CHAPTER ONE

>

> 1.1 BACKGROUND TO THE PROBLEM

> Acquired Immune Deficiency Syndrome is a human condition

affecting many people in all countries worldwide. It is the most

devastating known pandemic particularly in developing countries

where many Governments have declared it an emergency (World

Health Organization December 1, 2008 in the people daily).

According to Masiaga 2003, India is leading the world in absolute

Members of HIV infection, estimated at three to five million.

>

> Around half of all people who become infected with HIV do so

before they are 25 years and die of AIDS before they are 35 years.

The rate of new infections has gone down in several countries

but this trend has so far been particularly offset by increase in

new infections in other countries (UNAIDS 2008).

>

> According to International Conference on HIV/AIDS and

Sexually Transmitted Infections in Africa (ICASA) 2000, it was

reported that Sub-Saharan Africa is currently the worst affected

region by HIV in the world with a population of twenty two million

or two thirds(2/3) of the Worlds Aids infections. More than six

thousand, five hundred (6,500) people die everyday in Sub-

Saharan Africa due to HIV/AIDS (WHO 2007).

>

> According to Uganda Aids Commission (September 2003), the

fight against HIV started before 1986. More so Uganda was the

first Government in the continent to recognize the danger of HIV

to national development. As such in July 1998, with the help from

Family Planning International Assistance, the Friends of Children

Association (FOCA, a programme of Planned Parenthood

Federation of America), initiated the Adolescent Reproductive

Health Project for street youth under the age of 20years in

Kampala, Uganda. The project provided sex education and

contraceptive services to help street youths avoid unintended

pregnancy, unsafe abortion and STIs including HIV AIDS.

>

> In Kenya the first HIV/AIDS case was reported in the year 1984.

The youths face severe threats to their health and general

wellbeing. It is estimated that twenty percent (20%) of all reported

AIDS patients are young people aged 15-24 years (Chilimba S

Hawavhwa 2007). The emerging and unattended youth’s health

concerns, is a challenge attributed to lack of access to needed

Reproductive Health Information and Services, perceived hostility

of the service providers who at any rate lack the appropriate

skills to deal with Adolescents Reproductive Health Problems.

Thus the majority of adolescents hesitate to use the existing

health services. In 1999, a partnership between family health

international, the international centre of Reproductive Health, and

the Kenyan Ministry of Health established nine VCT centers in

Mombasa . One VCT centre was in a Youth Counseling Centre

(YCC) where trained youths offered voluntary counseling and

testing and young nurses provided STI treatment (Family Health

International 2000). The Youth Counseling Centre offered rapid

testing for HIV, providing results within fifteen minutes. These

centers attracted the youths because each offered a library,

sports opportunities, general leisure activities and a drama

group.

>

> In efforts to address the youth’s health needs, the Government

of Kenya developed a National Adolescents Reproductive Health

and Development Policy in 2003. One of the strategic actions for

the Youths health was to establish and promote Youth Friendly

Voluntary Counseling and Testing (YVCT) sites and link them to

appropriate services.

>

> Youth Friendly Services refers to a broad based health and

related services provided to young people to meet their individual

health needs in a manner and environment to attract interest and

Sustain their motivation to utilize such services. The WHO

describes Youth friendly services variably as “Services that is

accessible, acceptable and appropriate for adolescents. They are

in the right place, at the right price (free where necessary) and

delivered in the right style to be acceptable to young people. They

are effective, safe and affordable. They meet the individual health

needs of young people who return when they need to and

recommend these services to friends.”

> 1.2 STATEMENT OF THE PROBLEM

> Youth friendly centers have existed from the year 2004. This

was as a result of a recommendation of the Adolescents

Reproductive Health and Development Policy in 2003. The

purpose of the policy was to address the sexual and reproductive

health concerns among the youths. Such health concerns include

sexually transmitted infections including HIV/AIDS.

>

> Youth friendly centers are ideal for management of STIs and

HIV/AIDS among the youths. These centers do have objectives

they endeavor to meet for the well being of the youths. Such

objectives include peer education, nutritional awareness,

screening, prevention and treatment of STIs as well as provision

of youth friendly voluntary counseling and testing services

(YVCTs). All these objectives are focused to the management of

HIV/AIDS among the youths. This is geared towards improving

the heath status of the youths and helping them stay healthy to

complete their journey to adulthood.

> However the realization of the above stated objectives remains

largely unevaluated. More so youth centers have disparities in

geographical areas and they seem to thrive well in some areas

incomparisson to others (save the children Canada 2005).

>

> Previously services offered to the young people have been

fragmented and varied as the youths were referred from one

institution to another. The youth’s health services had not been

put together collectively in a health faculty and therefore the

youths tended to receive mixed messages as a result of referrals

from one health institution to another. The personnel in the

existing faculties tended not to devote time to attend to youth’s

concerns as they attend to more urgent health complications

(Adolescents Reproductive Health and Development Policy

2003). It is through the youth friendly centers that it has been

possible to initiate a package of health facilities to address the

individual youth health needs. After putting together the youth’s

health services in the youth centers through the ‘one stop’

approach, it’s an issue of intellectual challenge whether these

centers have realized the objectives for which they were initiated.

>

> There is generally lack of information as to what impacts the

youth friendly centers have on the management of HIV/AIDS

among the youths. This study therefore sought to evaluate the

role that Lokiriama Youth friendly center have played towards

management of HIV/Aids among the youths.

>

>

> 1.3 OBJECTIVES OF THE STUDY

> GENERAL OBJECTIVE

> To determine the role played by lokiriama Youth Friendly Centre in

management of HIV/AIDS among the youths.

> SPECIFIC OBJECTIVES

> 1. To find out whether nutritional education is a role played by

the Youth Friendly Centre in management of HIV/AIDS among

the youths.

> 2. To establish whether peer education assist in management

of HIV/AIDS among the young people

> 3. To investigate the effect of counseling and testing service in

management of HIV/AIDS among the youths

>

> 1.4 RESEARCH QUESTIONS

> 1. Is nutritional education a role played by the Youth Friendly

centre in management of HIV/Aids?

> 2. Does peer education assist in management of HIV/AIDS?

> 3. Do counseling and testing assist in management of

HIV/AIDS?

>

> 1.5 JUSTIFICATION OF THE STUDY

> Adolescents and youths are generally believed to be healthy

because death rates for this age group are lower than for children

or for the elderly people (National Population Policy for

Sustainable Development 2000). However death rates are an

extreme measure of health status and tell only part of the story.

There are many interrelated reasons why we should pay attention

to the heath of adolescents. It is due to this situation that the

government adopted the Adolescents Reproductive Health and

Development Policy and the establishment of Youth centers in

2003 and 2004 respectively.

>

> Although the overall burden of disease may be lower among

the youths compared to children and the adult population, there

specific conditions that are much more common and have life

long devastating effects on this age group if not addressed.

These include sexual and reproductive health problems such as

early and unwanted pregnancies, unsafe abortions, STIs

including HIV/AIDS, vulnerability to outdated harmful cultural

practices among other health complications. It’s due to this that

Youth Friendly Centers came up.

> Despite the existence of Youth friendly centers from the year

2004 in Provincial and District hospitals, the health concerns for

the youths have not been addressed as expected. The impact of

these centers on the management of HIV/AIDS among the

youths has been largely unevaluated, thus necessitating the need

of the study. There is need for research to determine whether the

YFCs have realized the objectives for which they were initiated.

>

> The study will therefore be of benefit to the centers as it will

enable the management teams to know the drawbacks and

limitations to achieving their objectives and determine the

possible mechanisms to addressing them.

>

> The findings of the study will outline the significance of the

YFCs towards addressing the health concerns among the youths.

Therefore this will act as the basis for establishment of more

youth friendly centers in the country through the support of NGOs

such as USAID, Save the children Canada and private investors

interested in the plight of youth’s health.

>

> In addition the study will be of benefit to the Government as it

budgets and funds the YFCs thus ensuring an equitable,

significant pace of development towards the achievement of

Millennium Development Goals (MDGs).

>

> 1.6 OPERATIONAL DEFINITION OF TERMS AND CONCEPTS

> 1.6.1 Nutritional Education

> The researcher operationalized nutritional education to mean

the knowledge that a health and balanced nutrition play an

important role in delaying the rate of progression of HIV to full

blown AIDS by suppressing the HIV virus. Nutrition intervention

improves the immune system, the effectiveness of medication,

helps recovery from opportunistic infections and prologues life. It

is convention wisdom that food is medicine for a person living

with HIV.

> 1.6.2 Peer Education

> This refers to the dissemination of information about HIV/AIDS

to the youths by young health service providers. Mostly the

information passed on to the youths regards to basic education

of preventive measures to contracting HIV/AIDS, behavior

change communication, training youths in life skills and

education. This is done by peer group leaders who provide

training together with Sexual and Reproductive Health

Counseling to their peers. They must have participated in peer

education seminars and workshops. As such they should

demonstrate leadership skills and responsibility.

> 1.6.3 Counseling and Testing

> This is operationalized to refer to the youth friendly counseling

and testing services. These services are acceptable, accessible

and appropriate for the youths. They are in the right place, at the

right price (free where necessary) and delivered in the right style

to be acceptable to young people. They are effective, safe and

affordable.

> 1.6.4 Youth Friendly Center

> Refers to a medical facility with an integrated package of health

services provided in a Youth Centre. These centers attract youths

because each offers a library, sports activities, general leisure

activities, and a drama group. The centers use the IEC

(information, education communication) to effectively reach to

the youths. IEC includes video sessions, sporting events and

concerts.

> 1.6.5 Youths

> According to the study, the term youth is operationalized to

refer to the persons aged between 15-35 years. This age bracket

is the primary target of youth friendly centers.

> 1.6.6 Voluntary

> This refers to the act of doing something willingly without being

forced. The study operationalized the term to indicate the

willingness of youths to seek for health services in the youth

friendly centers incase of health complications without being

coerced.

> 1.6.7 Counseling

> It refers to a service that involves consultation, discussion,

deliberation and exchange of ideas and advice in the process of

decision making. The researcher operationalized it to refer to a

skilled and principled use of the youths - service provider’s

relationship to develop self knowledge, attitude and behavior

change to enable the youths complete their journey to adulthood.

> 1.6.8 Management

> This refers to the control and organization of an institution.

However the study used the term to refer to the interventions

used so as to prevent new HIV infections and delay the rate of

progression of HIV to AIDS among the infected youths. These

interventions reduce the rate of new infections and suppress the

severity of AIDS among the youths.

>

>

> CHAPTER TWO

>

> 2.1 LITERATURE REVIEW

> In this chapter literature was reviewed according to the

variables of the study.

> 2.1.1 NUTRITIONAL EDUCATION

> According to National Aids Control Council (2005) on health

and nutrition, a balanced nutrition plays an important role in

suppressing the HIV virus. It is convention wisdom that food is

medicine for persons living with HIV. Persons/ youths who are

malnourished and live with HIV are much more likely to succumb

to AIDS than those who have access to a basically good nutrition.

>

> Adequate food security is a requisite for optimum nutrition

health and survival, but HIV/AIDS reduces the youth’s

productivity by suppressing the able bodied youth’s labor that

would otherwise be engaged in agricultural production or any

other form of earning income.

> Good nutrition does the following for people (youths) living with

HIV/AIDS (WHO 1999);

> · It delays the rate of progression of HIV to AIDS and the

further advances of AIDS itself.

> · It preserves musclemasss, slows the loss of lean tissue,

prevents weight loss and improves body strength and energy.

> · It increases resistance to ineffective disease and improves

the health supply.

> · It lessens severity of infections, improves the response to

treatment for opportunistic infections and speeds the rate of

recovery.

> · It boosts the immune system and therefore reduces the

frequency of episodes of morbidity.

> · It replaces lost micronutrient and provides the body with

all essential nutrients required for good health.

>

> According to life skills development and empowerment for

PLWHAS by save the children Canada (2000), nutrition

intervention boosts the immune system and a persons’ esteem

by maintaining body weight, improving effectiveness of

medication and prolonging life. A number of micro nutrients

supplement including vitamin A, Zinc and Iron have been found

to boost the immune system of a person living with HIV infection.

Multivitamins can reduce the risk of death and improve immune

function. Good, proper and well balanced nutrition can therefore

play an important role in the comprehensive management of

HIV/AIDS as it improves the immune system, boosts energy and

helps recovery from opportunistic infections.

> 2.1.2 PEER EDUCATION

> Young people encounter significant obstacles in receiving

sexual and reproductive heath services for the purposes of

preventing sexually transmitted infections including HIV. Youth

Friendly Centers are meant to erode obstacles to sexual health

care. Examples of such projects operate in Greece , Ghana ,

Uganda and Kenya (Barnett and Katz 2005).

>

> Research has identified major barriers to young people’s ability

to access contraception and HIV testing. These barriers relate

primarily to specific aspects of reproductive and sexual health

services and include the characteristics of facilities, the design of

services, the providers’ attitude and actions (Macharia S Masiaga

D.2001). World wide initiatives are emerging that attempt to

erode these barriers and help reach young people with the

services they need (Mitra D. 2000). Research identifies several

features in the design of services that may actively discourage

young people to use the services. Design obstacles include but

not limited to cost, crowded waiting rooms, counseling spaces

that do not afford privacy, appointment times that do not

accommodate young people’s work and school schedules, and

little or no accommodation for walk in patients. Hearing about

these obstacles may prevent young people from making a first

visit while encountering them may discourage them from

returning.

>

> Moreover young people will not seek services if they do not

understand the importance of sexual health care or know where

to access health care services from. If they visit a different heath

care facility for each needed service, youths may discontinue

health care.

>

> Many facilities are too close to the youth’s homes or very far

away. Surveys by Family Health International revealed that young

people do not want to run into family members and neighbors

when entering, utilizing or leaving sexual health services.

However, many youths have difficulty in traveling very far away,

unless public transportation is available. Other related barriers

include; lack of privacy, no area set aside where young people

can wait before they are attended, and décor that is overly clinical

and too adult.

>

> According to Senderowitz J 1999, youths may be hesitant using

health facilities because of the service providers’ attitudes. In

many societies and cultures, adults have difficulty accepting

teenagers’ sexual development as a natural and positive part of

growth and maturation. Young people are not encouraged to

seek heath care if they encounter providers whose attitude tend

to indicate that youths should not be seeking sexual health

services. Young people may be deeply embarrassed and refuse

to return for services if the staff asks personal questions loudly

enough to be overheard by others. Youths may reject sexual

health services if any member of staff in the facility fails to take

seriously the young persons need for services, threatens him or

her without respect and or tries to dissuade him or her from

having sexual intercourse. Instead the service providers should

enlighten the youths on the dangers of pre-marital sex such as

being infected by HIV/AIDS.

>

> In attempts to ensure youth friendly health provision, the

Government of Kenya , international donor partners, local and

international Non governmental organizations, Faith Based

Organizations and other facets of civil society are involved in

activities and services to prevent HIV/AIDS among the youths.

Some of the activities implemented by the above organizations

include; basic education and dissemination of information about

HIV, behavior change communication, training youths in life skills

and education (NASCOP 2005).

>

> The use of peer educators in client outreach through Youth

Friendly Centers management and other psychosocial

interventions play a key role in the development and delivery of

HIV services (Gilliam and Bales 2001). Peer educators roles and

responsibilities vary greatly among the centers. However they all

have identified youth involvement in the development and

delivery of program services as being key to ensuring that young

clients utilize more services such as HIV testing and referrals to

medical or psycho social services (Francharis 2006).

>

> According to the Health Resources and Services Administration

in the United States 1993, the involvement of peers in reaching

out for the youths health concerns has the following benefits;

> · Consumer Insight and Perspectives whereby using peer

heath service providers’ results in unique insights and

perspectives from current or past clients. Peer staff insight and

perspectives were used to develop effective programs and

program materials, as well as to better identify and address

program barriers, the need and desires of the youths served.

> · Client Retention in that at a time when the successful

medical management of HIV/AIDS disease is increasingly

possible, the retention of clients in HIV programs is a key element

to positive health outcomes. Youth involvement was strongly

linked to client’s ability to utilize care and increased likelihood of

client retention. This success is in large part due to the fact that

the project staff and the young people targeted are peers.

>

> · Clients served have a closer connection to young service

providers in that peer educators are a vital source of information

about youth needs. Programmes that utilize peer staff tend to

address young clients needs and concerns more sensitively and

accurately. Youths often perceive their peers as being a safer and

more understanding source of information. Projects employing

youths as outreach workers, were for example successful in

reaching HIV positive and youths under high risk and linking

them to age appropriate care.

> · Service locations are youth sensitive. Youths are far less

likely to access services in settings that do not make them feel

safe and comfortable. Youth involvement enabled projects to

develop youth friendly and sensitive service settings that access

barriers found in many traditional youth service settings.

Significant barriers frequently deter African youth from obtaining

urgently needed sexual health services. Programs in Ghana ,

Kenya and Uganda are rapidly and effectively dismantling the

barriers that keep young people from receiving HIV and STI

testing and counseling as well as reproductive health care. By

replicating and or adapting these programs in culturally

appropriate ways, other agencies in Sub-Saharan Africa can

create their own programs to meet the sexual health needs of

young people (International Planned Parenthood Federation

2001).

>

> 2.1.3 COUNSELLING AND TESTING

> According to pathfinder International and the African Youths

Alliance (2004), youths centers have played an important role in

tackling the youth reproductive health’s concerns and especially

the management of HIV/AIDS. This is through ensuring that the

VCT services provided are friendly and motivates the youths to

utilize the services again when need be. Action Aid Kenya (2002)

on youths health needs recognized that Youth friendly voluntary

counseling and testing centers should have characteristics that

motivate the youths to utilize the services provided. These

characteristics include; convenient location, adequate space and

sufficient privacy, convenient hours of working, comfortable

surrounding and inbuilt monitoring and evaluation systems. The

service providers (staff) should be specially trained (have

interpersonal communication skills), respect the young people

with a non-judgmental attitude and also hold high standards of

privacy and confidentiality.

>

> According to Guttmacher and Brindis (1998), in designing

facilities where youths seek medical attention, the following

should be done;

> · Youth Centers should be located where public

transportation is available and close to places where young

people gather such as schools, markets and community centers.

> · To ensure youths privacy, set aside a separate space for

their services, or if that is not possible, set aside some hours just

for youths in the late after noon and even on weekends.

> · Within the space and time set for youths, create an

atmosphere that is well coming, youthful, informal and culturally

appropriate for all the youths using the services.

> · Involve young people in designing and running services.

The youths may be more able than adults to accurately identify

the needs of their peers and propose appropriate ways to meet

those needs. Youths should be trained as peer educators.

> · Offer youths free or low cost health services.

> · Schedule appointments to minimize waiting time and

crowding in the waiting rooms.

> · Permit youths to walk in for services without an

appointment and reserve appointment spaces for youths in the

evening and on weekends.

> · Ensure that counseling spaces are private and that others

cannot overhear.

> · Welcome clients’ partners, when they wish their partners

to accompany them.

> · Offer as many services as possible in a single location. If

necessary refer young people to youth friendly facilities where

they can obtain all services they need.

> · Provide culturally appropriate information in the language

and at the comprehension level of the client. Make sure the

information meets youth’s needs and concerns.

> · Reach out with activities that make young people aware of

the importance of sexual health care. Inform youths about

available services and assure them confidentiality.

>

> In addressing the service provider’s attitudes towards the

youths, the following should be done;

> · Treat young people with respect as adults. Avoid judging

youth’s behavior and instead work to develop solid, mutually

trusting relationships with them.

> · Provide all staff with ongoing training in adolescent

development, understanding young people’s needs and concerns

and treating youths confidentially and respectively. Staff may

need assistance in recognizing and changing attitude that pose

barriers to youths.

> · Encourage counselors to spend as much time as

necessary with each adolescent client in order to address all of

his or her health concerns.

>

> In January 2001, the Planned Parenthood Association of Ghana

(PPAG) implemented a youth counseling centre project to

increase young people sexual health knowledge, access to

reproductive and sexual health services, demands for and use of

such services and participation in the planning, implementation

and evaluation of programs. PPAG opened the “young and wise

centre” at its headquarters in Accra . The centre includes a clinic,

counseling unit, main hall, library and computer centre. It offers a

range of educational, artistic and entertainment activities.

Providing non-sexual health services enables PPAG to also

effectively deliver sexual education and services to youths,

including HIV counseling and testing.

>

> The center’s marketing campaigns include the brand “young

and wise”, as well as a logo and the slogan “be wise”, promotes

the centers services through outreach print and electronic media.

Its environment, operating hours, staff attitude, privacy and

policies on confidentiality are all youth friendly. In addition the

youths participate at every stage of the project, giving young

people a strong sense of ownership and attracting new and

return clients of varied socio-economic background. During its

first eight months of operation, the centre served 2,646 clients

and counseled 102 youths with an additional 600 to 800

counseled by telephone.

>

> However, addressing the healthy needs of the youths is a

challenge that goes beyond provision of health services (USAID

2003). The legal framework, social policies, and opportunities of

education, employment and recreation are but some of the key

needs for their development.

>

> For a long time in Kenya , there were no clear policies

supporting the provision of heath services to the youth. The

service providers were unclear how to respond to some health

and related concerns, particularly those touching on sexual and

reproductive health. However in response to ICDP plan of action

1994, concerns expressed in the National for Sustainable

Development (NPPSD 2000), National youth policy, the children’s

act 2001, other national and international conventions on

children and youths, the government adopted the Adolescent

Reproductive Health and Development Policy(ARH$D) in 2003.

The policy recommended the establishment of Youth friendly

centers to address the emerging youth’s health concerns.

>

> 2.2 THEORETICAL FRAMEWORK

> This section discusses theories related to the variables of the

study. The study used Albert Banduras social learning theory of

1969 and Maslow’s hierarchy of needs propounded by A.H

Maslow in 1908-1970 to explain the variables.

>

> 2.2.1 SOCIAL LEARNING THEORY

> This theory was used to explain peer education and the

counseling and testing variables.

> The theory was propounded by Albert Bandura in 1969. It is

based on the premise that behavior is learned. According to

Bandura, many variables such as person’s expectancies, values

competencies, encoding strategies and personal constructs

together with self regulatory system and plans are important in

the social learning perspective on personality.

>

> It states that the major part of human learning consist of

observational learning. The idea holds that people often learn not

only by having their behaviors “reinforced” but also by observing

other people perform “behaviors” and receive reinforcement.

These other people are called the models. By means of a model

of ones choice, the individual gains some independence from his

or her immediate environment and at the same time establishes

a unique relation with selected portion of social world. The

person acquires self chosen identity which is valued and

contributes to self esteem. Through the model, behavior acquires

meaning and becomes something more than conformity to

convention expectations.

>

> The theory emphasizes on the importance of environment or

situational determinants behavior. Behavior is as a result of

continuous interactions between the person and environmental

variables with the environmental conditions shaping behavior

through the process of learning. A person’s behavior in turn

shapes the environment. Therefore the person and the situation

influence each other reciprocally. According to this theory, the

individual difference in behavior results mainly from difference in

the course of growing up. Some behavior patterns are learned

through direct observation.

>

> Programs that utilize peer education tend to address young

clients needs and concerns more sensitively and accurately. This

is inline with Finger (2000). The peer educators are the real life

models of the youths in a youth friendly centre. There are

informal, continuous discussions between the service providers

and the youths. These continuous interactions shape the youths

behavior from being poor seekers of health and instead they are

free and willing to hold discussions on matters of health with the

peer health service providers.

>

> The associations with peer health service providers and the

informal interactions enable the youths acquire a variety of new

responses like change of attitude in discussing their health

problems and willingness to utilize the health services. The

youths also refer their friends to the youth centers to

seek help incase of medical complications. This change in

behavior among the youths assist to delay the progression of HIV

to AIDS hence the management of the pandemic disease.

>

> The theory was also used to explain the counseling and testing

variable.

> Voluntary counseling and testing services in youth friendly

centers are offered in convenient location that assures privacy

and convenient hours for the youths. There is also rapid testing

for HIV providing results within fifteen minutes.

>

> There are comfortable surroundings or youthful environment

with posters and literature touching on their health concerns

displayed conveniently on the VCT unit. This encourages the

youths to open up and seek health help. Therefore the

environment becomes the situational determinant of behavior on

the youths. The environment influences the youth’s behavior to

seek health services. Through observational learning on the

environment the youths fear and perception on the VCT is

changed thus this becomes the motivational drive to utilize the

counseling and testing service provided by the youth friendly

centers.

>

> 2.2.1.1 LIMITATIONS OF THE THEORY

> The theory over emphasizes on the importance of situational

influence on behavior to utilize the youth centers.

Therefore it loses the person. It does not explain whether

curiosity among the youths to understand some of the survival

strategies of managing HIV/AIDS could be a motivating factor of

the youths to utilize the Youth centers. As such the study

adopted the Maslows Hierarchy of needs theory to explain the

nutritional awareness variable.

>

> 2.2.2 MASLOWS HIERACHY OF NEEDS THEORY

> According to the American psychologist A.H Maslow (1908-

1970), individuals are motivated by five level of need. When a

person has satisfied the first level of need, then he or she moves

on to satisfy the second, third, fourth etc. The five categories of

needs in the order in which Maslow supposed the individual

would seek to gratify them are as follows;

> 1. Physiological needs- These include food, clothing, good

health, shelter and all survival requirements.

> 2. Security needs- Refers to job tenure, security and

protection against reduced living standards and insurance

policies.

> 3. Social needs- These are the needs of affection, belonging

and acceptance.

> 4. Esteem needs- This is the desire for physical possession

for recognition by others (evidenced perhaps by the acquisition

of status symbols). It also entails the need for authority over

others and internal psychological demands for self respect and

self assurance.

> 5. Self actualization need- This refers to the search for

personal fulfillments.

>

> The theory has been widely used as a frame reference to

explain how human beings fulfill the various needs which lead to

self actualization. The principle of the study states that a person

cannot get to the next level of needs without having satisfied the

basic needs in life. As such human beings strive hard in life to

acquire basic needs of which without them life may come to a

stand still. An example is the need for good health whereby for

one to achieve the higher needs in the hierarchy, one has to be

healthy.

>

> With reference to the study, youths require highly nutritious

food to boost their immune system and lessen the severity of

HIV/AIDS. Inadequate nutrition would lead to malnourishment,

weakening the immune system and faster progression of HIV to

full blown AIDS hence death. For example lack of iron, protein,

energy giving foods and vitamins would lead to the reduction of

CD4 cells as a result of the weakened immune system hence

death. Subsequently the youths would be hindered from being

self actualized.

>

> The research study came up with a model to explain the

variables

>

> 2.3 CONCEPTUAL MODEL

>

>

> INDEPENDENT VARIABLES

DEPENDENT VARIABLE

> MANAGEMENT OF HIV/AIDS

> NUTRITIONAL EDUCATION

> PEER EDUCATION

> COUNSELLING AND TESTING

> EXPLANATION OF THE MODEL

>

> Nutritional Education- The consumption of a well balanced diet

in adequate quantities strengthens the immune system, improves

effectiveness of medication, helps recovery from opportunistic

infections and delays the rate of progression of HIV to AIDS.

Therefore an infected youth would use the strategy to prologue

life whereas an uninfected youth would disseminate the

nutritional knowledge in relation to HIV/Aids to his/her

counterparts thus assisting to manage the scourge.

>

> Peer Education - Youths often perceive their peers as being a

safer and more understanding source of information. Peer group

leaders tend to address the health concerns of the youths more

accurately and sensitively thus motivating the youths to utilize

the Youth centres hence the management of HIV/AIDS.

>

> Counselling and Testing – There is rapid testing for HIV

providing results within fifteen minutes. The sports opportunities,

general leisure activities, a drama group and other recreational

facilities attract the youth’s motivational force to utilize VCT

services in the youth friendly centers. The youths are advised to

shun from irresponsible sexual behaviors thus increasing the

chances of fighting HIV/AIDS by reducing the rate of new

infections.

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> CHAPTER THREE

> RESEARCH METHODOLOGY

> 3.1 Site Description

> The study was carried in Lokiriama Youth Centre which is within

the Catholic Cathedral Church.Its located in lodwar town,Turkana

Central Division,Turkana Central Sub-county,Kenya.Lokiriama Youth

Centre boaders Township to the East,Catholic cathedral Church

to the North,St mary girls primary to the South and juniorates home

to the south.

> The study was carried out in lokiriama Youth Centre due to

the fact that it was the first to be established in Lodwar town

This indicates that the centre serves a large population of youths

in the area with different health difficulties and it’s more

experienced due to a long term of operation. The establishment

of the centre also outlined the concern of the Government of

Kenya in collaboration with donor agencies e.g. USAID and Save

the children Canada , on the youths health problems in the area

and hesitating to use the existing health facilities. The HIV

infection in Turkana and its boarders is a problem attributed to drug

and substance abuse among the youths in the area. This

subsequently results to risky behaviors of indulging in

irresponsible sexual acts hence the HIV prevalence.

>

> 3.2 Research Design

> The research study adapted a case design to gather

information. A sample size of 30 respondents was used to

represent the entire population. The method was used because

Lokiriama Youth Centre acts as a referral of all the programs

pertaining to the youths health concerns in Turkana central sub-county. It

was the first Youth Health Facility to be established in

Turkana central sub county thus has a long period of operation and

experience in addressing youth’s health concerns. As such other

youth health programs in the County collaborate and network

with the centre.

> The youth health service provision being an upcoming

approach to address the youth’s health concerns, there is a

limited number of Youth Centers in the country and in

the area of study thus adapting a case due to time and cost.

Interview schedules and an interview guide were used to gather

information that is relevant to the study. They were formulated

according to the variables of the study.

> 3.3 Population and Sampling

> 3.3.1 Population

> The study was carried out in Lokiriama Youth Centre. The

population consisted of one hundred and ten youths in groups

linked with the centre.

>

> 3.3.2 Sample Size

> There were thirty target respondents who were youths in

groups linked with the centre and two key informants who

comprised of two VCT counselors in the Youth Centre. The target

respondents were aged between 15-35 years.

>

> 3.3.3 Sampling Procedure

> The units of the study were youths in groups linked with the

Youth Centre. The institution of study and key informants were

selected purposively. The study then used Simple random

Sampling to identify five youth groups linked with the centre from

the register of ten groups issued. The sampled groups had a total

population of 110 members (24, 20, 26, 18 and 22). Systematic

Sampling was then used proportionally to determine the number

of respondents to be selected from each group. Simple random

sampling was later used to determine the starting point after

which systematic sampling was used again to obtain a sample

size of 30 respondents.

>

> 3.3.4 Methods of data collection

> The study involved gathering information from target

respondents and key informants. The information was gathered

using interview schedules and interview guides. The interview

schedules were administered to collect data from target

respondents while the interview guide was administered to the

key informants. Observation method of data collection was also

used to access the various recreational facilities e.g. the playing

ground, social hall, a library etc. The relationship between the

youths, peer educators and VCT youth counselors was also

observed. The study also used documentary analysis and

focused group discussions to gather information.

>

>

> 3.4 Ethical Considerations

> The names of the respondents were not included in data

collection to ensure that their identity remained anonymous in

the entire study. All the information gathered from the

respondents was analyzed in strict confidence for ethical

purposes.

>

> 3.5 Limitations of the study

> There were several limitations that came up during the research

undertaking. This is whereby some of the respondents

compromised participating in the study in fear that they might

expose their dark side especially now that the study targeted

both HIV infected and affected youths.

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> CHAPTER FOUR

>

> 4.1 DATA ANALYSIS AND INTERPRETATION

> This chapter deals with the analysis and interpretation of data

obtained from respondents interviewed on how the Lokiriama Youth

Centre assist in management of HIV/AIDS. The study

used frequency tables, pie charts, bar graphs, and descriptive

techniques to present the data. The data here in was obtained

from thirty target respondents (youths) and further two key

informants who constituted of two counselors.

>

> BACKGROUND INFORMATION

> This included the respondents age, marital status, gender and

form of employment. The respondents’ age is as presented in

table 4.1

>

> Table 4.1 Respondents age distribution

> Age (Years)

> Frequency

> Percentages

> 18-20

> 1

> 3.3

> 21-23

> 5

> 16.7

> 24-26

> 14

> 46.6

> 27-29

> 5

> 16.7

> 30-32

> 3

> 10

> 33-35

> 2

> 6.7

> TOTAL

> 30

> 100

>

> From the findings, it indicated that majority of the respondents

24 (80%) were between the ages 21-29 years. This indicated that

the respondents developed a stronger sense of identity and

related strongly with peers.

>

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> On finding out the gender of the respondents, the findings are

as illustrated in figure 1

>

> The study sought to find out the respondents marital status

whereby, 4(13.3%) of the youths were married, 24(80%)

unmarried while 2(6.7%) were separated. This implies that

majority of youth centre clients 24(80%) were unmarried

youths.

>

> The study sought to find out if the source of income had any

bearing on the youth’s behavior to seek health care. The findings

are indicated in table 4.2

>

> Table 4.2 Respondents source of income

> Source of income

> Frequency

> Percentage

> Professional job

> 2

> 6.7

> Self employed

> 4

> 13.3

> Casual labor

> 24

> 80

> TOTAL

> 30

> 100

>

> From table 4.2, 24(80%) of the respondents had no any reliable

source of income. Asked if they paid for the health services from

the youth centre, 100% said NO. The findings are inline with WHO

report 2004 which outlined that the cost of health services

hinders a significant number of young people from seeking

health care. Majority of the youths are in school, unemployed and

can hardly afford the cost of health services. They depend on

their parents, guardians or relatives to meet these costs. This

situation makes them reluctant to seek for health services

fearing that they may be forced to disclose some of the intimate

conditions to their relatives.

> To establish the respondents’ main source of attraction to the

centre, the responses were as tabulated in tableajoubleendly

centre clientsy, tal status, 4.3

>

> Table 4.3 Respondents source of attraction to the centre

> ...