SCHOOL OF EDUCATION AND COMMUNICATION
JÖNKÖPING UNIVERSITY

"AIDS is not the end of life"

How information about HIV/AIDS affect Kenyan students

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"AIDS är inte slutet på livet"
Hur information om HIV/AIDS påverkar Kenyanska studenter

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HIV/AIDS är ett av det mest förödande hälso- och utvecklingsproblem i modern tid. Det är mycket viktigt att nå ut med information i syfte att hindra att sjukdomen sprids. En stor mängd information cirkulerar i dagens samhälle men effekten kan vara svår att mäta.

Studien utfördes i en liten stad vid namn Voi i Kenya där problemet med HIV/AIDS är större än genomsnittet i landet. Kenya är det tredje värst drabbade landet i Afrika.

Vi har undersökt varifrån ett urval studenter i Voi får sin information om HIV/AIDS och vad informationen innehåller. Studien syftar också till att undersöka hur informationen påverkar studenternas vardag och om det leder till attityd- eller beteendeförändringar. Kunskapen om hur information om HIV/AIDS ska formas och presenteras för att nå bäst effekt är värdefull för flera intressenter.

En metod av kvalitativ karaktär valdes där fyra gruppintervjuer genomfördes med studenter från The Institute of Technology College i Voi.

Resultatet visade att de källor där studenterna huvudsakligen hämtade sin kunskap om HIV/AIDS var radio, skolor och organisationer. Informationen innehåller riktlinjer för hur man undviker att själv bli smittad, hur man fortsätter leva om man blivit smittad och hur man bör bete sig mot de som är smittade. Informationen har skapat en medvetenhet bland våra respondenter och majoriteten har ändrat sina attityder och sitt beteende.

Nyckelord: HIV/AIDS, kommunikation, information, attityder, beteende, Voi

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ABSTRACT

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HIV/AIDS is one of the most challenging health and development issue of modern times. It is of high importance to reach out with information in order to impede the disease from spreading. There is a lot of information circulating but the effect can be difficult to measure.

The study takes place in Kenya which is the third most affected country in Africa. The research has been conducted in a small town called Voi, where the problem with HIV/AIDS is larger than average in Kenya.

We have investigated from where and what kind of information about HIV/AIDS the students in Voi receive. It was also our aim to find out how the information affect their daily lives, if it leads to any change in attitudes and behavior. It is valuable to see how information about HIV/AIDS should be formed and presented in order to achieve the best effect.

A method of qualitative approach was chosen in order to find the answers. Four group interviews were conducted with students from The Institute of Technology College, in Voi.

The result showed that the main sources from which the students' gain knowledge about HIV/AIDS was radio, schools and organizations. The information contains guidelines on how to prevent oneself from contracting the disease, how to live positively if one get infected and how to act toward infected people. The information has created an awareness among the respondents and the majority have changed their attitudes and behavior.

Keywords: HIV/AIDS, communication, information, attitudes, behavior, Voi

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14 December, 2010

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"It's there, it's real, it can happen to anybody at any age"
(Brenda, 18)

1 Introduction

No one could have predicted how the HIV/AIDS epidemic would spread across the world and change many millions of lives. No one had heard about the disease as recently as 40 years ago and now more than 25 million people around the world have died of AIDS-related diseases (avert.org 1, 2010). The disease has proven to be the most challenging health and development issue of modern times.

Today a total of 33 million people in the world are suffering from HIV and the overwhelming majority, 22 million people, live in Africa, south of the Sahara (UNAIDS, 2010). This study focuses on the country of Kenya and is carried out in a small town called Voi. Kenya is home to one of the world's harshest HIV/AIDS epidemics. In 2007, about 1.42 million people in the age of 15-64 years were infected with HIV in Kenya (KAIS, 2009).

The HIV/AIDS epidemic has become one of the biggest information problems in the last 30 years. In order to fight the epidemic it is important to inform and implement knowledge at an early age. More than half of all new cases reported are adolescents aged 15-24 years (unicef.se, 2009). Many actors are working to disseminate information about HIV/AIDS and they all have different strategies for how the information should reach the target group. Most strategies are based on health education or behavior change models (Ford, Odallo & Chorlton, 2003). The effect of these strategies varies. For instance, in media-based information campaigns, the coverage rate is large but the impact is difficult to measure since the receivers' interpretation skills differ (avert.org 2, 2010). According to these differences, we think it is important to deepen the understanding of how adolescents perceive the information sources and how they react to the information and turn it into practice.

Information intends to influence the target group and it is generally accepted that successfully delivered information will cause a change in the individual's behavior (Ford, Odallo & Chorlton, 2003). One of the main goals of second generation HIV surveillance systems in Kenya is to monitor trends in behaviors and to target prevention interventions (Kenya update, 2008). In this context, we find that our research is relevant as investigating adolescents' behavior according to HIV/AIDS is a part of the study.

The study has a qualitative approach in which students from the Institution of Technology College in Voi have been interviewed in groups in order to receive a deeper understanding of their attitudes and behavior relating to HIV/AIDS. The aim is to examine how the students experience and react to the information about HIV/AIDS. In order to create a change of behavior one must have an understanding of the target group's situation since it affects how they perceive information. The study focuses on the receivers' perspective. Investigating the entire communication process would require a more extensive research. The study is also limited to a specific area with certain respondents, which does not make it representative for the entire population. We still think it could be an important contribution to the understanding of how information about HIV/AIDS should be formed and presented in order to achieve the best effect.

This paper first gives a brief overview of HIV/AIDS as a disease and how it has affected Kenya. Thereafter, we present what has previously been done in the research field in order to create an understanding for how this study relates to the research field. Our purpose with the study and our research questions are presented in chapter 3, followed by chapter 4 where we outline the theoretical framework. To increase the validity we will, in chapter 5, describe in detail how the study has been conducted. The chapter also addresses the methodological issues we have been facing. In chapter 6 we present the results which are analyzed and reflected upon in chapter 7. The essay ends with chapter 8 where we draw conclusions and summarize the research.

2 Background

This chapter will first give an explanation of HIV/AIDS as a disease: how it occurs, how it affects a human's life and body and how it has been widely spread across the world. Thereafter the situation in Kenya is outlined where actions, specific risk groups and our choice of research location is described. The chapter ends with a selection of previous research that describes what has already been done within this context.

2.1 HIV/AIDS

HIV, human immunodeficiency virus, is a retrovirus which means that the virus is stored in the infected person's gene pool. It lowers the immune defense system and exists in the infected person's blood and body fluids. The virus is transmitted through sexual intercourse, blood transfusion and breast milk, and the majority of infections are transmitted through heterosexual intercourse (avert.org 3, 2010). In a short time, the virus can develop into AIDS, and when it weakens the body, it becomes unable to resist infections.

In the past, the infected usually died within one year after the AIDS outbreak. Treatment for people with HIV has improved enormously since the mid-1990s but there is still no cure for AIDS. Nowadays, individuals who get treatment and take their drugs as prescribed can expect to recover their health markedly and live a normal life without developing AIDS (UNAIDS, 2010). Nevertheless, each year about 2 million people die of AIDS and 2.7 million become infected with HIV. That is almost 7,400 a day, according to UNAIDS (2009).

HIV has been most severe in some of the poorest countries in Africa. Developing countries do not have the same possibilities since the drugs required are costly and difficult to manage. In the end of 2009, in sub-Saharan Africa, less than half of those in need of treatment were receiving it (WHO, UNICEF, UNAIDS, 2010). When people, because of the illness, lose their capacity for work they become poor. The situation reduces the possibility for children to attend school and to gain knowledge about HIV/AIDS. Without knowledge, the epidemic will continue to spread.

Receiving a positive HIV result may cause the individual to end up in crisis. The infected person may feel that his security, social identity and other significant life goals are threatened. How the crisis dissolves or progresses is due to both personal characteristics and external life situations. In order to cope with the crisis, support from friends and family is operative. (Cullberg, 1999)

2.2 The situation in Kenya

HIV/AIDS is spread all over Africa, but some areas are more affected than others. Kenya is the third most heavily affected country of the continent (avert.org 4, 2010). According to Kenya National Bureau of Statistics, 1.5 - 2 million people out of 38.6 million inhabitants, are living with HIV/AIDS. The first case of HIV in Kenya was diagnosed in 1984 (KAIS, 2009). Ten years later the disease had killed 100,000 people.

Fig.1 Map of Kenya

Kenya is divided into eight provinces, and the coast province has a HIV prevalence of 8.1% which makes it the third worst affected province according to the number of inhabitants (Fig 2.7 in KAIS, 2009). The biggest city in the province is Mombasa, which is the starting point of Mombasa Highway. It is the main transportation artery linking Kenya, Tanzania, and Uganda with Southern Africa. This heavily trafficked highway crosses through the center of a town called Voi. It is a small town with approximately 35, 000 inhabitants but the problem with HIV/AIDS is larger than the average of Kenya (Voi, 2010). Epidemiological evidence shows that HIV spreads throughout Eastern and Southern Africa via the Highway (Nzyuko, 1991) since it is common that truck drivers stop and have sexual intercourse with young girls.

Voi counts as a rural area and according to the UNGASS (2010) report there is a difference between the HIV prevalence in rural and urban areas. The epidemic is more common in urban areas but since 75 percent of the population lives in rural areas, the total number of people living with HIV is higher in rural settings.

The number of people infected with HIV has increased and the government of Kenya has made many attempts to reduce the number of infected. For instance, they have published informative articles in the press and launched a poster campaign to encourage people to use condoms, be faithful and avoid indiscriminate sex (AIDS newsletter, 1987). Public AIDS campaigns are still a common approach since the assumption is that people will respond to risk according to their level of HIV/AIDS awareness (Akwara et.al 2003). The government also introduced sentinel surveillance at the antenatal and STI clinics (KAIS, 2009).

The Kenyan President declared the HIV/AIDS epidemic a national disaster in 1999 and a National AIDS Control Council, with policy guidelines for the disease, was established (KAIS, 2009). Through this, Kenya's education sector integrated AIDS education into all subjects at

school. Evaluations show that education about HIV/AIDS effectively promotes healthy behaviors and reduces the risk of infection (Kenya National AIDS Control Council, 2009).

Although the government has been fighting the epidemic with health-care facilities and prevention through health education messages in early ages, none of these strategies have halted the spread of HIV/AIDS. One of the more successful attempts is the Primary School Action for Better Health, which aims to create a change in behavior among primary school students. Evaluations of the program showed an increase in condom use and a decrease or delay of sexual activity (UNESCO, 2009). As a result, many people are now aware of the danger of HIV, yet millions of people become infected every year.

There are certain groups within the population that are particularly vulnerable, including women who are sex workers and their clients, men who have sex with men, injecting drug users and men in mobile occupations such as long distance truck drivers (UNGASS 2008). In Kenya, AIDS was associated with these high-risk groups for a long time. As a result, people continue to discount their own risk because they do not identify themselves with these groups (Akwara et.al 2003).

2.3 Previous research

In a scientific article written by Ford, N., Odallo, D., Chorlton, R., (2003) we found that The Rockefeller Foundation had identified some guidelines in order to change the way information about HIV/AIDS is delivered. They claim that professionals need to hand over the responsibility of informing on to community groups. It is not only a change of behavior that is vital but also communication for social change. This is defined as a process of public and private dialogues where people identify themselves, what they desire and how they can receive it. According to the Rockefeller Foundation, the information should change:

> From facility-based programs to community-based programs.

> From teaching people about HIV/AIDS to peer exchanges and shared learning on innovative responses to the pandemic.

> From a dependence on expert knowledge to integrating expert knowledge with experiential, local or traditional knowledge.

> From transferring Western models to African situations, to sharing good African models.

> From a problem orientation to a positive orientation or a focus on best practices.

> From modeling the behavior of outsiders as role models (such as football stars) to promoting the behavior of insiders, community members or local heroes as role models.

If the development professionals change their perspectives, there will be a social change instead of just a change of behavior. These shifts will help the local people to take command of their own situation. These guidelines are interesting for us to take into consideration when investigating how the students react to the information they are given.

A study conducted by Kuhn, Steinberg, & Mathews, (1994) in a South African high school showed that the education about HIV/AIDS at school was not always successful. In this case, the intention with the education was to reduce negative attitudes toward HIV/AIDS; instead it created rumors about the people living with the infection. The result of the study highlighted the problem with stigmatization[1] and it became clear that more research is needed in order to understand people's attitudes and to eliminate the stigmatization.

Stigmatization can be defined as a short term consequence of HIV/AIDS. According to Catherine A. Sanderson (2010), many adolescents are more concerned about short term consequences than the consequences that appear later in life. She gives an example of college students who claimed that having an unplanned pregnancy would be worse than getting HIV. A pregnancy would become an instant problem, while HIV would be a more distant problem since it does not develop immediately. Sanderson refers to a study where the result showed that college students were more likely to use sun screen after receiving information about the short term negative effects of tanning such as increasing wrinkles, aging etc. The long term negative effects such as skin cancer and other health risks did not make much impact. This study may create a good base for our study since it shows the importance of emphasizing short term consequences rather than long term consequences when changing attitudes.

A review of quantitative and qualitative studies shows that individuals are more likely to underestimate than to overestimate their risk of HIV infection. It is a common attitude for people to ignore the risks, believing it would not happen to them (Akwara et.al 2003). The result of this review will be valuable in our study since we are investigating how students get affected by information about HIV/AIDS. If they underestimate their risk of HIV infection, the information they receive is uneffective.

We do not intend to extend any of these four studies but they have inspired us and will create a basis for our approach. Since our study aims to examine how students relate to the information they receive about HIV/AIDS and how it affects their attitudes and behavior, we believe it will be useful in the theoretical ongoing discourse about how to make information more effective.

[1] Stigmatization is a derogatory designation, a contempt for groups or individuals who differ from their own social norm.

3 Purpose of the study

Our study aims to examine how students in Voi describe their experiences and reactions to the information about HIV/AIDS and how it affects their daily lives.

3.1 Research questions

To find out how the students relate to the information and in what way they think it affects their attitudes and behavior, the following research questions will be addressed:

- Where does the information that the students receive come from?
- What kind of information have they received?
- In what way do they think the information affects their attitudes and behavior?

The questions above will work as guidelines for the entire study. The first two questions aim to get an overview of the sender, message and channel in the information process. The third question opens up for deeper meanings to be found related to the receivers' perspective, for instance, concerning how they react to the information and how they get affected by it.

4 Theoretical framework

The chapter begins with a short presentation of the process school within the field of communication studies. Thereafter, we will present three different communication models founded by Lasswell, Shannon & Weaver and Newcomb. In addition, a short outline about one of Schramm's models is made. Thereafter, a theoretical framework of attitudes and behavior will follow. We present several reasons of why behavior and attitudes do not always corresond with each other. The chapter ends with an explanation of the cognitive dissonance concept.

4.1 Communication Theory

Whether we realize it or not, every time we communicate we send messages that might affect someone else. Therefore the skill to create a message has become more and more important. Since this study aims to investigate where information about HIV/AIDS comes from, what it contains and how it affects the receivers, we have chosen to outline a number of communication models to explain the context.

This study has the process school in focus which sees communication as transmission of messages. It is explained as a process in which one communication participant affects another's behavior or mood, or a process in which all participants mutually influence each other. By structuring the communication into models one can derive the potential disturbance and thus investigate where in the process problems occur (Fiske, 2009). Examples of this will be presented in the pages ahead.

Severin and Tankard (2010) define a model as a "theoretical and simplified representation of the real world". A model is not a unit by itself, but it helps to shape a theory. Here, it suggests relationships between components and helps to explain problems that may occur in the communication process. A model may also point out gaps and suggest areas where research is needed. Models are simplifications and if a model turns out to be deficient, it is possible to develop and improve it.

4.1.1 Lasswell

Harold D. Lasswell developed a formula adapted for mass communication. This formula is relevant since the information about HIV/AIDS is supposed to reach a large mass. It is shaped as a linear model which sees communication as a transfer of messages. His famous sentence states, "Who says what in which channel to whom with what effect?" This sentence explains the communication process and illustrates that the sender has a clear intent to influence the receiver (Moore & Dwyer, 1994 s 88; Fiske, 2009 s 48). It is also illustrated as a graphical model as shown in figure 2.

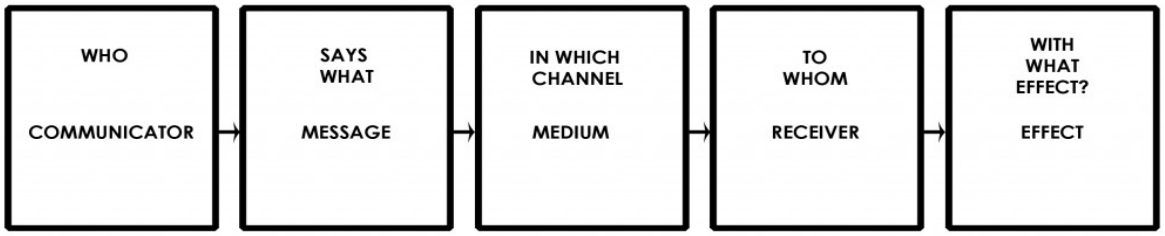

Fig. 2, Lasswell's model

Lasswell focuses on the effect rather than the meaning. The effect implies a change within the receiver which messages often intend to do. The desired effect could be the politicians' wish of finding argument in order to attract new voters or the advertisers' effort to convince people to buy certain products (Angelöw & Johnsson, 1990). If the desired effect is not encountered one could change any of the elements in the model. The sender, the message or the channel can alter: each of these changes should induce the desired effect.

Lasswell also used his model to describe different kinds of communication research. The *says who* raises the question of the control of the messages as in control analysis. The *says what* is the subject of content analysis. The studies concerning *in which channel* are dealing with media analysis. Audience analysis is the focus of studies in the *to whom* and the *with what effect* can be viewed as studies studying impact or effect analysis on the audience (Severin & Tankard, 2010; Moore & Dwyer, 1994)

4.1.2 Shannon and Weaver

The fundamental communication model which has become a model for many subsequent models is Shannon and Weaver's "Mathematical theory of communication". It is widely recognized as one of the main foundations from which the communication theory has developed. Shannon and Weaver see communication as a transfer of messages, which makes their theory a clear example of the process school (Fiske, 2009). The model is unidirectional and describes communication as a linear phenomenon as shown in figure 3.

The *information source* is seen as the one that selects a desired *message* out of a set of possible messages. The selected message can consist of spoken or written words, or of pictures, music etc. The chosen message is transformed into a signal by the *transmitter* (henceforth called sender). The signal is transmitted to the *receiver* through the *communication channel* (Shannon & Weaver, 1998). The same process is conducted by the receiver in order to transfer the message to the destination which is the final target for the message. In verbal communication one's mouth is the sender, the varying sound pressure is the signal which is transmitted through the air, the channel, and reaches the ear of the receiver (Fiske, 2009). The destination in the example above would be the brain of the receiver.

There is one part of the process left to be explained, the *noise*. Noise is defined as anything added to the signal that is not intended by the information source. If noise interrupts the

communication process, then the received message may contain certain errors. The intentions of the sender might be distorted either by the channel, the audience, the sender or the message itself. It would limit the amount of desired information to be sent (Fiske, 2009). Noise can appear in many forms, for example, static on the radio, distortions of sound in telephones or shadows on the television screen (Severin & Tankard, 2010). According to Fiske, even thoughts can be seen as noise, for example, when a student's thoughts become more interesting than listening to what the teacher has to say.

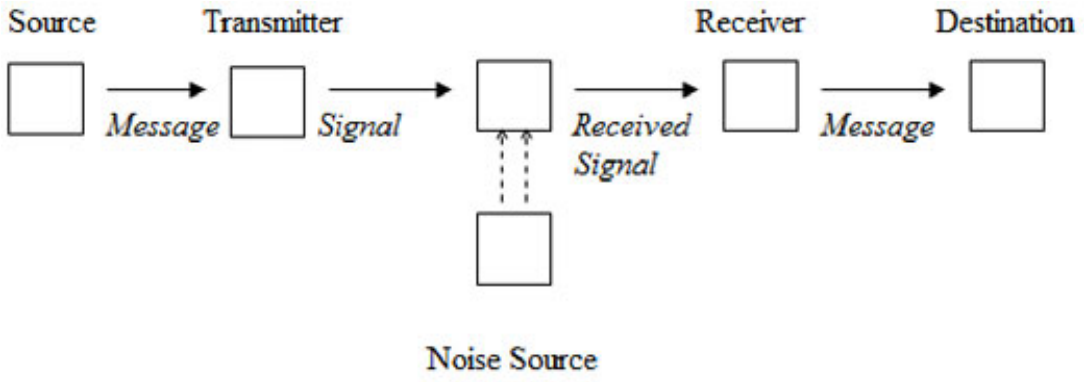

Fig. 3, Shannon & Weaver's Model

In order to prevent eventual problems caused by noise in the communication process, Shannon & Weaver identify three levels of communication problems:

Level A: How accurately can the symbols of communication be transmitted?
(The technical problem)

Level B: How precisely do the transmitted symbols convey the desired meaning?
(The semantic problem)

Level C: How effectively does the received meaning affect the behavior in the desired way?
(The effectiveness problem)

The *technical problem* is easy to understand and concerns the accuracy of the message to be transferred from the transmitter to the receiver.

The *semantic problem* is concerned with the interpretation of meaning by the receiver, as compared with the intended meaning of the transmitter.

The *effectiveness problem* measures the success in which the meaning conveyed to the receiver leads to any impact.

Shannon & Weaver's "Mathematical theory of communication" has inspired many followers, whereas several have been critical and suggested that important components are missing. One of them is Wilbur L. Schramm, who developed three different models. The first

one is a modification of Shannon & Weaver's model, however, it describes the encoding process more clearly. His second model, which is the most relevant for this study, introduces the concept of experience fields where the surroundings of the sender and the receiver are included. This cover the cultural aspects crucial in this study. Schramm suggests that only what is shared between both the source and the destination within this field is actually communicated. A message does not exist unless it fits within the experience field of both communication partners (Severin & Tankard, 2010).

The receiver's possibility to transmit a reaction to the sender is called *feedback*. Shannon & Weaver do not use this concept, but other followers have found it valuable. Feedback allows the sender to adapt the message to the receiver's needs and response. The deliverance of messages often becomes more effective when feedback is possible because it makes the receiver more involved. If the receiver is aware of the sender's interest in the response, it makes the receiver more willing to take part of the sender's message. Being unable to express reactions can lead to frustration, which contributes to so much noise that the message disappears (Fiske, 2009).

4.1.3 Newcomb

A model that includes feedback is Theodore Newcomb's Symmetry Model which has a social psychological nature and concerns interaction between human beings. It shows the interaction between individuals and is of importance when it comes to interpersonal communication[2] about HIV/AIDS. It is the first model that introduces the role of communication in a society or a social community. As seen in figure 4, unlike previous linear models, this model is triangular.

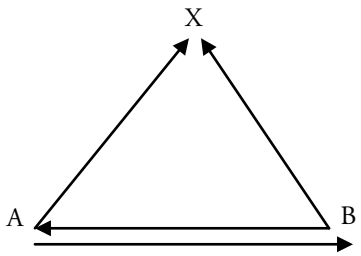

Figure 4, Newcomb Symmetry Model
Person *A*, transmits information to another person, *B*, about something, *X*.

Two individuals communicate about an object, an idea or even another person. Both *A* and *B* are communicators and receivers; it can be between individuals or between government and citizens. X is a part of their social environment. If applying this model to our study, *A* could be a teacher and *B* could be the students. Then *X* would represent HIV/AIDS. The three constitute a system and their internal relationships are interdependent. If *A* changes it will affect the others, if *A* changes its relationship to *X* the other part has to change its relation to either *X* or *A*. It is

[2] Interpersonal communication is communication that happens between people, emphasis is on dialogues, talking to each other face to face.

important that *A* and *B* possess similar attitudes toward *X* in order to make the system balanced (Fiske, 2009). A change in any part of the system will force the internal parts to restore balance or symmetry, because imbalance or lack of symmetry is experienced as psychologically uncomfortable. To create effective communication, the relations between *A*, *B* and *X* need to be balanced because a person's attitude can have a great impact on another's (Severin & Tankard, 2010).

4.2 Attitudes and behavior

Information about HIV/AIDS aims to change people's attitudes toward the epidemic and to instill a more conscious behavior. In order to change attitudes and behavior, knowledge about how attitudes and behavior interplay and how they affect one another is of importance.

Attitudes are people's predispositions toward things and refer to whether or not a person likes something and help us understand the world and situations in our surroundings. They also play an important role when interpreting daily situations and expressing our values. The last functions to be mentioned is our ability to protect our self esteem, strengthen our self confidence and defend ourselves against criticism (Angelöw & Jonsson, 1990).

When communicating topics which concern many people, for instance, health practices such as AIDS prevention or smoking campaigns, attitudes are of high importance. Attitudes influence actions and determine people's behavior. Within the social psychological research the concept *attitude* includes three different components (Severin and Tankard 2010; Angelöw and Jonsson 1990):

An affective component, liking or feeling about an object

A cognitive component, beliefs about an object

A behavioral component, actions toward the object.

Studies of attitudes are an important branch of social psychology. Early experiments in social psychology performed by Sherif in 1935, looks at how individuals behave according to the rules of society. During the Second World War an interest of human behavior in social situations emerged. Studies focused on how attitudes were formed and changed by the social context. Topics which are central in research of today are social perception, aggression, relationships, decision making, prosocial behavior and attribution (Brown, 2006).

Already 400 years BC, Aristotle identified three important relations which had an impact on the development of how attitudes can change: the source, the audience and the message. Modern theories have developed these three factors and added a fourth: the social context in which the communication takes place. The following conclusions concern the role of the sender and his or her impact on the efficiency of the message (Angelöw & Jonsson 1990):

- A reliable and convincing sender is a person who is both an expert and inspires confidence.
- A person who argues against his own interests is more convincing than a person who delivers a message for his own benefit.

- A speaker is more persuasive if it does not show that the speaker tries to convince his audience.
- If the sender is similar to its audience, he is more convincing. Physically attractive senders appear to be more persuasive than unattractive.

What is even more important is the nature of the receiver. Different aspects determine to which message he or she will attend. Among the most crucial factors are the receivers' needs. According to Maslow (2000), a human's basic needs are categorized into: physiological, safety, social, esteem and self actualization. These needs can have an immediate influence on our behavior. If the needs are not met, the receiver will choose information that satisfies them. For a person who has not eaten for several days, messages about food are more likely to attract his or her attention than any other information. People also choose messages according to their experience and how well the messages suit their opinions and values. Attitudes, preferences and predispositions about particular topics, persons or situations affect what messages one chooses to receive (Ruben & Stewart, 1998).

Children are highly dependent on the needs, wants and desires of their parents. This dependency affects the way of information reception for most people. Every stage in life adds new problems and challenges, therefore the needs and selection of information will change over time (Ruben & Stewart, 1998).

Knowledge of people's attitudes is of importance in order to predict behavior. This is valuable, for example, when health educators design promotional material with the intention of changing attitudes. Messages in brochures, signs or posters can be designed to suit the target group's attitudes. As a result, one can reach the desired behavior of the target group whether it is about driving sober, using condoms or quitting smoking (Sanderson, 2010).

There are different opinions on how a message should be performed in order to be convincing. Frightening examples are often argued to be a preferable way to change attitudes and influence a desired behavior, though research has shown contradictory results (Angelöw & Jonsson, 1990). The book *Communication Theories* (Severin & Tankard, 2010) describes a model based on a classic experiment by Janis and Feshback. The model suggests that the relationship between fear appeal and attitude change is formed in a u-shaped curve. The model shows that low and high levels of fear in a message will lead to a smaller change of attitude, while moderate levels of fear will lead to a larger change. Fear tactics rather cause defensive reactions from the individual. To avoid anxiety, frightening information gets rejected. However, if the information is immediately followed by instructions on how to avoid the problem, the fear appeal becomes more effective (Angelöw & Jonsson, 1990).

4.2.1 Why behavior does not always reflect the attitudes

There are a number of reasons why our behavior does not always reflect our attitudes. When judging a person, the attitudes expressed and particularly the actual behavior becomes crucial. What a person says is one thing, how he behaves is another. Times of election are an example. Parties declare many promises in order to enlist voters but then behave in a different way. People

are often put in situations where it can be difficult to live up to one's attitudes. Time constraints, material comfort or fear of deviating from the group's opinions, can be decisive factors. It also depends on how important we find our attitudes. Another reason can be if the current attitude is not investigated sufficiently, which also can contribute to difficulties in connecting attitudes to behavior. A person may say it is very important to vote, but did not vote in the last election. One can then conclude that his attitudes are not consistent with his actual behavior. However, if a more thorough investigation had been made it may have shown that he actually had voted in each of the previous elections, and that this instance was just an exception. Another reason is if attitudes and behavior are not investigated simultaneously. Changes may occur which will lead to a difference between attitude and behavior. In, for instance, an opinion poll before the election, the polls may say one thing and the outcome of the election another. Previous attitudes may change depending on various circumstances (Angelöw & Jonsson, 1990).

Social norms can also influence the connection between one's attitudes and behavior. A person's negative attitude toward drinking and driving would lead him to refuse to drive after drinking. However, when his friends do not share this attitude, peer pressure arises. This may affect the person to engage in a behavior that is not in line with his attitude; he may drive after drinking (Sanderson, 2010). These reasons to why behavior does not always reflect the attitudes are difficult to get around. Sanderson argues that information is a way of creating a balance between behavior and attitudes in certain situations. People who are well-informed about a topic are likely to have greater attitude-behavior consistency than those who are poorly informed.

4.2.2 Cognitive dissonance

The concept of cognitive dissonance was developed by Leon Festinger. He argued that this condition occurs when two ideas or opinions are in disharmony with each other. Theories assume that people are trying to ensure, both to themselves and to others, that their attitudes and behvior correspond (Angelöw & Jonsson, 1990). If engaged in an act that is not in line with one's attitude it causes dissonance, which is an unpleasant feeling. This may lead to a change of attitude in order to justify the behavior (Sanderson, 2010). Brown (2006) argues that aside from changing thoughts, beliefs or attitudes, one can also attend to information which supports one's beliefs and ignores the other. The cognitive dissonance phenomenon is illustrated in the example below.

"Imagine that you are a member of a student organization that encourages recycling, but one day you toss an empty soda can into the nearest trashcan instead of carrying that can until you find a recycle bin. This act should create the state of cognitive dissonance because you've engaged in a behavior (e.g., throwing a can into a trashbin) that is not in line with your attitude (e.g., recycling is very important)." (Sanderson, 2010)

People strive for consistency between their attitudes and behaviors. The concept of consistency is based on the notion that people act rationally. Rationalization is used as an attempt to explain irrational behavior in a rational and consistent way. The desire to appear rational or consistent to ourselves often leads to a change either of attitudes or behavior that may seem irrational and inconsistent to others (Severin & Tankard, 2010).

5 Methodology

This is a minor field study partly financed through a scholarship by SIDA[3], conducted during the period of 17 October - 11 December 2010 in Voi, Kenya. This chapter outlines how the research process has progressed. First, the choice of a qualitative approach will be argued, followed by the method for sampling and a description of the sample. Then, we describe how the interviews were performed and how we constructed our interview guide. Thereafter, the transcription as well as the data analysis process will be presented. Finally, some methodological issues will be outlined in order to show the problems we have dealt with.

5.1 Choice of method

This study has a qualitative approach since the aim is to get a deeper understanding of the respondents' attitudes and experiences. The intention is not to generalize, therefore a quantitative method could be excluded. The aim of a qualitative study is not to reach consensus about, or find the solution to an issue. Instead, it aims to bring forth different viewpoints on an issue (Kvale, 2007). The qualitative method is also profitable since it allows a low grade of standardization (Trost, 2010). In this case, where the study was conducted in a different culture, it was important to be flexible and to adapt to the situation. It was decided that group interviews was preferable to focus groups for this investigation, since focus groups are mainly used to find out opinions on a given topic or problem (Wibeck, 2002).

The term "group interview" means that an interviewer, in this case, two, are interviewing several people at the same time (Trost, 2010). Opinions, attitudes and feelings are often a part of argumentative structures that are difficult to access when using interview questions. The more controlled the situation, the less likelihood for diverse expressions. Argumentative structures emerge mainly in conversations, which a group interview aims to provide (Wibeck, 2002). Interaction may facilitate expressions of viewpoints usually not accessible in the individual interview (Kvale, 2007; Wibeck, 2002). Individual interviews were excluded here; the fact that the HIV/AIDS subject can be seen as a sensitive taboo topic suggests that group interview is preferable. Group interview creates an open atmosphere for a subject that may be sensitive. The less shy participants can bring up a taboo topic and thereby encourage others to share their thoughts (Wibeck, 2002).

In this study, the interviews will be of structured character but the questions will be less structured, thus the group interviews may be cited as semi-structured (Trost, 2010). For the semi-structured type of interview the interviewer will have an observant role, but also control the conversation so that it does not steer too far from the subject. Interview questions will be formed as topics and also follow up the respondent's answers and the new directions they may open up.

[3] Swedish International Development Co-operation Agency

Semi-structured interviews, according to Kvale (2007), are more likely to achieve spontaneous, lively and unexpected answers. Open questions will be used because they deliberately seek longer answers, which results in a deeper understanding of their attitudes and behavior (Dalen, 2008).

5.2 Selection of respondents

Respondents for the group interviews were recruited from *The Institute of Technology College* in Voi, Kenya. This is the only governmental college in Voi and that is why it was chosen. Students from the same school were chosen in order to make a homogeneous group of respondents. A basic assumption is that people who have common experiences and interests are more willing to share opinions and personal information with each other (Wibeck, 2002). The respondents are familiar with each other, but they are studying different subjects in school. According to Trost (2010), it is an advantage to have respondents of different age, gender and education in order to get a variety of people in the interview groups. Students at the college are 18 years or older and most of them are on campus. Participants of these ages are quite mature and hopefully they have been reached by a lot of knowledge. According to European Aids Clinical Society (2009), the majority have their sexual debute at the age of 15-20 years. In this study, the target group is represented by people who are supposed to be aware of the HIV/AIDS epidemic and are likely to be sexually active.

A teacher at the college, who works as a counselor and a trainer in many subjects, acted as a recruiter since he is respected and well known among the students. The purpose of the study was thoroughly discussed with the teacher and the students before the sample selection to carry out a desired sampling. A list of requirements was also given to the teacher to get the right group composition. The list included age, gender and language skills. Students who were interested in participating were randomly chosen by the teacher and divided into groups of four with a balanced mix of men and women.

5.2.1 Sample

The sample resulted in sixteen respondents of which all were students at The Institute of Technology College in Voi, Kenya. Both genders were represented equally. Their ages ranged from 18 to 29, where the average age was 22.2 years. Eleven students stayed on campus and the majority had started their college education in 2010. Together, they represented a broad variety of programs, such as marketing, engineering, tourism, business, economic and social development. The students' origins varied, they came from nine different rural areas of which Voi was most represented. All students were Christian. Large families were common since 3.75 was the average number of siblings. However, one has to consider that the range varied from zero to ten.

We let the students remain anonymous in the results, and thus give them fictitious names. They are named after the interview group they belonged to; the students in the first group have names beginning with A, in the second group all names start with B etc. to enable the reader to see the connection between who said what in which situation. It also brings the reader closer to the respondents.

5.3 Interviews

Interviews were used to reach an understanding of the students' attitudes toward HIV/AIDS. In order to make the respondents feel safe, the interviews were held in a small and quiet conference room. Trost (2010) suggests a place which is neutral for the respondents as well as the interviewer. According to Trost, the home of the respondents can be a suitable location for the interview in order to make them feel comfortable but it is also easy to be interrupted. In this case, the house of the respondents would not be a possible choice since several respondents would participate in each interview. To conduct the interview in the home of the interviewer is neither an option; it might put the interviewee in a weak position (Trost, 2010).

According to Kvale (1996), one should interview as many respondents as necessary to find out what one needs to know. In this study, four interviews are believed to be enough, including one pilot interview. The groups are homogenous and further interviews would probably yield little new knowledge. The decision to have interview groups of four participants were made based on Trost's (2010) opinion that a number of five participants is what you can manage to keep track of. The number of four participants instead of five was chosen because of the expected difficulties with the language barrier and cultural differences. The selection of four was also substantiated to create a balance between men and women. A smaller group also allows interaction where everyone is heard. To achieve intimacy between participants and facilitate discussion, students from the same school were chosen.

The choice of one or two interviewers depends on the situation. In this case, two interviewers were preferable since the subject may be perceived as sensitive and culture differences may cause difficulties in understanding one another. Having two interviewers could be seen as a disadvantage and thus could be perceived as power superiority (Trost, 2010). However, since the respondents were twice as many as the interviewers and the interviews were held in their home country the superiority was reduced. They also possessed knowledge that the interviewers would like to receive, which gave them the advantage.

All interviews started with a welcome and a presentation of the researchers and the purpose of the study. Thereafter, the respondents were told that the interview was going to last between one and one-and-a-half hours. They were informed that the interview was going to be recorded and that they would be anonymous to meet the confidentiality requirement[4]. Due to the possible language difficulties the importance of speaking loudly and clearly were high-lighted. The respondents were also told that they should ask if there was something they did not understand. They were asked to leave their e-mail addresses to make it possible to contact them later. The ability to get in touch with the respondents after the interview is crucial in order to avoid any misunderstandings in the analysis process. During the interview, the respondents were served refreshments to create a friendly and relaxed atmosphere.

[4] According to the confidentiality requirement it is not allowed to disclose personal information about the respondents to third parties and the report should be done in ways that cannot be identified by the individual.

After the introduction, an anonymous questionnaire, (see appendix 1) was handed out to each participant in order to collect personal data with variables such as gender, age and family. Even more extensive questions such as *"Do you know anyone who has passed away as a result of HIV/AIDS?"* were asked. The purpose of the questionnaire was to get to know the respondents, give them a chance to answer some sensitive questions in private and to initiate them into the subject.

5.3.1 Construction of the interview guide

The interview guide is divided into three parts, each covering one of the research questions presented in chapter 3. According to Dalen (2008), the interview guide should be designed with the overarching research questions turned into specific themes with underlying questions, which we also chose to do (see appendix 2). The three parts, followed by suggested questions, became the three topics: *from where, form and content,* and *effects on attitude and behavior.* The questions were expressed in the everyday language of the respondents to avoid misunderstandings. The questions were organized in a sequence that went from general to more private and emotive, which Dalen (2008) considers preferable. How strictly the interview guide was used depended on each interview.

How the initial questions are asked in the interview is crucial for the outcome. If the questions are sensitive, it may be difficult to build the respondents' confidence (Trost, 2010). Therefore the interviews always started with the question,*"Where did do you get your information about HIV/AIDS from?"* It is a brief and simple question and it concerns a concrete situation, which according to Kvale (2007) is preferable.

5.4 Data analysis

All interviews were recorded and during the interview we also observed and noted down the respondents' non verbal communication. Even if the focus was on the recorded material, these impressions could be valuable. The interviews were carefully listened to and the recorded material was transcribed word for word as far as possible. This was a time-consuming process since the respondents' language sometimes was poor and difficult to understand. The information we received was then categorized under the three topics: *from where*, *form and content,* and *effects on behavior and attitude*. Reflections made during the transcription were written down and put between brackets. Noteworthy quotations were written in italics in order to distinguish them from the material. This kind of meta information was valuable in the analyzing process as well as in the results in order to make the respondents come alive and give the reader a more vivid picture of the students' situation.

The pilot interview was valued equally with the remaining material because according to Trost (2010) one should use all material available. There is no need to discard the material if the quality is of good standard. A pilot interview is preferable since it allows the interview guide to be tested. It reveals whether the questions need to be reconsidered or if the structure needs to be rearranged. Another advantage is the opportunity to test the equipment and sound quality of the audio recording. When we tested the equipment the quality of the recording was poor, which made it

difficult for us to hear what the respondents said. Consequently, we could not use that many quotes from that interview in our result. Nevertheless, notes had been taken during the interview which were of sufficient good quality that made it possible to include the interview in our data material.

5.5 Methodological issues

It is necessary to gather sufficient knowledge before entering a field that is different from one's own. A three-day course[5] arranged by SIDA was attended a few weeks before departure, where eventual problems that could arise in the field were discussed. As the study took place in another country with a different culture, several difficulties were faced. Our contact could offer us an insight of the world in which the respondents live.

Having four respondents in each group was optimal, as the group size allowed for all participants to be heard, even though some were more active than others. This phenomenon is difficult to avoid because people are unique, some are more dominating than others. As the group also included both genders, the discussion became dynamic with different point of views arising. HIV/AIDS can be perceived as a sensitive subject which may affect the respondents' input. Whether it would be preferable with respondents of only one gender is uncertain. In this case, the subject did not seem to be taboo since both parts contributed with opinions. The discussion would have probably turned out differently in single gender groups, but that aspect remains for further research.

Another practical aspect was if the sampling method would be valid. Uncertainty arose as to whether the teacher would choose the students considered "most suitable" for the purpose. This would not have been scientifically accurate as it would be a subjective selection. It was necessary to clarify the importance of objectivity to overcome this kind of problem, and a list of requirements was given to the teacher, who then selected the participants randomly.

5.5.1 Communication and cultural difficulties

In a culture that differs from one's own the importance of speaking in the respondent's everyday language is even more vital (Trost, 2010). English is accepted throughout Kenya. Schools, marketing and signs within the community all use English as the primary language. Thus the majority of inhabitants speak English in their daily lives. Nonetheless, it seemed that the respondents had difficulties in understanding parts of what was said during the interview. Several times they asked for repetition and sometimes we were not sure whether they really understood or if they pretended that they did. The respondents took a remarkably long time to complete the questionnaire given in the beginning of the interview, even though it did not contain much text. This caused us to wonder whether the formulation of the questions or the students' perception would generate misleading answers. Language is obviously not the single key to mutual

[5] 1-3 September 2010, Gothenburg

understanding. It becomes clear that cultural differences and interpretations need to be taken into consideration at each stage of the research.

Difficulties in understanding the questions were not only found among the respondents. It was sometimes difficult to see a common thread in their argumentation. When they tried to explain a situation it could take a long time to get to the point. They had a tendency to deviate from the topic, which made it difficult for us to understand. Some of the respondents were also shy and spoke very quietly. This became a problem in the transcription process and made some groups and persons more represented with quotes in the results chapter than others.

Other factors that influenced the communication process are what Shannon and Weaver (1998) call noise. A laptop was used to record the interview and it was situated on the table where everyone could see it. In an environment where high technology equipment is not very common it may cause a barrier between us as interviewers and the respondents. Even the fact that knowing about the recording could influence how the respondents' expressed themselves.

Furthermore, the quality of buildings had an impact on the accuracy of the transcription. In developing countries many houses are defective as noise easily gets through. Small disturbances such as bird singing and people talking outside made a large impact on the sound recording and created difficulties in the transcription. In the interview situations it also attracted the participants' attention and disrupted their focus.

5.5.2 Preconceptions

When entering the field it is important to be aware of our prejudices to reduce the risk of letting false preconceptions affect the results. During our stay we lived close to the inhabitants in the rural area of Voi, Kenya. To increase our understanding of the field we tried to socialize with the inhabitants and took every opportunity to talk to people about HIV/AIDS to see their reaction to the subject to determine whether the subject is seen as taboo or not.

Our contact person in the field, who is a native Kenyan, is aware of the cultural differences between Sweden and Kenya since she has visited Sweden on several ocassions. We had the opportunity to get in contact with her before leaving Sweden to organize our visit. Once we arrived in Kenya she introduced us and answered questions about the African culture and the potential respondents of the study. We tried to adapt to the African culture and learn about the social norms as much as possible. With this knowledge it became easier to conduct the interviews.

6 Results

This chapter is structured to follow our three research questions, which begins with a brief summary of the questionnaire that was handed out during the interviews. Then, what has been said during the group interviews is presented and quotes are highlighted in order to emphasize important views and opinions.

6.1 Questionnaire data

The results of the questionnaire (see appendix 1) show that, according to the ten respondents who ticked this option, television is the medium that most students use at least once a week. Internet is the second most common alternative, with eight users, followed by radio with seven users. Five persons declared that they read a newspaper at least once a week. In response to an individual interview question, "Do you have any family members who have contracted HIV?" the majority of twelve respondents answered "No". In contrast, eleven respondents answered "Yes" to the question "Is there anyone in your family or among your close friends who has passed away as a result of HIV/AIDS?". A conclusion to be drawn is that many seemed to have had close friends who passed away rather than a family member. These results show that the respondents have a connection to the disease, which may have given them awareness about the gravity of the epidemic.

6.2 Where the information comes from

Information about HIV/AIDS comes from various channels, which here follows in no particular order: TV, radio, newspapers, organizations, books, films, musicians, schools, internet, parents, friends, hospitals and churches. All of the respondents say that radio is one of the main sources. Radio has a large coverage since it reaches people in the rural areas and is broadcasted in many tribal languages. Accordingly, the students assume that radio is the most popular medium.

"Most people afford radio, at least in each and every house there is a radio. This communication source is easy to access. It's in a cheaper price than TV and newspapers which are a bit expensive so even in my early life stage I used to listen to radio." (Dickson, 20)

However, Dickson noted a disadvantage with the radio of not always being present when programs are being broadcasted. This problem does not occur in newspapers since you decide when to read. Newspapers use storytelling in their communication in addition to advertisements and informative articles. There is a monthly magazine consisting human interest stories of people who have contracted HIV, which many of the respondents read and find interesting. They also criticize the newspapers' approach to communication for embellishing the HIV/AIDS problem and focussing too much on prevention. The fact that one can continue to live a good life even once you are infected gets highlighted, rather than the negative effects.

"Maybe I've just read in the newspaper that HIV and AIDS is transmitted through this and this and this. But when you get the disease yourself it's not going to be easy." (Beatrice, 24)

Organizations are also mentioned as a main sources of information. They visit schools and public areas, using the same technique as newspapers. Affected persons tell their life story and their experiences of contracting the disease. Red Cross and Aphia 2[6] are the organizations mentioned. This way of spreading information seems to be common and is very appreciated among the students. Christopher says "*Experiences from other people is the best teacher."* Organizations also arrange voluntary seminars and youth groups where students get the opportunity to interact and discuss the problem. An advantage with organizations is their possibility to reach out to rural areas, which few other media can. Organizations are also open to the opportunity of giving feedback.

"To me, I prefer the youth groups. Because you have time to ask questions but in newspapers you can't ask anything. To me I prefer groups, because you can discuss." (Benson, 26)

The schools also have a major role in disseminating information about HIV/AIDS. In primary schools all over Kenya the government have implemented a subject called "life skills" where HIV/AIDS education is included. When we asked where the students heard about HIV/AIDS for the first time, we got two different answers from those who even remembered. They had either got information from their family or they had heard it in primary school. They all agreed that it is good to start educating at an early age.

"Let's say, if you want to teach a dog a skill, teach it when it's small. The same for HIV/AIDS. If you want to learn about it, start from early age." (Brenda, 18)

"According to me I think it's good because nowadays people mature very quickly. So I think it's good that they get introduced to the disease at an early age. So they understand the dangers and be able to control themselves." (David, 23)

Even though everyone thinks it is important to educate children, nonetheless there are some problems. Someone claimed that when the children are too young they do not know how the body system works and that may have an impact on their understanding. Bernard confirms this by the following quote:

"To me I used to hear it but at that time I didn't take much in about HIV/AIDS because I didn't understand much about it. So it was like storytelling to me because I didn't understand what the teacher was talking about, because I was too small." (Bernard, 21)

The Institute of Technology College offers a special class in which everyone is free to join. This class is called social study and teaches social life and current social problems where HIV/AIDS is the major one. The schools also offer counseling for students who have problems or questions. If

[6] AIDS, Population and Help Intergrated Assistance is an organization founded by the United States that seeks to improve the health of Kenyans.

the students want to gather more information on their own, the internet seems to be the main source. They use internet at school and they search for information rather than joining forums and discussion groups. The forums can be a good way for HIV-positives to communicate and to encourage others in the same situation.

When we asked which channel they thought the most effective, two different channels were mentioned. Some thought that educating one another is the most effective way since that provides information from the primary source.

"I think the best way is to train the local people. They go to different areas and spread it, like word-of-mouth. You see, if you are told something from someone you know, you can trust that person." (David, 23)

Others thought that media, especially radio, is the best way since it has a large coverage. One respondent also criticized the person quoted above since she thought that it would feel awkward to have a stranger come knocking at your door. The majority of the respondents think that the information is reliable regardless of its source. Three sources appeared to be most reliable. The first mentioned was the media, such as radio, TV and news papers, because of its coverage.

"In Kenya, the source which people really depend on, which people really trust is the media. The media takes a lot of coverage when they want to educate people." (Charles, 22)

Even parents are seen as one of the most reliable sources because of their responsibility to educate their children. The church is also mentioned since it requires that couples who are about to get married are able to prove their HIV status. This indicates that churches take the disease seriously. The pastor encourages people to talk about HIV/AIDS at the Sunday services. The respondents believe the information to be important and much needed.

Studies based on scientific evidence are another trustworthy source. The students refer to our study and argue that it is reliable since we use them as a source of information: the ones who are most affected by the epidemic. They count themselves as a primary source which they believe is a preferable and reliable way of collecting information.

6.2.1 HIV/AIDS as a topic of conversation

Talking about HIV/AIDS with friends and parents is a controversial topic. Overall, the students do not seem to have a problem to talk with their friends about HIV/AIDS. Factors that may complicate the conversation are if the friend is HIV-positive or not interested in the subject.

"Yes, it's easy, because most of us are confident about it. But I'm sure if it is someone who got the disease it wouldn't be that easy". (Brenda, 18)

"It is easy to talk about when both of you are negative. But if one of you is positive, it's difficult. It's hard." (Benson, 26)

Asking whether they could communicate with their parents about the disease incurred an embarrassing atmosphere. The respondents started to giggle and squirm. They argued that it is

hard to discuss the subject with parents because then you reveal indirectly that you are sexually active. Parents relate HIV to sex. This means that if one can talk to his or her parents about sex, one can also talk about HIV. It depends on how open the relationship is and how strictly the parents hold to the traditions. Some African traditions do not allow talking about topics like HIV/AIDS. According to the tradition, HIV is not a disease, it is a curse.

"Because in African tradition, talking about sex is taboo, it's not good. Although you know that sex is there, but talking about it with children… it's covered, sex is covered. So when you want to talk to someone about HIV/AIDS you have to bring sex in. It's one of the major causes." (Dickson, 20)

Parents can bring up the topic after a Sunday service if the sermon was about HIV/AIDS. It can also be brought up if visiting a friend of the family who is ill or if there is a relative or family member who has died as a result of the disease. If the parents have heard or seen something related to HIV during the day they are more likely to bring up the topic when they come home. Then they will encourage their children to abstain from sex and be careful because they may have seen how someone is suffering. They do not go straight to the point but they advise indirectly.

How willing to talk about the disease depends on the parents' occupation. Cassandra claimed that she had no problems talking to her parents. Christopher had a father who was active in Aphia2 and therefore he had no problem talking about the disease. Everyone was not in agreement:

"Sitting down with your family talking about HIV/AIDS, the first thing is: Why are we even talking about it in the first place? Like one day I told my mum that I wanted to go and do a test at the VCT[7]. She was like; Are you doubting yourself or what? I was like; No, I just want to go and have a test. She was like; Why are you doubting yourself? I was like... and then I've panicked already because she had already installed the fear in me so I would not go." (Brenda, 18)

Charles suggested that it is the children's responsibility to gain knowledge for their own safety. The parents have a major role in educating but it has to be a mutual responsibility. The general view was that parents who are educated are more likely to talk to their children. Parents lacking knowledge usually avoid the topic. Charles and Christopher argued that it would be dangerous if parents refused to talk with their children about the disease:

"According to me, it would be very dangerous. Because they say that a problem shared is half solved. Now, if they decide to keep the disease to themselves, who would be really affected here? It is not them because they already have the information /../" (Charles, 22)

"But also some parents assume that their children are not aware of the disease so they just don't share the information to their children because they say; They are still young, they don't know of these things. So they wait for them to be grown ups, and in the process the children can die because of lack of knowledge. Then it can be too late." (Christopher, 22)

[7] VCT is an organization set by the Kenyan government through the Ministry of Health in order to provide free and voluntary testing, guiding and counseling to the Kenyan inhabitants.

The respondents are aware of the disease and they think that information is easily accessible. Information is everywhere, it is just for one to decide what one wants to take part of. They argue that one cannot hide from the information; wherever you are, the information will reach you. Charles claimed that almost 95% of the population can access the information. This was discussed even in group B:

"Now and then you are learning about it, you are hearing about it, people even perform about it. So it's all around you and it's like a day-to-day routine." (Beatrice, 24)

6.3 What kind of information the students receive

Information about HIV/AIDS is comprehensive. It includes, for example, various ways of getting the disease and how to avoid becoming infected. In many cases, the information is about preventative measures such as using condoms and how they should be used. Even the importance of how to treat an infected person and that you should not discriminate is repeated frequently. A lot of information also encourages people to test themselves. At the VCTs there is information on how to get tested and how the disease spreads. Many sources give guidelines on how to live as an HIV-positive and stay healthy. Even bad examples on how infected people behave are given, such as spreading the disease on to others out of anger.

"There is a story I read in the newspaper. This girl, she was in the university and then she got the disease. When she got the disease she was so angry at herself and the other and the rest so she decided to spread it, and you know she slept with 124 guys in the university she was. She listed a list." (Brenda, 18)

6.3.1 How the information is presented

Some organizations use human interest stories to produce videos with the aim of showing the reality. The students appreciate this form of information because it encourages others infected to accept the disease. The videos also encourage the infected people to take their medicine in order to stay healthy. Organizations also use infotainment[8] where they combine facts with drama. First they act and perform then they present facts in order to educate.

"Back when I was in high school, they used to come and tell you facts. Like one would come herself, her real self and tell you what have happened. And if it's acting in small groups, they would come and act, act, act and finally they would advise. /.../ So it's both forms, facts and acting." (Brenda, 18)

Another form of education often used by organizations is to arrange sport events which open up for interaction. People first participate in the activities and then they receive information. Organizations also encourage people to test themselves by putting up tents in villages where they offer consultation and HIV-testing.

[8] To communicate where a combination between information and entertainment is used.

"… Aphia2 also tent up in certain villages at night and put some music there to attract people and then they preach about testing. People come out, in large numbers, I've seen it. They come out in large numbers and they get tested." (Cassandra, 29)

"*Even during the market days they just set up a tent there and they encourage people to come and do a test."* (Charles, 22)

Aphia2 also arrange seminars where they demonstrate and let the students practise on how to use protections. This is important since lack of knowledge often is a reason why students sometimes perceive the information as frightening. If the message is to use a condom in order to not contract the disease, it becomes obvious that those who do not know how to use it get frightened.

The radio can present information in several different languages, which decreases the risk of language barriers being erected. In rural areas, where everybody does not understand English and Swahili, broadcasting can be in the inhabitants' mother tongue. This is an advantage both according to the different language skills and the problem with illiteracy.

Musicians can present messages through their lyrics and concerts. They, as well as other celebrities, are often seen as role models. What they say and how they act can have a large impact on people. According to Charles, some musicians claim that HIV/AIDS is just like any other disease. It's like malaria and there is no reason to be afraid. Not all students agreed that artists are inspiring role models:

"According to my opinion, these artists are talking about something good but again the way they dress, they're half naked. These local artists we have, sometimes they... in their songs they talk about AIDS, and their songs are educating but their concerts are very dirty. They talk about AIDS but they are half naked. So instead of concentrating on what he or she is saying, you get distracted." (David, 23)

6.3.2 Messages that are being used

Many different messages appear in the information process about HIV/AIDS. One of the first messages mentioned was:

"It's there, it's real, it can happen to anybody at any age." (Brenda, 18)

However, the most common message includes the ABC-concept[9]: Abstain, Be faithful, use Condoms. It is used as guidance, in order to prevent people from getting infected. Every group returned to this concept several times in various contexts. When we asked what they could do to stay healthy and prevent HIV/AIDS from spreading we received answers such as:

"Through abstaining and if one must have sex, you use the… protective… condoms that is (giggles). And have one partner, be faithful and avoid from being a drug addict. Because sometimes when you are a drug addict you must taking drugs and you are making bad decisions." (David, 23)

[9] ABC is a model for preventing AIDS/HIV A - abstinence or deferred sexual inception, B - for be faithful or partner reduction, and C - condom use.

Other measures mentioned was to openly discuss the disease, visit the clinics to get tested every three months and avoid sharp objects. They also argued that it is important to take part of the information available, in order to remain safe and create awareness. In every situation one should act responsibly and carefully.

"If one thinks that abstaining is difficult, I would encourage these that any time you feel like having an intercourse just take that responsibility of yourself. What are the consequences? First of all, you have to focus on you, the present of you, just focus ahead, on the consequences, before getting into an act. I think that one could easily reduce the risk." (Charles, 22).

Many messages highlight the importance of knowing one's HIV-status in order to get the right treatment and prevent the disease from spreading. If one is infected the respondents suggest that one should learn to live positively, visit the doctor regularly and take the medication required. It is preferable both for oneself and for others to admit the fact that one is infected and inform others.

6.3.3 Adapting the message to the target group

All interview groups had different opinions on whether the message is adapted according to the target group or not. Group A thought that when the message is directed toward adolescents it mainly encourages the of use condoms, whereas when directed toward married couples the importance of being faithful gets highlighted. Group B thought that it is the same sort of information but that the performance differs. When educating children it is common to use drama, while grown ups are being told the reality. Group C believed that the information is the same regardless of target group, as Cassandra expresses it: *"They preach the same gospel."* Even group D thought that the information is the same but that different terms are used according to the target groups.

6.4 How the information affects attitudes and behavior

A general perception among the students was that once you know how the disease is transmitted you change your behavior to avoid getting infected. The students in group C explained that the information made them act more responsibly. Even though they know that sex is the main source of contraction, they avoid sharing sharp objects with others in order to reduce the risk of infection via blood. Information about the means of transmission has made an impact on several students. A respondent in group D admits:

"The information I have, give me a great change. Because initially, I didn't even greet someone who was positive. I was afraid of shaking hands with that person because it could increase the chances to get the disease. But now that I have knowledge, I know in which way it is transmitted. And it has nothing to do with greeting, sharing things. So at least I can say that it has really changed me." (David, 23)

Every group has become aware of the risks and can relate to Benson's comment that *"what happens to others can also happen to me"*. This claim also appeared in the discussion of group A where they argued that HIV/AIDS can happen to anybody. In this group, they all agreed that the information creates fear, especially when it comes to sex. Expressions like "constant fear" and

"afraid" permeated throughout this interview. The feeling of fear was also found in group D where they meant that if someone tells you that you are going to die then you become scared, so naturally people fear HIV/AIDS because they fear death. A respondent claimed that the information he received has changed his behavior:

"I used to do sex without using condoms but like now I even don't want to do sex anymore." (David, 23)

"My attitude has become more strong, like we talk about to abstaining, I've found more reason to abstain. I think that's the best thing." (Dickson, 20)

Another student in the same group also believed that the information changed her behavior. She meant that drinking alcohol could lead to misbehavior. If you are drunk, you can't control yourself and may engage in unprotected intercourse which could lead to HIV/AIDS. Because of this she is about to give up alcohol.

It is not only the behavior that has been affected by the information but also the students' attitudes. They have learned how to treat people living with the disease and that they should not ignore them. Group B reveals that when HIV/AIDS was new, people used to fear and stigmatize the person with the disease. Therefore they think it is important to educate people so that one can help instead of reject. They claim that the situation has changed now when people have knowledge. Despite this, all the groups agreed that it is still a common problem even though the stigmatization has been reduced.

"I think so because I've gone on several counseling and they try to educate the way we can live better with this people who have the disease. It's said that stigmatization kills most of them HIV positive. So we are taught to accept them, because it is hard for them to live by themselves. The man is not an island but a social being he needs others to be with. So if you run away from the person it is hard for that individual to corporate. I've been taught and all my acting has been changed." (Dickson, 20)

The person quoted also claims that the information has made him aware that it is not only the disease itself that leads to death but also the stigmatization. HIV-positives may get rejected from society, have difficulties finding a job and can even be excluded from their families. To avoid this the respondent has changed his attitudes, now he tries to be more friendly to people infected.

6.4.1 Concerns about the future

When we asked if the respondents worried about their future, three out of four groups answered yes. The main reason is the difficulties in trusting someone. One can never know if one's partner is faithful. This can lead to an innocent person contracting the disease unknowingly. In Kenya, it is common to have long distance relationships because it is hard to find a job. Therefore the students argue that the temptation can be strong while being away from each other during a long period. Even the fact that the disease is not only transmitted through sex but also sharp objects and accidents, worries some of the respondents. Many of the female respondents also mentioned the risk of getting infected through rapes.

"Yeah, I'm worried because getting HIV/AIDS, it is not something you want personally for yourself. Nobody says: Well I'm just going to get the disease. It does not happen like that. Things happen, you might be raped and you get the disease, you may do something and you get the disease /.../ so I'm scared, sure." (Brenda, 18)

Another reason the majority of the students worry about is the lack of respect toward the disease. Several respondents argued that people do not take the disease seriously since they compare HIV to Malaria, claiming that it is just like any other disease. In the interview with group B the discussion about these careless attitudes led the conversation to the problem of prostitution.

"Okay, to me I'm still afraid. Despite that people get knowledge about AIDS, the rate of prostitution is still very high. In fact, it is growing so it is like they don't care. And such behavior accelerates the rate of HIV/AIDS. It is very dangerous, people they don't care. People say that, after all, we are all going to die. No one is going to live forever. So AIDS is just like a shortcut to death." (Benson, 26)

The only group that did not worry was group C. The students argued that there is no need to be afraid because there are ways of fighting the disease. They all have hope about the future. Christopher believed that the number of those infected is about to decrease. Charles was hoping for a generation free of HIV/AIDS and Christina put her trust in the scientists to come up with a cure. Among the groups that were worried about their future, only one person was of another opinion. He suggested that the information he had received was enough to make him feel safe.

"I'm not scared that I one day, one time might be one of those who are called HIV positive (embarrassed giggle). I'll just make sure that I do the right thing when I'm supposed to do it - protect myself. And now that I know that AIDS is transmitted through sex and also if you go to the hospital and get treated by some objects that are not sterilized. So unless such a thing happen I think I'm safe personally because I have the information that I need." (Dickson, 20)

6.4.2 How life would change if contracting HIV/AIDS

If the respondents would contract the disease themselves, they all agreed on the importance of accepting and trying to live positively. Two quotes illustrate this: *"Once you accept, you will survive*." (Abel, 26) *"If I don't accept, it won't take long for me to die*." (Bernard, 21). However, the majority mentioned that it would not be easy to accept in real life, but they would do their best. Christopher worries about his dream of becoming a doctor. He says that his dreams would be shuttered but he would still continue to study. Cassandra, on the other hand, does not see any obstacles and is determinded to live positively:

"Let's say, for example, I contract the disease. I would not die heart, in fact I'll keep on going as in taking the drugs, live positively, preach and also encourage myself to come out as an example: Now, I got the disease but that's not the end of me, I'm determined to go further. So I live positively and encourage others to live a good life so that they wouldn't get infected by the disease." (Cassandra, 29)

In the same group, Christina gave her opinion on how the disease could cause problems for her to start a family. She was concerned of spreading the disease and if infected, she would not have any offspring. Angela said that it would be very stressful to live with HIV. She meant that society

would assume that she has a bad behavior. Abel told us that in his village an infected person is called the *walking death*. It is based on the assumption that the person will die in the near future.

Beatrice and Brenda suggest that it would be easier to accept the disease if you are married because then you can blame your husband. If you can blame someone else people would have a deeper understanding.

The difficulties in accepting the disease is not only about the disease itself but also the embarrassment and stigma that it generates. Having to tell family and friends that you are infected is seen as the most shameful action that comes with the disease. The family would be disappointed and in some cases even reject that family member. It would be costly because the treatment is expensive and it can become a big burden to take care of people who are HIV-positive.

"My family would be so embarrassed and so disappointed. What you have achieved in your life would mean nothing. Nobody values you anymore." (Beatrice, 24)

"You're not like a normal human being." (Brenda, 18)

Some friends would accept it and be there to support the HIV-positive, while others would turn their back. The respondents avoid the sick person mainly because they do not want to be associated with them, not because they are afraid of contracting the disease. All the respondents agree that friendships could change and become more superficial. They also worry about what is being said behind their back. This would lead to a more lonely life. As Benson and Brenda express it:

"It's like psychological torture." (Benson, 26)

"Despite them behaving good, they still talk behind your back. When you're there they act very good but when you're gone... if you just happen to listen you'll be sure. But they don't show it." (Brenda, 18)

The following discussion between the respondents in group D summarizes difficulties in accepting the disease:

"You get information that you should live close to the positive but it is hard for both to accept. It is hard, you can't even accept that you're positive, it is so hard for you to accept it and it is also hard for people to accept you." (Diana, 20)

"It becomes hard to continue living especially if you're married and want to have a child. It becomes scary, what will happen?" (Deborah, 19)

"I think it is quite hard because a few incidents which I've seen of neglecting people who are HIV-positive. /.../ If I get the result that I have the disease although personal I would accept it but the environment like my friends and family members and other people would stigmatize and point at you and say that: There is the one who is infected." (Dickson, 20)

How people would look at you when infected was also discussed in group C. Cassandra expressed it like this: *"We are like books, we are being read."* This means that the way you live your life has a large impact on how other people see you.

"If you live your life carelessly then they say they can throw hands to you: Now he or she has got the disease, it's what he or she was looking for. But if you live carefully as in all the time maybe you go to church, you live okay, you have one partner and they always see you with one partner. They say maybe: I'm so sorry she contracted the disease, it could not be through sex, maybe through some other ways." (Cassandra, 29)

6.4.3 The connection between HIV/AIDS and bad behavior

When we asked if they connect HIV/AIDS with bad behavior, the majority answered that they do. With bad behavior the respondents mean a reckless lifestyle which includes drinking alcohol and taking drugs.

"A drinking person is always careless. He or she doesn't have the sense of thinking clearly because the alcohol is taking all control over him or her. /…/Bad behavior and the disease does somehow link." (Charles, 22)

"Yeah they link. According to the statistics, those people who take drugs they get infected more than those who don't take." (Christopher, 22)

Even Beatrice argues that people will be judged by their behavior, especially by the way they behaved before contracting the disease. If the person used to go out to clubs and have many partners, it is easy to work out how the disease got transmitted and thus judge that person. Cassandra, on the other hand, meant that it is unfair to judge a person without knowing how he or she got infected. *"It goes 50/50 yes. Some bad behavior, some they can get it through any other but from sex.".* Even Dickson shared this opinion but the others in group D disagreed on whether the disease is connected with bad behavior or not and a discussion between Diana and David arose:

"I don't agree. What if you are raped and you get HIV? It is not bad behavior, is it?" (Diana, 20)

"If you have many sex partners, you see, that one is a bad behavior." (David, 23)

"Having sex? Having sex is not a bad behavior!" (Diana, 20)

"But to several people, you see, it sounds bad. At least if you have one today, one tomorrow and this one another day and you know, some people can even have sex with two or three at the same time. You don't know who is infected." (David, 23)

Several students also connect HIV/AIDS with prostitution. This became very clear in the interview with group A. Even though we questioned the respondents' attitudes toward prostitutes they claimed that they know that the disease can be transmitted through other ways, the attitudes were still there. Some other respondents argued that there is a connection between HIV/AIDS and prostitution, especially among people in rural areas. They believe it is due to lack of knowledge.

6.4.4 Attitudes toward an infected friend

When we asked how they would react if one of their friends got infected it seemed that they had all been taught that they should not discriminate against infected people. The majority argued that they would encourage the friend to live positively, give advice and support. They mean that AIDS is not the end of life, there is still hope for living. Benson summarizes these opinions very clearly:

"To me I would just advise him or her and try to even give him more hope. You know when you get the disease it is not the end of everything. There are drugs nowadays that you can live more than 30 years so AIDS doesn't mean that it is the end of everything. You can still live confidently." (Benson, 26)

All respondents agree that they would continue to stay friends even if their friend got infected. They do not see a reason to isolate an infected person since it is like telling someone that they aren't fit to be with them. Cassandra said *"You do to others what you want to be done to you."* To stay friends is not as easy for everyone. Brenda told us that her first reaction would be anger and then she would be able to offer support and comfort. She would be angry because *"she is my friend, she is not supposed to be doing such things."*

Even though it is obvious for everyone to remain friends if someone becomes infected, some of them would be scared of the rumours that may arise. They believe that if they socialize with an HIV-positive person, people may think that the disease involves both of them. Diana claims that she would accept the disease but the friendship would never be the same. It is not just the rumors that worries them, but also the fear of becoming infected. As mentioned earlier, the respondents can sometimes be afraid of sharing things:

"To some extent you are so scared. If he uses your spoon I'm sure you will first rush and wash the spoon before you use it. Though you are told you can share, it's not dangerous. But you are still afraid, it's nature." (Brenda, 18)

To end the friendship is not an alternative for any of the respondents even though it would be shocking at first for some of them and some would still fear the disease. In the end, there is not much difference between those who are infected and those who are not. Christopher made the following comment showing that AIDS would not be a hindrance in his friendships:

"If a person is infected and it's my closest friend, what I can say is that I would just continue encourage him. The fun that we used to have, everything that we used to share, if possible, you can just even double it to make him or her feel better, so that, the friendship is still strong." (Christopher, 22)

The respondents agree that the information has the power to change HIV/AIDS attitudes for the better. They believe that there is hope for the future and that AIDS is not the end of life, it would not stop you from dreaming.

7 Theoretical analysis

In this chapter we reflect upon the channels which the students receive their information, how they experience the information and if they are concerned about the risks of getting infected. Their attitudes toward infected people and how they would react if they contracted the disease themselves will also be analyzed.

7.1 Communication channels

The students stated that there are three main sources of information: radio, schools and organizations. These sources all have advantages and disadvantages from a communication theoretical point of view. In Shannon and Weaver's (1998) communication model, noise plays an important role. In a communication process where the radio is the sender it is possible to distinguish a clear and distinctive noise. One of the students highlighted the problem with the receiver not being present when the important message is being sent. The radio is a medium that does not always have the receiver's full attention since the receiver can choose when to listen. The effectiveness of this source depends on the receiver's own selective process. On the other hand, radio can reach a large audience and be broadcasted in different tribal languages. The radio is less effective because it does not provide for feedback. If the receiver is unable to express reactions it can lead to frustration which contributes to so much noise that the message disappears (Fiske, 2009).

Newcomb includes feedback as an important part of his symmetry model. He claims that interaction between human beings is of great value, which makes us believe schools and organizations to be preferable sources. In this communication model, the receiver has a good opportunity to ask questions and participate in the process. It is of importance to have a balance between both parts so that the receiver is encouraged to participate. According to Newcomb, it is crucial that the sender and the receiver have similar attitudes toward the topic, in this case HIV/AIDS (Fiske, 2009). When a student is able to openly discuss the issue with a teacher or an organization, an opportunity for both parts to reach an equal level of mutual understanding is created. Students will gain a deeper knowledge of the subject and thus respect the disease and its consequences. Open discussions can also be disadvantageous for those who are shy or worried. Such individuals may avoid circumstances where interaction is included. They may prefer TV, radio or private counseling rather than verbal communication in group settings (Ruben & Stewart 1998).

7.2 Relating to the information

Information about HIV/AIDS becomes more effective if it exists in a reality that is shared by both the receiver and the sender. Schramm suggests that only what is shared within the experience field of both parts is actually communicated (Severin & Tankard, 2010). The problem with HIV/AIDS has to be a part of the students' experience field otherwise they will find no

reason to access the information. For example, the information would not have the same impact among students in Sweden since the problem is not as severe there. The problem also has to be a part of the sender's experience field. It would not have the same impact on the students in Kenya if a Swedish organization would come to inform about HIV/AIDS. This example is supported by Aristotle's arguments about the significance of the social context in which the communication takes place (Angelöw & Jonsson 1990). One conclusion Aristotle made was that the similarity between the sender and the receiver are of importance for its credibility. People attend to, and devote effort, to understanding and remembering messages which they think will be needed or useful (Ruben & Stewart 1998). Even the receiver's basic needs have an impact on the reception of messages. When our needs are not met they will influence the way we choose to receive information. The reality for the students we have interviewed in Voi is that HIV/AIDS is a part of their social environment. Several of them admitted that they had a loved one who passed away as a result of the disease. The disease exists within their experience field and affects them daily.

The results show that the students prefer information sources that allow interpersonal communication. They mentioned seminars which encourage interaction, infected people who come and tell their life stories and local people who are trained in spreading information. This is consistent with Newcomb's symmetry model since it emphasizes the interpersonal communication (Fiske, 2009). The sender and the receiver are equally involved in the communication process and HIV/AIDS is part of their social environment. This increases the credibility of the sender. We believe it is important that the source is perceived as credible because it increases the possibilities for attitude change. You do not change your behavior or attitude if you do not trust the source.

In one group where trustworthy sources were discussed, musicians got mentioned. Some of them even had musicians as role models. This was interesting as the musicians' behavior do not always match their attitudes. One student explained that their lyrics are about abstaining yet they dress in provocative clothes and tempt their audience. Here we see clear contradictions between attitudes and behavior. As Angelöw and Jonsson (1990) explain it: What a person says is one thing, how he behaves is another. This may influence the students in a negative way since they can get confused by these ambiguous messages. Musicians may not always be aware of the great influence they have over their audience.

According to Lasswell, the sender always aims to influence the receiver (Severn & Tankard, 2010). When it comes to information about HIV/AIDS it is of great importance to create a reaction and a change of attitudes and behavior among the receivers in order to impede the disease from spreading. Lasswell's communication model emphasizes that the message should lead to a desired effect. In this case, it is obvious that the information has made an impact on the students. In the previous chapter, we presented several changes in the students' attitudes and behavior. Shannon & Weaver's (1998) identified effectiveness problem measures how effectively the received meaning affect the behavior in the desired way. Since this study focuses on the receivers' perspective, it is impossible to know the sender's desired effect. Despite this, we believe that most of the changes we have seen are positive and satisfy the sender's aim. For example,

Charles who were very aware of the consequences claimed that it is necessary to think about the consequenses before you act.

7.3 Responsibility and visions

Severin and Tankard (2010) explain that attitudes are often thought of as having three components. The first is the affective component which relates to the feelings and emotions we have toward an object. As mentioned in the previous chapter, the majority were worried about their future for various reasons. Even though the students have received the same information, its impact differs. For example, the information about how the disease spreads has made some of them more afraid and some more calm. The former group claims that they are afraid because they cannot feel safe when knowing that they can catch the disease in so many ways. The others argue that knowledge about how the disease is transmitted only makes you aware of the risks and makes you behave more carefully. We find these views to counter each other and start to wonder what it could be due to. In the book Human Behavior (Ruben & Stewart, 1998), our level of intelligence and experiences of the topic are factors that determine how we are affected by the message. We also believe that one's background, social environment and family have an additional impact. According to Ruben and Stewart, children are highly dependent on the needs, wants and desires of their parents. We could conclude that those who grew up in a family where HIV/AIDS was openly discussed and where parents had good knowledge about the disease were those who are less afraid. The results from both the interviews and the questionnaire showed that the ones who had well educated parents were more likely to discuss HIV/AIDS with them. If a person, on the other hand, grew up in an environment where sex was taboo or had seen how infected people have been mistreated, it is more likely for him or her to fear the disease.

The social psychological behavioral component refers to our tendency to act in a certain way in relation to the current situation or person (Severin and Tankard, 2010). When we asked the students how they should act to avoid getting the disease it seemed that the ABC model had been well implemented among them since it got mentioned in every group. To follow the ABC model seemed obvious to all of them. It almost sounded too good to be true when everyone so confidently argued about the importance of abstinence, being faithful and using condoms. We wonder how well they act according to these attitudes in real life. It is easy to say how one should behave but when it comes to you it is not that easy. There are a number of reasons why our behavior does not always reflect our attitudes. Social norms can have an influence on the connection between attitudes and behavior according to Sanderson (2010). For example, if a person has a long distance relationship, he may be exposed to many temptations during the time he is away from his wife, thus breaking his vow of fidelity. According to the students, unfortunately this occurs very often. Angelöw and Jonsson (1990) explain that we are often put in situations where it can be difficult to live up to our attitudes. They mention time constraints and material comfort as decisive factors. For these students, material comfort may signify the availability of condoms. For many people in Kenya, sex is taboo, which makes it embarrassing for adolescents to buy condoms. One may have the attitude that it is important to use condoms when engaging in intercourse but when it comes down to it one may not have a condom and is

too excited to be able to refrain. Sex, according to Maslow (2000), is one of our basic needs, which makes it difficult to abstain from.

The third component which is included within the attitude conception is the cognitive component. It deals with the beliefs and the ideas we have about a particular object, situation or individual (Severin & Tankard, 2010). We believe that the students' thoughts about how their life would change if they got infected, belongs to this component. As reported in the results, all the students agreed on the importance of accepting the disease and trying to live positively. The majority argued that HIV is not the end of life, but even in this context we could discern contradictions. When we asked group B how it would be if they got infected, Brenda started to laugh and claimed that she would not be able to live, that it would be a shock and that she would die, the sooner the better. It seemed as if she became very uncomfortable with the situation and tried to get away by laughing. However, later in the interview, she clearly agreed with the statement that HIV is not the end of life. We believe that when she realized that the other students' did not share her attitudes, she changed them in order to reduce the dissonance. Brenda strives for a cognitive balance and tries to adapt to the values of the group (Sanderson, 2010).

The majority worry about the future, and they all share the attitude that they would accept it and try to live positively if they became infected. Despite this, we believe that if one of the students actually would become infected it may be difficult to behave according to one's attitudes. If you realize that it is too hard to accept and live positively, there is a great risk of cognitive dissonance. Then it is desirable to reduce the dissonance and ensure both for you and for others that your attitude and behavior correspond. In order to do this, you may change your previous attitudes to adapt them to the new situation (Angelöw and Jonsson 1990).

7.4 Social aspects

As the results show, all the interviewed students would have a positive attitude toward a friend who is infected. They mentioned several ways of how they would support and accept the person. We perceived them as eager to appear intelligent and aware, but we question whether they could follow these attitudes if one of their closest friends became infected. Other contexts reveal their attitudes about the severity of the disease and how much it would affect their lives. This makes us doubt how they would behave in a real situation. According to Angelöw and Jonsson (1990), a reason for why attitudes and behavior do not always correspond is if they are not investigated simultaneously. We examine the attitudes that exist in the current situation but they might change over time, for instance, when a close friend gets infected the students are put into a position that may contribute to a discrepancy between their attitude and actual behavior. They may become unable to act according to their attitudes since their reaction can be different from what they first expected.

The majority associate HIV/AIDS with bad behavior and argue that a person's behavior determines the attitudes toward him or her. As Cassandra said in the previous chapter, it is easier to accept a person with good behavior than someone who acts recklessly. This made us reflect on the importance of knowing *how* a person has caught the disease. If a friend got infected through unprotected sex, it seemed that the students would judge her harder than if she got the disease

through a blood transfusion. There is an underlying belief that a person with bad behavior may blame himself/herself if he/she contracts the disease. This contradicts what is stated above, that all students would have a positive attitude to an infected friend. If we read between the lines, there are other factors that have a major role in which attitudes one has toward an infected friend. How the person behaves, both before and after becoming infected, has a large impact on people's attitudes toward him. Even Angelöw and Jonsson (1990) discuss the way we judge people. They claim that the attitudes expressed, in particular, the actual behavior, determines how other people would look at you. We believe that this is a problem which is difficult to get around. We act on impulse in unexpected and sudden situations and do not always have time to think about our values and attitudes before we act. The attitudes that characterize the way we live are difficult to change because some of them are deeply imprinted. Even prejudices we have against people lead us to make judgments because of their behavior (Ruben and Stewart 1998). The prejudices against prostitutes are an example of this phenomenon. The interview with group A revealed that they associate HIV with prostitution even if they know that it is not only spread through sexual intercourse. It can thus be suggested that prejudices sometimes have a larger impact on our attitudes than knowledge.

Many of the female respondents thought it would be easier both for them and for others to accept the disease if you are married because then you can blame your husband. It seems that the students would have a deeper understanding of the person infected, and almost believe her to be innocent, if one could blame the disease on someone else. This argument is inconsistent with what they have said in other contexts. Earlier they claimed that if they themselves or a friend would become infected, they would accept the disease and be supportive. If this is something they truly believe in, then there is no need to lay blame on someone else.

All the arguments above belong to the behavioral component since they all describe how the students would act in different situations (Severin and Tankard, 2010). We get the feeling that the students share views which project a positive image of them. They tell us how they wish they would act rather than how they believe they would act in a real situation. We understand that the students do not always speculate honestly or admit their shortcomings. As self-esteem, confidence and respect of others are included in human being's basic needs we can understand their way of reasoning (Maslow, 2000).

Behind the students' positive attitudes toward the disease we can discern a feeling of fear. This feeling is related to the affective component since it describes the students' emotions toward the disease (Severin and Tankard, 2010). During the interview with group B, Brenda told us that she is afraid of sharing a spoon with someone who is infected. She admitted that even if she has the knowledge about how the disease is spread she is still afraid of sharing things, a feeling that she cannot deny. We believe that this phenomenon occurs in several situations where the students are torn between their attitudes and their actual behavior. The majority claimed that the reason for not socializing with an infected friend is not because they fear to be infected but because of the rumors that may circulate among friends speculating about whether the disease includes them both. They also fear that their family would turn their back on them, which we believe would be very devastating since one's family and relatives are of high importance in the African culture.

Dependency is high from both a social and economic perspective. Circumstances such as poverty and limited access to medicine complicate the possibility to survive on one's own. Safety is also a part of humans' basic needs where family, health and property are of high value (Maslow, 2000).

8 Discussion and conclusions

In this chapter we let our own thoughts permeate and seek connections to previous research. We will also reflect on how our study will be a part of the ongoing theoretical discourse. Finally, we are giving recommendations for furher research.

Our respondents' main source of information about HIV/AIDS seems to be media, schools and organizations. When talking about media, radio is mentioned as the biggest source. It is also mentioned as one of the most preferable since it has large coverage and reaches people in the villages and can be broadcasted in different mother tongues. Channels with other advantages are those which use infotainment and opens up for interaction. We think that organizations play an important role here; all interview groups count organizations as a primary source of information. The way they inform by using entertainment to draw attention, sport events to create engagement and seminars where HIV-infected tell their life stories seems like a winning concept. The students' opinions show that the guidelines of the Rockerfeller Foundation, mentioned in chapter 2.3, have been implemented in these students' social environment. One of the guidelines claimed that there needs to be *a shift from teaching people about HIV/AIDS to peer exchanges and shared learning* and *from a dependence on expert knowledge to integrating expert knowledge with experiential, local or traditional knowledge.* This proves that the shifts were necessary since the students prefer this way of learning.

The Rockerfeller Foundation was also skeptical about outsiders as role models. They claimed that *behavior of insiders, community members or local heroes should be promoted as role models*. We agree with this opinion and we believe that even the students do, to some extent. During the interviews, they gave many examples of people in their hometowns that had openly admitted the disease, which seemed to impress them; although there is a problem with the choice of role models that is difficult to get around. You cannot control which person someone will look up to, it is for the individual to decide.

The information the students receive is mainly about how to prevent oneself from becoming infected. Every group mentioned the ABC model and was aware of its meaning. We do see tendencies that the information is about to focus even more on learning how to live positively when infected and how to treat others who are infected, in order to reduce stigmatization. Even though the students know how the disease spreads, they are still afraid of shaking hands and sharing objects. They are afraid to get tested because they fear the results. One of the respondents chose to abstain from sex completely, another quit drinking alcohol. The fear shines through the interviews even though they try to keep up a positive spirit. We do not think that this fear is due to lack of knowledge among our respondents, but rather because of lack of knowledge among the society. There is a fear of being ostracized from society and becoming a burden to one's family and friends. The fear is justified since the respondents have seen this happen to other people. They have seen how HIV-positive people are treated by their friends and family and how they are excluded from society. The anxiety about what other people would say and think shows that the

students are more concerned with short term consequences than long term, which strengthens the results of the study Sanderson (2010) refers to.

HIV/AIDS has long been associated with high-risk groups, such as prostitutes. According to previous research (Akwara et.al 2003), this association might lead to people tending to discount their own risk because they do not identify with these groups. We do not find this phenomenon among our respondents, who seem to be well aware of the risks. Brenda's comment: *"It's there, it's real, it can happen to anybody at any age"* shows an awareness which we thought many of the respondents possessed.

This awareness has been developed as a result of the information the students have received. Many claimed that without that information, they would act differently. David admitted that he used to have unprotected sex, but when he got more knowledge he chose to abstain. Dickson has found more reasons to abstain and his attitude toward abstaining has become stronger. Charles has become aware of the consequences and argues that one has to take responsibility of one's actions. Our results show that the information has made an impact on the students, both on their attitudes and behavior, although some have been more affected than others. It was also clear that their background had made an impact on their attitudes and level of knowledge. We could see that students with well educated parents were more likely to have a deeper knowledge and the ones who had a close relationship to someone infected were more likely to have a positive attitude.

Even if the students have the knowledge, they are still afraid. They try to mitigate their concerns by claiming that HIV is not that dangerous. Life goes on and there is treatment and medication that helps you continuing living. They claim that they are not afraid of the disease but throughout every interview we could see tendencies that indicated a fear among them. The information is not presented through fear appeal but as Dickson said, if someone receives information declaring that HIV/AIDS will lead to death, people become afraid because naturally everybody fears death. In some interviews, there was a brief silence when we asked questions regarding their concerns about becoming infected and how it would affect their lives. This reaction is justified since HIV/AIDS is so close to their social environment. They have no choice but adapt to their life situation and try their best to have a positive attitude toward the disease.

8.1 Further research

The outcome of our study may contribute to a development of the HIV/AIDS communication process. It can be valuable for several interest groups in order to reach out with messages that intends to create a change in attitudes and behavior. The result show how the students perceive information about HIV/AIDS and their feelings toward the disease. To be able to reach out with a message, it is of high importance to understand the target group, which our study facilitates.

With our study as a base, it would be interesting to investigate the entire communication process including the sender. This would allow the possibility to see the sender's desired effect with a message and if it gets satisfied. It would also give an insight of what kind of information the different senders convey and what kind of noise that have an impact on the message. This study

would contribute to a deeper understanding of the entire communication process and outline weakenesses which can be improved.

In our study we have not considered whether our respondents were infected with HIV/AIDS at the time of the interviews. In our investigation this was not crucial. If only infected people would participate in a similar research, another angle could be viewed. It would outline an infected person's view of the information received and channels that are used. A study like this would make it possible to see how the infected people perceive the society's attitude towards them which would be valuable in order to reduce stigmatization. It would be a study of a more social psychological approach.

In the result of this study the respondents argue that it is of importance to start implement knowledge about HIV/AIDS in early ages. The respondents in this study was students on College but it would be interesting to apply the same study on younger persons to see what kind of information they receive and if they find information about HIV/AIDS relevant.

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9.4 Verbal source

Manase Mkofira, pastor and coordinator Bogesunds house, Voi Lutheran mission. 31-10-10

10 Appendices

10.1 Questionnaire

Female ☐ **Male** ☐

Age: _____

What year did you start college: _____

Do you stay on campus: Yes No

Hometown: _____

Religion: _____

How many siblings do you have: _____

What does your parents work with: _____

1. Tick the alternatives below that you use at least once a week:

Radio TV Internet News papers

2. How do you rate your knowledge about HIV/AIDS?

	1	2	3	4	5
Very little					Very good

3. Do you have any family members who have been transmitted by HIV?

Yes No

4. Is there anyone in your family or among your close friends who has passed away as a result of HIV/AIDS?

Yes No

10.2 Interview guide

From where

Where does the information that these young people has received come from?

Where have you heard about HIV/AIDS?
(radio, TV, internet, news papers, teachers, medical staff, parents, siblings, friends)

What do you think about the quality of the information? Where do you get the most reliable/less reliable information?

When did you *first* hear about HIV/AIDS?

Do you talk about HIV/AIDS with your parents and friends?
(*peer education)*

Are you looking for information about HIV/AIDS on your own?

Form and Content

What kind of information have they received?

What does the information look like? How is the information presented?
(practical activities or just theoretical?)

What is the information about? Is it information that you can relate to?
(*is abstinence advocated*, condom use etc.)

What are the most important messages in the information about HIV/AIDS?

How can you, according to the information, stop the disease from spreading?

What do you do with the information

In what way do they think the information affects their attitudes and behavior?

In what way have you been affected by the information? Do you think differently? Do you behave differently in some way?

How do you feel about the future and the HIV/AIDS situation? Are you worried about your future? (Are *you worried* that you might get infected by HIV, how big do you consider the risk)

If you get HIV/AIDS, in what way would your life change? Do you think the prognosis for individuals with HIV/AIDS is better today than it was ten years ago?

What can you do to stay healthy and prevent HIV/AIDS from spreading?