads to a low self-efficacy which makes women and young girls vulnerable to violence especially when negotiating for safe sex practices.

For HIV preventive behavior to be effective there has to be a sense of self-efficacy. The need to reduce risky sexual behavior has focused efforts towards self-efficacy beliefs (Bandura, 2012). This has led to interventions that focus on increasing self-efficacy. For instance, Goodman et al. (2016) noted that a small intervention made in addressing the knowledge and self-efficacy of orphans and vulnerable youth about negotiations on condom use was able to increase the knowledge, beliefs and condom use negotiation. Luchters et al. (2008) noted that peer mediated interventions increase self-efficacy and are able to change sexual behaviors and exposure to HIV. The fact that these interventions are from peers builds trust and ultimately self-efficacy. Interventions can also build optimism. Self-efficacy in a high degree can change high risky behaviors to low risky behaviors which are a process and the individual can stay committed to.

4.7.2 Comparison of Safe sex Attitude

HO₂: Stated that, there is no statistically significant difference in the level of attitude towards safe sex between the YLWHA who undergo guidance programme compared to those who do not. In order to test this hypothesis an independent t-test was used. The independent t-test is a test that is used to compare the means across two unrelated categories. In this study, the two categories are the control and the experimental groups whose means are tested in relation to the attitude towards safe sex variable. Levene's test for equality of variance was used at post-test.

Table.4.18: Independent sample t-test after the intervention to see if control and experimental groups were different in terms of safe sex attitude

Variances	Levene's Test for Equality of Variances		t-test for Equality of Means		
	F	Sig.	t	df	Sig. (2-tailed)
groups Equal variances assumed	0.071	0.791	-6.456	74	0.000
Equal variances not assumed			-6.456	8	0.000

P=0.000 while the t= -6.456.

The overriding hypothesis is that a training on the impact of HIV/AIDS and intervention measures needed, various skills on how to negotiate for safe sex and serostatus self-disclosure, among others; the identifying of common causes of risky behaviour; identify sources of self-efficacy and strategies for improving self-efficacy; as well as identifying causes of low Self-esteem and how to build positive self-esteem, can increase self-efficacy to choose safe sex, change safe sex attitudes and increase self-esteem among youth living with HIV. The changing of safe sex attitude would hence reduce risky sex behaviour. Findings from the study show that $p < 0.05$ and therefore there is a statistically significant difference

between the control and the experimental groups in relation to safe sex attitude after the intervention.

In order to affirm the results above, the further test that was carried out was a paired sample t-test to see if the experimental group's scores at pre-test were statistically different from its scores at post-test. In other words, the idea was to find out if after the intervention, their scores had improved in a statistically significant way. Results of this analysis are presented in Table 4.19.

Table 4.19: Comparing if scores for experimental group at pre-test are different from those of post-test in the variable safe-sex Attitude

Paired Samples Test					
Paired Differences		t	df	Sig. (2-tailed)	
Mean	Std. Deviation	Std. Error Mean			
-14.78947	12.57229	2.0395	-7.252	37	0.000

The results show that p-value is less than the significant level ($p < 0.05$) and therefore there is a statistically significant difference between pre-test and post-test for the experimental group in relation to safe sex attitude. There is a notable change that could be attributed to the intervention. In order to confirm the results, a test comparing the experimental and the control group categorised in to high and low safe sex attitude was performed. Results are shown in Table: 4.20.

Table: 4.20: Comparison of Control with Experimental Group post-test Safe sex Attitude Scores (categorised in to high and low safe sex attitude)

Categories		Safe sex attitude post-test in			Total
		Low safe sex attitude	High safe sex attitude		
Group	Control group	81.6%	18.4%		100.0%
	Experimental group	21.1%	78.9%		100.0%
Total		51.3%	48.7%		100.0%
Pearson Chi-Square value		27.861	df-1;	p-value	0.000

The results show that p-value is less than the significant level; that is $p < 0.05$. The comparison of the experimental with control group post-test safe sex score (categorised in to high and low safe sex attitude) showed that, the control group scored 81.6% on low safe sex attitude against the experimental group that scored 21.1% on low safe sex attitude. The experimental group scored 78.9% high safe sex attitude scores against the 18.4% high safe sex attitude for the control group.

Ho2: Stated that, “There is no statistically significant difference in the level of attitude towards safe sex between the YLWHA who undergo guidance programme compared to those who do not”. Since the results show that $p < 0.05$, meaning that there is a statistically significance deference in the level of safe sex attitude between the control and the experimental groups at post-test, then the hypothesis (Ho2) is thus rejected. This results thus show that, there is a statistically significance difference in the level of safe–sex attitude between the control and the experimental groups. This change can be attributed to the impact of the guidance programme on safe sex attitude change.

There is a new awakening that in the fight against HIV epidemic, there has to be more interventions on not just using condoms and observance to medication (Kaufman, Cornish, Zimmerman, and Johnson, 2014) Progresses in the treatment of HIV have led to optimism in

the way of life for people living with HIV. This has led to positive changes among people who have high risky behavior. There is a need to change the risky behavior of people and these cuts across political, socio-cultural and economic divides which can change an individual's awareness, sentiments, outlooks, and risky perceptions towards the HIV epidemic.

An individual has to be able to recognize that their behavior is high risky in terms of susceptibility to contract HIV. For this recognition to take place, the individual has to have the knowledge of the high risky undertakings that make them susceptible to HIV infection. In order for an individual to personally understand the high risks, they have to have knowledge on transmission of HIV. In a survey on demographics and health in Kenya, the Kenya National Bureau of Statistics (2015) , reported that 54% of young women and 64% of young men who were aged between 15-24 had a comprehensive knowledge on prevention of HIV. This has helped to reduce the HIV transmission rates but still more has to be done. Knowledge can lead to safe sex practices such as utilization of condoms in which the individual can find enjoyment while at the same time being safe. Hwenha (2014) notes that high HIV risky individuals should understand that they are able to contract HIV.

However, Jukes, Simmons, and Bundy (2008) are quick to point out that even though they are knowledgeable in how HIV is transmitted, individuals still engage in high risky behavior. There is a feeling of invulnerability. If one believes that they are invulnerable, they cannot change their high risky behavior. Such feeling of invulnerability may stem from traditional and cultural practices. A step further, Jukes, Simmons, and Bundy, (2008) assert that they have to believe that they do not want to have AIDS as it is undesirable. Individuals have to have a perception that their behavior places them at a high risk of HIV infection. The perception can be induced by self-observation or through close friends and even family. Communication in interpersonal relationships should be open and clear so as to allow, for

instance, sexual partners to communicate on past sexual relationships. Change can come from motivation from an intimate partner to change.

Parents, peers and mentors should also talk openly on various issues pertaining HIV/AIDS that are deemed to be socially sensitive (DiClemente & Peterson, 2013). Peer influences that are positive highly reduce the risk of contracting HIV and other related STIs. Luchters *et al.* (2008) observed that directly or indirectly, peer interventions have the capability of influencing an individual's decisions concerning high risky behavior. For those who do not believe that their behavior is high risky, peer attitudes and norms can help to reduce these perceptions. By virtue of being in the same demographic category, for example in terms of age, gender or belonging in the same high risky behavior group like injecting drug users, peer education has been seen to be efficacious. The findings of this study on safe sex attitude are also in agreement with earlier studies conducted in Kenya. In an assessment of impact of peer initiatives among female sex workers in Kenya, (Luchters *et al.* 2008) found out that in five years of the intervention, significant positive changes among the female sex workers were observed. The female sex workers were better placed to make autonomous sexual decisions which reduced high risky behaviors.

Peer educators are trained so that they can convey knowledge among their peers and thus increase awareness. Peer education involves distribution of preventive materials, individual counselling and referrals (Luchters *et al.* 2008). The peer educator creates a conducive environment in which open non-judgmental discussions take place. These discussion groups become a support system. Social networking is enhanced especially for the marginalized groups such as the sex workers. There should be social support. This may be in form of informal support groups geared towards behavioral change. Group norms in support group's help for instance through use of contraceptives. Support groups help to deal with stress and be able to cope. They provide relationships that are positive and promote the self-esteem of

an individual. Support systems help to affirm an individual that they are on the right path and so they can change their behavior. Support systems provide information and advice. Support groups can also help to provide resources such as employment or money to start a business. Support improves the psychological well-being of those living with HIV and those who are prone to high risky behavior.

Community norms should also be reinforced in a way that they will lead to a positive change from high risky behaviors (DiClemente and Peterson, 2013) There should also be community support that is not influenced by power imbalances. Assertions by Chitiga-Mabugu *et al.* (2014) insist on inclusion in the community. Both men and women should be considered in interventions geared towards changes in high risky behavior. Society's stigma that is associated with HIV should be dealt with in communities. There should be awareness creation about HIV related stigma and the negative effects it has on the communities. This builds a communal solidarity which supports safe sex behaviors and practices.

Structural and institutional interventions towards behavioral change in HIV transmission should be encouraged (Kalichman, 2014). This involves considering laws, customs and policies that encourage high risky behavior. Ellis *et al.*, (2007) notes that a lack of political will is detrimental in any interventions that seek to change high risky behaviors. Even with all these multi-level interventions, individuals have to be committed to reduce high risky activities. This means that they have to engage in low risky activities. Obviously, sexual abstinence is regarded as a paramount method of preventing sexual transmission of HIV. However, as noted by DiClemente and Peterson (2013) this method has failed as a strategy among a good proportion of adolescents and adults. It is deemed as an unrealistic method. To change high risky behavior, there has to be an insistence on continuous use of condoms. Of course consistency is influenced by certain factors such as age, gender and cultural differences. Injection drug users should also be committed to reducing sharing of

contaminated drug injection equipment. Commitment has to come from deep within. It is a decision to change. This may be difficult due to other aspects such as alcohol and substance abuse that may be connected to high risky behavior. It is imperative to show individuals that the benefits of change supersede the costs.

There have to be strategies to abolish the high risky activities. The strategies should come from the individual seeking help. The individual can seek information. Here, they can gather information and also ideas on how to change the high risky behavior. Health education gives specific information. According to Gregson *et al.* (2006), an individual who is empowered has the ability to make sound sexual decisions. Education is a form of empowerment. For instance, women should be educated on the female condom and its correct use. Financial empowerment is also fundamental in high risky behavior change. There should be also increased access to financial facilities that provide individuals with a source of funding and financial advisory services can help individuals to raise their socio-economic status. Income generating ideas helps to reduce vulnerability (Gillespie *et al.*, 2007). With economic resources, individuals are able to fend for their own. This reduces dependencies on other people (Glynn *et al.*, 200). For women and young girls, dependencies which lead to transactional sex and intergenerational casual sex relationships are dealt away with. According to Ellis *et al.* (2007) the Kenya Women Financial Trust provides funding for women's income generating activities which assists them in providing for the families and is also a step towards poverty reduction. The economic autonomy observed here reduces HIV related risky behaviors.

Education should be a priority towards changing the high risky behaviors. Literacy helps individuals to decipher what they want for their future and go after it. With increase of literacy levels, there is bound to be change from high risky behavior. Individuals with a higher education level are able to increase their income and even overcome income

inequalities that may be present in the society (Gillespie, *et al.*20077). There by reducing vulnerability. Public education campaigns help to gunner for behavior change. Kaufman *et al.* (2014) affirm that behavior change communication is vital in the raising awareness on HIV transmission, prevention and treatment. Behavioral change communication targets not only the high risky groups such as injectable drug users, but the general population (Singhal & Rogers, 2012) As such, behavior change communication can range it focus from a small group to the larger population.

In hard to reach populations, messages on HIV prevention can be broadcasted using the mass media. For development of positive behaviors, behavioral change communication should engage the community and also those that are experts in certain field such as development and behavioral change communication. Moreover, Mefalopulos (2008) affirms that development of behavioral communication messages should be participatory so that individuals can give their perspectives. These behavioral change messages touch on various matters such as reduction of multiple partner, condom use negotiation, correct and consistent condom use, and influence of the macro environment on HIV. An example of a behavior change message that has been so successful in Kenya is the '*mpango wa kando*' message by the Population Service International (Marube, 2011). This campaign focused on HIV related risks of extra marital affairs in Kenya. Mefalopulos (2008) Cites that the messages should put in mind the audience and given the nature of HIV/AIDS subject matter, the messages should also be culturally sensitive. Mass media channels such as the radio, newspapers, and television should address behavioral change with objectivity so as not to add on the already existent and deeply rooted social stigma that is HIV related.

Social media which has over the years been used as a platform for communication can be a vital tool in addressing adolescents and youths. Ephraim, (2013) posits that the interests of African Youth on technology have led to the abandonment of traditional media and they have

opted to social media. Social media, though with negative effects, behavior change communication can be more beneficial and reach a larger target audience on this platform. Behavioral change communication also takes in to consideration the influence of peer educators and works in combined efforts. Through these campaigns, people are able to be in more control of their sexual relationships and they are more likely use condoms (Kartikeyan *et al.*, 2007). Behavior change communication should be frequent so to ensure continual observance of the behavioral change.

Prevention programs can be initiated to help in risky behavior change. To be more effective, Padian et al. (2008) maintain that activities in the prevention programs should be integrated with structural and behavioral interventions. A holistic approach should be taken in this integration that looks at all HIV services such as access to ARV drugs for those with HIV infection and better primary care for the community members.

4.7.3 Comparison of self-esteem – independent sample t-test after the intervention

H₀₃: Stated that, there is no statistically significant difference in the level of self-esteem between the YLWHA who undergo guidance programme compared to those who do not.

In order to test whether there was a statistically significant difference in the level of self-esteem between the control and the experimental group after the intervention, an independent t-test was carried out as shown in Table: 4.21.

Table: 4.21:Independent sample t-test after the intervention to see if control and experimental group’s scores are statistically different after intervention

Variances	Levene's Test for Equality of Variances		t-test for Equality of Means		
	F	Sig.	t	df	Sig. (2-tailed)
Equal variances assumed	3.879	0.053	-4.493	74	0.000
Equal variances not assumed			4.493	69.011	0.000

The results of this test show that $p=0.000$. This p -value is less than the significant level of 0.05 and therefore, there is a statistically significance difference in the level of self-esteem between the control and the experimental group after the intervention.

In order to further verify these results, a Paired samples t-test was performed to check if the self-esteem scores changed between pre and post-test for experimental group. The results for the self-esteem variable, are thus shown in Table: 4.22.

Table: 4.22: Paired t-test to check differences in scores between pre and post-test for experimental group for the self-esteem variable samples

Paired Samples Test					
Paired Differences			t	df	Sig. (2-tailed)
	Std. Deviation	Std. Mean	Error		
Mean					
-4.697	7.263	0.833	-5.638	75	0.000

This results show that $P=0.000$ while the $t= -6.456$.

The overriding hypothesis is that a training on the impact of HIV/AIDS and intervention measures needed, various skills on how to negotiate for safe sex and serostatus self-disclosure, among others; as well as identifying causes of low self-esteem and how to build positive self-esteem, can increase self-efficacy to choose safe sex, change safe sex attitudes and increase self-esteem among youth living with HIV. The building of positive self-esteem would hence reduce risky sex behaviour. An additional test was performed, in order to confirm the results above. The test's main objective was to compare the experimental and the control group and was categorised in to high and low self-esteem. Results are shown in Table: 4.23.

Table 4.23: Comparison of control with experimental group post-test self-esteem scores (categorised in to high and low self-esteem)

Groups	Self-esteem post-test in categories		Total
	Low self esteem	High self esteem	
Control	60.5%	39.5%	100.0%
Experimental	23.7%	76.3%	100.0%
	42.1%	57.9%	100.0%
Pearson Chi-Square 10.581 df 1 p-value 0.001			

Findings of this test show that 60.5% of the control group had low self-esteem compared to the 23.7% of the experimental group. The experimental group had a high self-esteem score of 76.3% compared to 39.5% of the control group. The p-value which was (p=0.001) was less than the significant level of 0.05. This results show that there was a statistically significant difference between the experimental and the control group at post- test and thus the Ho3 was rejected.

4.8 Gender Differences in Attitude towards Guidance Programme

Guidance had been defined as counseling or advice on educational, vocational, or psychological matters. Guidance has been defined as a systematic and organized procedures, tools and facilities to assist an individual in securing knowledge and skills needed in making plans and services, and in interpreting life. In the context of this study, guidance programme refers to a systematic organized programme of activities that focuses on specific HIV/AIDS information, self-esteem and Effective risky behavior reduction.

4.8.1 Views towards Guidance Programme Attitude

H0₄: Stated there is no statistically significant relationship between Guidance programme attitude and respondents gender. Attitude towards guidance programme was evaluated using eight metrics that is knowledge on how to manage risky behaviours, not being worried as

previous in relations to the illness, knowledge on how to take care of stress, and acceptance of HIV status and readiness to disclose to a sex partner. Other items include feeling of worth compared with others, ability to do things as well as other people, feeling of having much to be proud of and having respect over self. The test was carried out as shown in Table: 4.24.

Table 4.24: Guidance Programmed Attitude Frequency Distribution

	SD	D	A	SA	Total
	Freq.	Freq.	Freq.	Freq.	Freq. %
	(%)	(%)	(%)	(%)	
I know how to manage my risky behavior now	0.0%	5.3%	26.3%	68.4%	100.0%
I am not as worried as I used to be about my illness	2.6%	15.8%	31.6%	50.0%	100.0%
I now know how to take care of my stress	2.6%	0.0%	26.3%	71.1%	100.0%
I now accept my HIV status and i am ready to disclose to a sex partner	2.6%	5.3%	39.5%	52.6%	100.0%
I feel that I' am of worth, compared with others	2.6%	5.3%	26.3%	65.8%	100.0%
I am able to do things as well as most other people	5.3%	0.0%	34.2%	60.5%	100.0%
I feel I have much to be proud of	0.0%	0.0%	28.9%	71.1%	100.0%
I feel I have more respect for myself	0.0%	5.3%	13.2%	81.6%	100.0%

Source: Researcher (2017)

The results show that, a majority of 68.4% of the respondents strongly agreed on having knowledge on management of risky behaviours, with only 5.3% disagreeing. Half of all the respondents that is, 50% indicated that they were not as worried as they used to be about their illness before the intervention, while only 2.6 % were still in the state of worry. On knowing how to take care of the stress, 71.1% of the respondents were able to take care of their stress compared to only 2.6 % who were completely not able to do so. Respondents who were able to accept their HIV status and not only doing so but as well as being able to disclose the status to a sex partner were 56.2% Of the total population, compared to 2.6 % who were still not able to do it.

On feeling of worth and the ability to do things as well as most other people, a majority of 65.8% and 60.5% respectively responded in a positive manner. On the metrics, I feel I have much to be proud of and that I feel I have more respect for myself, respondent scored the highest that is, 71.1% and 81.6% respectively. Table 4.24 shows the frequency distributions thereof.

4.8.2 Gender Differences in Attitude towards the Guidance Programme

As noted earlier, the metrics of the guidance programme attitude was evaluated using a four scale likert scale that is Strongly Disagree, Disagree, Agree and Strongly Agree which were coded as 1, 2, 3, and 4 respectively. Scores for eight items listed above were computed for each respondent in the experimental group and the final scale was used to compare gender differences using independent samples t-test. Table 4: 25 presents the statistics of t-test comparing males and females on the computed scale. Evidently, there are no statistically significant differences between males and female with respect to their views or attitudes towards the guidance programme (t-test value of 0.844; p-value of 0.352 when equal variances assumed and 0.398 when Equal variances are not assumed, both of which are greater than the threshold of 0.05).

Table 4.25: Independent Samples Test Comparing Males and Female on Attitude towards the Guidance Programme

	Levene's Test for Equality of Variances		t-test for Equality of Means		
	F	Sig.	t	df	Sig. (2-tailed)
Equal variances assumed	2.159	0.15	-0.944	36	0.352
Equal variances not assumed			-0.869	15.852	0.398

To further investigate gender differences in attitudes towards the programme, the scale was recorded into a categorical variable with two categories namely Negative Attitude and Positive Attitude and the categorized variable was subjected to a cross-tabulation with Chi-square test. Table: 4.26. Is a cross-tabulation of gender and attitude towards the programme. From the Chi-square test, it is evident that the receptivity to the programme did not differ according to the gender of the client.

Table 4.26: Percent distribution of respondent in the experimental group according to their views on the guidance programme

Gender	Negative attitudes	Positive attitudes	Total
Male	63.6%	36.4.6%	100.0%
Female	48.1%	51.9%	100.0%
Total	52.6%	47.4%	100.0%

Pearson Chi-Square 0.752 p-value 0.386

The results show that $p > 0.05$ and therefore there is no statistically significant difference in views on the guidance programme in respect to gender. The results show that the p-value is greater than the significant level of 0.05 and therefore the hypothesis four (Ho4) was accepted.

Qualitative findings on views on the guidance programme Comments of respondent in the experimental group according to their views on the guidance programme

During the course of the Guidance program, in one of the activities, the participants were asked to put down in writing the following.

- i. Identify a behaviour that you would like to change
- ii. What are the risks in the behaviour that you identify?
- iii. Construct a statement of what you want to do in order to change the behaviour

(The participants were to do so, without disclosing their identity).

The participants were to report back at the end of the guidance training session.

One of the respondents had this to say:

“I would like to change the following behaviors;

- Admiring sexual intercourse –admiring of sexual intercourse may lead to forceful sexual behaviour, this may hinder a person’s ability of self-control.
- Admiring wealth before I become stable-the risky of admiring wealth is, it may lead to evil things e.g. pornography, sodomy, incest, prostitution in order to gain wealth.
- Avoid friends that or who may make me disown my goals through evil behaviour- friends or wrong models may lead a person to lack self-control hence interfere with self-dignity and self-control.
- I will abstain from any evil behaviour”

This was an indicator that some degree of attitude towards safe sex and change of risky behaviour had taken place.

Another one had this to say;

- “I would like to change the behaviour of infecting the uninfected-many people will die because of one person.
- Will counsel the infected and uninfected, one to be faithful to or use condom”

This was another indicator that the person had learned something that led him or her to change the sex attitude from a risky behaviour one to safe sex.

Another participant said;

- “having unprotected sex”-this may result to getting STDs, HIV and unwanted pregnancies”.
- “I am going to negotiate with my partner before engaging in sex. I will take time to talk before sex.

On identifying the behaviour one wants to change, one participant talked of low efficacy and that low efficacy brought about, poor focus, stress and lack of prudence and alertness.

In order to change the behaviour, the participant talked of “focusing on what God says about me and focusing on my strengths and not weaknesses. This was also an affirmation of improvement in self-efficacy and behaviour change. 70% of the participants had similar comments to make. This affirms the findings above.

The UNAIDS, (2008), argues that, the stigma associated with HIV has long undermined HIV prevention and treatment efforts. HIV-related stigma inhibits open discussion of the epidemic, and fear of discrimination or disapproval may also deter individuals from seeking the services they need. In some instances, individuals may actually avoid taking steps to protect against HIV transmission out of fear that they may be considered potentially infectious or thought to belong to a marginalized group that has been heavily affected by the epidemic. This fear may lead to continuation of risky behavior, which is lack of disclosure of one’s status, not making use of condoms and hence unsafe sex that leads to infection or re-infection with the virus.

Research suggests that as many as one in three people living with HIV-AIDS engage in unprotected intercourse subsequent to knowing that they have HIV, and that continued risky behavior often occurs with uninfected partners (Kalichman, 2000). For people living with HIV-AIDS, sexual decisions are closely linked to knowledge of a sex partner’s HIV status and disclosure of their own HIV status to sex partners (Wenger, Kusseling, Beck, & Shapiro, 1994). In their study on transactional sex among university female students in Ghana, Adjei *et al.* (2014) found out that, all the respondents concealed their relationships from “other” friends and families for fear of reprimand and stigmatization, discrimination and name calling.

It is therefore often the case that people who have HIV infection do not disclose their HIV status to their sex partners (Bayer, 1996). Schnell *et al.* (1992), for example, reported that 11% of HIV infected men do not disclose their HIV status to primary sex partners. In a study of mostly low-income Hispanic men, Marks *et al.* (1991) found that 52% had not disclosed their HIV serostatus to at least one of their sex partners. In a similar study, 24% of HIV seropositive women had not disclosed to sex partners and 13% had not disclosed being HIV infected to anyone (Simoni *et al.*, 1995). Effective HIV disclosure decision-making is therefore a difficult challenge facing most people living with HIV-AIDS, particularly within the context of their sexual relationships. Among the many factors that influence decisions to disclose one's HIV status to sex partners, self-efficacy for making effective disclosure decisions may be of particular importance. In the guidance programme, topics such as "Development of exercise of self-efficacy over life span" were covered with emphasis.

4.9 Professional Qualifications of VCT Personnel

The professional qualifications of the VCT personnel were examined through use of their education levels that is no training, certificate level, diploma level, higher diploma, and degree level.

4.9.1 Demographic Characteristics of VCT Personnel

The demographic characteristics of the VCT personnel were examined through age, gender, marital status, and professional experience. A majority of 74.1% of VCT professionals were 19 - 34 years with those who were 35 - 45 years being 25.9%. In the context, of gender the male VCT professionals were 44.4% of the respondents while the female respondents were 55.6%. In respect to marital status, 59.3% of the VCT professionals were married, and 40.7% were single. On the other hand, a majority of VCT professionals had worked for a period of 7 - 10 years (40.7%), while those who had worked for 4 - 6 years, and 3 years and below were an equal number of 29.6% each.

Table 4.17: Age Distribution of VCT Professionals

		Frequency	Percentages
Age	19 - 34 years	20	74.1%
	35 - 45 years	7	25.9%
	Total	27	100.0%
Gender	Male	12	44.4%
	Female	15	55.6%
	Total	27	100.0%
Marital Status	Married	16	59.3%
	Single	11	40.7%
	Total	27	100.0%
Professional Experience	3 Years and Below	8	29.6%
	4-6 Years	8	29.6%
	7-10 Years	11	40.7%
	Total	27	100.0%

Source: Researcher (2017)

4.9.2 Educational Qualifications of VCT Personnel

The education qualifications of the VCT professionals who worked in the health facilities where majority of the Youth living with HIV were tested was measured. The level of qualification was measured by grouping under certificate, diploma, higher diploma, degree, and no training respectively. Those who had certificate level of education were 55.6% who formed a majority of the VCT professionals in guidance and counseling, while those who had a degree level of education were the minority at 3.7%. Certificate, diploma, and higher diploma had 55.6%, 22.2%, and 7.4% respectively.

The education qualifications of the VCT professionals who had training on psychological counseling were measured by grouping under certificate, diploma, higher diploma, degree, and no training. An equal number of respondents (3.7%) had higher diploma and degree levels of education. The certificate, diploma, and no training had 51.9%, 11.1%, and 29.6% respectively. 59.3 % of The VCT professionals undertook clinical counseling had no training while 29.6% and 11.1% had diploma and certificate levels of training, respectively.

Table 4.28: Frequency Distributions of Educational Qualifications of VCT Personnel

		Frequency	Percentages
Guidance and Counselling	Certificate	15	55.6%
	Diploma	6	22.2%
	Higher Diploma	2	7.4%
	Degree	1	3.7%
	No Training	3	11.1%
	Total	27	100.0%
Psychological Counselling	Certificate	14	51.9%
	Diploma	3	11.1%
	Higher Diploma	1	3.7%
	Degree	1	3.7%
	No Training	8	29.6%
	Total	27	100.0%
Clinical Counselling	Certificate	8	29.6%
	Diploma	3	11.1%
	No Training	16	59.3%
	Total	27	100.0%

Source: Researcher (2017)

The world Health Organization (WHO) defined a lay health worker as “any health worker who performs functions related to health-care delivery; was trained in some way in the context of the intervention; but has received no formal professional or paraprofessional certificate or tertiary education degree” (WHO, 2014). According to Flynn et al.(2017), an analyses of national policies for HIV testing across 50 countries showed that 42% allowed lay providers to perform testing using rapid diagnosis tests(RDTs)(64% in African countries) and even more allowed lay providers to perform pre-and post-test counseling (56% overall and 80% in Africa).

Several countries limit these roles to trained health care providers due to concerns about lay providers ability to perform RDTs (whether finger stick blood or oral fluid) and administer HIV-testing-related services, including pre-and post-test counseling, linkage to appropriate prevention and clinical care services, and coordination with laboratory services to ensure the

delivery of correct test results (WHO, 2015). A political will ensures that health infrastructure is improved so as to provide better services such as primary care to the people. More mobile clinics would be provided to lessen the distances to health care facilities. There would also be a motivated staff that would take care of the patients and also provide voluntary counseling testing in observance to confidentiality. The findings of this study were that, a majority of the people working in VCT centres that is an average of 59.3%, were not professionally trained. This is in concord with Kalichman, (2014), who stated that Voluntary HIV Testing and Counseling is also seen as an effective way for reducing high risky behaviors. The counselling that an individual goes through in the testing process helps them to make informed decision not only for the present HIV testing but also for high risky behavior change. Individuals are informed on HIV transmission and various methods of risky reduction. This provides a self-reflection opportunity for the individuals. Knowledge of one's HIV status can be helpful in preventing spread of HIV to other sexual partners.

In their article, Kennedy *et al.* (2017) suggest a need for additional research on the effectiveness and values and preferences around using lay providers for HIV testing services (HTS). They are of the opinion that, future studies could examine the effect of tasks-shifting HTS services to lay providers on uptake of HTS, linkage to care and ART initiation, adverse events, sexual behaviour, HIV sero status disclosure, and other health and well-being outcomes. Findings from multiple settings could also help elucidate how these issues differ across diverse health systems and HIV epidemics.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter presents the summary of the major findings of the study, conclusions arrived at and the recommendations thereof based on the conclusions. The chapter further indicates suggestions for further research on the topic. This study sought to find the impact of the guidance programme in enhancing risky behaviours change amongst Youth Living with HIV/AIDS in Nakuru County, Kenya. The study has specific objectives including examination of differences amongst youths that underwent through the guidance programme compared to those who did not in relations to self-efficacy and serostatus disclosures, attitudes towards safe sex, and self-esteem levels. Additionally, the study was interested in establishing whether there was significant relationship between guidance program attitude and respondents' gender. The study also sorts to establish the level of professional qualification of the personnel who worked in the VCT centres, in terms of guidance and counseling.

5.2 Summary

The target population of this study was 76 youth living with HIV/AIDS within Nakuru County. The respondents who volunteered for the study were divided into two equal groups that is an experimental group and a control group of 38 respondents each. The response rate was therefore 100% as all the targeted YLWHA participated in the study. The respondents involved in this study were made up of 28.9% male respondents and 71.1% female respondents. As for the percentage, comparison of the two groups in the variable marital status the results showed that the difference thereof was quite minimal, that is, there was 44.7% married for the control group compared with 39.5% married in the experimental group. Under the category of the single, that is those who had never been married there was

55.3% in the control group compared to 60.5% in the experimental group .The variable; “marital status” therefore did not affect the study in a negative manner.

The age distribution results showed that the majority of the youth fell in bracket of between 19-34 years with a majority of (63.2%). This is not very far from the Kenya National Policy (2006), definition of Youth, as people aged between 15 to 30 years (GoK, 2006: 3).

The study also sought to investigate the professional qualification, demographic characteristics of personnel working in VCT centers in Nakuru County. The professional qualifications of the VCT personnel were examined through use of their education levels that is no training, certificate level, diploma level, higher diploma, and degree level. The demographic characteristics of the VCT personnel were examined through age, gender, marital status, and professional experience. A majority of VCT professionals were 19 - 34 years (74.1%) and those who were 35 - 45 years were 25.9%. In the context, of gender most of the VCT professionals (55.6%) were female. In respect to marital status, most of the VCT professionals (59.3%) were married, and 40.7% were single. Most of the VCT professionals had worked for a period of 7 - 10 years (40.7%), while those who had worked for 4 - 6 years, and 3 years and below were an equal number of 29.6% each.

5.2.1 The impact of the Guidance programme on Self-Efficacy Behaviours

The first objective was to establish the impact of the guidance programme on self-efficacy on YLWHA. The self-efficacy behaviours were examined by evaluating the perceived ability to perform various actions. These actions included effective decision to disclose HIV positive status, perception of safety in HIV positive status disclosure, safe sex practice, refuse unsafe sex in the different scenarios given in this study (Story 1 Version A, Story 1 Version B, Story 2 Version A, Story 2 Version B, Story 3 Version A, and Story 3 Version B). An independent samples t-test was carried out to see if the control group was statistically different from the

experimental group after the treatment. The test was thus done in order to accept or otherwise reject hypothesis one.

Hypothesis one, H_{01} : Stated that there is no statistically significant difference in the level of self-efficacy and serostatus disclosure between the YLWHA who undergo guidance programme compared to those who do not. The findings of this test showed that the p-value is less than the significant level of 0.05 that is ($p < 0, 05$) and therefore the null hypothesis was rejected. This difference can be attributed to the intervention thereof, which is exposure to the guidance programme since other variables were kept under control. According to Eaton and Kalichman (2009), self-efficacy refers to the self -evaluative belief held by an individual that he or she can effectively perform a specific behavior under specified conditions. The self-efficacy beliefs are critical in this study as the self-efficacy beliefs are closely associated with decisions to disclose HIV status to sex partners as well as negotiating safer sex practices amongst people living with HIV/AIDS (Tadesse & Yakob, 2015). The Guidance programme had a positive impact on raising the level of self-efficacy on YLWHA.

5.2.2 Safe Sex Behaviours and Safe Sex Attitude

Objective two was to investigate the impact of the guidance programme on the level of attitude of YLWHA towards safe sex. The concept of safe sex behaviour was examined through the use of condom in various sex acts including hetero sex (penis in vagina), anal sex (penis in anus), oral sex (tongue in vagina), and oral (penis in mouth). The levels of safe sex attitude amongst the respondents were determined by scoring the safe sex questionnaire across the four types of sex orientations.

The overriding hypothesis is that a training on the impact of HIV/AIDS and intervention measures needed, various skills on how to negotiate for safe sex and serostatus self-disclosure, among others; the identifying of common Causes of Risky behaviour; identifying

of sources of self-efficacy and strategies for improving self-efficacy; as well as identifying causes of low Self-esteem and how to build positive self-esteem, can increase self-efficacy to choose safe sex, Improve on safe sex attitudes and increase self-esteem among youth living with HIV. The changing behaviour of safe sex attitude would hence reduce risky sex behaviour. Findings from the study showed that $p < 0.05$ and therefore there was a statistically significant difference between the control and the experimental groups in relation to safe sex attitude after the intervention.

In order to affirm the results above, the further test that was carried out was a paired sample t-test to see if the experimental group's scores at pre-test were statistically different from its scores at post-test. In other words, the idea was to find out if after the intervention, their scores had improved in a statistically significant way. The results showed that p-value was less than the significant level ($p < 0.05$) and therefore there was a statistically significant difference between pre-test and post-test for the experimental group in relation to safe sex attitude. There is a notable change that could be attributed to the intervention which is the guidance programme.

The comparison of the experimental with control group post-test safe sex scores (categorised in to high and low safe sex attitude) showed that, the control group scored 81.6% on low safe sex attitude against the experimental group that scored 21.1% on low safe sex attitude. The experimental group scored 78.9% high safe sex attitude scores against the 18.4% high safe sex attitude for the control group.

In order to test hypothesis two, a t-test was performed. The results showed that p-value was less than the significant level; that is $p < 0.05$. Ho2: Stated that, "There is no statistically significant difference in the level of attitude towards safe sex between the YLWHA who undergo guidance programme compared to those who do not". Since the results showed that

$p < 0.05$, meaning that there was a statistically significant difference in the level of safe sex attitude between the control and the experimental groups at post-test, then the hypothesis (H_02) was thus rejected. This difference was attributed to the intervention thereof that is the guidance programme. The results indicate that the Guidance programme had a positive impact on enhancing positive attitude towards safe sex among youth living with HIV/AIDS.

5.2.3 Comparison of self-esteem – independent sample t-test after the intervention

Objective three sought to examine the impact of the guidance programme on the self-esteem of YLWHA. The self-esteem was examined using the Rosenberg self-esteem scores. This Rosenberg self-esteem score was measured using 10 metrics that is feelings of being a person of worth at least on an equal plane with others, feeling of possession of good qualities, inclination towards feeling of being a failure, and capacity to do things as well as most other people. Other aspects include feelings of not having much to be proud of, taking of positive attitude towards self, holistic satisfaction with one's self, wishing of having more respect towards one's self, feeling of being useless at times and sometimes thinking of not being good at all. The scale ranged from 0-30 indicating the highest score possible. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem.

Findings of this test show that 60.5% of the control group had low self-esteem compared to the 23.7% of the experimental group. The experimental group had a high self-esteem score of 76.3% compared to 39.5% of the control group. The p-value which was ($p = 0.001$) was less than the significant level of 0.05. These results showed that there was a statistically significant difference between the experimental and the control group at post-test and thus the H_03 was rejected. H_03 : stated that "There is no statistically significant difference in the level of self-esteem between the YLWHA who undergo guidance programme compared to those who do not". This difference can be attributed to the impact of the guidance programme in enhancing self-esteem.

5.2.4 Views towards Guidance Programme Attitude

The fourth objective of the study was to investigate if there were gender differences in the receptivity of the intervention. Attitude towards guidance programme was evaluated using eight metrics that is knowledge on how to manage risky behaviours, not being worried as previous in relations to the illness, knowledge on how to take care of stress, and acceptance of HIV status and readiness to disclose to a sex partner. Other items include feeling of worth compared with others, ability to do things as well as other people, feeling of having much to be proud of and having respect over self. A majority of 68.4% of the respondents strongly agreed on them having knowledge on management of risky behaviours, with only 5.3% disagreeing. Half of all the respondents that is, 50% indicated that they were not as worried as they used to be about their illness before the intervention, while only 2.6 % were still in the state of worry. On knowing how to take care of the stress, 71.1% of the respondents were able to take care of their stress compared to only 2.6 % who were completely not able to do so. Respondents who were able to accept their HIV status and not only doing so but as well as being able to disclose the status to a sex partner were 56.2% Of the total population, compared to 2.6 % who were still not able to do it. On feeling of worth and the ability to do things as well as most other people, a majority of 65.8% and 60.5% respectively responded in a positive manner. On the metrics, I feel I have much to be proud of and that I feel I have more respect for myself, respondent scored the highest that is, 71.1% and 81.6% respectively.

As noted earlier, the metrics of the guidance programme attitude was evaluated using a four scale likert scale that is Strongly Disagree, Disagree, Agree and Strongly Agree which were coded as 1, 2, 3, and 4 respectively. Scores for eight items listed above were computed for each respondent in the experimental group and the final scale was used to compare gender differences using independent samples t-test. Evidently, there are no statistically significant differences between males and female with respect to their views or attitudes towards the

guidance programme (t-test value of 0.844; p-value of 0.352 when equal variances assumed and 0.398 when Equal variances are not assumed, both of which are greater than the threshold of 0.05).

To further investigate gender differences in attitudes towards the programme, the scale was recorded into a categorical variable with two categories namely Negative Attitude and Positive Attitude and the categorized variable was subjected to a cross-tabulation with Chi-square test. From the Chi-square test, it is evident that the receptivity to the programme did not differ according to the gender of the client. The results showed that $p > 0.05$ and therefore there was no statistically significant difference in views on the guidance programme in respect to gender. The results showed that the p-value is greater than the significant level of 0.05 and therefore the hypothesis four (Ho4) was accepted.

Ho4: stated that, “There is no statistically significant relationship between Guidance programme attitude and respondents gender”. The findings showed that, despite the difference in the number of HIV infection in relation to gender, more females are affected compared to the males. There was no statistically significant difference in the guidance programme attitude in respect to the respondent’s gender.

5.2.5 Professional Qualifications of VCT Personnel

The education qualifications of the VCT professionals who worked in the health facilities where majority of the Youth living with HIV were tested was measured. The level of qualification was measured by grouping under certificate, diploma, higher diploma, degree, and no training respectively. Those who had certificate level of education were 55.6% who formed a majority of the VCT professionals in guidance and counseling, while those who had a degree level of education were the minority at 3.7%. Certificate, diploma, and higher diploma had 55.6%, 22.2%, and 7.4% respectively.

The education qualifications of the VCT professionals who had training on psychological counseling were measured by grouping under certificate, diploma, higher diploma, degree, and no training. An equal number of respondents (3.7%) had higher diploma and degree levels of education. The certificate, diploma, and no training had 51.9%, 11.1%, and 29.6% respectively. 59.3 % of The VCT professionals undertook clinical counseling had no training while 29.6% and 11.1% had diploma and certificate levels of training, respectively.

5.3 Conclusions

The study concluded that there was a statistically significant difference in the level of self-efficacy and serostatus disclosure between the YLWHA who undergo guidance programme compared to those who do not. In respect to the safe sex attitude differences, the study concluded there was statistically significant difference in the level of attitude towards safe sex between the YLWHA who undergo guidance programme compared to those who do not. The study also found that there was statistically significant difference in the level of self-esteem between the YLWHA who undergo guidance programme compared to those who do not. Finally, the study found that there were no guidance programme attitude differences amongst the gender respondents. In conclusion, all the test results showed that the guidance programme had an impact in enhancing self-efficacy and sero status disclosure, safe sex attitude and self- esteem and hence enhanced risky behaviour change among youth living with HIV/AIDS in Nakuru county Kenya.

5.4 Recommendations

The study recommended that the guidance programme used in this study should be adopted in reference to the enhancing of the self- efficacy, safe sex attitude as well as self-esteem aspects amongst the YLWHA. The study recommends that the guidance programme should also be adopted and used among other intervention programmes used in the institutions dealing with YLWHA.

5.4.1 Policy Recommendations

The study also recommends that the VCT centers be manned by professionally trained personnel to deal with matters of Guidance and Counseling.

5.4.2 Recommendations for further research

The study suggests that, for further studies, the self-efficacy should be given more contact time in the guidance programme.

A study should also be done on perception on influence of culture in female HIV infection vulnerability.

REFERENCES

- Abasiubong, F., Udoh, S. B., Idung, A. U., & Umoiyoho, A. J. (2012). Attitudes and sexual behaviours of unmarried people with HIV/AIDS living in the Niger Delta region of Nigeria. *Mental Health in Family Medicine*, 9(4), 225–232.
- Abbink, J. & Ineke, Van Kessel. 2005. *Vanguard or Vandals: Youth Politics and Conflict in Africa*. Leiden: Brill African Journal of Reproductive Health, Vol. 16 No. 4, pp. 35-46.
- Abler, L. A., Sikkema, K. J., Watt, M. H., Eaton, L. A., Choi, K. W., Kalichman, S. C., Pieterse, D. (2014). Longitudinal cohort study of depression, post-traumatic stress, and alcohol use in South African women who attend alcohol serving venues. *BMC Psychiatry*, 14(1), 224. <https://doi.org/10.1186/s12888-014-0224-9>
- Alemu, A., Shegaze, M., Gobena, T., Abraha, H., & Temesgen, G. (2015). Assessment of Substance Use and Risky Sexual Behaviour Among Public College Students in Bonga Town, Southwest Ethiopia. *American Journal of Biomedical and Life Sciences*, 3(5), 91–97. <https://doi.org/10.11648/j.ajbls.20150305.11>
- Altschuler, J., & Rhee, S. (2015). Relationship power, sexual decision making, and HIV risky among midlife and older women. *Journal of Women & Aging*, 27(4), 290–308. <https://doi.org/10.1080/08952841.2014.954499>
- Amo-Adjei, J. (2012), “Age-mixing and protected first heterosexual intercourse in Ghana”,
- Amo-Adjei, J., Kumi-Kyereme, A., & Anamaale Tuoyire, D. (2014). Transactional sex among female university students in Ghana: Implications for HIV education. *Health Education*, 114(6), 473–486. <http://doi.org/10.1108/HE-02-2014-0013>
- Arrey, A. E., Bilsen, J., Lacor, P., & Deschepper, R. (2015). “People don’t know that I’m HIV positive”: self-stigma in the lives of sub-Saharan African migrant women in Belgium. *Global Advanced Research Journal of Medicine and Medical Science (ISSN: 2315-5159) Vol, 4(3)*, 121–131.
- Arseniou, S., Arvaniti, A., & Samakouri, M. (2014). HIV infection and depression. *Psychiatry and Clinical Neurosciences*, 68(2), 96–109. <https://doi.org/10.1111/pcn.12097>
- Auerbach, J. D., Parkhurst, J. O., & Cáceres, C. F. (2011). Addressing social drivers of HIV/AIDS for the long-term response: conceptual and methodological considerations. *Global Public Health*, 6(sup3), S293–S309.
- Azim, T., Bontell, I., & Strathdee, S. A. (2015). Women, drugs and HIV. *International Journal of Drug Policy*, 26, S16–S21. <https://doi.org/10.1016/j.drugpo.2014.09.003>
- Barham, T., ... White, C. M. (2014). A systematic review of interventions for reducing HIV risky behaviors among people living with HIV in the United States, 1988–2012. *AIDS (London, England)*, 28(5), 633. <https://doi.org/10.1097/QAD.000000000000108>
- Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological Review*, 84(2), 191.

- Bandura, A. (2006). Guide for constructing self-efficacy scales. *Self-Efficacy Beliefs of Adolescents*, 5(307–337).
- Bandura, A. (2012). On the functional properties of perceived self-efficacy revisited. *Journal of Management*, 38(1), 9–44. <https://doi.org/10.1177/0149206311410606>
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood cliffs, NJ: Prentice Hall.
- Bandura, A. (1994). Social cognitive theory and exercise of control over HIV infection (pp. 25-60). In R. DiClemente & J. Peterson, *Preventing AIDS: Theories, methods, and behavioral interventions*. New York: Plenum.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.
- Bayer, R. (1996). *AIDS prevention-sexual ethics and responsibility*. *New England Journal of Medicine*, 334, 1540-1542.
- Belin, C. J. (2012). Ethnic identity, self-esteem, self-efficacy, and satisfaction with life as determinants of sex differences in achievement among Black adolescents. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, 72(8–A), 2863.
- Berhan, Y., & Berhan, A. (2015). A Meta-Analysis of Risky Sexual Behaviour among Male Youth in Developing Countries. *AIDS Research and Treatment*, 2015, 1–9.
- Boafo, I., Dagbanu, E., & Oppong, K. (2014). Dating Violence and Self-Efficacy for Delayed Sex among Adolescents in Cape Town, South Africa. *African Journal of Reproductive Health*, 18(2), 46–57.
- Bandura, A. (2013). The role of self-efficacy in goal-based motivation. *New Developments in Goal Setting and Task Performance*, 147–157.
- Baumeister, R. F. (2013). *Self-Esteem: The Puzzle of Low Self-Regard* (3rd ed.). USA: Springer Science & Business Media.
- Becker, J., & Kleinman, A. (2013). *Psychosocial Aspects of Depression*. USA: Routledge.
- Bell, S. A., & Aggleton, P. (2014). Economic vulnerability and young people's sexual relationships in rural Uganda. *Journal of Youth Studies*, 17(6), 814–828.
- Benzon, M., Denler, H., & Wolters, C. (2014). *Social cognitive theory*.
- Carey, M.P., Scott-Sheldon. *et al.* (2012) *Attitudes toward sexual partner concurrency; development and evaluation of a brief, self-report measure for field research*. *Aids and Behavior*
- Chakrapani, V., Newman, P.A, Shunmugam, M., Dubrow, R. (2010) *Prevalence and contexts of inconsistent condom use among heterosexual men and women living with HIV in India: implications for prevention*. *AIDS Patient Care STDS* 24:49–58. doi: 10.1089/apc.2009.0214.

- Chakrapani, V., Velayudham, J., Shunmugam, M., Newman, P. A., & Dubrow, R. (2014). Barriers to antiretroviral treatment access for injecting drug users living with HIV in Chennai, South India. *AIDS Care*, *26*(7), 835–841.
- Chango, J. M., McElhaney, K. B., Allen, J. P., Schad, M. M., & Marston, E. (2012). Relational stressors and depressive symptoms in late adolescence: Rejection sensitivity as a vulnerability. *Journal of Abnormal Child Psychology*, *40*(3), 369–379. <https://doi.org/10.1007/s10802-011-9570-y>
- Chersich, M. F., Luchters, S., Ntaganira, I., Gerbase, A., Lo, Y.-R., Scorgie, F., & Steen, R. (2013). Priority interventions to reduce HIV transmission in sex work settings in sub-Saharan Africa and delivery of these services. *Journal of the International AIDS Society*, *16*(1).
- Collins Dictionary. (2014, October). Collins English Dictionary (12th ed., p. 2305). UK: HarperCollins Publishers Limited.
- Colman, A. M. (2015). *A Dictionary of Psychology* (4th ed.). Oxford: Oxford University Press.
- Crepaz, N., Tungol, M. L. V., Higa, D. H., Vosburgh, H. W., Mullins, M. M., Cherie, A. (2012). Peer Pressure Is the Prime Driver of Risky Sexual Behaviors among School Adolescents in Addis Ababa, Ethiopia. *World Journal of AIDS*, *2*(3), 159–164. <https://doi.org/10.4236/wja.2012.23021>.
- Chilisa, R., Tlhabano, K., & Vista, C. (2012). Self-efficacy, Self-esteem and the Intention to Practice Safe Sex among Batswana Adolescents. *International*, *9*(2), 87–95. Retrieved from <http://iosrjournals.org/iosr-jhss/papers/Vol9-issue2/L0928795.pdf>
- Chitiga-Mabugu, M., Karuaihe, S., Reddy, V., Motala, S., Morison, T., Botsis, H., Tsoanamatsie, N. (2014). *as champions of change* (1st ed., Vol. 1). Cape Town: Human Sciences Research Council.
- Dahal, S., Pokharel, P. K., & Yadav, B. K. (2013). Sexual Behaviour and perceived risky of HIV/AIDS among returnee Labour migrants from overseas in Nepal. *Health Science Journal*, *7*(2), 218–228.
- D'Amico, S., Marano, A., Geraci, M. A., & Legge, E. (2013). Perceived self-efficacy and coping styles related to stressful critical life events. *PloS One*, *8*(7), e67571. <https://doi.org/10.1371/journal.pone.0067571>
- Dellar, R. C., Dlamini, S., & Karim, Q. A. (2015). Adolescent girls and young women: key populations for HIV epidemic control. *Journal of the International AIDS Society*, *18*(2Suppl 1).
- Du, H., Li, X., Chi, P., Zhao, J., & Zhao, G. (2015). Relational self-esteem, psychological well-being, and social support in children affected by HIV. *Journal of Health Psychology*, *20*(12), 1568–1578.
- Duby, Z., Colvin, C., & Kitungulu, B. (2011). Heterosexual anal sex: knowledge, attitudes and practice in 5 East African communities. In *1st International HIV Social Science and Humanities Conference* (pp. 11–13). South Africa.

- Dyk, A. C. V. (2010). *HIVAIDS Care and Counselling: A Multidisciplinary Approach*. South Africa: Pearson South Africa.
- Dyk, A. C. V. (2012). *HIV and AIDS Education, Care and Counselling: A Multidisciplinary Approach*. Cape Town: Pearson Education.
- Dynes, M., Stephenson, R., Rubardt, M., & Bartel, D. (2012). The influence of perceptions of community norms on current contraceptive use among men and women in Ethiopia and Kenya. *Health & Place*, 18(4), 766–773. <https://doi.org/10.1016/j.healthplace.2012.04.006>
- Doku, D. (2012). Substance use and risky sexual behaviours among sexually experienced Ghanaian youth. *BMC Public Health*, 12(1), 571. <https://doi.org/10.1186/1471-2458-12-571>
- DiClemente, R. J., & Peterson, J. L. (2013). *Preventing AIDS: Theories and Methods of Behavioral Interventions*. New York: Springer Science & Business Media.
- Ellis, A., Cutura, J., Diona, N., Gillson, I., Manuel, C., & Thongori, J. (2007). *Gender and Economic Growth in Kenya: Unleashing the Power of Women*. Washington: World Bank Publications.
- Ephraim, P. E. (2013). African youths and the dangers of social networking: a culture-centered approach to using social media. *Ethics and Information Technology*, 15(4), 275–284. <https://doi.org/10.1007/s10676-013-9333-2>
- Eaton, L. A., & Kalichman, S. C. (2009a). Changes in transmission risky behaviors across stages of HIV disease among people living with HIV. *The Journal of the Association of Nurses in AIDS Care: JANAC*, 20(1), 39–49. <https://doi.org/10.1016/j.jana.2008.10.005>.
- Eaton, L. A., & Kalichman, S. C. (2009b). Changes in Transmission Risky Behaviors Across Stages of HIV Disease among People Living with HIV/AIDS. *The Journal of the Association of Nurses in AIDS Care: JANAC*, 20(1), 39–49. <https://doi.org/10.1016/j.jana.2008.10.005>.
- Eaton, L. A., Kalichman S. C. (2009). Changes in Transmission Risky Behaviors Across Stages of HIV Disease Among People Living With HIV, 20(Issue 1.), p1-86.
- El-Bassel, N., Shaw, S. A., Dasgupta, A., & Strathdee, S. A. (2014). People who inject drugs in intimate relationships: it takes two to combat HIV. *Current HIV/AIDS Reports*, 11(1), 45–51.
- Eller, L. S., Rivero-Mendez, M., Voss, J., Chen, W. T., Chaiphibalsarisdi, P., Ipinge, S., Sullivan, K. (2014). Depressive symptoms, self-esteem, HIV symptom management self-efficacy and self-compassion in people living with HIV. *AIDS Care*, 26(7), 795–803. <https://doi.org/10.1080/09540121.2013.841842>
- Fennel, R. (2015). *Humanizing Pedagogy Through HIV and AIDS Prevention: Transforming Teacher Knowledge*. New York: Routledge.

- Flynn, D. E., Johnson, C., Sands, A., Wong, V., Figueroa, C., & Baggaley, R. (2017). Can trained lay providers perform HIV testing services? A review of national HIV testing policies. *BMC Research Notes*, 10, 2510.
- Forsyth, A.D., & Carey, M.P. (1998). *Measuring self-efficacy in the context of HIV-risky-reduction: Research challenges and recommendations*. *Health Psychology*, 17, 559-568.
- Fonner, V. A., Armstrong, K. S., Kennedy, C. E., O'Reilly, K. R., & Sweat, M. D. (2014). School based sex education and HIV prevention in low-and middle-income countries: a systematic review and meta-analysis. *PloS One*, 9(3), e89692.
- Fordham, G. (2014). *HIV/AIDS and the Social Consequences of Untamed Biomedicine: Anthropological Complicities*. Routledge.
- Fraenkel, J. R. & Wallen N. E (2007) *How to design and Evaluate Research in Education*. San Francisco: McGraw-Hill.
- Falola, T., & Heaton, M. M. (2007). *HIV/AIDS, Illness, and African Well-being*. New York: University Rochester Press.
- Fan, W., & Williams, C. M. (2010). The effects of parental involvement on students' academic self-efficacy, engagement and intrinsic motivation. *Educational Psychology*, 30(1), 53–74.
- Gillespie, S., Kadiyala, S., & Greener, R. (2007). Is poverty or wealth driving HIV transmission? *AIDS*, 21(7), S5–S16
<https://doi.org/10.1097/01.aids.0000300531.74730.72>
- Glynn, J. R., Caraël, M., Auvert, B., Kahindo, M., Chege, J., Musonda, R., ... others. (2001). Why do young women have a much higher prevalence of HIV than young men? A study in Kisumu, Kenya and Ndola, Zambia. *Aids*, 15, S51–S60.
- Gong, E. (2015). HIV testing and risky sexual behaviour. *The Economic Journal*, 125(582), 32–60. Government of Kenya. (2006). *National Youth Policy*.
- Goodman, M. L., Harrell, M. B., Gitari, S., Keiser, P. H., & Raimor-Goodman, L. A. (2016). Self-Efficacy mediates the association between partner trust and condom usage among females but not males in a Kenyan cohort of orphan and vulnerable youth. *African Journal of Reproductive Health*, 20(2), 94–103.
- Gregson, S., Garnett, G. P., Nyamukapa, C. A., Hallett, T. B., Lewis, J. J., Mason, P. R., Anderson, R. M. (2006). HIV decline associated with behavior change in eastern Zimbabwe. *Science*, 311(5761), 664–666.
- Hall, H. I., Holtgrave, D. R., & Maulsby, C. (2012). HIV transmission rates from persons living with HIV who are aware and unaware of their infection. *Aids*, 26(7), 893–896.
<https://doi.org/10.1097/QAD.0b013e328351f73f>
- Herek, G. M. (2014). HIV-related stigma.

- Horrocks, C., & Johnson, S. (2014). A socially situated approach to inform ways to improve health and wellbeing. *Sociology of Health & Illness*, 36(2), 175–186. <https://doi.org/10.1111/1467-9566.12114>.
- Hwenha, S. (2014). Laying the foundation for success. *Lessons Learnt from CSI-Funded ECD Programmes in South Africa, Tshikululu Social Investments*.
- Insight Start Study Group. (2015). Initiation of antiretroviral therapy in early asymptomatic HIV infection. *N Engl J Med*, 2015(373), 795–807.
- Iwelunmor, J., Ezeanolue, E. E., Airhihenbuwa, C. O., Obiefune, M. C., Ezeanolue, C. O., & Ogedegbe, G. G. (2014). Socio-cultural factors influencing the prevention of mother-to-child transmission of HIV in Nigeria: a synthesis of the literature. *BMC Public Health*, 14(1), 771.
- Jacoby, M. (2016). *Shame and the origins of self-esteem: A Jungian approach* (Classic). New York: Taylor & Francis.
- Jasseron, C., Mandelbrot, L., Dollfus, C., Trocmé, N., Tubiana, R., Teglas, J. P., ... Warszawski, J. (2013). Non-disclosure of a pregnant woman's HIV status to her partner is associated with non-optimal prevention of mother-to-child transmission. *AIDS and Behavior*, 17(2), 488–497.
- Jewkes, R., Fulu, E., Naved, R. T., Chirwa, E., Dunkle, K., Haardörfer, R., & Garcia-Moreno, C. (2017). Women's and men's reports of past-year prevalence of intimate partner violence and rape and women's risk factors for intimate partner violence: A multicountry cross-sectional study in Asia and the Pacific. *PLoS Medicine*, 14(9), e1002381.
- Julien, H., & Fourie, I. (2015). Reflections of affect in studies of information behavior in HIV/AIDS contexts: An exploratory quantitative content analysis. *Library & Information Science Research*, 37(1), 3–9. <https://doi.org/10.1016/j.lisr.2014.09.001>.
- Jukes, M., Simmons, S., & Bundy, D. (2008). Education and vulnerability: the role of schools in protecting young women and girls from HIV in southern Africa. *Aids*, 22, S41–S56.
- Kalichman, S. C. (2014a). *Preventing AIDS: A sourcebook for behavioral interventions*.
- Kalichman, S.C. & Nachimson, D. (1999). *Self-efficacy and disclosure of HIV positive* Psychology Press.
- Kalichman, S. C. (2014b). *Preventing Aids: A Sourcebook for Behavioral Interventions*. New York: Psychology Press.
- Kang'ethe, S. M., & Xabendlini, S. (2014). Exploring myths associated with HIV/AIDS with examples from a few countries of the world. *J Hum Ecol*, 46(1), 55–61.
- Kimanga, D. O., Ogola, S., Umuro, M., & others. (2014). Prevalence and incidence of HIV infection, trends, and risky factors among persons aged 15–64 years in Kenya: results from a nationally representative study. *Journal of Acquired Immune Deficiency Syndromes* (1999), 66(Suppl 1), S13.

- Kitui, J., Lewis, S., & Davey, G. (2013). Factors influencing place of delivery for women in Kenya: an analysis of the Kenya demographic and health survey, 2008/2009. *BMC Pregnancy and Childbirth*, 13(1), 40. <https://doi.org/10.1186/1471-2393-13-40>
- Kalichman, S.C., Rompa, D., DiFonzo, K., Simpson, D., Kyomugisha, F., Austin, J., & Luke, W. (2001). *Initial Development of Scales to Assess Self-Efficacy for Disclosing HIV Status and Negotiating Safer Sex in HIV-Positive Persons*. *AIDS & Behavior*, 5, 291-296.
- Kang'ethe, S. M., & Chikono, G. (2014). Exploring Feminization of HIV/AIDS in Zimbabwe: A Literature Review. *J Hum Ecol*, 47(2), 139–145.
- Kartikayan, S., Bharmal, R. N., Tiwari, R. P., & Bisen, P. S. (2007). *HIV and AIDS:: Basic Elements and Priorities*. Netherlands: Springer Science & Business Media.
- Kaufman, M. R., Cornish, F., Zimmerman, R. S., & Johnson, B. T. (2014). Health behavior change models for HIV prevention and AIDS care: practical recommendations for a multi-level approach. *Journal of Acquired Immune Deficiency Syndromes (1999)*, 66(Suppl 3), S250.
- Kaul, R., Cohen, C. R., Chege, D., Yi, T. J., Tharao, W., McKinnon, L. R., ... Kimani, J. (2011). Biological Factors that May Contribute to Regional and Racial Disparities in HIV Prevalence. *American Journal of Reproductive Immunology*, 65(3), 317–324. <https://doi.org/10.1111/j.1600-0897.2010.00962.x>
- Kazdin, A. E. (1992). *Research design in clinical psychology* (2nd ed.). Boston: Allyn & Bacon.
- Kenya AIDS Response Progress Report, (2014), Towards zero.
- Kenya National Bureau of Statistics. (2015). *Kenya Demographic and Health Survey 2014*. KNBS.
- Kirtley, S., & Chien, P. (2013). Women out loud: how women living with HIV will help the world end AIDS. *BJOG: An International Journal of Obstetrics and Gynaecology*, 120(5), 652. <https://doi.org/10.1111/1471-0528.12205>
- Kitui, J., Lewis, S., & Davey, G. (2013). Factors influencing place of delivery for women in Kenya: an analysis of the Kenya demographic and health survey, 2008/2009. *BMC Pregnancy and Childbirth*, 13(1), 40. <https://doi.org/10.1186/1471-2393-13-40>
- KNBS, & ICF. (2010). *Macro: Kenya Demographic and Health Survey 2008-09*. Calverton, MD: Kenya National Bureau of Statistics and ICF Macro, 430(2).
- Koga, V. R. (2011). Media framing of sexual and gender-based violence in Kenya: reporting of justice for Liz. *JOURNALISM*, 50, 67873.
- Kazdin, A. E. (1992). *Research design in clinical psychology* (2nd ed.). Boston: Allyn & Bacon.
- Kennedy, C. E., Fonner, V. A., Sweat, M. D., Okero, F.A., Baggaley, R., & O'Reilly, K. R. (2013). Provider-initiated HIV testing and counseling in low- and middle-income countries: A systematic review. *AIDS and Behavior*, 17(5), 1571-1590.

- KenyaAIDS Indicator survey. (2012). *National AIDS and STI control programme, Ministry of Health Kenya: Preliminary report (3, 12-16)*. Nairobi, Kenya.
- Kenya National Bureau of Statistics, ICF Macro (2010). *Kenya Demographic and Health Survey 2008–09*. Calverton, Maryland (USA): Kenya National Bureau of Statistics, ICF Macro.
- Government of Kenya. (2006). *National Youth Policy*.
- King, M.B. (1990) *Psychological aspects of HIV infection and AIDS- what have we learnt?British journal of psychiatry, 156, 151-156.*
- Langebeek, N., Sprenger, H. G., Gisolf, E. H., Reiss, P., Sprangers, M. A. G., Legrand, J. C., ... Nieuwkerk, P. T. (2014). A simplified combination antiretroviral therapy regimen enhances adherence, treatment satisfaction and quality of life: results of a randomized clinical trial. *HIV Medicine, 15*(5), 286–290. <https://doi.org/10.1111/hiv.12112>
- Loukid, M., Abadie, A., Henry, E., Hilali, M. K., Fugon, L., Rafif, N., ... Préau, M. (2014). Factors associated with HIV status disclosure to one’s steady sexual partner in PLHIV in Morocco. *Journal of Community Health, 39*(1), 50–59. <https://doi.org/10.1007/s10900-013-9739-0>
- Lwoga, E. T., Nagu, T., & Sife, A. S. (2017). Online information seeking behaviour among people living with HIV in selected public hospitals of Tanzania. *Journal of Systems and Information Technology, 19*(1/2), 94–115. <https://doi.org/10.1108/JSIT-06-2016-0038>
- Lera, M. (2014). Guidance Services. Retrieved from <https://www.slideshare.net/mielera/guidance-counseling-guidance-services>
- Lewis, D., & Orderson, C. (2012). Digital activism and violence against women: Changing landscapes of feminist activism in Southern Africa. *IT for Change, 60*.
- Luchters, S., Chersich, M. F., Rinyiru, A., Barasa, M.-S., King’ola, N., Mandaliya, K., Temmerman, M. (2008). Impact of five years of peer-mediated interventions on sexual behavior and sexually transmitted infections among female sex workers in Mombasa, Kenya. *BMC Public Health, 8*(1), 143. <https://doi.org/10.1186/1471-2458-8-143>
- Magadi, M. A. (2011). Understanding the gender disparity in HIV infection across countries in sub-Saharan Africa: evidence from the Demographic and Health Surveys. *Sociology of Health & Illness, 33*(4), 522–539. <https://doi.org/10.1111/j.1467-9566.2010.01304>
- Maleche, A., & Day, E. (2011). Traditional Cultural Practices and HIV: Reconciling Culture and Human rights. *Kelin Kenya*. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/TRADITIONAL-CULTURAL-PRACTICESHIV-RECONCILING-CULTURE-AND-HUMAN-RIGHTS.pdf>.
- Marube, A. M. (2011). *Impact of behaviour change campaigns on prevention of HIV AIDS in Kenya: a case study of Mpango wa Kando* (Thesis). University of Nairobi, Kenya, Nairobi, Kenya.

- Masten, J. (2010). *Aging with HIV: A Gay Mans Guide*. Oxford: Oxford University Press.
- Mefalopulos, P. (2008). *Development communication sourcebook: Broadening the boundaries of communication*. Washington: World Bank Publications.
- Moskowitz, D. A., & Seal, D. W. (2011). Self-esteem in HIV-positive and HIV-negative gay and bisexual men: implications for risky-taking behaviors with casual sex partners. *AIDS and Behavior*, *15*(3), 621–625. <https://doi.org/10.1007/s10461-010-9692-1>.
- Marks, G., Richardson, J. L., & Maldonado, N. (1991). *Self-disclosure of HIV infection to sexual partners*. *American Journal of Public Health*, *81*, 1321-1323.
- Marczyk, G. R., Deatteo, D., & Festinger, D (2005). *Essentials of research design and methodology*. John Wiley and sons Inc,111River Street, Hoboken, NJ.
- Madise, N., Zulu, E., & Ciera, J. (2017). Is poverty a driver for risky sexual behaviour? Evidence from national surveys of adolescents in four African countries. *African Journal of Reproductive Health*, *11*(3), 83–98. <https://doi.org/10.2307/25549733>.
- Mazhnaya, A., Andreeva, T. I., Samuels, S., DeHovitz, J., Salyuk, T., & McNutt, L. A. (2014). The potential for bridging: HIV status awareness and risky sexual behaviour of injection drug users who have non-injecting permanent partners in Ukraine. *Journal of the International AIDS Society*, *17*, 1–6. <https://doi.org/10.7448/IAS.17.1.18825>.
- Ministry of Health. (2017). *Kenya Aids Response Progress Report 2016*. Retrieved from nacc.or.ke/wp-content/uploads/2016/11/Kenya-AIDS-Progress-Report_web.pdf.
- Ministry of Health (2017) Retrieved from <http://nacc.or.ke/wp-content/uploads/2016/12/Kenya-HIV-County-Profiles-2016.pdf>
- Mosha, N. F., & Manda, P. (2012). “HIV/AIDS information and changing sexual behaviour among undergraduate students in Tanzania”, *Aslib Proceedins*, Vol.64 Iss 5 pp.509-518.
- MOH & ORC Macro (2006). *Uganda HIV/AIDS Serobehavioural Survey 2004-2005*, Uganda Ministry of Health and ORC Macro, Kampala and Calverton.
- Musinguzi, G., Bwayo, D., Kiwanuka, N., Coutinho, S., Mukose, A., Kabanda, J., ... Nuwaha, F. (2014). Sexual Behavior among Persons Living with HIV in Uganda: Implications for Policy and Practice. *PLoS ONE*, *9*(1), e85646. <https://doi.org/10.1371/journal.pone.0085646>
- Madise, N., Zulu, E., & Ciera, J. (2017). Is poverty a driver for risky sexual behaviour? Evidence from national surveys of adolescents in four African countries. *African Journal of Reproductive Health*, *11*(3), 83–98. <https://doi.org/10.2307/25549733>.
- McGrath, N., Eaton, J. W., Newell, M.-L., & Hosegood, V. (2015). Migration, sexual behaviour, and HIV risky: a general population cohort in rural South Africa. *The Lancet HIV*, *2*(6), e252–e259.

- Mhalu, A., Leyna, G. H., & Mmbaga, E. J. (2013). Risky behaviours among young people living with HIV attending care and treatment clinics in Dar Es Salaam, Tanzania: implications for prevention with a positive approach. *Journal of the International AIDS Society*, 16(1).
- Ministry of Health. (2017). *Kenya Aids Response Progress Report 2016*.
- Moskowitz, D. A., & Seal, D. W. (2011). Self-esteem in HIV-positive and HIV-negative gay and bisexual men: implications for risky-taking behaviors with casual sex partners. *AIDS and Behavior*, 15(3), 621–625. <https://doi.org/10.1007/s10461-010-9692-1>
- Musinguzi, G., Bwayo, D., Kiwanuka, N., Coutinho, S., Mukose, A., Kabanda, J., ... Nuwaha, F. (2014a). Sexual Behavior among Persons Living with HIV in Uganda: Implications for Policy and Practice. *PLoS ONE*, 9(1), e85646. <https://doi.org/10.1371/journal.pone.0085646>
- Musinguzi, G., Bwayo, D., Kiwanuka, N., Coutinho, S., Mukose, A., Kabanda, J., ... Nuwaha, F. (2014b). Sexual behavior among persons living with HIV in Uganda: implications for policy and practice. *PloS One*, 9(1), e85646.
- Mwanga, J. A. (2012). Hiv Sero Status Disclosure and Associated Factors Among People Living With Hiv / Aids Attending a Care and Treatment Centre in Kisarawe District Hospital , Tanzania. *Muhimbili University of Health and Allied Sciences*, (November).
- National AIDS and STD Control Programme (2006). *Preparedness for HIV/AIDS servicedelivery: The 2005 Kenya Health Workers Survey*. Nairobi: NASCOP, Ministry of Health
- National AIDS Control council (Kenya) (2012): The Kenya AIDS epidemic update, 2012: Nairobi, Kenya.
- National AIDS Control (2011) sustainable Financing of AIDS in Kenya.
- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.(1979). The Belmont Report: Ethical principles and guidelines for the protection of human subjects of research. Washington DC: U.S Government Publishing Office.
- Nattabi, B., Li, J., Thompson, S. C., Orach, C. G., Earnest, J. (2009) A systematic review of factors influencing fertility desires and intentions among people living with HIV/AIDS: implications for policy and service delivery. *AIDS Behav* 13: 949–968 [doi: 10.1007/s10461-10009-19537-y](https://doi.org/10.1007/s10461-10009-19537-y) Epub 12009 Mar 10428.
- Ncube, N. M., Akunna, J., Babatunde, F., Nyarko, A., Yatich, N. J. et al. (2012) Sexual riskybehaviour among HIV-positive persons in Kumasi, Ghana. *Ghana Med J* 46: 27–33.
- Nicholas, R. (2010). HIV prevention for young women of Uganda must now address poverty and gender inequalities. *Journal of Health Organization and Management*, 24(5), 491–497.
- Nkebukwa, A. K. (2006). "The generation and dissemination of information for HIV/AIDS prevention in rural Tanzania", PhD thesis, University of Dar es salaam, Dar es salaam.

- Nyoni, J. (2008). "Dynamics in HIV/AIDS communication intervention", MA dissertation, University of Dar es salaam, Dar es salaam.
- Ndinda, C., Chimbwete, C., McGrath, N., & Pool, R. (2008). Perceptions of anal sex in rural South Africa. *Culture, Health & Sexuality*, 10(2), 205–212.
- Noah, M. (2003). The effects of self-efficacy and locus of control on the sexual behaviors of college females. *Student Work*, (240), 66.
- Nyambura, H. (2004, February 7). Kenya: Permissive African Sexual Traditions Spread AIDS [Health]. Retrieved September 25, 2017, from <http://www.thebody.com/content/art26974.html?ts=pf>
- Nyamukapa, C. A., Gregson, S., Wambe, M., Mushore, P., Lopman, B., Mupambireyi, Z., Jukes, M. C. H. (2010). Causes and consequences of psychological distress among orphans in eastern Zimbabwe. *AIDS Care*, 22(8), 988–996. <https://doi.org/10.1080/09540121003615061>
- Naidoo, P., Chirinda, W., Mchunu, G., Swartz, S., & Anderson, J. (2015). Social and structural factors associated with vulnerability to HIV infection among young adults in South Africa. *Psychology, Health & Medicine*, 20(3), 369–379.
- Namir, S., Wolcott, D., Fawzy, F., & Alumbaugh, M. J. (2013). Implications of different strategies for coping with AIDS. In *Psychosocial Perspectives on Aids: Etiology, Prevention and Treatment*. New Jersey: Psychology Press.
- Ngure, K., Baeten, J. M., Mugo, N., Curran, K., Vusha, S., Heffron, R., ... Shell-Duncan, B. (2014). My intention was a child but I was very afraid: fertility intentions and HIV risky perceptions among HIV-serodiscordant couples experiencing pregnancy in Kenya. *AIDS Care*, 26(10), 1283–1287. <https://doi.org/10.1080/09540121.2014.911808>
- Otsola, J. K. (2012). *Baseline Survey Report on Gender Based Violence in Kasarani, Nairobi* (Baseline Survey) (p. 76). Nairobi, Kenya: Kenya Women and Children's Wellness Centre. Retrieved from <http://kwcwc.org/docs/GBVReport2.pdf>
- Pallant, J. F. (2011). *SPSS Survival Manual: a step by step guide to data analysis using SPSS* (4th ed.). Crows Nest, NSW: Allen & Unwin.
- Parsons, T. D., Braaten, A. J., Hall, C. D., Robertson, K. R., Better quality of life with neuropsychological improvement of HAART. *Health and Quality of Life Outcomes*. 2006; 4:11. [PubMed: 16504114].
- Patel, S., Schechter, M. T., Sewankambo, N. K., Atim, S., Lakor, S., Kiwanuka, N., & Spittal, P. M. (2014). War and HIV: sex and gender differences in risky behaviour among young men and women in post-conflict Gulu District, Northern Uganda. *Global Public Health*, 9(3), 325–341.
- Paula, Á. D., Shapira, G., & Todd, P. E. (2014). How beliefs about HIV status affect risky behaviors: Evidence from Malawi. *Journal of Applied Econometrics*, 29(6), 944–964.

- Phillips, A. N., Cambiano, V., Nakagawa, F., Brown, A. E., Lampe, F., Rodger, A., ... Johnson, A. M. (2013). Increased HIV incidence in men who have sex with men despite high levels of ART-induced viral suppression: analysis of an extensively documented epidemic. *PloS One*, *8*(2), e55312.
- Platt, L., Jolley, E., Rhodes, T., Hope, V., Latypov, A., Reynolds, L., & Wilson, D. (2013). Factors mediating HIV risky among female sex workers in Europe: a systematic review and ecological analysis. *BMJ Open*, *3*(7), e002836.
- Padian, N. S., Buvé, A., Balkus, J., Serwadda, D., & Cates, W. (2008). Biomedical interventions to prevent HIV infection: evidence, challenges, and way forward. *The Lancet*, *372*(9638), 585–599. [https://doi.org/10.1016/S0140-6736\(08\)60885-5](https://doi.org/10.1016/S0140-6736(08)60885-5)
- Ramirez, L. M. (2014). *Guidance & counseling: Guidance Services*. Education, USA.
- Ramiro, M. T., Teva, I., Bermúdez, M. P., & Buéla-Casal, G. (2013). Social support, self-esteem and depression: Relationship with risky for sexually transmitted infections/HIV transmission. *International Journal of Clinical and Health Psychology*, *13*(3), 181–188.
- Rodkjaer, L., Chesney, M. A., Lomborg, K., Ostergaard, L., Laursen, T., & Sodemann, M. (2014). HIV-infected individuals with high coping self-efficacy are less likely to report depressive symptoms: a cross-sectional study from Denmark. *International Journal of Infectious Diseases*, *22*, 67–72.
- Rosenberg, M. (1965) *Society and adolescent self-image*. Princeton, NJ; Princeton University Press.
- Sahu, S. (2015). Gender and Power: Women’s Vulnerability to HIV/AIDS in India. *Journal of Health Management*, *17*(4), 495–509. <https://doi.org/10.1177/0972063415606323>
- Sarna, A., Luchters, S., Musenge, E., Okal, J., Chersich, M., Tun, W., ... Kalibala, S. (2013). Effectiveness of a community-based positive prevention intervention for people living with HIV who are not receiving antiretroviral treatment: a prospective cohort study. *Global Health: Science and Practice*, *1*(1), 52–67.
- Schadé, A., van Grootheest, G., & Smit, J. H. (2013). HIV-infected mental health patients: characteristics and comparison with HIV-infected patients from the general population and non-infected mental health patients. *Bmc Psychiatry*, *13*(1), 35. <https://doi.org/10.1186/1471-244X-13-35>.
- Shelby, R. D., Aronstein, D. M., & Thompson, B. J. (2014). *HIV and Social Work: A Practitioner’s Guide*. New York: Routledge.
- Smith, A. D., Muhaari, A. D., Agwanda, C., Kowuor, D., Van Der Elst, E., Davies, A., Sanders, E. J. (2015). Heterosexual behaviours among men who sell sex to men in coastal Kenya. *AIDS (London, England)*, *29*(0 3), S201.
- Sofolahan-Oladeinde, Y., & Airhihenbuwa, C. O. (2014). “He Doesn’t Love Me Less. He Loves Me More”: Perceptions of Women Living With HIV/AIDS of Partner Support in Childbearing Decision-Making. *Health Care for Women International*, *35*(7–9), 937–953.

- Sue, D., Sue, D. W., Sue, S., & Sue, D. M. (2012). *Understanding Abnormal Behavior* (10th ed.). USA: Cengage Learning.
- Sarna, A., Luchters, S., Pickett, M., Chersich, M., Okal, J. *et al.* (2012) *Sexual behavior of HIV-positive adults not accessing HIV treatment in Mombasa, Kenya: Defining their prevention needs. AIDS Res Ther* 9: 1742–6405.
- Savaş, A. C., Bozgeyik, Y., & Eser, İ. (2014). A Study on the Relationship between Teacher Self Efficacy and Burnout. *European Journal of Educational Research*, 3(4), 159–166.
- Schnell, D., Higgins, D., Wilson, R., Goldbaum, G., Cohn, D., & Wolitski, R. (1992). *Men's disclosure of HIV test results to male primary sex partners. American Journal of Public Health*, 82, 1675-1676.
- Sekaran, U. (2003). Towards a guide for novice research on research methodology: Review and proposed methods. *Journal of Cases of Information Technology*, 8(4), 24–35.
- Shirish, T. S. (2012). *Research Methodology in Education*. Lulu Publications.
- Simoni, J., Mason, H., Marks, G., Ruiz, M., Reed, D., & Richardson, J. (1995). *Women's self-disclosure of HIV infection: Rates, reasons, and reactions. Journal of Consulting and Clinical Psychology*, 63, 474-478.
- Sue, D., Sue, D.W. & Sue, S. (2000). *Understanding abnormal behavior* (6th Ed.). Boston: Houghton Mifflin.
- Schwarzer, R. (2014). *Self-Efficacy: Thought Control Of Action*. New York: Taylor & Francis.
- Sheer, V. C. (2014). A meta-synthesis of health-related self-efficacy instrumentation: Problems and suggestions. *Journal of Nursing Measurement*, 22(1), 77.
- Shelby, R. D., Aronstein, D. M., & Thompson, B. J. (2014). *HIV and Social Work: A Practitioner's Guide*. New York: Routledge.
- Simoni, J. M., Huang, B., Goodry, E. J., & Montoya, H. D. (2006). Social support and depressive symptomatology among HIV-positive women: The mediating role of self-esteem and mastery. *Women & Health*, 42(4), 1–15.
- Singhal, A., & Rogers, E. (2012). *Entertainment-Education: A Communication Strategy for Social Change*. New York: Routledge.
- Smith, M. K. (2002). Gender, poverty, and intergenerational vulnerability to HIV/AIDS. *Gender & Development*, 10(3), 63–70. <https://doi.org/10.1080/13552070215914>
- Stadler, J. J., Delany, S., & Mntambo, M. (2007). Sexual coercion and sexual desire: ambivalent meanings of heterosexual anal sex in Soweto, South Africa. *AIDS Care*, 19(10), 1189–1193.
- Tadesse, G., & Yakob, B. (2015). Risky sexual behaviors among female youth in Tiss Abay, a semi-urban area of the Amhara Region, Ethiopia. *PLoS ONE*, 10(3), 1–16. <https://doi.org/10.1371/journal.pone.0119050>

- Tura, G., Alemseged, F., & Dejene, S. (2012). Risky Sexual Behavior and Predisposing Factors among Students of Jimma University, Ethiopia. *Ethiopian Journal of Health Sciences*, 22(3), 170–80. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3511895&tool=pmcentrez&rendertype=abstract>
- Tumukunde, D., Nuwaha, F., Ekirapa, E., Kityo, C., Ssali, F. *et al.* (2010) *Sexual behaviour among persons living with HIV/AIDS in Kampala, Uganda. East Afr Med J* 87: 91–99. doi: 10.4314/eamj.v87i3.62194
- UNAIDS, U. (2015). All in to end adolescent AIDS. Geneva: Joint United Nations Programme on HIV/AIDS & United Nations Children's Fund.
- UNAIDS (2010). *Outlook Breaking News: Young People Are Leading the HIV Prevention Revolution*. Geneva: Joint United Nations Programme on HIV/AIDS.
- UNAIDS (joint United Nations Programme on HIV/AIDS). (1999), *AIDS Epidemic Update*, UNAIDS, New York, NY.
- UNAIDS (2013), *Efficient and sustainable HIV Responses*. Case study on country progress.
- United Nations (2007). "World Youth Report 2007: Young People's Transition to Adulthood: Progress and Challenges." New York: United States
- Van Dyk, A. (2001). HIV/AIDS Care and counseling (2nd Ed) –Pearson Education South Africa Hanli Venter.
- Van Andel, T., de Korte, S., Koopmans, D., Behari-Ramdass, J., & Ruyschaert, S. (2008). Dry sex in Suriname. *Journal of Ethnopharmacology*, 116(1), 84–88. <https://doi.org/10.1016/j.jep.2007.11.003>.
- Wandera, B., Kanya, M. R, Castelnuovo, B., Kiragga, A., Kambugu, A. *et al.* (2011). *Sexual behaviors over a 3-year period among individuals with advanced HIV/AIDS receiving antiretroviral therapy in an urban HIV clinic in Kampala, Uganda. J Acquir Immune Defic Syndr* 57: 62–68. doi: 10.1097/QAI.1090-b1013e318211b318213f318212.
- Watson, D., Weber, K. Assenheimer, J. S., Clark, L. A Strauss, M. E. & McCormic, R.A.(1995). Testing a tripartite model; 1. Evaluating the convergent and discriminant validity of anxiety and depression symptoms scale. *Journal of Abnormal psychology*, 104, 3-14.
- Weinhardt, L. HIV diagnosis and risky behavior. In: Kalichman SC, editor. *Positive Prevention: Reducing HIV Transmission among People Living with HIV/AIDS*. Springer Science; New York: 2005. pp. 29–60.
- Wenger, N., Kusseling, F., Beck, K., & Shapiro, M. (1994). *Sexual behavior of individual infected with human immunodeficiency virus. Archives of Internal Medicine*, 154, 1849-1854.
- WHO. (2014). *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task-shifting*.
- WHO. (2015). *Consolidated guidelines on HIV testing services*.

- WHO (2006). Preventing HIV/AIDS in Young People: A Systematic Review of Evidence, World Health Organization technical report series, WHO, Geneva, p. 938.
- WHO/UNAIDS/UNICEF(2013). *Global update on HIV treatment 2013; June 2013.* www.unaids.org/.../HowAIDSchanged... Joint United Nations Programme on HIV/AIDS GLOBAL STATISTICS www.unaids.org/www.unesco.org/education/uie/pdf/Kawewa.pdf UNAIDS. *How AIDS Changed Everything*; 2015. UNAIDS. *2015 Epidemiological slides – How AIDS Changed Everything report*; 2015. www.slideshare.net/mielera/guidance-services-downloaded-2016-07-28
- Wachira, J., Naanyu, V., Genberg, B., Ndege, S., Siika, A. M., Kimayo, S., ... Braitstein, P. (2014). Perceived health facility barriers to HIV linkage and retention in western Kenya. *BMC Infectious Diseases, 14*(2), P30.
- Wamoyi, J., Stobeanau, K., Bobrova, N., Abramsky, T., & Watts, C. (2016). Transactional sex and risky for HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. *Journal of the International AIDS Society, 19*(1). <https://doi.org/10.7448/IAS.19.1.20992>.
- WHO. (2012). *Guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: recommendations for a public health approach.* Switzerland: World Health Organization.
- WHO.(2014). Violence against women. Retrieved March 22, 2017, from http://www.who.int/topics/gender_based_violence/en/.
- WHO, & UNAIDS.(2009). *AIDS Epidemic Update: December 2009.* Geneva: WHO Regional Office Europe.
- Wingood, G. M., DiClemente, R. J., Mikhail, I., McCree, D. H., Davies, S. L., Hardin, J. W., Saag, M.(2007). HIV discrimination and the health of women living with HIV. *Women & Health, 46*(2-3), 99–112. https://doi.org/10.1300/J013v46n02_07
- Wira, C. R., & Fahey, J. V.(2008). A new strategy to understand how HIV infects women: identification of a window of vulnerability during the menstrual cycle. *AIDS (London, England), 22*(15), 1909.

APPENDICES

AppendixI: Letter of Introduction

I am a student at Kabarak University and I am conducting a study on Guidance programme among Youth Living with HIV/AIDS. The main Objective of the study is to find out the Impact of the programme. You are requested to fill in some questionnaire and answer some interview questions. Both your responses and participation will be very helpful for the success of this study. Your identity will not be disclosed under any circumstances whatsoever. Please take some time, at least one hour to complete the questionnaire as faithfully as possible.

Thank you

R.G. KARIUKI

GDE/M/0828/09/14

Appendix II: The Risky Behavior Scale

This questionnaire has four sections **A, B, C and D**. Fill in all the sections. The contents of this questionnaire are absolutely confidential. Your identity will not be disclosed under any circumstances. Your responses will be very helpful for the success of this study. Please take some time to complete it as faithfully as possible.

Section A.

1. Please indicate your age by putting a tick in to the applicable box below.

Age;

- | | | |
|--------------|---|-----|
| 15- 18 years | | [] |
| 19-34 years | ` | [] |
| 35-45 years | ` | [] |

Please indicate your gender by putting a tick in the appropriate box below.

- | | | |
|---------|--------|-----|
| Gender; | Male | [] |
| | Female | [] |

2. Please indicate your marital status by putting a tick in the appropriate box below.

- | | | |
|-----------------|-----------|-----|
| Marital status; | Married | [] |
| | Single | [] |
| | Divorced | [] |
| | Separated | [] |
| | Widow | [] |
| | Widower | [] |

Section B: Self-Efficacy Scales (HIV Serostatus Disclosure and Safer Sex)

Please read the following stories; 1A,B. 2A,B and 3A,B and answer the questions 1, 2, 3, and 4 by putting a (tick) in the appropriate box.

Please read story 1 version A and answer the questions 1, 2, 3, and 4 by putting a (tick) in the appropriate box.

1. Story 1 Version A

This week has been difficult for you and you want to forget all of your problems for a while. You go out walking and meet up with some people you know. You go off with them and have a drink to relax. Even though you haven't had much to drink you feel it affecting you. One of your friends introduces you to someone you have seen before and felt attracted to in the past. This person seems to be making it clear that they want to have sex with you. You feel interested.

1. How confident are you that you could make an effective decision of whether to tell this person you are HIV positive in this situation?

Cannot do at all []

Somewhat certain can do []

Certain can do []

2. How confident are you that you could know whether it was safe to tell this person in this situation that you are HIV positive?

Not well at all []

Somewhat well []

Very well []

3. How confident are you that you could bring up the need to practice safer sex in this situation?

Cannot do at all []

Somewhat certain can do []

Certain can do []

4. How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe?

Cannot do at all []

Somewhat certain can do []

Certain can do []

Please read story 1 version B and answer the questions 1, 2, 3, and 4 by putting a (tick) in the appropriate box.

2. Story 1 Version B

Just like in the previous story, imagine that this week has been difficult for you and you want to forget all of your problems. You go out walking and meet up with some people you know. You go off with them and have a few drinks. You get to feeling pretty buzzed when one of your friends introduces you to someone you have been attracted to in the past. This person seems to be making it clear that they want to have sex with you. You feel like you are a little drunk. You also feel interested in being with them.

1. How confident are you that you could make an effective decision of whether to tell this person you are HIV positive in this situation?

Cannot do at all []

Somewhat certain can do []

Certain can do []

2. How confident are you that you could know whether it was safe to tell this person in this situation that you are HIV positive?

Not well at all []

Somewhat well []

Very well []

3. How confident are you that you could bring up the need to practice safer sex in this situation?

Cannot do at all []

Somewhat certain can do []

Certain can do []

4. How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe?

Cannot do at all []

Somewhat certain can do []

Certain can do []

Please read story 2 version A and answer the questions 1, 2, 3, and 4 by putting a (tick) in the appropriate box.

3. Story 2 Version A

As in the previous story, imagine that you have had a difficult week. You have been feeling lonely and you realize that it has been some time since you had sex with anyone. You decide to go out and meet some friends to get something to eat. While out, you meet a person that you have seen around and think is attractive. They seem interested in you and seem to be flirting with you. Soon it becomes clear that they want to have sex with you.

1. How confident are you that you could make an effective decision of whether to tell this person you are HIV positive in this situation?

Cannot do at all []

Somewhat certain can do []

Certain can do []

2. How confident are you that you could know whether it was safe to tell this person in this situation that you are HIV positive?

Not well at all []

Somewhat well []

Very well []

3. How confident are you that you could bring up the need to practice safer sex in this situation?

Cannot do at all []

Somewhat certain can do []

Certain can do []

4. How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe?

Cannot do at all []

Somewhat certain can do []

Certain can do []

Please read story 2 version B and answer the questions 1, 2, 3, and 4 by putting a (tick) in the appropriate box.

4. Story 2 Version B

As in the previous story, imagine that you have been feeling lonely and depressed. You realize that it has been a long time since you were intimate with someone. While you are out you meet a person that you have seen around and think is attractive. They seem interested in you and you want to be with this person.

1. How confident are you that you could make an effective decision of whether to tell this person you are HIV positive in this situation?

Cannot do at all []

Somewhat certain can do []

Certain can do []

2. How confident are you that you could know whether it was safe to tell this person in this situation that you are HIV positive?

Not well at all []

Somewhat well []

Very well []

3. How confident are you that you could bring up the need to practice safer sex in this situation?

Cannot do at all []

Somewhat certain can do []

Certain can do []

4. How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe?

Cannot do at all []

Somewhat certain can do []

Certain can do []

Please read story 3 version A and answer the questions 1, 2, 3, and 4 by putting a (tick) in the appropriate box.

5. Story 3 Version A

While out with some friends and having fun, you unexpectedly run into an ex-partner from your past. You had sex with this person many times long before you became HIV positive. They start telling you how much they missed being with you and that they think of you often. Then they say that they are not currently partnered. You are feeling good and the mood seems right for the two of you to get together. Because you still like this person and have feelings for them you want to be with this person.

1. How confident are you that you could make an effective decision of whether to tell this person you are HIV positive in this situation?

Cannot do at all []

Somewhat certain can do []

Certain can do []

2. How confident are you that you could know whether it was safe to tell this person in this situation that you are HIV positive?

Not well at all []

Somewhat well []

Very well []

3. How confident are you that you could bring up the need to practice safer sex in this situation?

Cannot do at all []

Somewhat certain can do []

Certain can do []

4. How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe?

Cannot do at all []

Somewhat certain can do []

Certain can do []

Please read story 3 version B and answer the questions 1, 2, 3, and 4 by putting a (tick) in the appropriate box.

6. Story 3 Version B

Imagine that you had been in a relationship with someone who just left you and ended it. You unexpectedly run into an ex-partner from your past who is visiting in town. You had sex with this person many times long before you became HIV positive. After telling you how much they missed being with you and that they think of you often, this person asks you to come to their hotel room. You are feeling really good, the mood seems right, and you want to have sex with this person.

1. How confident are you that you could make an effective decision of whether to tell this person you are HIV positive in this situation?

Cannot do at all []

Somewhat certain can do []

Certain can do []

2. How confident are you that you could know whether it was safe to tell this person in this situation that you are HIV positive?

Not well at all

Somewhat well

Very well

3. How confident are you that you could bring up the need to practice safer sex in this situation?

Cannot do at all

Somewhat certain can do

Certain can do

4. How confident are you that you would refuse to have unsafe sex in this situation even if your partner pressures you to be unsafe?

Cannot do at all

Somewhat certain can do

Certain can do

Section C: Safe Sex Attitude Questionnaire

This questionnaire has two part one and part two.

PART ONE: QUESTIONNAIRE ON SEX BEHAVIOUR FOR LAST TWO MONTHS

Please respond by putting a tick in the appropriate box

1. How many times have you had hetero sex (penis in the vagina) without a condom in the last two months?

None 1 2 3 4 5 over 5

2 How many times have you had anal sex (penis in the Anus) without a condom in the last two months?

None 1 2 3 4 5 over 5

3 How many times have you had oral sex (tongue in the vagina) without a condom in the last two months?

None [] 1 [] 2 [] 3 [] 4 [] 5 [] over 5 []

4 How many times have you had oral sex (penis in the mouth) without a condom in the last two months?

None [] 1 [] 2 [] 3 [] 4 [] 5 [] over 5 []

Part TWO: Safe Sex Attitude Questionnaire

Please respond to the following statements according to your feelings now, about your Safe sex behavior by ticking where appropriate. Strongly Agree (SA), Agree (A), Disagree (D) Strongly Disagree (SD).

	Item	SA	A	D	SD
1	Most sex partners i meet only engage in safer sex practices				
2	I have trouble letting a sex partner know that I want to have safer sex				
3	I am able to avoid behavior that may put me at risk of HIV infection HIV infection.				
4	I can choose safer sex with a man/woman I have sex with regularly				
5	I find it difficult to have safer sex with a man/woman I have very strong sexual feelings for.				
6	I find it difficult to have safer sex when i am under the influence of drug /alcohol				
7	I am less concerned about having anal sex without a condom now that new anti-HIV drug combination treatments are available				
8	I never lose sight of what I consider safer sex, no matter what I am feeling				

9	I feel confident that I will never slip from safer sex				
10	Someone can talk me out of safer sex by persuading me they are HIV-negative				
11	If I ever did something risky, I am confident that I would go back to having safer sex right away				
12	I find it difficult telling a sex partner not to do something I think is risky				
13	I can avoid situations that I consider sexually risky				
14	I am confident that I can have safer sex even if my partner really doesn't want to				
15	I find it difficult telling a sex partner I won't have anal intercourse without a condom				
16	I find it difficult telling a sex partner I won't have oral sex without a condom				
17	I can choose safer sex with a man/woman I have never had sex with before				
18	By taking the new drug combinations, an HIV-positive man decreases the chances that he will infect his partner with HIV				
19	By taking the new drug combinations, an HIV-positive woman decreases the chances that she will infect her partner with HIV				
20	I can use condoms with any sexual partner I might have				

Section D: Self-Esteem Inventory

Below is a list of statements dealing with your general feelings about yourself. If you **Strongly Agree**, circle **SA**. If you **Agree** with the statement, circle **A**. If you **Disagree**, circle **D**. If you **Strongly Disagree**, circle **SD**.

	Item	Strongly Agree	Agree	Disagree	Strongly Disagree
1	I feel that I'm a person of worth, at least on an equal plane with others.	SA	A	D	SD
2	I feel that I have a number of good qualities.	SA	A	D	SD
3	All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
4	I am able to do things as well as most other people.	SA	A	D	SD
5	I feel I do not have much to be proud of.	SA	A	D	SD
6	I take a positive attitude toward myself.	SA	A	D	SD
7	On the whole, I am satisfied with myself.	SA	A	D	SD
8	I wish I could have more respect for myself.	SA	A	D	SD
9	I certainly feel useless at times.	SA	A	D	SD
10	At times I think I am no good at all.	SA	A	D	SD

Section E: Interview Schedule For Guidance Programme Evaluation

Introduction

Your response in this interview will be treated with total confidentiality. Please answer the following questions as truthfully as you can.

Part 1

1. What did you learn from the guidance programme?

.....
.....
.....
.....
.....

2. What topics did you like most?

.....
.....
.....
.....
.....

3. What are your intentions about risky sex behavior in future?

.....
.....
.....
.....

Part 2

Please respond to the following statements according to your Intentions now, about your Risky behavior by ticking where appropriate. Strongly Agree (SA), Agree (A), Disagree (D) and Strongly Disagree (SD).

		SA	A	D	SD
1	I know how to manage my risky behavior now				
2	I am not as worried as I used to be about my illness				
3	I now know how to take care of my stress				
4	I now accept my HIV status and i am ready to disclose to a sex partner				
5	I feel that I am of worth, compared with others				
6	I am able to do things as well as most other people				
7	I feel I have much to be proud of				
8	I feel I have more respect for myself				

Section F:A questionnaire to find out the counseling professional level of personnel working in Voluntary Counseling and Testing centers

1. Please indicate your age by putting a tick in to the applicable box below.

Age;

19-34 years []

35-45 years []

Above 45 years []

2. Please indicate your gender by putting a tick in the appropriate box below.

Gender; Male []

Female []

3. Please indicate your marital status by putting a tick in the appropriate box below.

Marital status;

Married

Single

Divorced

Separated

Widow

Widower

4. Please indicate your Highest Professional level of training by putting a tick in the appropriate box below.

5. Type of training and the level thereof

1. Guidance and counseling

Certificate level

Diploma level

Higher Diploma

Degree level

Master's degree

Doctorate

No training

5. Psychological counselling

Certificate level

Diploma level

Higher Diploma

Degree level

Master's degree

Doctorate []

No training []

6. Clinical counseling

Certificate level []

Diploma level []

Higher Diploma []

Degree level []

Master's degree []

Doctorate []

No training []

7. Please indicate your Experience in the Professional practice in the field of guidance/
counselling by putting a tick in the appropriate box below.

3 years and below []

4-6 years []

7-10 years []

11-13years []

Above 14 years []

Appendix: III: The Content and Process of the Guidance Programme

Introduction

Guidance programme - is an organized programme offered for research purpose that focuses on specific HIV/AIDS information, self-esteem, self-efficacy and Effective risky reduction behavior programmes.

Duration of the programme

The programme will take three months of four weeks each; with a two hours session of training in each week. The learners will spend one hour per week in the duration of the training where he /she will be expected to practice some of the skills learned (as a practicum) and keep a record thereof. The whole programme will thus cover a total of Thirty six hours of training.

Objectives

By the end of the training programme the learner should be able to:

- discuss the impact of HIV/AIDS and intervention measures needed
- discuss various skills on how to negotiate for safe sex and serostatus self-disclosure
- identify common Causes of risky behaviour
- identify sources of self-efficacy and strategies for improving self-efficacy
- identify causes of low Self-esteem and how to build positive self-esteem

Contents

Week one, and two

The impact of HIV/AIDS and intervention measures

- *The HIV virus, mutation the different strains and hybrid virus*

Participants will learn how the virus attacks the defense cells in the body and how it mutates forming difference strains and high breed virus that may be even resistant to the anti-ritual viral drugs.

- *Risky behaviors and viral load*

Engaging in risk behaviours may cause one to have a high breed virus and hence re-infection. Different high breed viruses may cause a new type of strain that could also be resistant to drugs.

- *HIV co-infection*

When people living with HIV Virus engage in unprotected sex they get co-infection a state that lead to a faster development of AIDS.

The impact of HIV/AIDS and intervention measures
HIV (human immunodeficiency virus) is the virus that causes aids (acquired immunodeficiency Syndrome).

The virus has been found in most body fluids of an infected person. These fluids are; Blood, Semen, Vaginal secretion and Breast Milk.

The Virus can also be found in Unsterilized equipment such as needles , body tattooing instruments , knives , razor blades and the like.

Only body fluids with a comparatively high concentration of virus may cause infection.

The Virus can also be found in unsterilized equipment such as needles, knives, tattooing instruments, razor blades and such like.

TYPES OF HIV

There are Two types,:

- HIV- 1 and
- HIV-2.

Both types are transmitted by sexual contact, through blood, and from mother to child and they appear to cause clinically indistinguishable AIDS.

However it seems that HIV- 2 is less easily transmitted and the period between initial infection and illness is longer in the case of HIV-2.

Sub-Types of HIV

How many subtypes of HIV are there?

The strains of HIV-1 can be classified into Four groups: the “Major” group **M**, the outlier group **O** and two new groups , **N** and **P**.

Within group M there are known to be at least nine genetically distinct subtypes (or clades) of HIV-1. These are subtypes A, B, C, D, F, G, H, J, and K Occasionally , two viruses of different subtypes can meet in the cell of an infected person and mix together their genetic material to create a new hybrid virus.

Subtype C is predominant in Southern and East Africa, India and Nepal. It has caused the world’s worst HIV epidemics and is responsible for around half of all infections. Some Strains develop AIDS sooner than others and the patients die sooner if they do not receive antiretroviral treatment.

Effects of HIV Virus on the Body Immune System

HIV virus directly attacks the most important defensive cells of the human immune system the CD4 cells or the T-Helper cell.

Opportunistic infections can only overwhelm the body once the number of CD4 cells has become radically depleted.

When HIV virus hijacks the CD4 cells , it turns it into an efficient virus factory to manufacture more viruses.

The new viruses move out into the blood stream or surrounding tissue to infect more cells- and repeat the whole process again (thus the CD4 cells decrease while the viral load increases).

When the CD 4 cells decrease in the body it causes the viral load to go higher meaning the body's resistance becomes weaker and thus the patient may develop AIDS faster.

Mutation and the Different Strains

Mutation- is a change of a plant or animal that causes it to become different from others of its kind.

HIV is highly variable virus which mutates very readily

. This means there are many different strains of HIV, even within the body of a single infected person.

Because of this mutation, the body cannot defend itself against its enemy because it's enemy is constantly changing its identity.

Is it possible to be infected more than once?

“Many cases of people co infected with two or more Strains have been documented. It is thought Super infection” is occurring. In these cases, the second infection occurred several months after the first.

It would appear that the body’s immune response to the first virus is sometimes not enough to prevent infection with a second strain, especially with a virus belonging to a different subtype.

Week three and four (Group Discussions and Plenary Feed Back)

- Various skills on how to negotiate for safe sex and Serostatus self- disclosure

Participants will discuss in groups on how to negotiate for safe sex and Serostatus self-disclosure.

-Tips on safe sex

-Negotiation skills about using condoms

Week four and five

- identify common Causes of Risky behaviour
 - Theories and models of behaviour change
 - Hints on change of behavior

Risky Behaviour and Viral Load

Activity

In the activities on risky behaviour, the participants are asked to work individually and do the exercise below. They are not supposed to disclose their identity as they hand in their work to the facilitator. The activities are:

- Identify a behaviour that you would like to change.(each participant is expected to identify a Risky behaviour that he/she would like to change)

- What are the risks involved in the behaviour that you identified? Participants are expected to identify the risks in the behaviour and record them)
- Construct a statement of what you want to do to change the behaviour. This is the strategies the participant will engage in so as to change the so said behaviour.
- What are the obstacles you experience or you would experience if you attempted to change the behaviour. (These are anticipated obstacles in the course of trying to change the behaviour)
- What benefits will you accrue if you succeeded in changing the behaviour? These will be achieved as a result of changing the behaviour.

Hints on Change of Behaviour

You are likely to change your behaviour if you:

- Realize the need for behaviour change
- Know exactly what specific behaviour needs to be changed and how to go about changing it.
 - Have the intension to commitment to perform the behaviour
 - Have positive attitude toward the behaviour that you want to change
 - Have the support of friends in changing the behaviour
 - Have a strong believe (high self-efficacy) in your ability to perform the specific required behaviour.
 - Know exactly how to perform the behaviour effectively.
 - Perceive that many more benefits and rewards will accrue from the new behaviour.
 - Have the necessary skills to perform and maintain the behaviour (the communication, negotiation and problem solving skills).

Week six, and seven eight nine ten and eleven,

Strategies that help improve Self-esteem

- *Causes of Self-esteem (low and high Self-esteem)*
- *Four main strategies that help improve Self- esteem*

The Four Main Strategies that help Improve Self-Esteem

Researchers have found that four main strategies help to improve Self-esteem:

- i. Identifying the cause of Self-esteem
- ii. Experiencing emotional support and approval
- iii. Achieving
- iv. Coping

Tips to Fight Low Self-esteem Issues

- i. Always avoid negative situations.
- ii. Try to get into a company of positive people.
- iii. Use a journal to record the positive things happening around you.
- iv. Always have *positive thinking*
- v. Do not hesitate to seek help in difficult times
- vi. Seek professional assistance to deal with serious problems.

Guidance Information (Emphasis on Self-Efficacy And Self-Esteem)

Self-esteem and self-efficacy

People have a sense of self, which can be either positive or negative, based on one's experiences in life and perceptions and assessment of self. However, the problem is that our perception of ourselves is often distorted, and it is not always accurate.

This perception can be distorted by previous experiences. For instance, a person growing up in a perfectionistic family, may view himself/ herself as always falling short of the expectations of the family. This affects the person in such a way that, despite the fact that he/she might be successful, he or she will always view herself/himself as a failure.

A child who is constantly rebuked by his/her sibling may come to believe the labels thereof. Unfortunately, people who believe certain labels will often live up, or live down, to those labels. The labels can create a self-fulfilling prophecy of expectation of the self.

Self-Concept (What Is Self-Concept?)

Self-concept is a factual description of how one perceives the self. If One's perception of self is distorted, this description may not be an accurate depiction of the self, but it IS an accurate statement of what one believes about the self.

The self-concept is derived from self-esteem and self-efficacy. If a person has low self-esteem, the self-concept may be skewed in the direction of a negative description. If a person has high self-esteem, the self-concept may be skewed in the direction of a positive description. Some aspects of the self-concept may be purely statements of fact such as "I have no wealth, or I am not as good as other people" "evaluation of whether it is good or bad.

People with a good self-esteem and self-efficacy are often able to recognize their limitations without a judgment attached. For instance, "I don't have any education" can be just a statement of fact without feeling good or bad about it.

Self Esteem

(What self-esteem means).

Self-esteem means self-worth. This means that one has a good opinion of self ,a person with self-admiration and possible feelings regarding the self is said to have a high self-esteem.

Low self-esteem is the negative feeling of the self.

Self-Efficacy (Meaning Of Self Efficacy)

Self-efficacy refers to a person's belief in his/her ability to accomplish some specific goal or task.

Self-efficiency corresponds to the level of complete.

An individual feels. however competence can vary from one situation to another. For instance a person might feel quite capable completing in games but may not feel competent in debates. This means then .as a result, overall self-efficacy may not be completely accurate as it is assessing an individual's general feeling of competence across a variety of situations or tasks.

Characteristics of Low-Self Esteem

The following are characteristics of low-self-esteem.

1. Feeling of Unhappiness

When a person has a low self-esteem, he/she feels of satisfaction and contentment with life. For some people, low self-esteem may contribute to depression and even inability to function in life. there are however people who derive their happiness from other sources such as spiritual beliefs and may thus not find their degree of happiness impacted by the self-esteem.

2. Feelings of Anxiety

Quite number of people with low-esteem experience anxiety and more so. Social anxiety frequently, this is a consequence of the social evaluative aspect of self-esteem. In other words, people tend to evaluate their self based upon comparison to other people. Many other people are concerned about others' evaluating them and assume that others will see the same flaws and incompetence's that they see within themselves. Such a concern leads to a feeling of anxiety.

3. Feeling of Inferiority or Superiority

Most people who have low self-esteem feel inferior to others. They have the belief that they do not measure up to some standards that others meet. They feel that they are not as good as others. In addition, they feel that some flaw within them means that they are not worthwhile or deserving. This flaw is not overt but rather something magnified by the person with low self-esteem due to past experiences. For example, a person who was labeled as careless during her childhood will believe so even though his/her behavior as viewed by others may be quite careful and orderly.

There are other people with low-esteem who may present an air of superiority. This may be a way of covering how they truly feel about themselves, or individuals who have low-esteem but are perfectionists due to their concern about what others may think of them, may appear to others as thinking themselves superior. However, not all feelings of superiority are due to low-esteem. There is another category of people who actually feel they are superior to others, intellectually, financially or spiritually. One can distinguish them in that people who have low-esteem and feelings of superiority will often have other characteristics of low-esteem such as happiness or anxiety.

4. Impatient With Self or Others

Most people who have low self-esteem have a tendency to be impatient or easily irritated by mistakes, plus or inadequacies. In most cases, this behavior is directed at self but it can as well be directed at other people.

5. Externally Oriented Goals

Another characteristic of people who have low self-esteem is to determine goals and direction in life based upon what others might want or need. They do not feel that their needs or desires are of importance. Such kind of an attitude can lead to resentment due to always taking care of others while their own needs are not addressed.

6. Negativity

Individuals who have low self-esteem are negative with no appreciative attitude toward life. This negativity may not always be externally observed but internal self-talk thereof is negative. Other behaviors include that are observable include criticizing the one self, excessively apologizing or commenting about negative observations that may be noticed by other people. Generally people tend to avoid individuals who are excessively negative which can reinforce the low self-esteem.

Characteristics of High Self Esteem

There are two types of self esteem

- An artificially inflated self esteem
- Genuine self esteem

An artificially inflated self-esteem is one where someone tries to appear to have high self-esteem. Such individuals who do so lack the following characteristics of people with high self-esteem; responsibility, goal commitment, genuineness forgiving, having internal values positivity and self-improvement

People with high self-esteem have the following characteristics in abundance and consistency

i. Responsibility

People with high self-esteem can accept themselves completely and since they can do so they are able to take responsibility for themselves and the consequences of their actions without being excessively critical of themselves

ii. Goal Commitment

People with high self-esteem have a strong sense of purpose and have commitment to life goals.

High self-esteem individuals tend to be persistent in achieving life goals as their commitment does not fluctuate based on success or failure. They are active participants who also do not tend to strive for perfection but for excellence

iii. Genuineness

Since high esteemed people know others and are not fearful of them, they tend to be genuine in interaction with others they can be honest with themselves both emotionally and intellectually.

iv. Forgiving

High self-esteem tends to correspond with tolerance and acceptance of limitations. As a result, people who have high self-esteem are forgiving of themselves and others.

v. Internal values.

Individuals with high self-esteem tend to have internally-based values rather than externally-based values. In other words, they have a strong identity based on chosen values rather than values they believe due to the demands or expectations of others.

This type of identity is usually considered an "achieved identity" in which a person has analysed their beliefs and values to decide the set of internal principles or values that they will adhere to.

vi. **Positivity.**

People with high self-esteem are positive with an appreciative and grateful attitude towards life. They can freely praise themselves and others and tend to look for the positive aspects of life and not dwell on the negative.

vii. **Self-improvement.**

Generally, there is a strong tendency to strive towards self-improvement among those with high self-esteem. As they don't view the need for self-improvement as a negative quality they are able to examine themselves uncritically. In addition, they can ask for help as needed because they don't view the need for help as shameful or negative.

What are the Characteristics of low Self-Efficacy?

i. **Fear of risks.**

Individuals with low self-efficacy see themselves as unable to be successful. This makes them often unwilling to take risks or try new things because they are convinced that the result will be a failure. It should be noted that one way of increasing self-efficacy is through practice and experience hence this is unfortunate for such a people who cannot attempt risky taking.

ii. **Fear of uncertainty.**

Low self-efficacy often is related to self-doubt and uncertainty. An individual with low self-efficacy does not want to try anything without a guarantee of success. As a result, they may never discover things at which they could be successful.

iii. **Feelings of failure.**

Those with low self-efficacy frequently have feelings of failure. In many occasions they might avoid or not try new things due to the risky involved thereof. On the other hand, they might only try something half-heartedly. This results to being less likely to experience success and more likely to see themselves as a failure.

iv. Impression management.

Impression management is the attempt to control how others might perceive you in order to be seen more positively. People with low self-efficacy feel they are not capable but may try to present a successful and competent image to others. They may put a great deal of energy into behaving in a way to obtain approval from others and experience a great deal of worry about being found out to be a fraud. For instance, they may try to hide wrong doing from others rather than learn from them which in turns them from increasing their sense of self-efficacy.

The Characteristics of High Self-Efficacy

➤ **Self-confidence.**

One of the most obvious characteristics of high self-efficacy is self-confidence. People with high self-efficacy approach tasks or situations with a sense of their ability to be successful. This self-confidence tends to lead to more experience which increases their ability which leads to greater self-confidence. This positive cycle lends itself to increasing self-efficacy even further.

➤ **Accurate self-evaluation.**

Individuals with high self-efficacy are neither overly-critical nor overly positive but are able to examine themselves realistically in order to pursue self-improvement. They tend to be able to accurately evaluate their performance.

➤ **Willingness to take risks.**

Those with high self-efficacy are willing to take risks because they understand that taking calculated risks increases the chances of success. As they are not fearful of failure or mistakes, reasonable risks can only increase self-efficacy.

➤ **Sense of accomplishment**

Generally people with high self-efficacy feel a sense of an entire fulfilment because they are often more successful due to the willingness to take risky and to pursue interests. Even if they fail or make mistakes they feel a sense of accomplishment because they view mistakes positively; they view them as opportunities to improve themselves.

How Can Someone Have A Good Sense Of Self-Efficacy But Low Self-Esteem?

Self-efficacy and self-esteem are similar concepts but they are not the same thing. They do tend to correspond so that a person who is low in one is more likely to be low in the other. But it is also possible to have low self-esteem and yet have high self-efficacy. This combination is common with perfectionists.

Therefore, someone may tend to be overly-critical and negative about himself/herself and yet see himself/herself as quite capable in certain areas. For instance, he might see himself/herself as uninteresting and unlikeable but see himself as a competent artist. This occurs frequently with perfectionists because they are often competent at tasks with clear guidelines but feel uncertain in situations without clear "rules" such as relationships.

How Can Self-Esteem Be Improved?

i. Eliminate negative self-talk.

First and foremost, people with low self-esteem need to eliminate harmful self-talk. The negative labels and frequent self-criticism can only cause further damage. Eliminating negative self-talk doesn't mean you can't recognize and address problems, but it means to be careful about how you talk to yourself and to not be self-destructive.

ii. Recognize strengths.

Those with low self-esteem tend to focus on their weaknesses rather than focusing on their strengths sometimes claiming that there isn't anything positive they can say about themselves. That is unlikely to be true. It is important to pay attention to strengths and to appreciate the strengths no matter how small they may seem. Once you recognize the strengths you need to reinforce the strengths through frequent focus on them. If possible keep a note of whatever achievement you have made however small.

iii. Recognize self-worth.

It is important to recognize that you are a unique human being and have worth. Recognize that you deserve to take care of yourself and set limits. You deserve respect and to be treated well. Again, you need to frequently reinforce this idea by continuing to focus on your self-worth. Focus on the positive side of self and avoid as much as possible the negative.

iv. Accept mistakes.

Recognize that mistakes and flaws are part of the human condition. They don't make you less than others. Instead, you are like everyone else. You have flaws and you make mistakes. The more actively you are involved in life, the more mistakes you will make. But being actively involved allows you more opportunity for success as well. Accept yourself—flaws and all.

v. Accept rejection

Remember that not everybody will like you or even talk good of you. The more you can believe that everyone doesn't have to like you, the less you need to feel bad or be ashamed of your imperfections. No one can be liked by everyone! It is an impossible task. However, the person with low self-esteem often feels a failure

if someone is disapproving or rejecting. Instead, congratulate yourself if someone doesn't like you because you are being a genuine person. You are unique and there is no one else like you in the whole world.

How to Improve Self-Efficacy

i. Develop skill set.

The most important way to improve self-efficacy is to develop the skill set you need to be effective. If you are having trouble being successful in your work, identify your areas of deficit and determine what you need to do to improve. Ask others to honestly evaluate your skills and to give specific advice regarding improvement. Once you know what you need to do, then you need to do a lot of practice in it trying to perfect it until you feel competent. That's how competence develops. People aren't born with competence; they have to learn and practice in order to become competent. You should always tell yourself “ I can make it”

ii. Modelling

Observing others and learning from them is one way to learn the necessary skills. You can observe successful completion of tasks to learn how to achieve success. When you observe others being rewarded for their performance or successful completion of a task, you are more likely to be able to model yourself after their behaviour.

iii. Focus on specifics

To improve self-efficacy, it is best to focus on specifics. If someone gives you general feedback especially if it is negative you are less able to make changes than if someone can provide specific feedback. For instance, if you want a child to learn how to wash clothes, don't say “These clothes aren't clean,” instead you say “Let me show you how to wash clothes and put them on the line.”

iv. **Reinforcement.**

The more behaviour is reinforced, the more likely it will continue. If you want to improve your self-efficacy focus on what you do well and reinforce it by giving yourself specific praise.

Don't Mistake Positive Thinking For Changing Thinking.

A common error that people make when trying to increase self-esteem or self-efficacy is what we call the "Saturday Night Live" phenomenon. Most people are acquainted with Al Franken's rendition of Stuart Smalley's self-improvement statements: "I'm good enough, I'm smart enough, and doggone it, people like me!"

The problem with this type of positive thinking is that it is not believable, therefore it cannot change the self-esteem. My challenge as a therapist working with people with low self-esteem is to develop believable statements. Otherwise my clients are likely to respond with "You're just saying that because you are my therapist." If I make a statement that is believable they are more likely to accept it and use it. And, very simply, a believable statement is one that is true.

So the challenge for you in improving your self-esteem is to develop believable statements. Telling yourself "I'm wonderful in every way" is not likely to help. However, you are more likely to change self-esteem if you are able to identify particular strengths such as "I'm a person who is willing to learn about myself and make improvements" or "I have courage because I am facing something that is very difficult for me" or "I am persistent. Even though happiness has eluded me I keep trying."

Notice with these statements there are specifics attached to them. They are not general and overly positive. Instead, the statements are realistic with specific reasons why they are true.

To change self-esteem, it is necessary to create these types of statements. So, how is this done?

Steps to Create Believable Statements

- i. **Write a negative statement you use to describe yourself.** Try to be as fully descriptive as possible with the statement.
- ii. **Identify what is true and what is false about the statement.** People will often have difficulty with this step because they don't fully expand the statement. As a result the statement may appear to be true on the surface when it is actually false.
- iii. Such statements are false because they are implying more than what is actually being stated. So, for example, if you write "I'm fat" you might argue "That statement is true. According to the standards of obesity, I am fat." However, more is being implied by the statement. If this statement affects how you feel about yourself, then your full statement is probably something like "I'm fat and I'm undesirable because I'm fat" or "I'm fat which means I'm weak-willed" or "I'm fat and worthless."

As you can see, when the full statement is written out, then it is possible to identify what is true or false about the statement. For example, many people are fat and yet are still desirable. In fact, when I ask people "Have you ever known an overweight woman who is so confident and engaging that she attracts men like flies to honey?" most people respond "Yes, I have." Therefore, we have just demonstrated that being fat doesn't in and of itself cause a person to not be desirable so the idea that being fat makes you undesirable is false. However, the belief that you are not desirable because you are fat is likely to cause you to be undesirable because that belief affects how you relate to others.

- iv. **Re-write your statement using facts.** Once you have determine what is false, leave that part out of your statement and add in what is true. Also, it is best to not use

negative labels because of what they imply. Instead of using the word "fat" use "overweight" or instead of "stupid" use "lack knowledge." Instead of saying "I'm fat (and all that implies)" you can say "I may be overweight but I present myself well." Or, "I might lack knowledge about that subject but I'm still an intelligent person."

- v. **Evaluate the statement.** A well-written statement should be something with which you can agree or believe, and yet, it makes you feel good about yourself. Once you have evaluated the statement you can use it as an affirmation to help improve your feelings about yourself. The more frequently you use the affirmation, the more quickly you will come to see yourself that way. And the more believable the affirmation, the more likely you are to use it.

Week eight and nine,

=Sources of Self-efficacy

-Efficacy activated process

Week ten and eleven,

-Adaptive Benefits of optimistic self-belief of efficacy

-Development of exercise of self-efficacy over the life span

Week twelve, *Revision and gathering of field reports*

Methodology --Participatory, lecture and discussion methods will be used in the training.

During the participatory approach, the participants share personal experiences, self-disclosure and ask questions in topics that need clarification.

Lectures are given by the facilitator using power point but the participants are allowed to seek clarifications as well as respond when asked to.

During the discussions, the participants are given topics by the facilitator to discuss in groups and then report in plenary. Other participants may seek clarification, give suggestions or share personal experiences with the group.

-Practicum will be carried out in the field as an assignment

Evaluation

Evaluation will be done by the use of the questionnaire and the interview schedule used for the study.

Appendix IV: The Consent Form for Interview of Minors

(The under eighteen years)

I am a student at Kabarak University and I am conducting a study on Guidance programme among Youth Living with HIV/AIDS. The main Objective of the study is to find out the Impact of the programme. Your child has been identified as one of the participants.

You are humbly requested to allow him/her to participate in the study by filling in some questionnaire and answer some interview questions. The responses and participation will be very helpful for the success of this study. His/her identity will not be disclosed under any circumstances whatsoever.

Yours:

Reuben Gathii Kariuki

Please Fill in the spaces below.

I.....ID. No.do hereby allow my child-Name(.....) to participate in the study exercise.

Signature.....

Date.....

Appendix V: Authorization to Proceed with Field Research by the Institute of Post Graduate Studies and Research



INSTITUTE OF POST GRADUATE STUDIES AND RESEARCH

Private Bag - 20157
KABARAK, KENYA
E-mail: directorpostgraduate@kabarak.ac.ke

Tel: 0773265999
Fax: 254-51-343012
www.kabarak.ac.ke

9th August, 2016

Ministry of Education, Science and Technology,
National Commission for Science, Technology and Innovation,
9th Floor, Utalii House,
P.O. Box 30623 – 00100,
NAIROBI.

Dear Sir/Madam,

RE: RESEARCH BY GDE/M/0828/9/14– REUBEN GATHII KARIUKI

The above named is a Doctoral student at Kabarak University in the School of Education. He is carrying out research entitled “The Impact of Guidance Programme in Enhancing Risk Behaviour Change Among Youth Living with HIV/AIDS in Nakuru County, Kenya”

The information obtained in the course of this research will be used for academic purposes only and will be treated with utmost confidentiality.

Please provide the necessary assistance.

Thank you.

Yours faithfully,

Dr. Betty Tikoko
DIRECTOR POST GRADUATE STUDIES & RESEARCH



Kabarak University Moral Code

As members of Kabarak University family, we purpose at all times and in all places, to set apart in one's heart, Jesus as Lord. (1 Peter 3:15)

Appendix VI: Research Authorization Permit



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471,
2241349,3310571,2219420
Fax:+254-20-318245,318249
Email:dg@nacosti.go.ke
Website: www.nacosti.go.ke
when replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref. No.

Date:

NACOSTI/P/16/73219/13184

26th August, 2016

Reuben Gathii Kariuki
Kabarak University
Private Bag - 20157
KABARAK.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on *“The impact of guidance programme in enhancing risk behaviour change among youth living with HIV/AIDS in Nakuru County Kenya”* I am pleased to inform you that you have been authorized to undertake research in **Nakuru County** for the period ending **26th August, 2017**.

You are advised to report to **the County Commissioner and the County Director of Education, Nakuru County** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.


BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Nakuru County.

The County Director of Education
Nakuru County.

THIS IS TO CERTIFY THAT: Permit No : **NACOSTI/P/16/73219/13184**

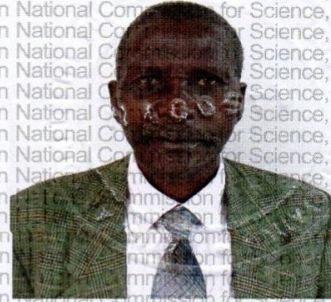
MR. REUBEN GATHII KARIUKI Date Of Issue : **26th August, 2016**

of KABARAK UNIVERSITY, 47-20114 Fee Received : **Ksh 2000**

Kabazi, has been permitted to conduct research in Nakuru County

on the topic: THE IMPACT OF GUIDANCE PROGRAMME IN ENHANCING RISK BEHAVIOUR CHANGE AMONG YOUTH LIVING WITH HIV/AIDS IN NAKURU COUNTY KENYA

for the period ending: 26th August 2017



Applicant's Signature

**Director General
National Commission for Science,
Technology & Innovation**

CONDITIONS

- 1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.**
- 2. Government Officer will not be interviewed without prior appointment.**
- 3. No questionnaire will be used unless it has been approved.**
- 4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.**
- 5. You are required to submit at least two(2) hard copies and one (1) soft copy of your final report.**
- 6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice**



REPUBLIC OF KENYA



**National Commission for Science,
Technology and Innovation**

**RESEACH CLEARANCE
PERMIT**

Serial No. A11791

CONDITIONS: see back page

Appendix VII: Letter of Research Authorization from the County Commissioner
Nakuru County



OFFICE OF THE PRESIDENT
MINISTRY OF INTERIOR AND
CO-ORDINATION OF NATIONAL GOVERNMENT

Telegrams: "DISTRICTER", Nakuru
Telephone: Nakuru 051-2212515
When replying please quote

COUNTY COMMISSIONER
NAKURU COUNTY
P.O. BOX 81
NAKURU

Ref. No. **CC.SR.EDU 12/1/2 VOL.II/54**

5th September, 2016

The Deputy County Commissioner,
NAKURU TOWN WEST SUB-COUNTY.

RE: RESEARCH AUTHORIZATION - REUBEN GATHII KARIUKI

The above named student has been given permission to carryout research on ***"The impact of guidance programme in enhancing risk behavior change among youth living with HIV/AIDS in Nakuru County"*** for the period ending 26th August 2017.

Kindly give him all the necessary support to facilitate the success of his research.

ANGELA MAKAU
FOR: COUNTY COMMISSIONER
NAKURU COUNTY

Appendix VIII: Letter from County Director of Education Nakuru County

MINISTRY OF EDUCATION
State Department of Basic Education

Telegrams: "EDUCATION",
Telephone: 051-2216917
Fax: 051-2217308
Email: cdenakurucounty@yahoo.com
When replying please quote
Ref. NO. CDE/NKU/GEN//4/1/21/VOL.
IV/106



COUNTY DIRECTOR OF EDUCATION
NAKURU COUNTY
P. O. BOX 259,
NAKURU.

5TH SEPTEMBER, 2016

TO WHOM IT MAY CONCERN

RE: RESEARCH AUTHORIZATION – REUBEN GATHII KARIUKI
PERMIT NO.NACOSTI/P/16/73219/13184

Reference is made to Permit No. NACOSTI/P/16/73219/13184 dated 26th August, 2016.

Authority is hereby granted to the above named to carry out research on ***“The impact of guidance programme in enhancing risk behavior change among youth living with HIV/AIDS in Nakuru County Kenya”*** for a period ending **26th August, 2017.**

Kindly accord him the necessary assistance.

A handwritten signature in blue ink, appearing to read 'Mutula'.

CYPRIAN MUTULA
FOR: COUNTY DIRECTOR OF EDUCATION
NAKURU COUNTY.

Copy to:

Kabarak University
Private Bag - 20157
KABARAK.

Appendix IX: Conference Presentation



KABARAK UNIVERSITY

Certificate of Participation

This is to certify that

Reuben Gathii Kariuki

Successfully Presented a paper titled
*“Coping Training Programme an Alternative Strategy
for Lowering Depression Level in Persons Living with
Hiv/Aids in Nakuru North District, Kenya”*

in the 5th Annual Kabarak International Research Conference
held on 14th – 17th July 2015

Conference Theme

*Research, Innovation For Sustainable Development and a Secure
World*

A handwritten signature in black ink, appearing to be 'J. D. K.', written over a horizontal line.

**Registrar
(Academic & Research)**

A handwritten signature in black ink, appearing to be 'K. K. K.', written over a horizontal line.

**Deputy Vice Chancellor
(Academic & Research)**



KABARAK UNIVERSITY

Certificate of Participation

Awarded to

Reuben Gathii Kariuki


for participating in the 7th Annual Kabarak University
International Research Conference on 5th and 6th
October 2017

Title of Paper


*“Relationship between attitude towards guidance program and
gender: An experimental study among youth living with HIV/AIDS in
Nakuru County, Kenya.”*

Conference Theme

*Research, Innovation and Knowledge Translation for Community
Transformation*



Registrar
(Academic & Research)



Deputy Vice Chancellor
(Academic & Research)

MARA RESEARCH JOURNAL OF HUMANITIES & SOCIAL SCIENCES

ISSN: 2519-1491

Certificate of Publication

This is to certify that the paper entitled "**The Impact of Guidance Programme in Enhancing Self-Esteem for Risk Behaviour Change among Youth Living with HIV/AIDS in Nakuru County, Kenya**" submitted by the author(s)

Reuben G. Kariuki, James M. Muola, & Dr. Bernard Chemwei

has been published with details as follows:

Kariuki, R.G., Muola, J.M., and Chemwei, B. (2017). The Impact of Guidance Programme in Enhancing Self-Esteem for Risk Behaviour Change among Youth Living with HIV/AIDS in Nakuru County, Kenya. *Mara res. j. humanities soc. sci.* Vol. 2, No. 2, Pages 57 - 66, ISSN: 2519-1489

November 18, 2017



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"We believe in equal opportunities, the strength of cultural diversity, full participation in all aspects of society, and education & research as a means of bridging cultures."

MARA RESEARCH JOURNAL OF HUMANITIES & SOCIAL SCIENCES

ISSN: 2519-1491

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Reuben G. Kariuki, James M. Muola, & Dr. Bernard Chemwel

has been published with details as follows:

Kariuki, R.G., Muola, J.M., and Chemwel, B. (2017). The Impact of Guidance Programme in Enhancing Self-Efficacy among Youth Living with HIV/AIDS in Nakuru County, Kenya. *Mara res. j. humanities soc. sci.* Vol. 2, No. 2, Pages 34 - 48, ISSN: 2519-1489.

October 27, 2017



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Prof. Kefa Rabah, PhD MBA; Editor-in-Chief



"We believe in equal opportunities, the strength of cultural diversity, full participation in all aspects of society, and education & research as a means of bridging cultures."

Appendix XI: Nakuru County Map

